Accreditation Report

Quality Innovation Performance Accreditation Report

Assessment Details

Health Service Name	Hobart Private Hospital and St Helens Private Hospital
Health Service ID	HP1297
Accreditation Contact	Ms Sharon Groves
Standards	NSQHS Standard Ed 2

Assessors	Mr Anastasios Kambouris Ms Nicole McKenzie Dr Scott Phipps
Date of Assessment	Tuesday, 23 March 2021
Assessment Type	Full Assessment
Assessment Location	Collins Street, Cnr Argyle Street HOBART TAS 7000

Accreditation Status

Accreditation Decision	Accredited
Accreditation Decision Maker	Nicole Paez
Decision Maker Signature	
Date	5 May 2021
Accreditation Period	2 October 2021 – 2 October 2024

This assessment was conducted according to the requirements of the NSQHS Standard Ed 2 and Accreditation Program. The health service is required to maintain compliance with these standards throughout the accredited period.

Foreword

Accreditation is independent recognition that an organisation, practice, service, program or activity meets the requirements of defined criteria or standards. Accreditation provides quality and performance assurance for owners, managers, staff, funding bodies and consumers.

The achievement of accreditation is measured against the sector specific Standards which have been set as the minimum benchmark for quality. Compliance with the Standards is demonstrated through an independent assessment.

Accreditation can help an organisation to:
- Provide independent recognition that the organisation is committed to safety and quality
- Foster a culture of quality
- Provide consumers with confidence
- Build a more efficient organisation using a systematic approach to quality and performance
- Increase capability
- Reduce risk
- Provide a competitive advantage over organisations that are not accredited, and
- Comply with regulatory requirements, where relevant.

Continuous quality improvement (CQI) underpins all AGPAL/QIP accreditation programs and the organisation/practice/service through:
- Looking for ways to improve as an essential activity of everyday practice
- Consistently achieving and maintaining quality care that meets consumer/patient needs
- Monitoring outcomes in consumer/patient care and seeking opportunities to improve both the care and its results.
- Constantly striving for best practice by learning from others to increase the efficiency and effectiveness of processes

The following report is based on an independent assessment of the service's performance against National Safety and Quality Health Service (NSQHS) Standards 2nd Edition . The report includes compliance level ratings for each indicator, criteria and standard and includes explanatory notes for key findings. Where an indicator is not rated as 'met', corrective action is specified.

Assessment Ratings

Four levels of attainment are used consistently throughout this report to give an overall rating for each Standard. The levels of attainment are:
- Met
- Met with recommendations
- Not Met
- Not Applicable

In order to meet accreditation requirements all of the Standards must be rated as met or not applicable.

Executive Summary

Scope of Assessment

The scope of this report and the accreditation is described by the agreed Scope of Assessment and Accreditation Statement signed by the organisation and the Licensed Provider, the central elements of which are set out below.

Service

Hobart Private Hospital and St Helens Private Hospital

Executive Summary

The Hobart Private Hospital (HPH) And St Helen's Private Hospital (SHPH) are two hospitals in Hobart that are owned and operated by Healthscope Limited, being two of the 43 hospitals that the company has in Australia. HPH is co-located with the Royal Hobart Hospital and has 142 inpatient beds along with ten-day procedure beds, offering a range of medical, surgical and obstetric services, as well as a 24-hour emergency department. SHPH is located on a separate site about 20 minutes' walk from HPH. It is predominantly a mental health hospital, with 31 inpatient beds and a full range of day programs. It also has a mother and baby unit of 8 beds to cater for mothers with mental health problems or for babies with simple problems.

Because they have been separate hospitals in the past, there is somewhat of a legacy in the management of the two sites, whereby clinical governance has only recently been combined into one system. HPH provides the space for the leadership team, with the General Manager spending some time each week at SHPH. Whilst some processes are now shared, for instance the Medical Advisory Committee (MAC), others are separate. For instance, staff education is somewhat divided between the two sites.

The assessment team were given full access to both sites, provided with personal security pass-keys, and allowed to conduct the assessment without any restriction as to where or to whom they spoke. Staff guided the team to their various sections but then left the assessors alone to conduct their work. The leadership team was accommodating and facilitated the supply of any and all documents that were requested, including allowing access to sensitive documents. Some issues were raised by an anonymous source late in the assessment period and staff were quick to provide the team with the relevant information. The team were satisfied that the issues raised by this person were adequately managed by the hospital on the evidence provided.

Standard One

The assessors considered that the two hospitals have a clear focus on safety and quality, recognising these activities as essential to their functions. The Healthscope Corporation provides a lot of the framework for the hospitals' activities and the assessors found that there is a robust quality and safety framework and quality plan in place. Across the two hospitals, there was a clear commitment to the principles of continuous quality improvement, including publishing the results widely to all

staff and consumers. There is evidence of the input of local knowledge and needs. However, at the time of the assessment Healthscope had been undertaking a review of the mandatory training requirements, with some surprising omissions recognised by the assessment team. This fact had already been recognised by the corporate office and corrective action was delivered during the assessment. Nevertheless, care is needed to ensure that local needs for education are recognised and met.

Clinical governance has a framework set by the corporate office and there is a system of some ten local governance committees in operation, including medical craft groups. These groups deal with the expected range of clinical governance activities, with support from the corporate office as needed. The problem is that there is a degree of lack of coordination between the groups, plus between the two hospitals, since some matters can cover several areas of the services provided. The result has been that the MAC has been trying to manage to provide this link, but it itself has only been a combined committee for both hospitals for a relatively short time and this is not really its role. There has been recognition of this problem, so a new Clinical Governance Review committee has just been established which should facilitate a better overview of all the problems in both campuses. Similarly, there is no Chief Medical Officer (CMO) role in the local organisation at present. There is a CMO at the corporate level, but that position is likely to be too remote to deal with the simpler, local issues. It is recommended that the HPH/SHPH group consider the appointment of a part-time CMO to complete and strengthen the clinical governance framework.

The assessors detected a range of relatively minor environmental problems, mainly at SHPH, most of which are already known to the leadership team, with corrective actions planned. Nevertheless, the assessors have needed to comment on the matters in the report.

Standard Two

People who choose to identify themselves as of Aboriginal or Torres Strait Islander origin comprise approximately 2% of patients at both sites. Nevertheless, the hospitals have embraced the policies and procedures set by the corporation and are working to create and maintain a welcoming service. There have been contacts created with local indigenous groups and staff have found the education provided to be valuable. Consumer engagement is conducted primarily through consumer advocates in both hospitals. They are frequently onsite and conduct patient surveys, manage feedback and provide advice to the quality team.

Both people have developed a good profile within the hospitals and are well known to staff and patients. There is also a consumer engagement group that has been established, with a plan to expand the number of consumer representatives to six as well as including representatives of the local Aboriginal and Torres Strait Islander groups. It is expected that the consumer advisory group will expand its role to include more representation at the higher governance levels.

Standard Three

The organization has considered their role, responsibility and accountability in the prevention and control of Healthcare Associated Infections (HIA) in reducing the cause of harm, and have also reviewed healthcare associated infections. This has been attributed to the governance of the organisation, risk identification and management, surveillance activities and safety of systems required to meet Standard 3.

The organisation presented evidence which was supported by data that was made transparent and promoted to staff and consumers from all areas of the Infection Prevention and Control Standard. All data reviewed showed continual improvement from past reporting periods. There was no data that informed risk or not met indicators. There were two issues communicated by the organisation which required focused attention over the past couple of years involving post-surgery infection rates and superficial infection rates. The organisation demonstrated the use of the quality framework to ensure these issues were reported, investigated and resolved appropriately.

During the assessment of Standard 3, the team ensured that we observed processes, reviewed documents, interviewed staff and patients and verified all information in relation to the standard and aligning regulation. The standards covered Clinical Governance, Infection Prevention and Control, Re-processing of Re-usable Medical Devices and Antimicrobial Stewardship.

Standard Four

Governance of medication safety and quality at HPH and SHPH is overseen by a Medication Safety Committee, with a Terms of Reference and a set agenda that is aligned with the requirements of the Standard. The Committee is accountable to the Quality and Risk Management Committee and also reports to the Medical Advisory Committee. Membership of the Committee is multidisciplinary and includes senior medical and nursing staff as well as a senior pharmacist who provides expert opinion. Clinical pharmacists also play a critical role in monitoring medication prescribing and administration practices to ensure clinical safety.

Corporate and local medication policy and procedures outline the requirements for each hospital to promote accountable approaches to medication management. HPH and SHPH have a medication audit schedule in place and are required to participate in the biennial Australian Commission for Safety and Quality in Healthcare Hospital Medication Chart Audit. Previous audit results for the period September to October 2020 identified a practice gap in the documentation of medication indications at HPH and SHPH as well as the completion of risk assessments and venous thromboembolism prophylaxis at HPH. A quality improvement plan is in place to address these practice gaps but is not yet complete. This forms the basis of the single ‘met with recommendation’ rating for Standard 4.

The Pharmacy Department is contracted to deliver four in-service topics to nursing staff every three months. Staff are also required to complete mandatory training in medication safety that includes the principles of medication safety, information about common types of medication errors and the management of high-risk medications (as defined by the A PINCH acronym). Mandatory training completion rates are high across both sites in 2020, although it is noted a reduced percentage for period October to December 2020 at HPH as training completion rates have been reset. At interview, clinical staff confirmed that they had received training in incident reporting and felt supported to identify medication errors and near miss events.

Areas for improvement for Standard 4 relate to the implementation of separate adult and paediatric medication charts, additional strategies to reduce noise and other distractions during medication preparation and administration and a consolidated action plan for presentation at the Medication Safety Committee meetings.

Standard Five

The organisation has considered their role, responsibility and accountability to the Comprehensive Care standard providing adequate and comprehensive care to patients. The organisation has demonstrated that they can provide collaborative and continuous care and work in partnership with patients and the responsible person identified, ensuring communication occurs between all involved in the healthcare for the client.

The organisation conducts comprehensive audits, reviewing screening, assessment, care planning and the delivery of care. They work to minimize harm through various initiatives such as reducing fall rates such as “Catch a Falling Star” and pressure injuries. The organisation reviews and assesses clients' pressure injury risk, falls risk, nutrition, cognition and behaviour.

The organisation has proven they can link the Comprehensive Care standard to other standards and have processes to integrate these.

Standard Six

A clinical handover system is in place for the transfer of responsibility and accountability for patient care between clinicians and other staff at HPH and SHPH. In the absence of a Communicating for Safety Committee, oversight of Standard 6 is provided by the Quality and Risk Management Committee and the Senior Nurses' Committee. While the functions of a Standard 6 Committee are adequately addressed, it is likely that clinical governance could be improved with the establishment of a dedicated Communicating for Safety Committee.

A number of policy and procedure documents support clinical handover across HPH and SHPH. This includes a Clinical Handover Framework that outlines the minimum dataset for each type of clinical handover. Structured communication processes ensure that the agreed content is effectively

communicated. Staff use ISBAR for clinical handover and SOAP or SOAPIE for clinical notes. A bedside handover approach is used across both facilities and staff are sensitive to patient, family and carer participation. Observation of clinical handover between nursing staff at HPH and SHPH finds that it was generally well done. Patient boards are well utilised and updated during handover and these provide a snapshot of the patient journey.

The national Healthscope 'Back to Bedside' project has been well received and staff report that this has been associated with improvements in patient-centred and family-centred care. Education on patient identification is provided to all staff on induction and forms part of the student nurse and graduate nurse training program. Participation in shared "learnings" is expected and provides a forum to discuss issues related to communication and clinical handover.

Staffing deficiencies at SHPH pose a risk that critical information will not be handed over between medical staff for patients undergoing Electro-Convulsive Therapy. While there are some risk mitigation strategies in place, plus it is confirmed that the organisation is continuing to try to recruit a position to decrease risk, the risk remains active. In addition, four improvement opportunities have been identified. These relate to the re-establishment of a Standard 6 Committee, the development of a clinical handover matrix and a review of references included in policy and procedure documents to ensure they contain up-to-date and relevant information.

Standard Seven

The use of blood and blood products is mostly an elective procedure within HPH. Overall, the assessors considered that the standard was satisfactorily met, with patient engagement recognised by all as a key responsibility. The occasional urgent use of blood is usually the result of a procedure. The massive transfusion protocol is rarely used but the organisation experienced two occasions in the past twelve months where it was required. These events were used to review and improve the procedures and to develop rapid response kits to smooth the activation of the process. The expected haemovigilance activities are undertaken and the clinicians responsible for ordering blood participate in the reviews of the processes and observe the national guidelines.

Two issues were identified. One was that blood safe training has been reduced from an annual mandatory to a single training on orientation and then only when required if issues occur. The assessors consider that this is not sensible; risk management means identifying a potential problem before it occurs. Since the administration of blood is not a frequent occurrence, maintaining the skill and knowledge is even more important. The second issue is that of clearly identifying, on a patient's record, when a person has stated a refusal to accept blood or blood products. The assessors consider that it is a key responsibility of the hospital to ensure that a patient's express wishes are respected and followed. The suggestion is to place a note on the alert sheet in the patient record.

Standard Eight

A Clinical Deterioration Committee has been established with multidisciplinary membership. The committee meets on a regular basis and has input from senior medical leadership, clinical experts, specialist nurses and education and training staff. Consumer Consultants gather patient experience data including satisfaction and knowledge of the Rapid Call system.

The aim of the Clinical Deterioration Committee is to provide oversight of systems that support recognition and response to acute deterioration, endorse policy and procedure that guide staff in their response, conduct case reviews of incidents with recommended actions and evaluation and ensure a consistent approach to the management of the deteriorating patient. Monitoring and review of the requirements of Standard 8, occurs via clinical incident management reports uploaded to 'Riskman', incident investigation and case reviews conducted by the Clinical Deterioration Committee. There is an audit schedule in place that aligns with the National Standard Audit Schedule, and both hospitals participate in the Australian Council of Healthcare Standards Clinical Indicator Program.

There are a range of policy and procedure documents in place for recognising and responding to acute deterioration. These are comprehensive in nature, use clear and simple language and are designed to support clinical judgement while mandating elements for a process for rapid escalation of care. Resuscitation guidelines included in these documents are in line with the latest version of the Australian and New Zealand Committee on Resuscitation Guidelines (as endorsed by the Australian Resuscitation Council). The Rapid Call system provides a three-step approach to support patients, families and carers to raises concerns if they are worried or feel their feedback has not been acted upon. Of the patients interviewed, all were aware of how to activate the Rapid Response Pathway.

Interviews with clinical and other staff found that a Medical Emergency Team (MET) response can be activated by anyone at either hospital by contacting switchboard on 222 and specifying the location of emergency. Of the staff interviewed, all felt comfortable activating the MET team without necessarily first consulting with senior nursing or medical staff. A review of MET call data over 13 months found they indicated appropriate calls and patient management and suggests a positive reporting culture.

Areas for improvement in Standard 8 relate to the Clinical Deterioration Committee and the creation of a consolidated action list for presentation at each meeting, together with the nominated action owner and date of completion. This would facilitate tracking of actions to completion. A second improvement opportunity is the development of a process to support family presence during cardiopulmonary resuscitation. A third area for improvement is the development of and implementation of a formal ligature and ligature assessment audit tool for use at HPH to ensure that higher risk areas have ligature and ligature points identified and removed where possible. Other improvement opportunities for Standard 8 are included in the body of the report.

Summary of Ratings

Overall Assessment of Standards

	Rating			
Standard	Met	Met with Recommendations	Not Met	Not Applicable
Clinical Governance Standard	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 1.8, 1.9, 1.10, 1.11, 1.12, 1.13, 1.14, 1.15, 1.16, 1.17, 1.18, 1.19, 1.20, 1.21, 1.22, 1.23, 1.24, 1.25, 1.26, 1.27, 1.30, 1.31, 1.32, 1.33	1.28, 1.29		
Partnering with Consumers Standard	2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 2.9, 2.10, 2.11, 2.12, 2.13, 2.14			
Preventing and Controlling Healthcare-Associated Infection Standard	3.1, 3.2, 3.3, 3.4, 3.5, 3.6, 3.7, 3.8, 3.9, 3.10, 3.11, 3.12, 3.13, 3.14, 3.15, 3.16			
Medication Safety Standard	4.1, 4.2, 4.3, 4.4, 4.6, 4.7, 4.8, 4.9, 4.10, 4.11, 4.12, 4.13, 4.14, 4.15	4.5		
Comprehensive Care Standard	5.1, 5.2, 5.3, 5.4, 5.5, 5.6, 5.7, 5.8, 5.9, 5.10, 5.11, 5.12, 5.13, 5.14, 5.15, 5.16, 5.17, 5.18, 5.19, 5.20, 5.21, 5.22, 5.23, 5.24, 5.25, 5.26, 5.27, 5.28, 5.29, 5.30, 5.31, 5.32, 5.33, 5.34, 5.35, 5.36			
Communicating for Safety Standard	6.1, 6.2, 6.3, 6.4, 6.5, 6.6, 6.7, 6.8, 6.9, 6.10, 6.11			
Blood Management Standard	7.1, 7.2, 7.3, 7.4, 7.5, 7.6, 7.7, 7.8, 7.9, 7.10			

Recognising and Responding to Acute Deterioration Standard	8.1, 8.2, 8.3, 8.4, 8.5, 8.6, 8.7, 8.8, 8.9, 8.10, 8.11, 8.12, 8.13			

Corrective Actions (Met with Recommendations Action Items)

Met with Recommendations Action Items

The following corrective actions do not need to be addressed before the health service can achieve accreditation; however, these actions will be reviewed at the health service's next onsite assessment. Met with recommendations cannot be awarded for the same action, for the same reason, in the same location for two consecutive assessment cycles. Should this occur, the action will be rated not met.

Criterion	Recommendations
Clinical performance and effectiveness	Clinical Performance and Effectiveness Documents/Records: 1.28 - Interviews with clinical leads confirmed that the organisation uses benchmarking against other Healthscope hospitals, as well as internal systems for monitoring and improving clinical systems and patient outcomes, by assisting the clinicians to review their practice to recognise risks and address variations in the care provided. The newly established Clinical Governance Review will play a key role in providing feedback and support to clinicians, along with managing the risks associated with clinical care. This role will augment those provided by the medical craft-based committees that share those responsibilities. This is an opportune time to review the overall governance of the two hospitals. Furthermore, the Healthscope corporate documents often refer to a CMO (Chief Medical Officer), in the terms of reference for governance committees. Hobart Private Hospital (HPH) and St Helen's Private Hospital (SHPH) do not have any such position at this time, although it appears that this was the case in the past. It was brought to the attention of the assessors that the leadership team can have difficulties managing the Visiting Medical Officers (VMO's) because some VMO's appear to take the view that they will only listen to advice or constructive criticism from a medical peer. At present, the chair of the MAC has to carry this responsibility, but this is not within the usual responsibilities of the MAC. Whilst it is recognised by the assessors that there is a corporate CMO, that position is remote and unlikely to be familiar with the local operations. It is considered that the two hospitals need to strengthen the governance of clinical outcomes, by considering the appointment of a part-time CMO. An experienced senior clinician, ready to wind down their clinical activities may be a suitable starting point. With the establishment of the new Clinical Governance Review committee, the organisation should review the overall governance of all services to seek improvements and

Criterion	Recommendations
	to streamline activities. The appointment of a Chief Medical Officer would complete the clinical governance.
Safe environment for the delivery of care	Safe Environment, Delivery of Care Documents/Records: 1.29 - Staff interviews and review of safety and quality documents shows that the maintenance of buildings, plant, equipment, utilities, devices and other infrastructure is undertaken to ensure that they are fit for purpose. However, several matters were identified by the assessors that need attention. Hobart Private Hospital: 1. A formal ligature audit needs to be conducted in the Department of Emergency Medicine (DEM). 2. Assess the risk that the chairs in the DEM waiting room are not fixed to the floor. St Helen's Private Hospital: 1. There is a need to display posters describing the safe use of the gym equipment that is used by the in-patients. 2. There is a store room that is not adequately temperature controlled. Plans to rectify this are in hand and need to be completed. 3. Doona covers on the patients' beds are too large and drape on the floor, posing a falls risk. 4. Some bathroom ramps do not have hazard tapes marking the edges, which creates a falls risk. 5. Mould was noted in some of the patients' bathrooms, which is a hygiene risk. 6. Mattress protectors are too small, leaving portions exposed. It is understood that replacement of these beds is under consideration which would mitigate the hygiene risk. 7. The Operating Theatre area (where only ECT is administered) is not well maintained with cracked tiles and exposed concrete creating a hygiene risk. 8. There are areas of carpet "waves" in the mothers and babies unit, implying that the floor is uneven, which creates a risk of falls.
Documentation of patient information	Medication Safety Documents/Records: 4.5 - Review of medication safety documentation including corporate and local policies for medication management shows a process is in place for obtaining and documenting a best possible medication history. This forms the basis for therapeutic decision making and supports the identification of adverse medicines events. All patients receive a comprehensive medications assessment by the nursing and medical staff on admission to hospital and patients at higher risk of harm are referred to the pharmacy service for review. Clinical leads interviewed could describe the processes used

Criterion	Recommendations
	to obtain and record a best possible medication history in the patient's healthcare record. It is noted that while SHPH achieved 100% compliance for Medication history documented on chart or documented elsewhere and cross referenced on chart for the National Standard Medication Chart Audit (reporting period 21 September to 16 October 2020), HPH received a compliance rate of only 49%. Staff interviewed could describe the medication safety strategies in place to address this gap in clinical practice. It was particularly noted that the medical officers are not routinely completing the "indication" section on the medication chart and that the VTE sections were not consistently completed where necessary. Since this is a continuing problem, as evidenced by previous audits, the assessors considered that this was a continuing risk and so have set a rating of met with recommendations. It is also noted that the Critical Care Flow Chart – Level 1 Trial document, currently in use in the Coronary Care Unit (CCU) at HPH, has limited space to record medication information including those delivered by intravenous infusion. This is a particular issue for the documentation of infusions with additives. The hospitals review the continuing issue with respect to incomplete medication charts and devise solutions to improve compliance.

Summary of Improvement Opportunities

Improvement Opportunities

The following actions have been rated as Met, improvement opportunities which the health service may or may not choose to undertake have been provided for these actions:

Criterion	Improvement Opportunities
Governance, leadership and culture	Governance, Leadership and Culture Documents/Records: 1.3 - Documents reviewed, plus observation of the organisation confirmed the information, provided by the clinical governance leads, that a clinical governance framework is in place and how it is monitored by the senior managers, the Medical Advisory Committee (MAC) and the corporate Board. This process drives the essential improvements in safety and quality. Review of clinical governance documents shows a clinical governance framework is in place that starts from the corporate office, through a number of committees and groups within the hospitals that deal with clinical governance, with information flowing in both directions. There is ongoing review of all aspects of clinical care, including consumer experiences. Reports are presented in dashboard format, which allows the clinical leads rapid and timely access to information. However, while this process drives the essential improvements in safety and quality, as well as risk management, the processes are somewhat basic, with medical craft groups meeting separately and independently. The result is that communication is through the Medical Advisory Committee, but that is not their main role and the concern is that information could be overlooked. Recently, a new committee was established, the Clinical Governance Review committee, and this is a good move towards streamlining and improving the process. Another starting point would be to review the terms of reference of the committees, to clearly align their work with the national standards. This would create a framework for all governance committees to complete their tasks, particularly if the standards are adopted as the basis for the agenda for the meetings. The organisation could review the terms of reference of all governance committees, to align them with the national standards, as well as consider using the standards to be the framework for the agendas of meetings.
Patient safety and quality systems	Patient Safety and Quality Systems Documents/Records: 1.7 - Interviews, observations and reviews of clinical governance documents shows that developing, authorising, and monitoring the implementation of the health service

Criterion	Improvement Opportunities
	organisation's policy documents is sound. There is work undertaken at both the corporate and local levels to ensure that the policies and procedures reflect contemporary best practice. However, it was noted that some of these documents contained outdated references. For instance, the Basic Life Support and Cardiopulmonary Resuscitation Policy (last review date of September 2018) refers to the first edition of the National Safety and Quality Health Service Standards (NSQHS) standards. Furthermore, some corporate policies reviewed did not contain the date of the next planned review, which is expected in modern document management systems. 1. The organisation conducts an audit on policies and procedures to ensure that they contain only the most recent references available. 2. The organisation reviews the document management system to ensure that all documents have a triennial review, at least. Patient Safety and Quality Systems Documents/Records: 1.9 - Review of safety and quality documents shows that timely reports on safety and quality systems and performance are provided to the governing body, workforce, consumers and other relevant health service organisations. This information is gleaned from the activities that review all services and is presented to the workforce and consumers through information placed on safety notice boards around the two hospitals. It could be useful to add this information to the Healthscope website. Review the possibility of adding the safety and quality data to individual hospital's section on the corporate website. Patient Safety and Quality Systems Documents/Records: 1.10 - Risk registers are maintained in the hospitals, with an overarching corporate risk matrix that allows the senior management of the hospitals, plus senior corporate managers, to have oversight of all significant risks. These risk registers are actively managed by the appropriate staff and there is a good awareness of the need to identify and record emerging risks. At the team level, there is discussion of risk identification and management. There are business continuity plans in the case of an emergency or disaster. The system is actively managed to assess its effectiveness, to seek improvements, and to create reports for the staff and community. It was noted at St Helen's Hospital that there are no fire

Criterion	Improvement Opportunities
	evacuation maps on the back of the doors in the patients' accommodation. Whilst it is recognised by the assessors that this is not a legal requirement in Tasmania, it would assist evacuation. There is a clinical risk that has been identified by the assessors, which pertains to the delivery of Electro-Convulsive Therapy (ECT) services at St Helen's Private Hospital. The anaesthetic nurse who coordinates the ECT sessions does not have an immediately available replacement, if she is unable to work or to take her annual holidays. The result is that ECT can be cancelled precipitously, with a risk to patient care. Furthermore, the position of a part-time medical officer, to support the psychiatrists by managing the physical aspect of patients' care, has been vacant for some months. It is accepted by the assessors that the organisation has been trying to recruit a doctor to this vacancy, but there is a continuing risk to patient care that needs to be resolved. The organisation needs to review these risks. 1. Progress with the plans to install fire evacuation maps on the back of each patient room at St Helen's Hospital. 2. Assess and plan for the need for a replacement anaesthetic nurse for the ECT services for both planned and unplanned changes. 3. The organisation should review and resolve the vacancy for a medical officer at St Helen's Private Hospital. Patient Safety and Quality Systems Documents/Records: 1.16 - The medical records in both hospitals are paper-based, with an electronic record of occasions of service maintained in the 'WebPas' software. The electronic records are easily accessed, whilst the paper records can be retrieved within a reasonable time. The privacy and security of healthcare records are maintained through individual, layered password access along with procedures to ensure that paper files are not left in public areas, nor left with any information visible. However, it was noted that the medical records office at Hobart Private Hospital had the door open on frequent occasions, apparently because ventilation is poor. The records are audited regularly for completeness and accuracy. There was an issue identified at St Helen's Private Hospital, where there was insufficient space to record details of both a mother and a boarder baby in the 'WebPas' database. It appears that this may be a misunderstanding of the use of the software.

Criterion	Improvement Opportunities
	1. The organisation reviews the use of the 'WebPas' software to ensure that all staff are familiar with its use, as well as discuss the problems with the software supplier. 2. Review the environmental concerns in the medical records department, to ensure that the security of records is not compromised.
Clinical performance and effectiveness	Clinical Performance and Effectiveness Documents/Records: 1.20 - Interviews with clinical leads confirmed training systems are in place that assess competency and training needs of the workforce and provide access to required training. Work focuses upon implementing an evidence-based practice approach into the provision of clinical practice, facilitating innovation and service improvement, supporting continuous quality improvement through a comprehensive program that is targeted to the individual needs of each clinician and fostering a culture of professional development. Participation is monitored. The assessors considered that the work was worthy of a commendation, albeit that some comments were warranted. There is a mandatory training program set by the corporate office, which has been revised recently when a new electronic program was introduced. Initially, it did not include hand hygiene as a mandatory annual competency, but this was reversed during the time of the assessment to reinstate it as an annual requirement. Some other locally focused programs have been scrapped and it is important that these be reviewed for their value. It was noted by the assessors that diversity and inclusion training rates are low, so it could be considered for inclusion as an item for mandatory training. Furthermore, staff in the obstetric unit considered that scenario training would be beneficial for them. In the emergency department, training in recognition and response to family violence as well as mental health first-aid were identified as areas that would benefit from extra training. 1. Review the new e-learning system to ensure that it allows the capture of local knowledge and educational requirements. 2. Review the place for mandatory diversity and inclusion training for the hospitals. 3. Review the benefit in arranging scenario training in the obstetric unit. 4. Review the education and training for the staff in the emergency department, with respect to recognising and responding to domestic violence and in providing mental health first-aid. Clinical Performance and Effectiveness Documents/Records:

Criterion	Improvement Opportunities
	1.21 - To meet the needs of its Aboriginal and Torres Strait Islander patients, the clinical leads interviewed confirmed that the organisation has strategies in place to improve the cultural awareness and cultural competency of the workforce. It was noted by the assessors that the term "ATSI" is used in several corporate documents, including the subject line. This terminology is not acceptable. The organisation removes any use of the term "ATSI" because it is considered offensive by some Aboriginal and Torres Strait islanders. Clinical Performance and Effectiveness Documents/Records: 1.25 - Managers interviewed could explain how the workforce is trained and given assistance to manage their roles and responsibilities for safety and quality of care. There is a range of quality committees and groups to promulgate the national standards throughout the organisation through using them to set agendas, advertise in the wards and clinical areas (including the patients/family) and other promotional activities. Agency and locum staff are particularly targeted to ensure that safety and quality aspects are well covered. It was noted that there is a plan to deliver security training to the orderlies in the emergency department, which is a sensible idea that needs to be completed. The organisation should complete the training in security of the staff orderlies in the emergency department. Clinical Performance and Effectiveness Documents/Records: 1.27 - Clinical leads interviewed could describe the clinical guidelines, clinical pathways and other decision support tools that are available, including the standards developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC). Clinicians are expected to follow contemporary accepted treatments and guidelines, with variations in care reviewed by the clinical governance teams when necessary. It was noted by the assessors that there were a number of outdated information documents displayed in the Hobart Private Hospital for example, some had passed their expiry date. Establishing a register of documents that includes the sites of display of a document will assist in this management. Consider the establishment of a document register to ensure that all information displayed in wards and other clinical areas are up-to-date.

Criterion	Improvement Opportunities
Safe environment for the delivery of care	Safe Environment, Delivery of Care Documents/Records: 1.33 - The managers interviewed explained how the organisation provides an environment that is welcoming for the cultural beliefs and practices of Aboriginal and Torres Strait Islander people. The Hospitals could consider expanding the patterns of the uniforms/patient gowns to include some Aboriginal and Torres Strait Islander motifs. The hospitals consider whether some gowns for patients and staff could be supplied in Aboriginal and Torres strait Islander motifs.
Partnering with patients in their own care	Partnering with Consumers Documents/Records: 2.3 - Review of the health service facilities shows a charter of rights is easily accessible for patients, carers, families and consumers. All patients receive a brochure that includes their rights and responsibilities, consistent with the Australian Charter. In St Helens Private Hospital (Mental Health Services), it may be useful to consider displaying the Mental Health Rights (nationally 2012) or those that have been developed across the country in the various jurisdictions.
Health literacy	Partnering with Consumers Documents/Records: 2.10 - The consumer information reviewed is available, easy to understand and relevant to the clinical needs of patients and carers, as well as addressing their needs after discharge. A useful measure to consider may be placing an information board (date, day, location) alongside the recovery bed of a patient who has undergone Electro-Convulsive Therapy (ECT) to aid in their re-orientation after the procedure. The organisation could consider placing an information board alongside the bed of a patient who is recovering from ECT to aid their orientation.
Clinical governance and quality improvement to prevent and control healthcare associated infections, and support antimicrobial stewardship	Infection Control Documents/Records: 3.2 - The Infection Control Committee has a membership from all areas of the hospital with Infection Control being on the agenda for all ward meetings. The Infection Control Committee feeds into the Medication Safety Committee and then up to the Executive. The organisation reports on its infection control data to the Executive and to consumers. There is a consumer representative within the Infection Control Committee, who has also conducted ward audits that are focused on infection control. The organisation should consider the promotion of their infection control strategies and ensure they explain the

Criterion	Improvement Opportunities
	meaning of the data to consumers for greater understanding into why and how this data was collected. Infection Control Documents/Records: 3.3- The health service organisation encourages consumers to participate in providing feedback, conducting audits and reviewing the data in relation to Healthcare Associated Infections (HIA). Data from audits is presented in all wards and waiting areas. The organisation uses this information to inform clients of any emerging issues. The organisation should ensure consumers are able to fully comprehend the nature of Healthcare Associated Infection data displayed in all wards and waiting areas.
Infection prevention and control systems	Infection Control Documents/Records: 3.5 - The organisation ensures training of all staff in transmission-based precautions and have maintained their COVID-19 initiatives, ensuring support through signage, check-ins, and process review. Policy and procedures cement the actions of the staff on a daily level from cleaners through to the Executive. All staff are aware of their responsibility. The organisation continually monitors its progress with the use of an audit schedule and being transparent in communicating their results to all staff and consumers. All staff are trained in transmission-based precautions with records in the Human Resources file and Clinical Nurse Educator data base. The organisation promotes the national standards via signage throughout the hospital including the use of transmission-based precautions. The organisation has developed a transmission-based precautions summary prompt sticker to clear patients of infectious diseases listed on the sticker. The Infection Control coordinator is notified of all positive pathology to ensure it is actioned at ward level. Although St Helen's Private Hospital has a buddy system in place to assist staff with donning and doffing of personal protective equipment (PPE), the assessor observed there were some minor issues with donning of masks. The organisation should ensure that all staff and visitors to the facility that are required to wear PPE are checked to ensure the PPE is worn correctly. Infection Control Documents/Records: 3.9 - The organisation has policies and procedures in place to ensure staff are trained and report on Aseptic Non Touch Technique (ANTT) through use of formal training and peer

Criterion	Improvement Opportunities
	review. Competencies and training records are maintained. Audits are conducted to assure compliance with ANTT in all areas of the hospital which are reported to the appropriate level of governance. All findings are communicated through to staff and added to the quality boards for consumers to review. It is noted that the mobile sharps bin in St Helen's Private Hospital's Operating Theatre is being used by one doctor as a table on which to place the intravenous (IV) cannulation tray while the patient is being cannulated. The organisation should ensure appropriate equipment is available for clinicians to use when inserting IV cannulas. The practice of using the mobile sharps bin to rest the IV cannulation tray on should cease. Infection Control Documents/Records: 3.11 - The health service organisation has an internal department known as Environmental Services and Catering which allows specific focus on environmental cleaning. Compliance with policy and procedure through regular auditing, spot checks and staff and consumer review enables the service to gain accurate knowledge of the environmental cleaning performance. All information from these reviews and audits are discussed at the Infection Control Committee and provided to the appropriate levels of governance. All data is reported through the organisation wide quality boards. Staff have a yearly refresher in PPE and are reminded through the e-learning system. Staff also receive training in cleaning and disinfectant products from 'ECOLAB' in an online format. All cleaning is conducted through schedules, allowing for spot cleaning to occur also. Maintenance of each site occurs through scheduled review and testing of the water outlets. All identified incidents and risk are reported through 'RISKMAN' and allocated to the appropriate meeting for discussion. It is noted that the Hobart Private Hospital and St Helen's Private Hospital have yet to implement stainless steel wire shelving in storage areas that complies with the latest hospital infection control guidelines. In addition some storage areas of the hospital remain carpeted. The organisation should review the storage areas of Hobart

Criterion	Improvement Opportunities
	Private Hospital and St Helen's Private Hospital and consider installing wire shelving that complies with the latest hospital infection control guidelines. Remove carpets from these storage areas where possible. Infection Control Documents/Records: 3.12 - The organisation does evaluate and review infection risks associated with linen, equipment, devices, products, building furnishings and fittings within the building. Linen audits are conducted together with ensuring the contracted linen company complies with best practice. The organisation has schedules in place to ensure all equipment, furnishings and fittings are audited to review compliance. All new processes, equipment and furnishings are risk reviewed, with staff trained in new equipment prior to use. The organisation should assess the risk of having carpet in clinical areas and remove the carpet.
Reprocessing of reusable medical devices	Infection Control Documents/Records: 3.14 - The organisation is compliant with the Commission Advisory AS 18/07 Reprocessing of Reusable Medical Devices in Health Service Organisations (March 2021) as below. The organisation does complete the segregation of clean and dirty activities with the implementation of strategies to ensure unidirectional work and airflow to reduce the risk of cross contamination. They have identified and managed the risks associated with the gaps between current status and compliance with relevant national or international standards and have documented this in a gap analysis identifying and managing any risks of cross contamination. The organisation adheres to the design of storage areas for sterile stock in Hobart Private Hospital and is required to do similar in St Helen's Private Hospital by 31 December 2022. The Commission expects organisations to comply with requirements in relevant national or international standards for storage of sterile stock in compliant shelving. The organisation has mitigated the risk of contamination of sterile stock in storage. This includes assessing and managing the risk of humidity and temperature on stored sterile stock. The co-location of sterile and non-sterile stock in a storage area has been assessed within the AS/NZ4187 Gap assessment.

Criterion	Improvement Opportunities
	Monitoring requirements for water quality have been occurring. Ensure sterile stock within St Helen's Private Hospital is stored correctly with the use of working air conditioners. The organisation is also completing the process of ensuring compliance with shelving requirements in each ward of the hospital and should maintain its momentum.
Clinical governance and quality improvement to support medication management	Medication Safety Documents/Records: 4.1 - It is noted that the Medication Safety Governance Policy and Procedure is referenced to the first edition of the National Safety and Quality Health Services Standards and other outdated documents, for example, Healthscope Shared Learning's April to June 2017. Review the Medication Safety Governance Policy and Procedure to ensure that it contains up to date and relevant information. 4.1 - The Medication Safety Committee is yet to create a consolidated action list that is presented to each meeting together with the nominated action owner and date of completion to facilitate tracking of the actions and their completion. Recommendation: Create a consolidated action list that is presented to each medication safety committee meeting, together with the nominated action owner and date of completion to facilitate tracking of the actions and their completion. A further improvement would be to include an evaluation of the implementation of actions. Medication Safety Documents/Records: 4.2 - Staff interview and direct observation of the medication area at SHPH finds that additional strategies could be implemented to reduce distractions during medication preparation and administration. Implement additional strategies to reduce noise and potential distractions during medication preparation and administration at SHPH. Review the location of medication errors to determine if this may be a cause of the higher rate of medication errors at SHPH. 4.2 - Staff interview and document review finds that separate medication charts for adult and paediatric patients are yet to be implemented. Progress with plans to implement separate adult and

Criterion	Improvement Opportunities
	paediatric medication charts. Medication Safety Documents/Records: 4.3 - Staff report that the readability of the quality boards in patient areas could be improved to ensure that patients understand the medication data presented. Review the quality boards and other notice boards in patient areas and assess the readability and patient comprehension of medication related information. Consider using pictures and infographics to improve patient comprehension.
Medication management processes	Medication Safety Documents/Records: 4.14 - Review of medication safety documentation shows a process is in place for the safe and secure distribution and storage of medicines (including Schedule 8, Schedule 4 and Schedule 4D medicines, temperature-sensitive medicines and cold chain management) and the correct disposal of unused, unwanted or expired medicines. Clinical leads interviewed could describe how all medicines (including temperature-sensitive medicines) are stored, handled and disposed of according to manufacturers' directions legislation, and jurisdictional requirements. Verification confirms the health service organisation ensures the safe and secure storage and distribution of medicines. Staff in the Coronary Care Unit state that the locked medication drawers are not big enough to store all patient medication that is permitted to be stored at the bedside. Review the size of the bedside medication drawers and consider allocating a larger space to incorporate all patient medications that are permitted to be stored at the bedside.
Documentation of patient information	Medication Safety Documents/Records: 4.5 - The Critical Care Flow Chart – Level 1 Trial document could include an expansion of sections related to medication administration including that pertaining to intravenous infusion.
Clinical governance and quality improvement to support comprehensive care	Clinical Gov and QI to Support Comprehensive Care Documents/Records: 5.1 - The organisation has a nurse led committee that encompasses quality and safety that reviews data from audits specific to comprehensive care which includes areas surrounding risk assessments, daily and comprehensive care planning. All data is submitted through appropriate levels of governance and communicated to staff. The organisation has clearly identified roles and responsibilities for all staff,

Criterion	Improvement Opportunities
	including allied health in ensuring comprehensive care. The organisation has screening and assessment processes for all departments of the service which include identifying patients at end of life care and minimising patient harm. Mandatory training in comprehensive care is conducted by the organisation. The organisation should clearly define the role of the "responsible person".
Clinical governance and quality improvement to support effective communication	Communicating for Safety Documents/Records: 6.1 - Review of documentation shows safety and quality systems are used when implementing policies, managing risks and identifying training for effective and coordinated clinical communication. Both HPH and SHPH have a local Clinical Handover Framework to support the transfer of clinical accountability and responsibility between healthcare professionals and enable continuity of care for the patient. It is noted that the functions of a Communicating for Safety Committee are currently undertaken by the Quality and Risk Management Committee and the Senior Nurses' Committee. Clinical leads interviewed could describe how the safety and quality systems are used when implementing policies, managing risks and identifying training requirements for effective and coordinated clinical communication. Observation of clinicians' practice showed use of the health service organisation's clinical communication processes. Observation of clinical handover in two wards of HPH found that handover was comprehensive and conducted in a similarly structured manner. Handover in theatre at SHPH was also observed and found to be consistent with best practice. It is noted that the functions of a Communicating for Safety Committee are currently undertaken by other committees including the Quality and Risk Management Committee and the Senior Nurses' Committee. The organisation could consider reconvening a dedicated Communicating for Safety Committee. Consider reconvening the Communicating for Safety Committee to review clinical communication practices across HPH and SHPH and facilitate alignment with the NSQHS standards. Communicating for Safety Documents/Records:

Criterion	Improvement Opportunities
	6.3 - Review of documentation shows consumer partnering processes are applied for involving patients, providing information and sharing decision making. This approach is supported by the Consumers – Partnering Policy (date last review October 2018) that sets out how each hospital is responsive to and maximises the involvement of patient, carers and families. Clinical leads interviewed could describe how consumer partnership standards are applied when involving patients in their care, meeting their information needs and shared decision making. Observation of clinicians' practice showed use of the health service organisation's processes for partnering with consumers. Clinical handover observed at HPH and SHPH found that patient were actively involved in the process. It is noted that the Consumers – Partnering Policy is referenced to outdated documents. Review the Consumers – Partnering Policy to ensure that it contains relevant and up-to-date information.
Correct identification and procedure matching	Communicating for Safety Documents/Records: 6.6 - Review of documentation shows processes are in place for correctly matching patients to care and the information that should be documented. For example, a Correct Patient, Correct Procedure, Correct Site Policy and Procedure (date last review July 2018) is in place that outlines the steps that must be taken to ensure that the correct surgery/procedure is performed on the correct patient, at the correct site and, if applicable, with the correct implant. Interviews with clinical leads confirmed processes are in place to correctly match patients to their intended care and that the information is documented and staff receive the required training. For example, mandatory training is completed on an annual basis in operating theatre and the cardiac catheterisation laboratory to reduce the risk of patient mismatching. Verification confirms the health service organisation has processes to correctly match patients to their care. It is noted that the Correct Patient, Correct Procedure, Correct Site Policy and Procedure is referenced to outdated documents. Review the Correct Patient, Correct Procedure, Correct Site

Criterion	Improvement Opportunities
	Policy and Procedure to ensure that it contains up-to-date and relevant information.
Clinical governance and quality improvement to support	Blood Management Documents/Records: 7.1 - Blood and blood products are only used at the Hobart Private hospital. It is not handled at the St Helen's Private Hospital campus. Interviews and review of blood and blood product documentation, shows that there are clear policies and procedures, set mainly by the national corporate office of Healthscope, to manage the risks and identify training requirements for blood management. Blood is almost always an elective procedure at Hobart Private hospital (HPH), with approximately 200 occasions in the past year. It has been decided by the corporate office to reduce blood safe training to a once-only mandatory, with retraining to be undertaken if there are incidents. Because this is a competency that is not used often by the nurses, this does not seem sensible from the perspective of risk management. It may be appropriate to make this a biennial training requirement. The organisation should review the risks and frequency of blood safe training to ensure that appropriate skills are retained by staff. Blood Management Documents/Records: 7.3 - Documents reviewed and staff interviewed confirmed that patients are included in the decision-making process, by providing adequate and appropriate information to allow them to be involved. Patients have the right to refuse the use of blood and blood products and the corporation has a form to record this choice. However, it would be better if that decision is highlighted, preferably on the "alert" sheet. Furthermore, the form refers specifically to Jehovah's Witnesses adherents, whereas it should simply have a generic reference to those patients who choose to refuse blood or blood products. 1. The organisation considers highlighting a patient's refusal to accept blood on the alert sheet. 2. The organisation considers changing the name of the refusal of blood/products document to a generic reference to those that do not want blood or blood products.
Clinical governance and quality improvement to support recognition and response systems	Acute Deterioration Documents/Records: 8.1 - It is noted that the corporate policy and procedure document Clinical Deterioration, Recognising and Responding to, was last reviewed in September 2017. Staff report that it is currently under review by the responsible parties.

Criterion	Improvement Opportunities
	Progress with plans to review with Clinical Deterioration, Recognising and Responding To, and ensure that it contains up to date and relevant information. 8.1 - The Clinical Deterioration Committee is yet to create a consolidated action list that is presented to each meeting together with the nominated action owner and date of completion to facilitate tracking of the actions and their completion. Create a consolidated action list that is presented to each clinical deterioration committee meeting, together with the nominated action owner and date of completion to facilitate tracking of the actions and their completion. A further improvement would be to include an evaluation of the implementation of actions. Acute Deterioration Documents/Records: 8.3 - Review of the Advanced Life Support Policy and Procedure document finds that while care of the family and carer is addressed during resuscitation this does not specifically mention family presence during cardiopulmonary resuscitation (CPR) or staff training to support family presence. Review the Advanced Life Support Policy and Procedure and include additional information about how family presence during CPR will be supported and the training requirements of staff.
Detecting and recognising acute deterioration, and escalation care	Acute Deterioration Documents/Records: 8.4 - It is noted that the Critical Care Flow Chart – Level 1 Trial document that is currently in use in the Coronary Care Unit (CCU) at HPH does not include “between the flags” bands for observation of haemodynamic and respiratory variables and there is limited space to record these observations. Further, the chart does not include a dedicated space for the date and number of days spent in CCU/Intensive Care Unit (ICU). Feedback regarding the Critical Care Flow Chart – Level 1 Trial document could include an expanded section to document haemodynamic and respiratory variables as well as a dedicated space for the date and number of days spent in CCU/ICU. Acute Deterioration Documents/Records: 8.5 - It is noted that the while the Self-Harm and Suicide (Threatened, Attempted or Completed) in a Non-Mental Health Facility Policy includes items of risk, including those

Criterion	Improvement Opportunities
	that can be used as a ligature or ligature point, there is no requirement to conduct ligature audits in higher risk areas of HPH, for example, the Emergency Department. Develop and implement a formal ligature and ligature assessment audit tool for use at HPH to ensure that higher risk areas have ligature and ligature points identified and removed where possible. Acute Deterioration Documents/Records: 8.7 - Review of the Rapid Response Posters for family escalation of care finds that the readability of these posters could be improved. In addition, these posters are quite small and could be missed by those concerned. Review the Rapid Response Posters to improve their readability. Consider involving consumers in the development of the new posters.

Clinical Governance Standard

Leaders of a health service organisation have a responsibility to the community for continuous improvement of the safety and quality of their services, and ensuring that they are person centred, safe and effective.

Intention of this standard
To implement a clinical governance framework that ensures that patients and consumers receive safe and high-quality health care.

Criterion:	**Governance, leadership and culture** Leaders at all levels in the organisation set up and use clinical governance systems to improve the safety and quality of health care for patients.			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
1.1	Governance, leadership and culture 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	Met	Governance, Leadership and Culture Documents/Records: Hobart Private Hospital (HPH) and St Helen's Private Hospital (SHPH) are part of the Healthscope Hospitals group. As such, the higher level strategic functions and governance controls sit with the Healthscope corporate activities. Observation, document review and interview with the clinical governance leads interviewed confirmed that the organisation has created a culture of safety and quality improvement, which is actively monitored by the local senior leadership and the corporate office. This has been achieved by setting the strategic direction of the organisation, establishing a clinical governance framework and quality plan to ensure that roles and responsibilities are clear and that partnering with the patients and families is actively pursued. The organisation monitors the clinical quality systems through senior committees that review the data, as well as monitoring the incident reporting system, with reports from those committees coming to the corporate office and the Board of the company.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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.			
1.2	Governance, leadership and culture 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	Governance, Leadership and Culture Documents/Records: There are very few (approximately 2%) of patients who choose to identify as Aboriginal or Torres Strait Islanders. Nevertheless, the clinical governance leads interviewed could describe how the specific health needs of Aboriginal and Torres Strait Islander people are addressed in the safety and quality priorities. This was confirmed by observation and document reviews.	Met
1.3	Organisational leadership 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	***Improvement Opportunities*** Governance, Leadership and Culture Documents/Records: 1.3 - Documents reviewed, plus observation of the organisation confirmed the information, provided by the clinical governance leads, that a clinical governance framework is in place and how it is monitored by the senior managers, the Medical Advisory Committee (MAC) and the corporate Board. This process drives the essential improvements in safety and quality. Review of clinical governance documents shows a clinical governance framework is in place that starts from the corporate office, through a number of committees and groups within the hospitals that deal with clinical governance, with information flowing in both directions. There is ongoing review of all aspects of clinical care, including consumer experiences. Reports are presented in dashboard format, which allows the clinical leads rapid and timely access to information. However, while this process drives the essential improvements in safety and quality, as well as risk management, the processes are somewhat basic, with medical craft groups meeting separately and independently. The result is that communication is through the Medical Advisory Committee, but that is not their main role and the concern is that information could be overlooked. Recently, a new committee was established, the Clinical Governance Review committee, and this is a	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			good move towards streamlining and improving the process. Another starting point would be to review the terms of reference of the committees, to clearly align their work with the national standards. This would create a framework for all governance committees to complete their tasks, particularly if the standards are adopted as the basis for the agenda for the meetings. The organisation could review the terms of reference of all governance committees, to align them with the national standards, as well as consider using the standards to be the framework for the agendas of meetings.	
1.4	Organisational leadership 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	Governance, Leadership and Culture Documents/Records: Staff interviews, observation and document review confirmed that the organisation has clear strategies to address the particular needs of Aboriginal and Torres Strait Islander people. The activities are guided by the Healthscope Reconciliation Action Plan, plus the HPH has developed contacts and relationships with the Tasmanian Aboriginal and Torres strait Islander groups. Staff undertake mandatory cultural awareness training and clerical staff have received training in how to obtain this information from patients.	Met
1.5	Organisational leadership The health service organisation considers the safety and quality of health care for patients in its business decision-making	Met	Governance, Leadership and Culture Documents/Records: Interviews with staff, along with documentation review and observation, confirmed that staff work within an established governance framework, which reviews safety and quality and ensures that roles for all staff are clearly defined through position descriptions and established scope of practice. There is a multi-layered governance structure, alongside a quality matrix, including regular audits, to ensure that all aspects of care are assessed and improved as required. All these activities are considered at the senior governance levels when making decisions about the business aspect of providing care to patients.	Met
1.6	Clinical leadership Clinical leaders support clinicians to: a. Understand and perform their delegated safety and quality roles and responsibilities b. Operate within the clinical	Met	Governance, Leadership and Culture Documents/Records: Managers and staff interviewed could describe how policy documents are managed, to ensure they are current, comprehensive, effective and comply with legislation and regulations, along with state or territory requirements. Clinical activities are monitored regularly to review and seek improvements, and to ensure compliance with policies and procedures. Staff education is a major activity to ensure that issues of safety and quality	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	governance framework to improve the safety and quality of health care for patients		are appropriately addressed, with oversight being provided by the various governance committees.	

Criterion:	**Patient safety and quality systems** Safety and quality systems are integrated with governance processes to enable organisations to actively manage and improve the safety and quality of health care for patients.			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
1.7	Policies and Procedures 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	***Improvement Opportunities*** Patient Safety and Quality Systems Documents/Records: 1.7 - Interviews, observations and reviews of clinical governance documents shows that developing, authorising, and monitoring the implementation of the health service organisation's policy documents is sound. There is work undertaken at both the corporate and local levels to ensure that the policies and procedures reflect contemporary best practice. However, it was noted that some of these documents contained outdated references. For instance, the Basic Life Support and Cardiopulmonary Resuscitation Policy (last review date of September 2018) refers to the first edition of the National Safety and Quality Health Service Standards (NSQHS) standards. Furthermore, some corporate policies reviewed did not contain the date of the next planned review, which is expected in modern document management systems. 1. The organisation conducts an audit on policies and procedures to ensure that they contain only the most recent references available. 2. The organisation reviews the document management system to ensure that all documents have a triennial review, at least.	Met
1.8	Measurement and quality improvement The health service organisation uses organisation-wide quality improvement	Met	Patient Safety and Quality Systems Documents/Records: Review of safety and quality documents shows organisation-wide quality improvement systems that identifies safety and quality measures and areas for improvement, and implements and monitors safety and quality improvement strategies. Consumers and the	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		workforce are involved in these reviews of safety and quality performance and systems. This information is achieved by having a rolling program of audits of activities, with outcomes reviewed at both the local and corporate levels, to improve the education provided.	
1.9	Measurement and quality improvement 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	***Improvement Opportunities*** Patient Safety and Quality Systems Documents/Records: 1.9 - Review of safety and quality documents shows that timely reports on safety and quality systems and performance are provided to the governing body, workforce, consumers and other relevant health service organisations. This information is gleaned from the activities that review all services and is presented to the workforce and consumers through information placed on safety notice boards around the two hospitals. It could be useful to add this information to the Healthscope website. Review the possibility of adding the safety and quality data to individual hospital's section on the corporate website.	Met
1.10	Risk management 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	Met	***Improvement Opportunities*** Patient Safety and Quality Systems Documents/Records: 1.10 - Risk registers are maintained in the hospitals, with an overarching corporate risk matrix that allows the senior management of the hospitals, plus senior corporate managers, to have oversight of all significant risks. These risk registers are actively managed by the appropriate staff and there is a good awareness of the need to identify and record emerging risks. At the team level, there is discussion of risk identification and management. There are business continuity plans in the case of an emergency or disaster. The system is actively managed to assess its effectiveness, to seek improvements, and to create reports for the staff and community.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters		It was noted at St Helen's Hospital that there are no fire evacuation maps on the back of the doors in the patients' accommodation. Whilst it is recognised by the assessors that this is not a legal requirement in Tasmania, it would assist evacuation. There is a clinical risk that has been identified by the assessors, which pertains to the delivery of Electro-Convulsive Therapy (ECT) services at St Helen's Private Hospital. The anaesthetic nurse who coordinates the ECT sessions does not have an immediately available replacement, if she is unable to work or to take her annual holidays. The result is that ECT can be cancelled precipitously, with a risk to patient care. Furthermore, the position of a part-time medical officer, to support the psychiatrists by managing the physical aspect of patients' care, has been vacant for some months. It is accepted by the assessors that the organisation has been trying to recruit a doctor to this vacancy, but there is a continuing risk to patient care that needs to be resolved. The organisation needs to review these risks. 1. Progress with the plans to install fire evacuation maps on the back of each patient room at St Helen's Hospital. 2. Assess and plan for the need for a replacement anaesthetic nurse for the ECT services for both planned and unplanned changes. 3. The organisation should review and resolve the vacancy for a medical officer at St Helen's Private Hospital.	
1.11	Incident management systems and open disclosure 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	Met	Patient Safety and Quality Systems Documents/Records: Staff are expected to report all incidents (or near-miss events) through the 'RiskMan' software and that leads to the appropriate governance teams becoming involved in reviewing incidents. Patient or family/carer feedback is actively encouraged. The outcomes of such events are provided to the workforce and consumer groups, as well as used to craft educational responses and inform the risk management systems. The organisation is always looking for ways to improve the processes.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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			
1.12	Incident management systems and open disclosure The health service organisation: a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework b. Monitors and acts to improve the effectiveness of open disclosure processes	Met	Patient Safety and Quality Systems Documents/Records: Corporate documents reviewed, plus interviews with staff and senior managers, confirmed that all staff are encouraged to follow the principles of open disclosure and that the organisation monitors the occasions when it is used. This activity is mostly conducted by the visiting medical staff where an event falls within their responsibility, or by Healthscope staff when the responsibility falls to their domain. Occasions where open disclosure occurs are monitored, aiming for improvements, which are then distributed to staff and medical officers.	Met
1.13	Feedback and complaints management The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care	Met	Patient Safety and Quality Systems Documents/Records: Review of the management of feedback and complaints shows that the system encourages patients, families and the workforce to report their concerns and comments. The goal is that they are reviewed and resolved by management in a timely manner. Senior management and the Healthscope company receive reports of complaints that have been analysed for trends, and use that information to develop quality and safety	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		activities, as well as to inform the risk management process. The organisation is actively reviewing the process, seeking ways to improve the system.	
1.14	Feedback and complaints management 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	Patient Safety and Quality Systems Documents/Records: Review of feedback and complaints management documents shows that there is an organisation-wide complaints management system that supports patients, carers and families, and the workforce to report complaints. Documentation shows the workforce and consumers are involved in the review of complaints and they are resolved in a timely way. Reports shows feedback is provided to the governing body, the workforce and consumers on the analysis of complaints and actions are taken to inform improvements. Documentation shows risks are identified from the analysis of complaints in the risk management system and regular reviews and actions to improve the effectiveness of the complaints management system are in place.	Met
1.15	Diversity and high-risk groups	Met	Patient Safety and Quality Systems Documents/Records: Documents reviewed, plus interviews with senior staff, confirm that the organisation is	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		analysing the demography of its patients, seeking to identify those patients who are at a higher risk of harm and how to best address their needs. This information is obtained by analysis of admissions and other corporate activities, then used in the planning and delivery of care, striving to reach the higher risk and marginalised groups.	
1.16	Healthcare records The health service organisation has healthcare records 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	***Improvement Opportunities*** Patient Safety and Quality Systems Documents/Records: 1.16 - The medical records in both hospitals are paper-based, with an electronic record of occasions of service maintained in the 'WebPas' software. The electronic records are easily accessed, whilst the paper records can be retrieved within a reasonable time. The privacy and security of healthcare records are maintained through individual, layered password access along with procedures to ensure that paper files are not left in public areas, nor left with any information visible. However, it was noted that the medical records office at Hobart Private Hospital had the door open on frequent occasions, apparently because ventilation is poor. The records are audited regularly for completeness and accuracy. There was an issue identified at St Helen's Private Hospital, where there was insufficient space to record details of both a mother and a boarder baby in the 'WebPas' database. It appears that this may be a misunderstanding of the use of the software. 1. The organisation reviews the use of the 'WebPas' software to ensure that all staff are familiar with its use, as well as discuss the problems with the software supplier. 2. Review the environmental concerns in the medical records department, to ensure that the security of records is not compromised.	Met
1.17	Healthcare records The health service organisation works towards implementing systems that can	Met	Patient Safety and Quality Systems Documents/Records: At present, the paper records cannot interact with My Health Record. However, the basic 'WebPas' system does connect to My Health Record and so some occasions of service can be uploaded.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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			
1.18	Healthcare records 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	Patient Safety and Quality Systems Documents/Records: This organisation is only uploading some materials to My Health Record, but there are plans to address the requirements.	Met

Criterion:	**Clinical performance and effectiveness** The workforce has the right qualifications, skills and supervision to provide safe, high-quality health care to patients			
Rating:	**Met with recommendations**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
1.19	Safety and quality training The health service organisation provides orientation to the organisation that	Met	Clinical Performance and Effectiveness Documents/Records: Staff interviewed from all areas of the hospitals confirmed that their orientation to the organisation included the roles and responsibilities for safety and quality.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		Documents reviewed confirmed that medical staff, nursing students and consumer representatives received appropriate orientation to the hospitals.	
1.20	Safety and quality training 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	***Commendations*** Clinical Performance and Effectiveness Documents/Records: The Education and Training Team have a large portfolio that includes supervision of undergraduate clinical placements and graduate nursing staff, core training programs, resuscitation and scenario training and clinical audit. The enthusiasm, motivation and professionalism of team members was notable as was their desire to positively influence the careers of younger staff and students. ***Improvement Opportunities*** Clinical Performance and Effectiveness Documents/Records: 1.20 - Interviews with clinical leads confirmed training systems are in place that assess competency and training needs of the workforce and provide access to required training. Work focuses upon implementing an evidence-based practice approach into the provision of clinical practice, facilitating innovation and service improvement, supporting continuous quality improvement through a comprehensive program that is targeted to the individual needs of each clinician and fostering a culture of professional development. Participation is monitored. The assessors considered that the work was worthy of a commendation, albeit that some comments were warranted. There is a mandatory training program set by the corporate office, which has been revised recently when a new electronic program was introduced. Initially, it did not include hand hygiene as a mandatory annual competency, but this was reversed during the time of the assessment to reinstate it as an annual requirement. Some other locally focused programs have been scrapped and it is important that these be reviewed for their value. It was noted by the assessors that diversity and inclusion training rates are low, so it could be considered for inclusion as an item for mandatory training. Furthermore, staff in the obstetric unit considered that scenario training would be beneficial for them. In the	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			emergency department, training in recognition and response to family violence as well as mental health first-aid were identified as areas that would benefit from extra training. 1. Review the new e-learning system to ensure that it allows the capture of local knowledge and educational requirements. 2. Review the place for mandatory diversity and inclusion training for the hospitals. 3. Review the benefit in arranging scenario training in the obstetric unit. 4. Review the education and training for the staff in the emergency department, with respect to recognising and responding to domestic violence and in providing mental health first-aid.	
1.21	Safety and quality training 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	***Improvement Opportunities*** Clinical Performance and Effectiveness Documents/Records: 1.21 - To meet the needs of its Aboriginal and Torres Strait Islander patients, the clinical leads interviewed confirmed that the organisation has strategies in place to improve the cultural awareness and cultural competency of the workforce. It was noted by the assessors that the term "ATSI" is used in several corporate documents, including the subject line. This terminology is not acceptable. The organisation removes any use of the term "ATSI" because it is considered offensive by some Aboriginal and Torres Strait islanders.	Met
1.22	Performance management 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	Met	Clinical Performance and Effectiveness Documents/Records: Clinical leads interviewed could describe the processes for conducting performance reviews, for identifying training needs and incorporating them into the training matrix. There are corporate policies and procedures that underpin this activity.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	requirements into the organisation's training system			
1.23	Credentialing and scope of clinical practice 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' practice 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	Clinical Performance and Effectiveness Documents/Records: Interviews with clinical leads confirmed that processes are in place to ensure that clinicians are working within the agreed scope of clinical practice. When required, the scope is reviewed to accommodate new procedures. This review is conducted by the Medical Advisory Committee (MAC) members, who are able to review the capacity of the hospitals to deliver a new service as well as the competency and experience of the clinicians who wish to provide that service. For example, the Hospitals and Healthscope are considering the introduction of nurse surgical assistants.	Met
1.24	Credentialing and scope of clinical practice 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	Clinical Performance and Effectiveness Documents/Records: Clinical leads interviewed confirmed that there are robust processes used to ensure that clinicians have the appropriate qualifications, experience, professional standing, competencies and any other relevant professional attributes needed to complete their tasks to meet professional standards.	Met
1.25	Safety and quality roles and responsibilities	Met	***Improvement Opportunities*** Clinical Performance and Effectiveness Documents/Records: 1.25 - Managers interviewed could explain how the workforce is trained and given	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		assistance to manage their roles and responsibilities for safety and quality of care. There is a range of quality committees and groups to promulgate the national standards throughout the organisation through using them to set agendas, advertise in the wards and clinical areas (including the patients/family) and other promotional activities. Agency and locum staff are particularly targeted to ensure that safety and quality aspects are well covered. It was noted that there is a plan to deliver security training to the orderlies in the emergency department, which is a sensible idea that needs to be completed. The organisation should complete the training in security of the staff orderlies in the emergency department.	
1.26	Safety and quality roles and responsibilities 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	Clinical Performance and Effectiveness Documents/Records: Interviews with clinical leads confirmed that staff are provided with training and assistance to complete their roles. This is achieved by having clear lines of responsibility in all the clinical services, monitoring of training requirements and personal professional development, as well as assessments of competencies.	Met
1.27	Evidence-based care 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	***Improvement Opportunities*** Clinical Performance and Effectiveness Documents/Records: 1.27 - Clinical leads interviewed could describe the clinical guidelines, clinical pathways and other decision support tools that are available, including the standards developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC). Clinicians are expected to follow contemporary accepted treatments and guidelines, with variations in care reviewed by the clinical governance teams when necessary. It was noted by the assessors that there were a number of outdated information documents displayed in the Hobart Private Hospital for example, some had passed their expiry date. Establishing a register of documents that includes the sites of display of a document will assist in this management. Consider the establishment of a document register to ensure that all information displayed in wards and other clinical areas are up-to-date.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
1.28	Variation in clinical practice and health outcomes 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 with recommendations	***Met with Recommendation:*** Clinical Performance and Effectiveness Documents/Records: 1.28 - Interviews with clinical leads confirmed that the organisation uses benchmarking against other Healthscope hospitals, as well as internal systems for monitoring and improving clinical systems and patient outcomes, by assisting the clinicians to review their practice to recognise risks and address variations in the care provided. The newly established Clinical Governance Review will play a key role in providing feedback and support to clinicians, along with managing the risks associated with clinical care. This role will augment those provided by the medical craft-based committees that share those responsibilities. This is an opportune time to review the overall governance of the two hospitals. Furthermore, the Healthscope corporate documents often refer to a CMO (Chief Medical Officer), in the terms of reference for governance committees. Hobart Private Hospital (HPH) and St Helen's Private Hospital (SHPH) do not have any such position at this time, although it appears that this was the case in the past. It was brought to the attention of the assessors that the leadership team can have difficulties managing the Visiting Medical Officers (VMO's) because some VMO's appear to take the view that they will only listen to advice or constructive criticism from a medical peer. At present, the chair of the MAC has to carry this responsibility, but this is not within the usual responsibilities of the MAC. Whilst it is recognised by the assessors that there is a corporate CMO, that position is remote and unlikely to be familiar with the local operations. It is considered that the two hospitals need to strengthen the governance of clinical outcomes, by considering the appointment of a part-time CMO. An experienced senior clinician, ready to wind down their clinical activities may be a suitable starting point. With the establishment of the new Clinical Governance Review committee, the organisation should review the overall governance of all services to seek improvements and to streamline activities. The appointment of a Chief Medical Officer would complete the clinical governance.	Met with recommendations

Criterion:	**Safe environment for the delivery of care** The environment promotes safe and high-quality health care for patients			
Rating:	**Met with recommendations**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
1.29	Safe environment 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 with recommendations	***Met with Recommendation:*** Safe Environment, Delivery of Care Documents/Records: 1.29 - Staff interviews and review of safety and quality documents shows that the maintenance of buildings, plant, equipment, utilities, devices and other infrastructure is undertaken to ensure that they are fit for purpose. However, several matters were identified by the assessors that need attention. Hobart Private Hospital: 1. A formal ligature audit needs to be conducted in the Department of Emergency Medicine (DEM). 2. Assess the risk that the chairs in the DEM waiting room are not fixed to the floor. St Helen's Private Hospital: 1. There is a need to display posters describing the safe use of the gym equipment that is used by the in-patients. 2. There is a store room that is not adequately temperature controlled. Plans to rectify this are in hand and need to be completed. 3. Doona covers on the patients' beds are too large and drape on the floor, posing a falls risk. 4. Some bathroom ramps do not have hazard tapes marking the edges, which creates a falls risk. 5. Mould was noted in some of the patients' bathrooms, which is a hygiene risk. 6. Mattress protectors are too small, leaving portions exposed. It is understood that replacement of these beds is under consideration which would mitigate the hygiene risk. 7. The Operating Theatre area (where only ECT is administered) is not well maintained with cracked tiles and exposed concrete creating a hygiene risk. 8. There are areas of carpet "waves" in the mothers and babies unit, implying that the floor is uneven, which creates a risk of falls.	Met with recommendations

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
1.30	Safe environment 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	Safe Environment, Delivery of Care Documents/Records: Observation of facilities and equipment confirms that the physical design of the environment includes consideration of safety for staff, patients and families and there are quiet areas, when it is clinically required.	Met
1.31	Safe environment The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose	Met	Safe Environment, Delivery of Care Documents/Records: Observation of facilities and equipment shows that signage and directions within the organisation are clear and fit for purpose. (Refer to the improvement opportunity for item 1.10)	Met
1.32	Safe environment 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	Safe Environment, Delivery of Care Documents/Records: Both hospitals have policies that allow flexible visiting arrangements, to meet patients' needs, when it is safe to do so.	Met
1.33	Safe environment 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	***Improvement Opportunities*** Safe Environment, Delivery of Care Documents/Records: 1.33 - The managers interviewed explained how the organisation provides an environment that is welcoming for the cultural beliefs and practices of Aboriginal and Torres Strait Islander people. The Hospitals could consider expanding the patterns of the uniforms/patient gowns to include some Aboriginal and Torres Strait Islander motifs.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			The hospitals consider whether some gowns for patients and staff could be supplied in Aboriginal and Torres strait Islander motifs.	

Partnering with Consumers Standard

Leaders of a health service organisation develop, implement and maintain systems to partner with consumers. These partnerships relate to the planning, design, delivery, measurement and evaluation of care. The workforce uses these systems to partner with consumers.

Intention of this standard
To create an organisation in which there are mutually valuable outcomes by having:
• Consumers as partners in planning, design, delivery, measurement and evaluation of systems and services
• Patients as partners in their own care, to the extent that they choose.

Criterion:	**Clinical governance and quality improvement systems to support partnering with consumers** Systems are designed and used to support patients, carers, families and consumers to be partners in healthcare planning, design, measurement and evaluation			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
2.1	Integrating clinical governance 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	Partnering with Consumers Documents/Records: Interviews with staff and a review of documentation shows that the organisation is continuing to develop consumer engagement processes, though strategies to engage patients by seeking their participation in governance processes as well as canvassing feedback from patients and their families. Two "consumer consultants" have been engaged to provide regular contact across the two campuses and they have been provided with education and support to perform their roles.	Met
2.2	Applying quality improvement systems 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	Met	Partnering with Consumers Documents/Records: Review of consumer documentation and staff interviews confirmed that quality improvement is the goal when engaging with consumers. There is an electronic feedback process in place ('Qualtrics') which can also be completed by the patient from home. This initiative has increased the number of returns, allowing better understanding of the consumers' experiences. Results of feedback from all sources are collated and reviewed, seeking to ensure continuing improvements, by the governance committees. The	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	processes for partnering with consumers c. Reporting on partnering with consumers		organisation publishes information about performance indicators in safety and quality, across the hospital as well as on the corporate website.	

Criterion:	**Partnering with patients in their own care** Systems that are based on partnering with patients in their own care are used to support the delivery of care. Patients are partners in their own care to the extent that they choose			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
2.3	Healthcare rights and informed consent The health service organisation uses a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights b. Easily accessible for patients, carers, families and consumers	Met	***Improvement Opportunities*** Partnering with Consumers Documents/Records: 2.3 - Review of the health service facilities shows a charter of rights is easily accessible for patients, carers, families and consumers. All patients receive a brochure that includes their rights and responsibilities, consistent with the Australian Charter. In St Helens Private Hospital (Mental Health Services), it may be useful to consider displaying the Mental Health Rights (nationally 2012) or those that have been developed across the country in the various jurisdictions.	Met
2.4	Healthcare rights and informed consent The health service organisation ensures that its informed consent processes comply with legislation and best practice	Met	Partnering with Consumers Documents/Records: Interview with management and document reviews confirmed that the consent processes are aligned with legislation and best practice. Compliance with consent procedures are audited and the trend analysis shows excellent improvement in the past three years.	Met
2.5	Healthcare rights and informed consent The health service organisation has processes to identify: a. The capacity of a patient to make decisions about their own care	Met	Partnering with Consumers Documents/Records: Review of documentation shows there is a range of corporate policies and procedures in place to establish a patient's capacity to make decisions, plus the process to be followed if a substitute decision-maker is required.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves			
2.6	Sharing decisions and planning care 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	Partnering with Consumers Documents/Records: Review of documentation shows that the workforce is encouraged and supported to create therapeutic partnerships with patients or carers, to help improve outcomes. The consumer consultants provide a key activity in this regard, providing patients with another avenue to have their comments and concerns heard. Consumer experience surveys address this issue as well. Advance Health Directives are received and recorded when presented.	Met
2.7	Sharing decisions and planning care 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	Partnering with Consumers Documents/Records: Consumer documentation reviewed shows that effort has gone into aligning communications with the needs identified for specific patients and their families. There has been work to ensure that the directives are understood by staff and that respecting the patient's wishes is expected. There are policies to assist in this matter and to ensure that the jurisdictional requirements are met.	Met

Criterion:	**Health literacy** Health service organisations communicate with consumers in a way that supports effective partnerships			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
2.8	Communication that supports effective partnerships The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and,	Met	Partnering with Consumers Documents/Records: Consumer documentation reviewed shows that effort has gone into aligning communications with the needs identified for specific patients and their families. There has been work to ensure that the directives are understood by staff and that respecting the patient's wishes is expected. There are policies to assist in this matter and to ensure that the jurisdictional requirements are met.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	where relevant, the diversity of the local community			
2.9	Communication that supports effective partnerships 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	Partnering with Consumers Documents/Records: Documentation reviewed confirmed that any internally developed information has been reviewed by consumer groups to ensure that it is effective. This activity is normally conducted by the corporate office and the consumer advisory group there, with local input from the Hobart consumer consultants undertaken.	Met
2.10	Communication that supports effective partnerships 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	***Improvement Opportunities*** Partnering with Consumers Documents/Records: 2.10 - The consumer information reviewed is available, easy to understand and relevant to the clinical needs of patients and carers, as well as addressing their needs after discharge. A useful measure to consider may be placing an information board (date, day, location) alongside the recovery bed of a patient who has undergone Electro-Convulsive Therapy (ECT) to aid in their re-orientation after the procedure. The organisation could consider placing an information board alongside the bed of a patient who is recovering from ECT to aid their orientation.	Met

Criterion:	**Partnering with consumers in organisational design and governance** Consumers are partners in the design and governance of the organisation			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
2.11	Partnerships in healthcare governance, planning, design, measurement and evaluation 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 local community	Met	Partnering with Consumers Documents/Records: Documentation reviewed shows that the health service involves consumers in the governance and evaluation of health care, through both the corporate activities and local initiatives. The consumer consultants are able to relate the consumer experiences directly to the governance teams and provide input to the designs and evaluation of services.	Met
2.12	Partnerships in healthcare governance, planning, design, measurement and evaluation 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	Partnering with Consumers Documents/Records: Documentation reviews and interviews show that consumers are given a clear orientation to the organisation and its functions as well as education and assistance to be effectively engaged in their work.	Met
2.13	Partnerships in healthcare governance, planning, design, measurement and evaluation The health service organisation works in partnership with Aboriginal and Torres	Met	Partnering with Consumers Documents/Records: Approximately 2% of patients choose to identify as Aboriginal and Torres strait Islander origin. Interviews, plus a review of documents, confirmed that the health service organisation has processes to work with Aboriginal and Torres Strait Islander patients and communities to address their healthcare needs. The consumer advisory group is active in this area.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	Strait Islander communities to meet their healthcare needs			
2.14	Partnerships in healthcare governance, planning, design, measurement and evaluation The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce	Met	Partnering with Consumers Documents/Records: Managers interviewed explained how the organisation seeks feedback from the consumers, through patient surveys and direct contact with the consumer consultants to incorporate their views and experiences into training and education for the workforce.	Met

Preventing and Controlling Healthcare-Associated Infection Standard

Leaders of a health service organisation describe, implement and monitor systems to prevent, manage or control healthcare-associated infections and antimicrobial resistance, to reduce harm and achieve good health outcomes for patients. The workforce uses these systems.

Intention of this standard
To reduce the risk of patients acquiring preventable healthcare-associated infections, effectively manage infections if they occur, and limit the development of antimicrobial resistance through prudent use of antimicrobials as part of antimicrobial stewardship.

Criterion:	**Clinical governance and quality improvement to prevent and control healthcare associated infections, and support antimicrobial stewardship** Systems are in place to support and promote prevention and control of healthcare-associated infections, and improve antimicrobial stewardship			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
3.1	Integrating clinical governance 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	Infection Control Documents/Records: Review of the Infection Control documents shows the organisation's local policies strengthen and are made more specific in parallel with national company policies covering infection prevention and control and anti-microbial stewardship. Risks have been embedded within the Risk Register ('RISKMAN') which is continually monitored and reviewed. Audits are conducted in line with policies and procedures together with surveillance audits that are reported to the Infection Control Committee to manage and communicate to the Executive. The Infection Control Committee is represented through all levels of the hospital infrastructure and governance levels. Consumers are also represented and included in auditing. Gap analysis and action plans have been put in place for AS/NZ4187, with completion of site refurbishment planned March 2022. Training of all staff in Infection Prevention and Control is managed through human resources with all clinical staff receiving mandatory training in all elements of infection prevention and control including the Commission on Safety and Quality in Healthcare training modules.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
3.2	Applying quality improvement systems 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	***Improvement Opportunities*** Infection Control Documents/Records: 3.2 - The Infection Control Committee has a membership from all areas of the hospital with Infection Control being on the agenda for all ward meetings. The Infection Control Committee feeds into the Medication Safety Committee and then up to the Executive. The organisation reports on its infection control data to the Executive and to consumers. There is a consumer representative within the Infection Control Committee, who has also conducted ward audits that are focused on infection control. The organisation should consider the promotion of their infection control strategies and ensure they explain the meaning of the data to consumers for greater understanding into why and how this data was collected.	Met
3.3	Partnering with consumers 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	***Improvement Opportunities*** Infection Control Documents/Records: 3.3- The health service organisation encourages consumers to participate in providing feedback, conducting audits and reviewing the data in relation to Healthcare Associated Infections (HIA). Data from audits is presented in all wards and waiting areas. The organisation uses this information to inform clients of any emerging issues. The organisation should ensure consumers are able to fully comprehend the nature of Healthcare Associated Infection data displayed in all wards and waiting areas.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
3.4	Surveillance 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	Infection Control Documents/Records: The organisation collects surveillance data on Healthcare Associated Infections and gave two examples of how they were identified and how they were resolved through a collaborative working group approach. The working group was able to identify issues that had caused the Healthcare Associated Infections and trialed different initiatives to correct the prevalence of the infections. The working group rectified the nature and source of infection through education and training staff on the new process.	Met

Criterion:	**Infection prevention and control systems** Evidence-based systems are used to prevent and control healthcare-associated infections. Patients presenting with, or with risk factors for, infection or colonisation with an organism of local, national or global significance are identified promptly, and receive the necessary management and treatment. The health service organisation is clean and hygienic.			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
3.5	Standard and transmission-based precautions The health service organisation has	Met	***Improvement Opportunities*** Infection Control Documents/Records: 3.5 - The organisation ensures training of all staff in transmission-based precautions and have maintained their COVID-19 initiatives, ensuring support through signage, check-ins,	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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 Healthcare, and jurisdictional requirements		and process review. Policy and procedures cement the actions of the staff on a daily level from cleaners through to the Executive. All staff are aware of their responsibility. The organisation continually monitors its progress with the use of an audit schedule and being transparent in communicating their results to all staff and consumers. All staff are trained in transmission-based precautions with records in the Human Resources file and Clinical Nurse Educator data base. The organisation promotes the national standards via signage throughout the hospital including the use of transmission-based precautions. The organisation has developed a transmission-based precautions summary prompt sticker to clear patients of infectious diseases listed on the sticker. The Infection Control coordinator is notified of all positive pathology to ensure it is actioned at ward level. Although St Helen's Private Hospital has a buddy system in place to assist staff with donning and doffing of personal protective equipment (PPE), the assessor observed there were some minor issues with donning of masks. The organisation should ensure that all staff and visitors to the facility that are required to wear PPE are checked to ensure the PPE is worn correctly.	
3.6	Standard and transmission-based precautions 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 pre-existing colonisation or infection with organisms of local or national	Met	Infection Control Documents/Records: The organisation has a process to asses infection risks when patients identify at the Emergency Department and comply by policy and procedure for transmission-based precautions which includes isolation. Communication occurs at a clinical level and responsibility is shared within the organisation to ensure high levels of communication and identification are occurring. The organisation utilises signage from the Australian Commission on Safety and Quality in Healthcare to identify the rooms where infection risks are managed. The organisation does not have negative pressure rooms, however have immediate processes to transfer the patient to the next door health facility where infection risks can be better managed. Staff are trained in the donning and doffing of PPE and the correct order in which it is to be worn. Staff are also subject to FIT testing of PPE with data collected to determine risk which flows onto the training needs for the organisation. The organisation also conducts environmental cleaning and has cleaning procedures for	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		any transmissions isolation which is documented. The organisation uses signage, handover and information within the patient record to identify those patients/areas that need transmission-based precautions.	
3.7	Standard and transmission-based precautions 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	Infection Control Documents/Records: The organisation has a written policy outlining how to identify, manage, transfer and discharge patients with a known infection in addition to how patients can be removed from the risk management system when they meet the clearance criteria. The organisation has a transfer form that identifies and prompts clinical discussion of any infectious status of the patient both internally and externally. All internal transfers are discussed and managed to appropriately limit the spread of infection ensuring patients are placed at the end of a referral list with appropriate cleaning organised post transition through the hospital. All external transfers are discussed and identified to prepare any external organisation accepting patients. Patient resources are available for patients and visitors for preventing the spread of infections.	Met
3.8	Hand hygiene The health service organisation has a hand hygiene program that: a. Is consistent with the current National Hand Hygiene Initiative, and	Met	Infection Control Documents/Records: The organisation has a policy to ensure all staff are compliant with the National Hand Hygiene Initiative with all data from audits being presented to appropriate levels of governance and promoted to clients. All training and compliance records are maintained by the organisation in relation to Hand Hygiene. The organisation hand hygiene rates are over 90% with the Visiting Medical Officers over 90% also.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	jurisdictional requirements b. Addresses noncompliance or inconsistency with the current National Hand Hygiene Initiative			
3.9	Aseptic technique 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	***Improvement Opportunities*** Infection Control Documents/Records: 3.9 - The organisation has policies and procedures in place to ensure staff are trained and report on Aseptic Non Touch Technique (ANTT) through use of formal training and peer review. Competencies and training records are maintained. Audits are conducted to assure compliance with ANTT in all areas of the hospital which are reported to the appropriate level of governance. All findings are communicated through to staff and added to the quality boards for consumers to review. It is noted that the mobile sharps bin in St Helen's Private Hospital's Operating Theatre is being used by one doctor as a table on which to place the intravenous (IV) cannulation tray while the patient is being cannulated. The organisation should ensure appropriate equipment is available for clinicians to use when inserting IV cannulas. The practice of using the mobile sharps bin to rest the IV cannulation tray on should cease.	Met
3.10	Invasive medical devices 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	Met	Infection Control Documents/Records: The Health Service Organisation provides policies and procedures for staff and VMOs that outlines processes for the selection, insertion, maintenance and removal of invasive medical devices. The infection control surveillance data reflects audits conducted in relation to invasive medical devices which are reported to the appropriate levels of governance and communicated back to staff through the quality boards. The health service organisation utilises an Invasive Devices Register to monitor the devices used and has followed on with specific training for each device. Checklists and audits are used for invasive procedures to ensure all products used are documented and checked post procedure.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
3.11	Clean environment 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 Healthcare, 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	***Improvement Opportunities*** Infection Control Documents/Records: 3.11 - The health service organisation has an internal department known as Environmental Services and Catering which allows specific focus on environmental cleaning. Compliance with policy and procedure through regular auditing, spot checks and staff and consumer review enables the service to gain accurate knowledge of the environmental cleaning performance. All information from these reviews and audits are discussed at the Infection Control Committee and provided to the appropriate levels of governance. All data is reported through the organisation wide quality boards. Staff have a yearly refresher in PPE and are reminded through the e-learning system. Staff also receive training in cleaning and disinfectant products from 'ECOLAB' in an online format. All cleaning is conducted through schedules, allowing for spot cleaning to occur also. Maintenance of each site occurs through scheduled review and testing of the water outlets. All identified incidents and risk are reported through 'RISKMAN' and allocated to the appropriate meeting for discussion. It is noted that the Hobart Private Hospital and St Helen's Private Hospital have yet to implement stainless steel wire shelving in storage areas that complies with the latest hospital infection control guidelines. In addition some storage areas of the hospital remain carpeted. The organisation should review the storage areas of Hobart Private Hospital and St Helen's Private Hospital and consider installing wire shelving that complies with the latest hospital infection control guidelines. Remove carpets from these storage areas where possible.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
3.12	Clean environment 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	***Improvement Opportunities*** Infection Control Documents/Records: 3.12 - The organisation does evaluate and review infection risks associated with linen, equipment, devices, products, building furnishings and fittings within the building. Linen audits are conducted together with ensuring the contracted linen company complies with best practice. The organisation has schedules in place to ensure all equipment, furnishings and fittings are audited to review compliance. All new processes, equipment and furnishings are risk reviewed, with staff trained in new equipment prior to use. The organisation should assess the risk of having carpet in clinical areas and remove the carpet.	Met
3.13	Workforce immunisation The health service organisation has a risk-based workforce immunisation program that: a. Is consistent with the current edition of the Australian Immunisation Handbook b. Is consistent with jurisdictional requirements for vaccine-preventable diseases c. Addresses specific risks to the workforce and patients	Met	Infection Control Documents/Records: The organisation has a policy and procedure for risk-based workplace immunisations creating a slogan of "no jab, no job". Compliance is regularly reviewed and reported with an outline clearly identified of the organisation's requirements.	Met

Criterion:	**Reprocessing of reusable medical devices** Reprocessing of reusable equipment, instruments and devices is consistent with relevant current national standards, and meets current best practice
Rating:	**Met**

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
3.14	Reprocessing of reusable devices 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	***Improvement Opportunities*** Infection Control Documents/Records: 3.14 - The organisation is compliant with the Commission Advisory AS 18/07 Reprocessing of Reusable Medical Devices in Health Service Organisations (March 2021) as below. The organisation does complete the segregation of clean and dirty activities with the implementation of strategies to ensure unidirectional work and airflow to reduce the risk of cross contamination. They have identified and managed the risks associated with the gaps between current status and compliance with relevant national or international standards and have documented this in a gap analysis identifying and managing any risks of cross contamination. The organisation adheres to the design of storage areas for sterile stock in Hobart Private Hospital and is required to do similar in St Helen's Private Hospital by 31 December 2022. The Commission expects organisations to comply with requirements in relevant national or international standards for storage of sterile stock in compliant shelving. The organisation has mitigated the risk of contamination of sterile stock in storage. This includes assessing and managing the risk of humidity and temperature on stored sterile stock. The co-location of sterile and non-sterile stock in a storage area has been assessed within the AS/NZ4187 Gap assessment. Monitoring requirements for water quality have been occurring. Ensure sterile stock within St Helen's Private Hospital is stored correctly with the use of working air conditioners. The organisation is also completing the process of ensuring compliance with shelving requirements in each ward of the hospital and should maintain its momentum.	Met

Criterion:	**Antimicrobial stewardship** The health service organisation implements systems for the safe and appropriate prescribing and use of antimicrobials as part of an antimicrobial stewardship program			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
3.15	Antimicrobial stewardship 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	Met	Infection Control Documents/Records: Review of infection control documents shows an antimicrobial stewardship policy is in place that incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard.	Met
3.16	Antimicrobial stewardship 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	Met	Infection Control Documents/Records: Review of documentation shows the antimicrobial stewardship program includes the review of antimicrobial prescribing and use, surveillance data on antimicrobial resistance, evaluates performance of the program and reports to clinicians and the governing body.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body in relation to • 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			

Medication Safety Standard

Leaders of a health service organisation describe, implement and monitor systems to reduce the occurrence of medication incidents, and improve the safety and quality of medication use. The workforce uses these systems.

Intention of this standard
To ensure clinicians are competent to safely prescribe, dispense and administer appropriate medicines and to monitor medicine use. To ensure consumers are informed about medicines and understand their individual medicine needs and risks.

Criterion:	**Clinical governance and quality improvement to support medication management** Organisation-wide systems are used to support and promote safety for procuring, supplying, storing, compounding, manufacturing, prescribing, dispensing, administering and monitoring the effects of medicines.			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
4.1	Integrating clinical governance 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	Medication Safety Documents/Records: Medication safety across HPH and SHPH is governed by the Medication Safety Committee. The primary aim of this Committee is to reduce medication-related errors and potential harm to patients. Governed by a Terms of Reference, the Committee meets on a regular basis and is accountable to the Quality and Risk Management Committee and reports to the Medical Advisory Committee. A senior pharmacist is available to assist with medication safety across both sites. Document review of corporate and local policies including the Medication Safety Governance Policy and Procedure (date last review March 2018), shows the safety and quality system is applied when implementing policies, managing risks and identifying training requirements for medication management. The development and review of medication policy is consistent with the broader Healthscope Policy Management Frameworks. The clinical leads interviewed at HPH and SHPH could describe how the safety and quality systems are applied when implementing policies, managing risks and identifying training requirements for medication management. Interview with the senior pharmacist provided further evidence that medication safety is taken seriously and that medication risks are able to be identified and escalated as necessary.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			Observation of clinicians' practice at HPH and SHPH demonstrated use of the health service organisation's processes for medication management. This is evidenced by quality Board information as well as audit and feedback mechanisms. ***Improvement Opportunities*** Medication Safety Documents/Records: 4.1 - It is noted that the Medication Safety Governance Policy and Procedure is referenced to the first edition of the National Safety and Quality Health Services Standards and other outdated documents, for example, Healthscope Shared Learning's April to June 2017. Review the Medication Safety Governance Policy and Procedure to ensure that it contains up to date and relevant information. 4.1 - The Medication Safety Committee is yet to create a consolidated action list that is presented to each meeting together with the nominated action owner and date of completion to facilitate tracking of the actions and their completion. Recommendation: Create a consolidated action list that is presented to each medication safety committee meeting, together with the nominated action owner and date of completion to facilitate tracking of the actions and their completion. A further improvement would be to include an evaluation of the implementation of actions.	
4.2	Applying quality improvement systems 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	Met	Medication Safety Documents/Records: Document review including the National Standard Medication Chart Audit Results for the period September to October 2020, shows the quality improvement system is applied when monitoring, improving and reporting on outcomes for medication management. It is noted that the audit results for HPH and SHPH have identified practice gaps in medication safety that the health service is in the process of addressing. For example, this includes medication history documented on chart or documented elsewhere and cross referenced on chart, indication documented on all medication orders and venous thrombo-embolism (VTE) risk assessment completed and where indicated prophylaxis	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	medication management outcomes and associated processes c. Reporting on outcomes for medication management		prescribed. This forms the basis of a Met with Recommendation included in Standard One. Clinical leads interviewed could describe how the quality improvement system is applied when monitoring, improving and reporting on outcomes for medication management. The staff described a culture that supports incident reporting and quality improvement. Verification shows processes are in place for clinicians to implement strategies to improve medication management outcomes and associated processes. For example, where opportunities for improvement in medication management at SHPH were identified by the Assessment Team, these were actioned immediately and a Quality Improvement Plan generated. ***Improvement Opportunities*** Medication Safety Documents/Records: 4.2 - Staff interview and direct observation of the medication area at SHPH finds that additional strategies could be implemented to reduce distractions during medication preparation and administration. Implement additional strategies to reduce noise and potential distractions during medication preparation and administration at SHPH. Review the location of medication errors to determine if this may be a cause of the higher rate of medication errors at SHPH. 4.2 - Staff interview and document review finds that separate medication charts for adult and paediatric patients are yet to be implemented. Progress with plans to implement separate adult and paediatric medication charts.	
4.3	Partnering with consumers Clinicians use organisational processes	Met	Medication Safety Documents/Records: Review of medication safety documentation shows the partnering with consumer standards are applied to ensure patients are actively involved in their own care and that information needs are met. For example, the Consumer Consultants do "rounds" and	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		invite patients to survey with the intention of understanding their satisfaction with medication information. Interviews with clinical leads confirmed process from partnering with consumers are applied when involving patients in planning and making decisions about their medication management. Staff report that patient specific information is available in languages other than English and an onsite interpreter service is requested as required. Observation of clinicians' practice shows use of the health service organisation's processes for partnering with consumers. It is noted that the readability of quality boards that provide medication related information needs to be improved to ensure patients with varied levels of health literacy understand the data. ***Improvement Opportunities*** Medication Safety Documents/Records: 4.3 - Staff report that the readability of the quality boards in patient areas could be improved to ensure that patients understand the medication data presented. Review the quality boards and other notice boards in patient areas and assess the readability and patient comprehension of medication related information. Consider using pictures and infographics to improve patient comprehension.	
4.4	Medicines scope of clinical practice 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	Medication Safety Documents/Records: Review of medication safety documentation including corporate credentialing and medication safety policy documents shows processes are in place to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians. Visiting Medical Officers must be credentialed and have a prescribed scope of clinical practice before commencing clinical practice in any capacity. An annual nursing credentialing audit is completed using the Australian Health Practitioner Regulation Agency (APHRA). Interviews with clinical leads confirmed processes are in place to ensure that only clinicians with the relevant authority prescribe, dispense or administer medicines. There	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			are robust reporting, investigation and response processes in place to ensure immediate action if any clinicians are observed to be operating outside of their scope of practice. Verification confirmed that processes are in place to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians. The assessment team observed an effective communication system to promote medication safety including the use of shared learnings and education sessions provided by the senior pharmacist.	

Criterion:	**Documentation of patient information** A patient's best possible medication history is recorded when commencing an episode of care. The best possible medication history, and information relating to medicine allergies and adverse drug reactions are available to clinicians.			
Rating:	**Met with recommendations**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
4.5	Medication reconciliation 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 with recommendations	***Met with Recommendation:*** Medication Safety Documents/Records: 4.5 - Review of medication safety documentation including corporate and local policies for medication management shows a process is in place for obtaining and documenting a best possible medication history. This forms the basis for therapeutic decision making and supports the identification of adverse medicines events. All patients receive a comprehensive medications assessment by the nursing and medical staff on admission to hospital and patients at higher risk of harm are referred to the pharmacy service for review. Clinical leads interviewed could describe the processes used to obtain and record a best possible medication history in the patient's healthcare record. It is noted that while SHPH achieved 100% compliance for Medication history documented on chart or documented elsewhere and cross referenced on chart for the National Standard Medication Chart Audit (reporting period 21 September to 16 October 2020), HPH received a compliance rate of only 49%. Staff interviewed could describe the medication safety strategies in	Met with recommendations

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			place to address this gap in clinical practice. It was particularly noted that the medical officers are not routinely completing the "indication" section on the medication chart and that the VTE sections were not consistently completed where necessary. Since this is a continuing problem, as evidenced by previous audits, the assessors considered that this was a continuing risk and so have set a rating of met with recommendations. It is also noted that the Critical Care Flow Chart – Level 1 Trial document, currently in use in the Coronary Care Unit (CCU) at HPH, has limited space to record medication information including those delivered by intravenous infusion. This is a particular issue for the documentation of infusions with additives. The hospitals review the continuing issue with respect to incomplete medication charts and devise solutions to improve compliance. ***Improvement Opportunities:*** The Critical Care Flow Chart – Level 1 Trial document could include an expansion of sections related to medication administration including that pertaining to intravenous infusion.	
4.6	Medication reconciliation 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	Medication Safety Documents/Records: Review of medication safety documentation shows a process is in place for medication reconciliation on admission, at transitions of care and on discharge. A medication reconciliation audit tool is in place to ensure compliance with the medication reconciliation process. This audit occurs biannually at HPH and SHPH. Medication reconciliation results are reported to the Australian Council on Healthcare Standards Clinical Indicator Program and are at a satisfactory level. Verification confirms the 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

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			Medication Safety Interview/Observation: Verification confirms the 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.	
4.7	Adverse drug reactions 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	Medication Safety Documents/Records: Review of medication safety documentation shows a process is in place for recording a patient's known medicine allergies and adverse drug reactions on presentation. Patient allergies are entered into 'Webpas' and in hardcopy on the patient alert sheet on admission to HPH and SHPH. This information is updated as required and forms parts of the patient's discharge summary. Interviews with clinical leads confirmed the processes for ensuring that a patient's history of medicine allergies and adverse drug reactions is recorded when taking a best possible medication history on presentation. Verification confirms processes are in place for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation. Adverse drug reactions and other medication incidents are a standing agenda item for the Medication Safety Committee and are reported to the relevant clinical review committees.	Met
4.8	Adverse drug reactions 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	Medication Safety Documents/Records: Review of medication safety documentation shows a process is in place for recording new medicine allergies and adverse drug reactions experienced during an episode of care. Alerts are included as part of the bedside clinical handover and red wrist bands are in use to indicate a medication risk. The reason for the red wrist band is established from the patient record. Clinical leads interviewed described the process for ensuring all medicine allergies and adverse drug reactions experienced by a patient during an episode of care are recorded in the patient's healthcare record, and reported in the incident management and investigation system. All adverse drug reactions are reported through 'Riskman' and to the Senior Pharmacist who reports directly to the Therapeutic Goods Administration.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			Verification confirms processes are in place 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.	
4.9	Adverse drug reactions 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	Medication Safety Documents/Records: Review of medication safety documentation shows a process is in place for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration. Interviews with clinical leads confirmed there is a process in place for reporting all new suspected adverse drug reactions experienced by patients during their episode of care to the Therapeutic Goods Administration. Verification confirms processes are in place for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements. Medication Safety Interview/Observation: Interviews with clinical leads confirmed there is a process in place for reporting all new suspected Adverse Drug Reactions (ADRs) experienced by patients during their episode of care to the Therapeutic Goods Administration (TGA). Medication Safety Observation: Verification confirms processes are in place for reporting Adverse Drug Reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements.	Met

Criterion:	**Continuity of medication management** A patient's medicines are reviewed, and information is provided to them about their medicines needs and risks. A medicines list is provided to the patient and the receiving clinician when handing over care.
Rating:	**Met**

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
4.10	Medication review 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	Medication Safety Documents/Records: Review of medication safety documentation shows processes are in place for medication reviews to be conducted and documented. Pharmacy reports of prescription errors and near miss incidents are reported to the Medication Safety Committee and any relevant Clinical Review Committee. Clinical leads interviewed could describe the processes in place for medication reviews and how these are documented. Staff report that examination of incident trends across both Hospitals has led to the development of local medication safety strategies. Verification confirms processes in are place to perform medication reviews for patients, in line with evidence and best practice.	Met
4.11	Information for patients The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks	Met	Medication Safety Documents/Records: Review of medication safety documentation shows patient information about their individual medicines needs and risks is available in different languages. Interview with clinical leads confirmed the process for providing patients with information about their individual medicines needs and risks. Observation of facilities and equipment shows that information about medicines needs and risks is available for clinicians to use during discussions with patients and carers. Visiting Medical Officers and nursing staff have access to the eMims for prescribing information, consumer medicine information and pharmaceutical product images.	Met
4.12	Provision of a medicines list 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	Met	Medication Safety Documents/Records: Review of medication safety documentation shows a process is in place to generate a current medicines list. This information is obtained on admission and updated throughout the patient's hospital stay. Clinical leads interviewed described the process to generate a current medicines list and distribute at transition of care or patient discharge. Medication profiles are completed for	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	to receiving clinicians at transitions of care c. Provide patients on discharge with a current medicines list and the reasons for any changes		high risk patients and reviewed by a clinical pharmacist. Verification shows processes are in place to generate a current medicines list and the reasons for any changes.	

Criterion:	**Medication management processes** Health service organisations procure medicines for safety. Clinicians are supported to supply, store, compound, manufacture, prescribe, dispense, administer, monitor and safely dispose of medicines			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
4.13	Information and decision support tools for medicines The health service organisation ensures that information and decision support tools for medicines are available to clinicians	Met	Medication Safety Documents/Records: Observation of facilities and equipment shows up-to-date decision support tools such as protocols, guidelines and medicine related information resources are available in clinical areas. The Medication Safety Committee is responsible for assessing the quantity and quality of available data and information related to medication safety and take appropriate actions to improve data/information sources. Clinical leads interviewed could describe how the health service organisation ensures that medicine-related information and decision support tools are up to date and available to clinicians at the point of decision-making. Observation of facilities and equipment shows that up-to-date decision support tools such as protocols, guidelines and medicine related information resources are available in clinical areas (in electronic or hard copy).	Met
4.14	Safe and secure storage and distribution of medicines The health service organisation complies	Met	***Improvement Opportunities*** Medication Safety Documents/Records: 4.14 - Review of medication safety documentation shows a process is in place for the safe and secure distribution and storage of medicines (including Schedule 8, Schedule 4 and Schedule 4D medicines, temperature-sensitive medicines and cold chain management)	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		and the correct disposal of unused, unwanted or expired medicines. Clinical leads interviewed could describe how all medicines (including temperature-sensitive medicines) are stored, handled and disposed of according to manufacturers' directions legislation, and jurisdictional requirements. Verification confirms the health service organisation ensures the safe and secure storage and distribution of medicines. Staff in the Coronary Care Unit state that the locked medication drawers are not big enough to store all patient medication that is permitted to be stored at the bedside. Review the size of the bedside medication drawers and consider allocating a larger space to incorporate all patient medications that are permitted to be stored at the bedside.	
4.15	High-risk medicines 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	Medication Safety Documents/Records: Review of medication safety documentation shows a process is in place for identifying, storing, prescribing, dispensing, administering and monitoring high-risk medicines. A high risk medication policy is in place to mandate the minimum requirements for the safe management of high risk medications across both hospitals. Interview with clinical leads confirmed high-risk medicines are identified and a system is in place to store, prescribe, dispense and administer them. Both hospitals display information about medications universally considered to be high risk as outlined by the A PINCH acronym. Verification confirms the health service organisation identifies high-risk medicines used within the organisation. Risk reduction strategies and best practice standards are in place for prescribing, dispensing or administering high risk medications.	Met

Comprehensive Care Standard

Leaders of a health service organisation set up and maintain systems and processes to support clinicians to deliver comprehensive care. They also set up and maintain systems to prevent and manage specific risks of harm to patients during the delivery of health care. The workforce uses the systems to deliver comprehensive care and manage risk.

Intention of this standard
To ensure that patients receive comprehensive care – that is, coordinated delivery of the total health care required or requested by a patient. This care is aligned with the patient's expressed goals of care and healthcare needs, considers the effect of the patient's health issues on their life and wellbeing, and is clinically appropriate.

To ensure that risks of harm for patients during health care are prevented and managed.
Clinicians identify patients at risk of specific harm during health care by applying the screening and assessment processes required in this standard.

Criterion:	**Clinical governance and quality improvement to support comprehensive care** Systems are in place to support clinicians to deliver comprehensive care			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
5.1	Integrating clinical governance 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	***Improvement Opportunities*** Clinical Gov and QI to Support Comprehensive Care Documents/Records: 5.1 - The organisation has a nurse led committee that encompasses quality and safety that reviews data from audits specific to comprehensive care which includes areas surrounding risk assessments, daily and comprehensive care planning. All data is submitted through appropriate levels of governance and communicated to staff. The organisation has clearly identified roles and responsibilities for all staff, including allied health in ensuring comprehensive care. The organisation has screening and assessment processes for all departments of the service which include identifying patients at end of life care and minimising patient harm. Mandatory training in comprehensive care is conducted by the organisation. The organisation should clearly define the role of the "responsible person".	Met
5.2	Applying quality improvement systems	Met	Clinical Gov and QI to Support Comprehensive Care Documents/Records: The organisation has strategies in place to improve health outcomes of their patients	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		through comprehensive care including reviewing processes, reviewing administrative and clinical data from audits of screening assessments and shared decision making processes. Data is presented to the appropriate committees for review. The organisation has created various initiatives which encompasses comprehensive care such as the Falls Project created to reduce the occurrences of post surgical and in hospitals falls.	
5.3	Partnering with consumers 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	Clinical Gov and QI to Support Comprehensive Care Documents/Records: The organisation has processes in place to include patients in their own care through acknowledging their care plans by signature and ensuring they understand all elements of their care plan.	Met
5.4	Designing systems to deliver comprehensive care 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	Met	Clinical Gov and QI to Support Comprehensive Care Documents/Records: The organisation has polices in relation to care planning and the responsible person. The healthcare record and the process of care flags patients with specific health needs and priorities. Clinicians interviewed also understand the process of how to assess patients, complete care plans including transfer/discharge planning and prioritising care through their roles and responsibilities and training. The organisation utilises standard tools and templates for care planning. Audits are conducted on the health care record including care planning and audit results are reported to the appropriate committee.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	specialist healthcare needs to relevant services d. Identify, at all times, the clinician with overall accountability for a patient's care		Collaboration with referring agencies also occurs via Memoranda of Understanding with the Royal Hobart Hospital in place for various emergent healthcare outcomes.	
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	Clinical Gov and QI to Support Comprehensive Care Documents/Records: Collaboration occurs within the organisation via involvement of allied health staff and VMO's through participation in joint committees and the open transfer of information from specific committees. Policy describes the collaboration process with the governance structure supporting communication processes. The staff interviewed are aware of reporting lines and communication processes.	Met
5.6	Clinicians work collaboratively to plan and deliver comprehensive care	Met	Clinical Gov and QI to Support Comprehensive Care Documents/Records: Review of documentation shows processes are in place that enable clinicians to work collaboratively to plan and deliver comprehensive care with supporting resources to promote decision making and collaborative practice.	Met

Criterion:	**Developing the comprehensive care plan** Integrated screening and assessment processes are used in collaboration with patients, carers and families to develop a goal-directed comprehensive care plan			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
5.7	Planning for comprehensive care 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	Developing the Comprehensive Care Plan Documents/Records: The organisation has processes in place through their screening tools to ensure risk of harm is assessed, reviewed and acted upon.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
5.8	Planning for comprehensive care 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	Developing the Comprehensive Care Plan Documents/Records: Review of documentation shows process are in place for identifying Aboriginal and Torres Strait Islander patients, and recording this information in administrative and clinical information systems. Developing the Comprehensive Care Plan Interview/Observation: Clinical leads interviewed could describe the processes in place for patients to identify as being of Aboriginal or Torres Strait Islander origin. Verification confirms 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
5.9	Planning for comprehensive care Patients are supported to document clear advance care plans	Met	Developing the Comprehensive Care Plan Observation: Verification confirms the health service organisation supports patients to document clear advance care plans.	Met
5.10	Screening of risk 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	Developing the Comprehensive Care Plan Documents/Records: Review of documentation shows processes are in place for conducting screening that identifies when routine screening will occur to identify cognitive, behavioural, mental and physical conditions, issues and risks of harm and social and other circumstances that may compound these risks. Developing the Comprehensive Care Plan Interview/Observation: Clinical leads interviewed could describe the processes used screening of risk at presentation, during clinical examination, at history taking and at other appropriate times. Developing the Comprehensive Care Plan Observation: Observation of clinicians' practice showed the use of relevant screening processes.	Met
5.11	Clinical assessment	Met	Developing the Comprehensive Care Plan Documents/Records: Review of documentation shows processes are in place to comprehensively assess the conditions and risks identified through the screening process.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	Clinicians comprehensively assess the conditions and risks identified through the screening process		Developing the Comprehensive Care Plan Interview/Observation: Clinical leads interviewed could explain the process for assessing the conditions and risks identified through the screening process. Developing the Comprehensive Care Plan Observation: Observation of facilities and equipment showed the use of standardised assessment processes, tools and resources.	
5.12	Developing the comprehensive care plan Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record	Met	Developing the Comprehensive Care Plan Documents/Records: Documentation reviewed shows processes for recording the findings of screening an clinical assessments. Developing the Comprehensive Care Plan Interview/Observation: Observation of facilities and equipment shows that workforce computer access to healthcare records in clinical areas. Developing the Comprehensive Care Plan Observation: Observation of facilities and equipment shows that workforce computer access to healthcare records in clinical areas.	Met
5.13	Developing the comprehensive care plan 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	Met	Developing the Comprehensive Care Plan Documents/Records: Review of documentation shows shared decision making processes consistent with best practice are in place to develop and document a comprehensive and individualised plan that addresses the significance and complexity of the patient's health issues and risks of harm and identifies agreed goals and actions for the patient's treatment and care. Documentation shows support people are identified and discharge planning commences at the beginning of the episode of care including a plan for referral to follow-up services. Developing the Comprehensive Care Plan Interview/Observation: Clinical leads interviewed could describe the processes in place for shared decision making between clinicians and the patient, carer and support people.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		Developing the Comprehensive Care Plan Observation: Observation of clinicians' practice confirms the use of the health service organisation's processes for shared decision making in undertaken.	

Criterion:	**Delivering comprehensive care** Safe care is delivered based on the comprehensive care plan, and in partnership with patients, carers and families. Comprehensive care is delivered to patients at the end of life			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
5.14	Using the comprehensive care plan 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	Delivering Comprehensive Care Documents/Records: Review of documentation shows processes are in place to ensure the workforce, patients, carers and families work in partnership to use the comprehensive care plan to deliver care, monitor the effectiveness, review and update and reassess the patient's needs if changes occur. Delivering Comprehensive Care Interview/Observation: Observation of clinicians, carers and patients confirmed a collaborative approach to deliver a comprehensive care plan, including monitoring and reviewing the plan as needed. Delivering Comprehensive Care Observation: Observation of clinicians, carers and patients confirmed a collaborative approach to deliver a comprehensive care plan, including monitoring and reviewing the plan as needed.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
5.15	Comprehensive care at the end of life 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	Met	Delivering Comprehensive Care Documents/Records: Review of documentation shows processes are in place for identifying patients who are at the end of life that are consistent with the Consensus Statement. Delivering Comprehensive Care Interview/Observation: Clinical leads interviewed could describe the processes in place to identify patients who are at the end of their life. Delivering Comprehensive Care Observation: Verification confirms the health service organisation has processes to identify patients who are at the end of life.	Met
5.16	Comprehensive care at the end of life The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice	Met	Delivering Comprehensive Care Documents/Records: Review of documentation shows processes to access specialist palliative care advice within the health service organisation or externally. Delivering Comprehensive Care Interview/Observation: Observation of facilities and equipment shows that information about how to access specialist palliative care advice is readily accessible for clinicians when providing care. Delivering Comprehensive Care Observation: Observation of facilities and equipment shows that information about how to access specialist palliative care advice is readily accessible for clinicians when providing care.	Met
5.17	Comprehensive care at the end of life 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	Delivering Comprehensive Care Documents/Records: Review of documentation shows the requirements for documenting advance care plans in the patient's healthcare record. Delivering Comprehensive Care Interview/Observation: Verification shows processes are in place to ensure that current advance care plans can be received from patients and are documented in the patient's healthcare record. Delivering Comprehensive Care Observation:	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			Verification shows processes are in place to ensure that current advance care plans can be received from patients and are documented in the patient's healthcare record.	
5.18	Comprehensive care at the end of life The health service organisation provides access to supervision and support for the workforce providing end-of-life care	Met	Delivering Comprehensive Care Documents/Records: Review of documentation shows processes for accessing supervision and support in providing end-of life care. Delivering Comprehensive Care Interview/Observation: Clinical leads interviewed confirmed that members of the workforce receive supervision and support when delivering end-of-life care. Delivering Comprehensive Care Observation: Observation of facilities and equipment shows that information about support services is readily available for the workforce that provides end-of-life care.	Met
5.19	Comprehensive care at the end of life 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	Delivering Comprehensive Care Documents/Records: Review of documentation shows processes for routinely reviewing the safety and quality of end-of-life care that is provided. Delivering Comprehensive Care Interview/Observation: Verification confirms processes are in place for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care. Delivering Comprehensive Care Observation: Verification confirms processes are in place for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care.	Met
5.20	Comprehensive care at the end-of-life Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the National Consensus Statement: Essential	Met	Delivering Comprehensive Care Documents/Records: Review of documentations shows processes are in place for clinicians to support patients, carers and families to make shared decisions about end-of-life care. Delivering Comprehensive Care Interview/Observation: Verification confirms that the clinicians support patients, carers and families to make shared decisions about end-of-life care.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	elements for safe and high-quality end-of-life care		Delivering Comprehensive Care Observation: Verification confirms that the clinicians support patients, carers and families to make shared decisions about end-of-life care.	

Criterion:	**Minimising patient harm** Patients at risk of specific harm are identified, and clinicians deliver targeted strategies to prevent and manage harm			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
5.21	Preventing and managing pressure injuries 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	Minimising Patient Harm Documents/Records: Review of documentation shows process are in place for preventing and managing pressure injuries that are consistent with best-practice guidelines. Minimising Patient Harm Observation: Observation of facilities and equipment shows that best-practice guidelines are used by the clinical workforce.	Met
5.22	Preventing and managing pressure injuries 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	Minimising Patient Harm Documents/Records: Review of documentation shows protocols for time frames and frequency of skin inspections are in place. Minimising Patient Harm Interview/Observation: Verification confirms that 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. Minimising Patient Harm Observation: Verification confirms that clinicians providing care to patients at risk of developing, or	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency.	
5.23	Preventing and managing pressure injuries 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	Minimising Patient Harm Documents/Records: Review of documentation shows process are in place to manage patients at risk of pressure injuries. Minimising Patient Harm Interview/Observation: Verification confirms that the health service organisation ensures that patients, carers and families are provided with information about preventing pressure injuries.	Met
5.24	Preventing falls and harm from falls 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	Minimising Patient Harm Documents/Records: Review of documentation shows process are in place for providing services to patients at risk of falls that are consistent with best-practice guidelines. Minimising Patient Harm Interview/Observation: Observation of facilities and equipment shows the use of falls prevention plans. Minimising Patient Harm Observation: Observation of facilities and equipment shows the use of falls prevention plans.	Met
5.25	Preventing falls and harm from falls 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	Minimising Patient Harm Documents/Records: Observation of facilities and equipment shows equipment, devices and tools are available to promote safe mobility and manage the risks of falls. Minimising Patient Harm Interview/Observation: Verification confirms equipment, devices and tools are available to promote safe mobility and manage the risks of falls.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			Minimising Patient Harm Observation: Verification confirms equipment, devices and tools are available to promote safe mobility and manage the risks of falls.	
5.26	Preventing falls and harm from falls 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	Minimising Patient Harm Documents/Records: Review of consumer documentation shows information is available about falls risks. Minimising Patient Harm Interview/Observation: Verification confirms the health service organisation provides care to patients at risk of falls and provide patients, carers and families with information about reducing falls risks and falls prevention strategies. Minimising Patient Harm Observation: Verification confirms the health service organisation provides care to patients at risk of falls and provide patients, carers and families with information about reducing falls risks and falls prevention strategies.	Met
5.27	Nutrition and hydration 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	Minimising Patient Harm Documents/Records: Documentation reviewed shows processes are in place for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice. Minimising Patient Harm Interview/Observation: Observation of facilities and equipment shows that best-practice guidelines about nutrition and hydration are accessible for the workforce that prepares nutrition plans. Minimising Patient Harm Observation: Observation of facilities and equipment shows that best-practice guidelines about nutrition and hydration are accessible for the workforce that prepares nutrition plans.	Met
5.28	Nutrition and hydration The workforce uses the systems for	Met	Minimising Patient Harm Documents/Records: Review of documentation shows systems for preparation and distribution of food and fluids are in place to meet, monitor, identify and support patients' nutritional needs and requirements.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		Minimising Patient Harm Interview/Observation: Observation shows the preparation and distribution of food and fluids to support and meet a patients' nutritional needs and requirements. Minimising Patient Harm Observation: Observation shows the preparation and distribution of food and fluids to support and meet a patients' nutritional needs and requirements.	
5.29	Preventing delirium and managing cognitive impairment 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 Standard, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation	Met	Minimising Patient Harm Documents/Records: Documentation reviewed shows processes are in place for providing services to patients who have cognitive impairment or are at risk of developing delirium. Minimising Patient Harm Interview/Observation: Clinical leads interviewed could describe the processes in place to manage safety and quality issues for patients with, or at risk of, developing cognitive impairment. Minimising Patient Harm Observation: Verification confirms 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.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
5.30	Preventing delirium and managing cognitive impairment 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	Minimising Patient Harm Documents/Records: Documentation reviewed shows systems are in place to be used for caring for patients with cognitive impairment. Minimising Patient Harm Interview/Observation: Verification confirms processes are in place to recognise, prevent, treat and manage cognitive impairment. Minimising Patient Harm Observation: Verification confirms processes are in place to recognise, prevent, treat and manage cognitive impairment.	Met
5.31	Predicting, preventing and managing self harm and suicide 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	Minimising Patient Harm Documents/Records: Review of documentation shows systems to support collaboration with patients, carers and families when a patient is at risk of self-harm or suicide. Minimising Patient Harm Interview/Observation: Observation of facilities and equipment shows that information about referring patients to specialist mental health services is accessible to clinicians. Minimising Patient Harm Observation: Observation of facilities and equipment shows that information about referring patients to specialist mental health services is accessible to clinicians.	Met
5.32	Predicting, preventing and managing self-harm and suicide	Met	Minimising Patient Harm Documents/Records: Documentation reviewed shows for people who have harmed themselves or reported suicidal thoughts have follow-up arrangements developed, communicated and	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts		implemented. Minimising Patient Harm Interview/Observation: Verification confirms the health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts. Minimising Patient Harm Observation: Verification confirms the health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts.	
5.33	Predicting, preventing and managing aggression and violence The health service organisation has processes to identify and mitigate situations that may precipitate aggression	Met	Minimising Patient Harm Documents/Records: Review of documentation shows process are in place to identify and mitigate situations that may precipitate aggression. Minimising Patient Harm Interview/Observation: Observation of facilities shows the design and use of the environment to minimise sources of potential conflict and additional stresses for patients. Minimising Patient Harm Observation: Observation of facilities shows the design and use of the environment to minimise sources of potential conflict and additional stresses for patients.	Met
5.34	Predicting, preventing and managing aggression and violence 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	Met	Minimising Patient Harm Documents/Records: Review of documentation shows process are in place to support collaboration with patients, carers and families for those identified at risk of becoming aggressive or violent. Minimising Patient Harm Interview/Observation: Clinical leads interviewed could describe the processes in place for predicting, preventing and managing aggression and violence. Minimising Patient Harm Observation:	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	minimise harm to patients, carers, families and the workforce		Observation of facilities and equipment showed that on-call members of the security workforce are available.	
5.35	Minimising restrictive practices: restraint 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	Minimising Patient Harm Documents/Records: Documentation reviewed shows systems are in place to minimise the use of restraint. Minimising Patient Harm Interview/Observation: Verification confirms the health service organisation has systems in place to minimise the use of restraint where clinically necessary to prevent harm. Minimising Patient Harm Observation: Verification confirms the health service organisation has systems in place to minimise the use of restraint where clinically necessary to prevent harm.	Met
5.36	Minimising restrictive practices: seclusion 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	Minimising Patient Harm Documents/Records: Review of documentation shows systems are in place to minimise the use of seclusion. Minimising Patient Harm Interview/Observation: Verification confirms the health service organisation has systems in place to minimise and, where possible, eliminate the use of seclusion. Minimising Patient Harm Observation: Verification confirms the health service organisation has systems in place to minimise and, where possible, eliminate the use of seclusion.	Met

Communicating for Safety Standard

Leaders of a health service organisation set up and maintain systems and processes to support effective communication with patients, carers and families; between multidisciplinary teams and clinicians; and across health service organisations. The workforce uses these systems to effectively communicate to ensure safety.

Intention of this standard
To ensure timely, purpose-driven and effective communication and documentation that support continuous, coordinated and safe care for patients.

Criterion:	**Clinical governance and quality improvement to support effective communication** Systems are in place for effective and coordinated communication that supports the delivery of continuous and safe care for patients			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
6.1	Integrating clinical governance 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	***Improvement Opportunities*** Communicating for Safety Documents/Records: 6.1 - Review of documentation shows safety and quality systems are used when implementing policies, managing risks and identifying training for effective and coordinated clinical communication. Both HPH and SHPH have a local Clinical Handover Framework to support the transfer of clinical accountability and responsibility between healthcare professionals and enable continuity of care for the patient. It is noted that the functions of a Communicating for Safety Committee are currently undertaken by the Quality and Risk Management Committee and the Senior Nurses' Committee. Clinical leads interviewed could describe how the safety and quality systems are used when implementing policies, managing risks and identifying training requirements for effective and coordinated clinical communication. Observation of clinicians' practice showed use of the health service organisation's clinical communication processes. Observation of clinical handover in two wards of HPH found that handover was comprehensive and conducted in a similarly structured manner. Handover in theatre at SHPH was also observed and found to be consistent with best practice. It is noted that the functions of a Communicating for Safety Committee are currently	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			undertaken by other committees including the Quality and Risk Management Committee and the Senior Nurses' Committee. The organisation could consider reconvening a dedicated Communicating for Safety Committee. Consider reconvening the Communicating for Safety Committee to review clinical communication practices across HPH and SHPH and facilitate alignment with the NSQHS standards.	
6.2	Applying quality improvement systems 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	Communicating for Safety Documents/Records: Review of documentation shows quality improvement systems are applied when monitoring, implementing and reporting on the effectiveness and outcomes of clinical communication processes. Quality key performance indicators are reported quarterly and include audit results and incidents related to clinical handover. The overall aim is to enhance patient safety by ensuring systems and processes are in place to provide a consistent approach to clinical handover. Interview with clinical leads confirmed the quality improvement system is applied when monitoring, implementing and reporting on the clinical communication processes. Verification confirms that HPH and SHPH monitor the effectiveness of clinical communication and associated processes and implement strategies to improve clinical communication and associated processes.	Met
6.3	Partnering with consumers 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	Communicating for Safety Interview/Observation: Clinical leads interviewed could describe how consumer partnership standards are applied when involving patients in their care, meeting their information needs and shared decision making. Communicating for Safety Observation: Observation of clinicians' practice showed use of the health service organisation's processes for partnering with consumers. ***Improvement Opportunities*** Communicating for Safety Documents/Records:	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			6.3 - Review of documentation shows consumer partnering processes are applied for involving patients, providing information and sharing decision making. This approach is supported by the Consumers – Partnering Policy (date last review October 2018) that sets out how each hospital is responsive to and maximises the involvement of patient, carers and families. Clinical leads interviewed could describe how consumer partnership standards are applied when involving patients in their care, meeting their information needs and shared decision making. Observation of clinicians' practice showed use of the health service organisation's processes for partnering with consumers. Clinical handover observed at HPH and SHPH found that patient were actively involved in the process. It is noted that the Consumers – Partnering Policy is referenced to outdated documents. Review the Consumers – Partnering Policy to ensure that it contains relevant and up-to-date information.	
6.4	Organisational processes to support effective communication 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	Met	Communicating for Safety Documents/Records: Review of documentation shows clinical communication processes are in place for identification and procedure matching, transferring care and critical information about a patient's care. The 'Webpas' clinical information system requires a minimum of three approved identifiers on emergency department registration and admission. Clinical leads interviewed described the process for patient identification, procedure matching, clinical handover and communication of critical information or risks. Patient identification is confirmed before any examination, treatment, investigations, collection of pathology samples, blood transfusion, drug administration or imaging undertaken. Verification confirms that HPH and SHPH have clinical communications processes in place to support effective communication when identification and procedure matching and patient handover of care occurs.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	care, including information on risks, emerges or changes			

Criterion:	**Correct identification and procedure matching** Systems to maintain the identity of the patient are used to ensure that the patient receives the care intended for them			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
6.5	Correct identification and procedure matching 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	Communicating for Safety Documents/Records: Review of identification and procedure matching documentation shows defined approved patient identifiers and processes to use at least three approved identifiers are in place. For example, the Patient Identification and Intra-operative Requirements Policy (date last review February 2017) clearly sets out the requirements for confirmation of the correct identification of patients entering the operating theatre and anticipation of unique or additional instrument/equipment requirements to ensure timely, safe and competent intra-operative care. Clinical leads interviewed could describe the processes used to ensure consistent and correct identification of patients and when three approved patient identifiers are used. Verification confirms that HPH and SHPH require 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. Communicating for Safety Interview/Observation: Clinical leads interviewed could describe the processes used to ensure consistent and correct identification of patients and when three approved patient identifiers are used. Communicating for Safety Observation: Verification confirms the health service organisation requires at least three approved	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated.	
6.6	Correct identification and procedure matching 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	***Improvement Opportunities*** Communicating for Safety Documents/Records: 6.6 - Review of documentation shows processes are in place for correctly matching patients to care and the information that should be documented. For example, a Correct Patient, Correct Procedure, Correct Site Policy and Procedure (date last review July 2018) is in place that outlines the steps that must be taken to ensure that the correct surgery/procedure is performed on the correct patient, at the correct site and, if applicable, with the correct implant. Interviews with clinical leads confirmed processes are in place to correctly match patients to their intended care and that the information is documented and staff receive the required training. For example, mandatory training is completed on an annual basis in operating theatre and the cardiac catheterisation laboratory to reduce the risk of patient mismatching. Verification confirms the health service organisation has processes to correctly match patients to their care. It is noted that the Correct Patient, Correct Procedure, Correct Site Policy and Procedure is referenced to outdated documents. Review the Correct Patient, Correct Procedure, Correct Site Policy and Procedure to ensure that it contains up-to-date and relevant information.	Met

Criterion:	**Communication at clinical handover** Processes for structured clinical handover are used to effectively communicate about the health care of patients
Rating:	**Met**

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
6.7	Clinical handover 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	Communicating for Safety Documents/Records: Review of clinical handover documentation shows it contains the required minimum information content, relevant risk and needs of the patient and the clinicians involved in the handover. The 2020 Clinical Audit Schedule for Communicating for Safety shows compliance rates above the set target of 92% at HPH and for the Electro-Convulsive Therapy Program at SHPH. Clinical leads interviewed could explain the minimum information content to be communicated at clinical handover and how this was decided and communicated to clinicians. Verification confirms the health service organisation ensures that minimum information content is communicated at clinical handover, based on best-practice guidelines. Communicating for Safety Interview/Observation: Clinical leads interviewed could explain the minimum information content to be communicated at clinical handover and how this was decided and communicated to clinicians. Communicating for Safety Observation: Verification confirms the health service organisation ensures that minimum information content is communicated at clinical handover, based on best-practice guidelines.	Met
6.8	Clinical handover 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	Met	Communicating for Safety Documents/Records: Review of clinical handover documentation shows a structured clinical handover process is in place that includes preparing and scheduling clinical handover, ensures relevant information and clinicians are present, checks that patients' goals and preferences are included, and supports patients' involvement in clinical handover and transfer of responsibility and accountability for care. Interviews with clinical leads confirmed there are structured clinical handover processes in place.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		Observation of clinicians' practice showed use of structured clinical handover processes and tools.	

Criterion:	**Communication of critical information** Systems to effectively communicate critical information and risks when they emerge or change are used to ensure safe patient care			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
6.9	Communicating critical information 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	Communicating for Safety Documents/Records: Review of clinical communication documentation shows critical information, alerts and risks are communicated to clinicians and patients, carers and families. Interview with clinical leads confirmed they use clinical communication processes to communicate critical information to other clinicians who can make decisions about care and to patients, carers and families. Clinical staff use the ISBAR clinical handover tool to ensure a standardised approach to clinical communication and SOAP or SOAPIE as a structure to document patient notes in a clear and consistent manner. Verification confirms processes are in place to ensure that 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.	Met
6.10	Communicating critical information	Met	Communicating for Safety Documents/Records: Review of documentation shows communication processes are in place for patients,	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		carers and families to directly communicate critical information and risks about care. Clinical leads interviewed confirmed there are communication processes for patients, carers and families to communicate critical information and risks to clinicians. Verification confirms there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians.	

Criterion:	**Documentation of information** Essential information is documented in the healthcare record to ensure patient safety			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
6.11	Documentation of information 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	Communicating for Safety Documents/Records: Review of documentation shows a process is in place that ensures complete, accurate and up to date information is recorded in the healthcare record. For example, the Documentation in the Medical Record Policy (date last review February 2021), sets out the basic requirements of documentation including the SOAP/SOAPIE format. Clinical leads interviewed described the process to ensure that completed, accurate and up to date information is recorded in the healthcare record. Observation of facilities and equipment shows that the workforce has computer access to healthcare records in clinical areas. Communicating for Safety Interview/Observation: Clinical leads interviewed described the process to ensure that completed, accurate and up to date information is recorded in the healthcare record. Communicating for Safety Observation:	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			Observation of facilities and equipment shows that the workforce has computer access to healthcare records in clinical areas.	

Blood Management Standard

Leaders of a health service organisation describe, implement and monitor systems to ensure the safe, appropriate, efficient and effective care of patients' own blood, as well as other blood and blood products. The workforce uses the blood product safety systems.

Intention of this standard
To identify risks, and put in place strategies, to ensure that a patient's own blood is optimised and conserved, and that any blood and blood products the patient receives are appropriate and safe.

Criterion:	**Clinical governance and quality improvement to support** Organisation-wide governance and quality improvement systems are used to ensure safe and high-quality care of patients' own blood, and to ensure that blood product requirements are met			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
7.1	Integrating clinical governance 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	***Improvement Opportunities*** Blood Management Documents/Records: 7.1 - Blood and blood products are only used at the Hobart Private hospital. It is not handled at the St Helen's Private Hospital campus. Interviews and review of blood and blood product documentation, shows that there are clear policies and procedures, set mainly by the national corporate office of Healthscope, to manage the risks and identify training requirements for blood management. Blood is almost always an elective procedure at Hobart Private hospital (HPH), with approximately 200 occasions in the past year. It has been decided by the corporate office to reduce blood safe training to a once-only mandatory, with retraining to be undertaken if there are incidents. Because this is a competency that is not used often by the nurses, this does not seem sensible from the perspective of risk management. It may be appropriate to make this a biennial training requirement. The organisation should review the risks and frequency of blood safe training to ensure that appropriate skills are retained by staff.	Met
7.2	Applying quality improvement systems The health service organisation applies the quality improvement system from	Met	Blood Management Documents/Records: Interviews and documents reviewed confirmed that HPH monitors all occasions of the use of blood, through audits of the process: from receiving the blood, through the	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		administration and observation of the patient to the process to avoid wasting blood or blood products. This information is used to improve practice.	
7.3	Partnering with consumers 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	***Improvement Opportunities*** Blood Management Documents/Records: 7.3 - Documents reviewed and staff interviewed confirmed that patients are included in the decision-making process, by providing adequate and appropriate information to allow them to be involved. Patients have the right to refuse the use of blood and blood products and the corporation has a form to record this choice. However, it would be better if that decision is highlighted, preferably on the "alert" sheet. Furthermore, the form refers specifically to Jehovah's Witnesses adherents, whereas it should simply have a generic reference to those patients who choose to refuse blood or blood products. 1. The organisation considers highlighting a patient's refusal to accept blood on the alert sheet. 2. The organisation considers changing the name of the refusal of blood/products document to a generic reference to those that do not want blood or blood products.	Met

Criterion:	**Prescribing and clinical use of blood and blood products** The clinical use of blood and blood products is appropriate, and strategies are used to reduce the risks associated with transfusion			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
7.4	Optimising and conserving patients' own blood	Met	Blood Management Documents/Records: Documents of audits and assessments conducted by the blood governance committee,	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		plus staff interviews confirmed that the clinicians are actively managing the patients, to review their blood status, managing risks of bleeding and ensuring that the need for blood is clinically appropriate. Risks are assessed and discussed with the patient.	
7.5	Documenting Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record	Met	Blood Management Documents/Records: Review of the audits conducted for blood and blood products, shows that the clinicians document the transfusion history as well as current details in the patient's healthcare record.	Met
7.6	Prescribing and administering blood and blood products The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria	Met	Blood Management Documents/Records: Blood and blood product documentation is audited and reviewed by the governance committee, to ensure that clinicians are educated to prescribe and administer blood and blood products in accordance with national guidelines and criteria.	Met
7.7	Reporting adverse events The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria	Met	Blood Management Documents/Records: All transfusion-related adverse events are recorded in the organisation's 'RiskMan' software and all incidents are reviewed by the governance committee, seeking improvements in procedures through education and training as required.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
7.8	Reporting adverse events The health service organisation participates in haemovigilance activities, in accordance with the national framework	Met	Blood Management Documents/Records: A review of documentation, along with interviews with staff and consultants, shows that haemovigilance activities are undertaken, which are in accordance with the national framework.	Met

Criterion:	**Managing the availability and safety of blood and blood products** Strategies are used to effectively manage the availability and safety of blood and blood products			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
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	Blood Management Documents/Records: Interviews and review of blood and blood product documentation shows that there is compliance with manufacturers' directions, legislation, and jurisdictional requirements to store, distribute and handle blood and blood products safely and securely. All blood can be traced through the organisation, from entry to transfusion.	Met
7.10	Availability of blood 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	Blood Management Documents/Records: The HPH has managed blood very well in the past year, with a wastage rate of less than 1%. A review showed that this occurred during a massive transfusion protocol, where a bag was missed and its time out of refrigeration expired. Furthermore, the hospital has revised its processes and created a kit to initiate the massive transfusion protocol. There are contingency plans in place to manage times of shortage. ***Commendations***	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			Blood Management Documents/Records: Blood management has been well done, with a very low wastage rate of less than 0.1 %.	

Recognising and Responding to Acute Deterioration Standard

Leaders of a health service organisation set up and maintain systems for recognising and responding to acute deterioration. The workforce uses the recognition and response systems.

Intention of this standard
To ensure that a person's acute deterioration is recognised promptly and appropriate action is taken. Acute deterioration includes physiological changes, as well as acute changes in cognition and mental state

Criterion:	**Clinical governance and quality improvement to support recognition and response systems** Organisation-wide systems are used to support and promote detection and recognition of acute deterioration, and the response to patients whose condition acutely deteriorates. These systems are consistent with the National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration, the National Consensus Statement: Essential elements for safe and high-quality end of-life care, the National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state, and the Delirium Clinical Care Standard			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
8.1	Integrating clinical governance 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	Acute Deterioration Documents/Records: Care of the deteriorating patient at HPH and SHPH is governed by the Clinical Deterioration Committee. The primary aims of this committee are to provide oversight of systems that support recognition and response to acute deterioration, endorse policy and procedure that guide staff in their response and conduct case reviews of incidents with recommended actions and evaluation of actions. The committee meets on a regular basis and receives input from an intensivist and staff development coordinator. Document review including corporate policy and procedure – Clinical Deterioration, Recognising and Responding to (date last review September 2017), Advanced Life Support, Adult Basic Life Support (date last review September 2018), and Cardiopulmonary Resuscitation (date last review September 2018), shows there is a process in place that applies safety and quality systems when implementing policies, managing risks and identifying training for recognising and responding to acute deterioration. Local clinical policies are also in place for HPH and SHPH and include Paediatric Emergencies, Clinical Deterioration, Recognising and Responding To (date last review May 2019) and Emergencies, Clinical Deterioration Recognising and Responding to (date last review July 2019). These policy documents are comprehensive and written in	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			simple terms with clear language. Clinical leads interviewed could describe the processes for implementing policies and procedures, managing risks and identifying training requirements for recognising and responding to acute deterioration. Observation of clinicians' practice at HPH and SHPH showed use of the health service organisation's processes for recognising and responding to acute deterioration. Nursing staff interviewed reported they felt comfortable to request emergency assistance without necessarily consulting with senior nurses or medical staff. ***Improvement Opportunities*** Acute Deterioration Documents/Records: 8.1 - It is noted that the corporate policy and procedure document Clinical Deterioration, Recognising and Responding to, was last reviewed in September 2017. Staff report that it is currently under review by the responsible parties. Progress with plans to review with Clinical Deterioration, Recognising and Responding To, and ensure that it contains up to date and relevant information. 8.1 - The Clinical Deterioration Committee is yet to create a consolidated action list that is presented to each meeting together with the nominated action owner and date of completion to facilitate tracking of the actions and their completion. Create a consolidated action list that is presented to each clinical deterioration committee meeting, together with the nominated action owner and date of completion to facilitate tracking of the actions and their completion. A further improvement would be to include an evaluation of the implementation of actions.	
8.2	Applying quality improvement systems The health service organisation applies	Met	Acute Deterioration Documents/Records: Document review including the Critical Systems Review (date last review August 2018), the Quality Management Policy (date last review April 2018) and the hospital audit schedules for HPH and SHPH (aligned to the National Standard Audit Schedule), finds	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		there is a process in place that applies the quality improvement systems when monitoring, improving and reporting on the recognition and response systems. Interview with clinical leads confirmed the organisation applies the quality improvement system when monitoring, improving and reporting on recognition and response systems. Episodes of adult, paediatric or neonatal clinical deterioration are reported via 'Riskman' and reviewed by the Quality Improvement Officer, Clinical Deterioration Committee and Clinical Review Committees as required. Recommendations arising from this review are communicated to staff, implemented and evaluated. Verification confirms processes for implementing strategies to improve recognition and response systems are in place.	
8.3	Partnering with consumers 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	Acute Deterioration Documents/Records: Document review including the Consumers Partnering With Policy (date last review October 2018) and the Advance Care Directives Policy (date last review March 2019), shows there is a process in place that applies consumer partnership when recognising and responding to acute deterioration that includes involving patients, meeting their information needs and sharing decision making. Interview with clinical leads confirmed processes from the Partnering with Consumers Standard are used to involve patients in planning and making decisions about recognising and responding to acute deterioration. For example, family members of high risk patients are assisted to access basic life support training. Observation of clinicians' practice showed processes are in place across HPH and SHPH for partnering with consumers. ***Improvement Opportunities*** Acute Deterioration Documents/Records: 8.3 - Review of the Advanced Life Support Policy and Procedure document finds that while care of the family and carer is addressed during resuscitation this does not specifically mention family presence during cardiopulmonary resuscitation (CPR) or staff	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			training to support family presence. Review the Advanced Life Support Policy and Procedure and include additional information about how family presence during CPR will be supported and the training requirements of staff.	

Criterion:	**Detecting and recognising acute deterioration, and escalation care** Acute deterioration is detected and recognised, and action is taken to escalate care			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
8.4	Recognising acute deterioration 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	Acute Deterioration Documents/Records: Review of documentation shows there are processes in place for clinicians including vital sign monitoring plans and the tracking of changes to detect acute deterioration. Age appropriate track and trigger charts are in place with rapid response clinical deterioration criteria clearly identified. Staff report that although Critical Care Flow Chart – Level 1 Trial document does not have a “between the flags band”, patient observations are also documented on an appropriate adult observation chart. Clinical leads interviewed could describe the processes in place to detect acute deterioration and how this is documented and monitored. For example, the Post Anaesthetic and Recovery Care Unit Chart has undergone a recent review to ensure it is sensitive to detecting clinical deterioration in all age groups. Verification confirms processes are in place to monitor patients as required by their individualised monitoring plan. ***Improvement Opportunities*** Acute Deterioration Documents/Records: 8.4 - It is noted that the Critical Care Flow Chart – Level 1 Trial document that is currently	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			in use in the Coronary Care Unit (CCU) at HPH does not include "between the flags" bands for observation of haemodynamic and respiratory variables and there is limited space to record these observations. Further, the chart does not include a dedicated space for the date and number of days spent in CCU/Intensive Care Unit (ICU). Feedback regarding the Critical Care Flow Chart – Level 1 Trial document could include an expanded section to document haemodynamic and respiratory variables as well as a dedicated space for the date and number of days spent in CCU/ICU.	
8.5	Recognising acute deterioration 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	Acute Deterioration Documents/Records: Document review including the Self-Harm and Suicide (Threatened, Attempted or Completed) in a Non-Mental Health Facility Policy (date last review November 2019) and the Comprehensive Care Plan Policy and Procedure (date last review September 2019), shows there are protocols in place for recognising acute deterioration in mental state that include monitoring patients, including known early warning signs in their plan, assessment of possible causes of acute deterioration, required level of observation and the documentation and communication of observed or reported changes in mental state. Clinical leads interviewed could describe the processes for recognising acute deterioration in mental health at HPH and SHPH. Verification confirms processes are in place for clinicians to recognise acute deterioration in mental state. ***Improvement Opportunities*** Acute Deterioration Documents/Records: 8.5 - It is noted that the while the Self-Harm and Suicide (Threatened, Attempted or Completed) in a Non-Mental Health Facility Policy includes items of risk, including those that can be used as a ligature or ligature point, there is no requirement to conduct ligature audits in higher risk areas of HPH, for example, the Emergency Department. Develop and implement a formal ligature and ligature assessment audit tool for use at	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			HPH to ensure that higher risk areas have ligature and ligature points identified and removed where possible.	
8.6	Escalating care 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	Acute Deterioration Documents/Records: Review of documentation shows there are protocols in place for escalating care including agreed vital sign parameters, indicators of deterioration in mental state, parameters and other indicators for calling emergency assistance, management of pain and concerns about acute deterioration. HPH provides multiple medical emergency team responses depending on the patient concerned (adult, paediatric or neonate). SHPH will activate emergency medical services in the first instance after providing basic or advanced life support (dependent on the skill set of the clinician). Clinical leads interviewed could describe the processes for escalating care. Mechanisms to escalate care across HPH and SHPH includes “identifying patients of concern” as part of clinical handover process. The “worried” factor is considered a valid reason to initiate Medical Emergency Team (MET) response. Verification confirms the health service organisation has protocols that specify criteria for escalating care.	Met
8.7	Escalating care The health service organisation has processes for patients, carers or families to directly escalate care	Met	Acute Deterioration Documents/Records: Review of documentation shows processes are in place for patients, carers or families to directly escalate care. At HPH and SHPH this occurs through the Rapid Response System, based on a three step model aiming for local resolution of patient, carer or family concern, prior to further escalation. Posters are displayed in all patient areas and information brochures are also available. Interview with clinical leads confirmed a process is in place for patients, carers or families to directly escalate care. Observation of the escalation system showed that it supports patients, carers and	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			families to directly escalate care. Acute Deterioration Observation: Observation of the escalation system showed that it supports patients, carers and families to directly escalate care. ***Improvement Opportunities*** Acute Deterioration Documents/Records: 8.7 - Review of the Rapid Response Posters for family escalation of care finds that the readability of these posters could be improved. In addition, these posters are quite small and could be missed by those concerned. Review the Rapid Response Posters to improve their readability. Consider involving consumers in the development of the new posters.	
8.8	Escalating care The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance	Met	Acute Deterioration Documents/Records: Review of documentation shows the workforce has the ability to escalate care and call for emergency assistance. At HPH this occurs through activation of the Medical Emergency Team (MET). Patients requiring a higher level of care at HPH, are transferred to a tertiary facility using the inter-hospital transfer pathway. Patients admitted to SHPH are transferred to a tertiary facility through activation of emergency medical services. Clinical leads interviewed could describe the procedures for the workforce to escalate care and call for emergency assistance. Activation of a Medical Emergency Team call, requires an immediate response from the MET team which at HPH includes an Emergency Department doctor, Coronary Care Unit Registered Nurse, Hospital Coordinator and Orderly. According to hospital policy, two MET calls in any episode of care require a response from an intensivist. This is more sensitive than the two MET Calls in 24 hours described by nursing staff. Interview with a student nurse found they could not immediately identify the number to call when activating the MET at HPH. The hospital response was immediate and the emergency activation number (222) is now displayed in each room across staff and	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			patient areas. Verification confirms the health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance.	
8.9	Escalating care The workforce uses the recognition and response systems to escalate care	Met	Acute Deterioration Documents/Records: Review of acute deterioration documents and records shows the workforce uses the recognition and response systems to escalate care. Compliance with the use of recognition and response systems is audited through the 'Riskman' system. Data is also reported to the Australian Council on Health Care Standards (ACHS) Clinical Indicator Program. Interviews with clinical leads confirmed they use the recognition and response systems to escalate care. Staff described a positive culture that supports MET team activation. There are clear protocols in place, clinician and patient feedback is supported, continuous evaluation is undertaken and staff training in emergency response is mandatory. Verification confirms the health service organisation ensures that the workforce uses the recognition and response systems to escalate care. Acute Deterioration Interview/Observation: Interview with clinical leads confirmed they use the recognition and response systems to escalate care.	Met

Criterion:	**Responding to acute deterioration** Appropriate and timely care is provided to patients whose condition is acutely deteriorating			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
8.10	Responding to deterioration	Met	Acute Deterioration Documents/Records: Review of human resource documents shows clinicians have the skills required to	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration		manage acute deterioration. Medical and nursing staff on the MET/Code Blue Team at HPH are required to have Advanced Life Support (ALS) skills. Nursing staff at SHPH are required to have Basic Life Support (BLS) skills as emergency medical services are immediately activated during any episode of patient deterioration. Clinical leads interviewed confirmed processes are in place that support the timely response by clinicians with the appropriate skills to manage episodes of acute deterioration. Verification confirms processes are in place that support timely response by clinicians with the skills required to manage episodes of acute deterioration. It was noted that compliance with BLS training in 2020 at HPH and SHPH was 83% and 96% respectively. Evidence was provided that compliance with BLS training at HPH has improved in 2021.	
8.11	Responding to deterioration 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	Acute Deterioration Documents/Records: Review of human resource documents shows the health service has rapid access to a clinician who can deliver Advanced Life Support (ALS). All medical and nursing staff working in the Emergency Department, Coronary Care Unit, Anaesthesia and Post Anaesthesia Care Unit at HPH are required to have ALS skills. An anaesthetist trained in ALS is required to be present at SHPH when Electro-Convulsive Therapy clinics are running. Clinical leads interviewed could describe the processes in place that ensure rapid access to a clinician who can deliver ALS. Verification confirms processes are in place to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver ALS.	Met
8.12	Responding to deterioration The health service organisation has processes to ensure rapid referral to mental health services to meet the	Met	Acute Deterioration Documents/Records: Review of documentation shows a process is in place for referral to mental health services for patients whose mental state has acutely deteriorated. Interview with clinical leads confirmed the process for rapid referral to a mental health service for patients whose mental state has acutely deteriorated. The Education Team	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	needs of patients whose mental state has acutely deteriorated		have included mental health scenarios in MET training and mock acute deterioration incidents. Verification confirms processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated are in place.	
8.13	Responding to deterioration The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration	Met	Acute Deterioration Documents/Records: Review of documentation shows a process is in place for referral to services that can provide definitive management of acute physical deterioration. A Memorandum of Understanding is in place between HPH and Royal Hobart Hospital (RHH) in the event of an episode of acute deterioration. Patients admitted to SHPH can be transferred by emergency medical services to either HPH or RHH, depending on the level of patient acuity. Clinical leads interviewed confirmed the process for rapid referral to services that provide definitive management of acute physical deterioration. Verification confirms processes for rapid referral to services that can provide definitive management of acute physical deterioration are in place.	Met

Quality
Innovation
Performance

Contact us

1300 888 329
info@qip.com.au
www.qip.com.au