NSQHS Standards Second Edition Organisation-Wide Assessment

Final Report

Norwest Private Hospital

Bella Vista, NSW

Organisation Code: 120901
Health Service Facility ID: 101779
Assessment Date: 09/03/2021 to 11/03/2021

Accreditation Cycle: 1

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Preamble

How to Use this Assessment Report
The ACHS assessment report provides an overview of quality and performance and should be used to:

1. provide feedback to staff
2. identify where action is required to meet the requirements of the NSQHS Standards
3. compare the organisation's performance over time
4. evaluate existing quality management procedures
5. assist risk management monitoring
6. highlight strengths and opportunities for improvement
7. demonstrate evidence of achievement to stakeholders.

The Ratings:
Each **Action** within a Standard is rated by the Assessment Team.

A rating report is provided for each health service facility.

The report will identify actions that have **recommendations** and/or comments for each health service facility.

The rating scale is in accordance with the Australian Commission on Safety and Quality in Health Care's Fact Sheet 4: Rating Scale for Assessment:

Assessor Rating	Definition
Met	All requirements of an action are fully met.
Met with Recommendations	The requirements of an action are largely met across the health service organisation, with the exception of a minor part of the action in a specific service or location in the organisation, where additional implementation is required.
Not Met	Part or all of the requirements of the action have not been met.
Not Applicable	The action is not relevant in the health service context being assessed.

Suggestions for Improvement
The Assessment Team may provide suggestions for improvement for the health service to consider implementing. They are not required to be implemented for an action to achieve a met rating. Suggestions for improvement are documented under the criterion level.

Recommendations
Not Met/Met with Recommendation rating/s have a recommendation to address in order for the action to be rated fully met. An assessor's comment is also provided for each Not Met/Met with Recommendation rating.

Risk ratings are applied to actions where recommendations are given to show the level of risk associated with the particular action. A risk comment is included if the risk is rated greater than low. Risk ratings are:

1. E: **extreme (significant)** risk; immediate action required.
2. H: **high** risk; senior management attention needed.
3. M: **moderate** risk; management responsibility must be specified.
4. L: low risk; manage by routine procedures

Executive Summary

Introduction

Norwest Private Hospital underwent a NSQHS Standards Second Edition Organisation-Wide Assessment (NS2 OWA) from 09/03/2021 to 11/03/2021. The NS2 OWA required 3 assessors for a period of 3 day(s). Norwest Private Hospital is a Private health service. Norwest Private Hospital was last assessed between 16/05/2017 and 18/05/2017. Below is a summary of the Health Service Facilities (HSFs) that were reviewed as part of this assessment:

Health Service Facility Name	HSF Identifier
Norwest Private Hospital	101779

General Discussion

Norwest Private Hospital (Norwest) underwent a National Safety and Quality Health Service (NSQHS) Standards Second edition Organisation-Wide Assessment (NS2 OWA) from the 9 -11 March 2021. The NS2 OWA required three assessors on site for three days. The assessment was deferred from March 2020 due to the COVID-19 pandemic.

Norwest Private Hospital is governed by Healthscope and is a 277-bed hospital. The hospital covers a number of specialities including a 24hour Emergency Department; operating theatre suite with 19 theatres, including a hybrid theatre; orthopaedic surgery; neurosurgery; major general surgery; cardiothoracic surgery; Coronary Care Unit (CCU) cardiac angiography suite; oncology; maternity and paediatrics; day oncology and day surgery.

Norwest Private Hospital has an enthusiastic executive and an appropriate governance structure with reporting both to Healthscope and to peak committees within the organisation, including the Executive Governance Committee, Medical Advisory Committee and Patient Care and Clinical Review Committee. A clinical governance framework is in place, including a Strategic Plan and Clinical Governance Framework.

Policies and procedures are current and available from both Healthscope and Norwest local policies. Quarterly Clinical Quality KPIs are submitted by Norwest Private Hospital to Healthscope National Hospital Quality Committee (NHQC) with key issues added to the Executive and Board agendas.
Incidents and near misses are reported on the RiskMan system and appropriate actions and improvements taken. Risks are entered onto the Risk register which is regularly reviewed.
Mandatory and competency training are provided with good compliance. A robust credentialling system is in place with all new appointments also reviewed at the MAC.

A culture of environmental safety was observed throughout the facility with preventive maintenance plans and logs.

Norwest has a strong commitment to partnering with their consumers. This is evident through executive leadership and as well as the Norwest Consumer Consultants input to patient safety and quality and patient information.

A well-developed infection prevention and control system is in place with governance, monitoring and reporting clearly evident throughout the hospital with a Standard 3 committee chaired by the Director of Clinical Services (DCS).

It was evident that standard and transmission-based precautions were in place and excellent hand hygiene practices were observed throughout the facility.

A gap analysis has been undertaken for AS 4187 and progress is continuing with the implementation of this. An Antimicrobial Stewardship Plan is in place and references the clinical care standard.

Norwest has a multidisciplinary Medication Safety committee with appropriate reporting lines, policies and procedures were readily available and reflective of both Healthscope and local Norwest needs with patient history and medication reconciliation occurring. A high risk medicine register was present. It was identified at assessment that compliance of medication documentation on the medication chart had been an area of focus and based on medication charts sighted at assessment this is an ongoing area for attention and improvement to drive consumer safety initiatives.

There are appropriate policies from Healthscope and Norwest regarding admission, assessment and care planning guiding the provision of comprehensive care at Norwest. A range of KPIs including Health Acquired Complications (HACs) inform quality improvements regarding comprehensive care. Norwest uses the Healthscope Comprehensive care and daily care plan. Over the past 12 months several quality improvements have been undertaken regarding end-of-life care. Norwest has risk assessments in place to identify patient, at risk and to minimise harm. Some examples of this are a low incidence of pressure areas at Norwest and cognitive assessments being conducted on admission.

Norwest has embraced contemporary models for communication and transfer of care to achieve safer patient outcomes. The model of communication is ISOBAR. Appropriate policies and procedures are in place to govern communication for patient safety.

Norwest has appropriate systems in place to correctly identify patients using at least three identifiers. This was observed during patient handover and team-time out (TTO) on the orthopaedic theatres.

Norwest maintains a strong focus on the safe and effective management of blood and blood products in partnership with their third-party pathology provider. This was evidenced in the successful use of the massive blood transfusion protocol, new initiatives to reduce blood wastage, and enhanced blood transport.

There has been significant improvement to reduce blood wastage in recent months with further improvements planned. New initiatives to reduce blood wastage is being undertaken with a risk aware mindset to ensure the complex and high acuity needs of patients is paramount.

It was great to see that over the last 12 months Norwest has undertaken significant improvement to enhance use of the MET. This improvement activity was multidisciplinary and included all areas of the organisation. The appropriate between the flags track and trigger charts are utilised. The MET criteria and observation processes are readily available and are also available to consumers to actively participate in their care and escalation of care.

Summary of Results

At Norwest Private Hospital's Organisation-Wide Assessment one Action was rated Not Met and five Actions were rated Met with Recommendation across 8 Standards. The following table identifies the Actions that were rated Not Met and Met With Recommendation and lists the facilities to which the rating applies.

Actions Rated Not Met	Action Required	Name of Health Service Facilities where action was deemed to be Not Met
4.1	Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management	All Facilities under membership

Actions Rated Met With Recommendation	Action Required	Name of Health Service Facilities where action was deemed to be Met With Recommendation
1.22	The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system	All Facilities under membership
4.2	The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management	All Facilities under membership
5.19	The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care	All Facilities under membership

Actions Rated Met With Recommendation	Action Required	Name of Health Service Facilities where action was deemed to be Met With Recommendation
5.22	Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency	All Facilities under membership

Final Assessment Requirement

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

Summary of Recommendations Subject to the Final Assessment

The recommendation associated with the NM rating is included below.

Action	Health Service Facility	Recommendation
4.1	All Facilities under membership	Enhance the frequency of the audit program to provide increased surveillance with direct links to improvement activities, including education (formal and informal) of the staff as to the requirements for safe medication prescribing and medication chart documentation. The regular audit program should be sustainable to not only measure immediate improvements but also ensure sustainable improvements are achieved.

The recommendations associated with the MwR ratings are included below. These recommendation(s) need to be addressed by the health service before the next onsite assessment.

Action	Health Service Facility	Recommendation
1.22	All Facilities under membership	The importance of annual performance review be reinforced in order to ensure that each staff member receives an annual performance review.
4.2	All Facilities under membership	Enhance the medication safety evaluation and monitoring processes to ensure sustainable results are achieved.

Action	Health Service Facility	Recommendation
5.19	All Facilities under membership	The End-of-Life Care Survey for Families be implemented, and the results of the surveys be regularly collated and provided to staff.
5.22	All Facilities under membership	A system is developed to ensure a consistent approach to recording the daily skin integrity check.

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

Norwest Private Hospital

Sites for Assessment

Sites for Assessment - Norwest Private Hospital

Norwest Private Hospital HSF ID:101779	
Address: Norwest Business Park 11 Norbrik Drive BELLA VISTA NSW 2153	Visited: Yes

Norwest Private Hospital

Reports for Each Standard

Standard 1 - Clinical Governance

Governance, leadership and culture

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

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

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

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

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

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

Assessment Team Summary:

Healthscope National, Healthscope Board and Norwest Private Hospital Executive provide leadership to the hospital and guide management and clinical governance to provide high quality and safe healthcare. There is a clear reporting line with an organisational chart and committee structure in place. The peak committees at Norwest are the Executive Governance Committee, the Patient Care and Clinical Review Committee (PCCR) and the Medical Advisory Committee (MAC). Both Healthscope National and Norwest have a Clinical governance Framework and a Strategic plan to set direction.

The standing agenda items and minutes of meetings reflect the key issues for the hospital and are discussed at these meetings.

There was a clear commitment at all levels of staff to safety and quality with projects recently completed or in progress to provide improved care for patients.

Healthscope developed a reconciliation action plan in 2019. This has a specific component on building relations with indigenous consumers, promoting positive relations, participation in NAIDOC week, cultural awareness training, indigenous workforce and identifying opportunities to improve health outcomes.

Patient safety and quality systems

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

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

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

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

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

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

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

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

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

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

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

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

Action 1.18	
The health service organisation providing clinical information into the My Health Record system has processes that: a. Describe access to the system by the workforce, to comply with legislative requirements b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system	
Met	All facilities under membership
Met with Recommendations	

Not Met	
Not Applicable	

Assessment Team Summary:

Norwest has a range of policies from Healthscope National on the electronic system (HINT) and local Norwest policies available on the L drive. Policies and compliance tracking system is available to advise when policies are due for review. Currency of policies are monitored and reported to the governing body and to local committees. It was noted by the assessors that several local policies appeared to be past their review date, however when discussed with the Executive, these policies had been updated and were awaiting archive. These policies were immediately archived.

There is a clear process to implement changes to legislation, regulations, and standards. Where relevant, based on the risk, adherence to policies is monitored through audits.

A large range of data is collected, and a quarterly report is provided to Healthscope National. Data and information are accessible to staff within the organisation and that staff use this information to discuss performance improvements at their ward meetings.

Staff are encouraged and supported to attend training and professional development opportunities. There are many examples of innovation and improvement across the organisation.

There are a number of Healthscope policies that support the governance of risk. The Norwest integrated risk register is located in RiskMan, with risks are reviewed according to their level of severity. Discussion of shared learnings and review of KPIs lead to improvements to risks identified. Risks are discussed at Executive and clinical committees relevant to the risk and at local meetings with staff. During assessment two high risk events were reviewed in regard to Norwest being able to manage risk and mitigate risk. The risks included a rapid increase in patients during a bushfire emergency with 40 patients being rapidly evacuated from a rehabilitation facility and transferred to Norwest. Norwest rapidly instigated their disaster plan and provided continued care to these patients. The clinical notes were transferred with the patients, allowing continuity of care and assisting in mitigating the risk. The other was a Jehovah's Witness patient requiring a blood transfusion, this risk was able to be mitigated by discussion with the patient and the provision of non-blood products to the patient, with a full recovery of the patient.

All clinical and workplace health and safety incidents and near misses are reported through the RiskMan system with the executive receiving an initial email to alert them.

There has been a focus over the past year on a culture of reporting resulting in an increase in reporting of 32%, a decrease of 58% in adverse events and a reduction of 31% in serious outcomes. Open disclosure occurs with patients should an adverse event occur based on the Australian Open Disclosure Framework.

A complaints management system is in place, with complaints being submitted to Healthscope National and included in the quarterly reports. These are also discussed at relevant department meetings and communicated to staff to provide feedback and make improvements. Some of the improvements include: the review of shelving in showers, easier access to the patient's room.

There is a clear process to implement changes to legislation, regulations and standards. Where relevant, based on the risk, adherence to policies is monitored through audits.

Health care records are available at the point of care and are currently paper based clinical assessments and notes. WebPas is electronic and is available for pathology and imaging results and alerts.

Clinical records are held securely and staff receive education on privacy and security of records. A gap analysis and action plan has been developed by Norwest and it complies with the milestones to meet Advisory 18/11 Implementing system that can provide clinical information into the My Health Record (MHR), Norwest is currently uploading event and discharge summaries into the My Health Record. Information is available to patients regarding the MHR.

Clinical performance and effectiveness

Action 1.19	
The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.20	
The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.21	
The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.22	
The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system	
Met	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Action 1.23	
The health service organisation has processes to: a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan b. Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.24	
The health service organisation: a. Conducts processes to ensure that clinicians are credentialed, where relevant b. Monitors and improves the effectiveness of the credentialing process	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.25	
The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.26	
The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.27	
The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.28	
The health service organisation has systems to: a. Monitor variation in practice against expected health outcomes b. Provide feedback to clinicians on variation in practice and health outcomes c. Review performance against external measures d. Support clinicians to take part in clinical review of their practice e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems f. Record the risks identified from unwarranted clinical variation in the risk management system	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Norwest has a comprehensive orientation program for all new staff, mandatory face-to-face induction, electronically through ELMO and in their workplace. The compliance with mandatory training was impressive, most being in the high 90%; these included Manual Handling, personal protective equipment, basic life support, fire and hand hygiene and aseptic technique.

There is good access to professional development and staff are well supported to undertake further education and training.

Credentialling of staff occurs through the Medical Advisory Committee (MAC). A Healthscope policy and robust processes in place for the review of qualifications, responsibilities, accountabilities and scope of practice. Policies and procedures are in place for the introduction of new procedures, with applications through the MAC. Position descriptions clearly state the requirement of each position and include relevant safety and quality responsibilities. Selection processes for professional staff are well structured. The assessors met with several members of the MAC and they were very supportive of the executive, clinical staff and described robust processes regarding the credentialling and morbidity and mortality processes. A well-established performance review process is in place for all staff working at Norwest. However, it was noted by assessors that where compliance with conducting performance review was excellent in some areas, in other the compliance was low with a recommendation being made to increase the compliance with performance review. Staff are well supported to access and attend education relating to their field of work.

Norwest provides information to clinicians regarding clinical practice and clinical care standards via meetings, memos, letters and education. The organisation was able to demonstrate that they had processes in place regarding the Clinical Care standards for several clinical care standards including colonoscopy antimicrobial stewardship, delirium, acute coronary syndrome, acute stroke and venous thromboembolism.

Norwest also provides data to several national registries that include ANZICS adult database, Australian Orthopaedic Joint Replacement Registry; NSW central cancer registry; Australian Breast device registry; cardiothoracic outcomes registry; TAVI ACOR registry and the National perinatal data collection to assist with identifying clinical variation.

Action 1.22
The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Met with Recommendation
Assessor Comment: There is a valid and reliable performance review process to allow the workforce to regularly participate in performance review. Many departments had good compliance with annual performance review, however there are some departments that have low compliance with completing the annual performance review.
Recommendation:
The importance of annual performance review be reinforced in order to ensure that each staff member receives an annual performance review.
Risk Rating:
Low
Risk Comment:
There is a risk that staff will not receive feedback on performance and the opportunity for continuous improvement.

Safe environment for the delivery of care

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

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

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

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

Action 1.33	
The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people	
Met	All facilities under membership

Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Norwest has well established policies and processes in place to provide maintenance to buildings, plant and equipment to be serviced and maintained in compliance with legislative requirements through a planned maintenance schedule. The assessors observed that building is clean and well maintained and logs and schedules were available to ensure that scheduled preventive maintenance occurs. Innovative practices to alert maintenance of everyday repairs that need attention such as blocked toilet, light need replacing have been implemented resulting a quick and efficient repair time. The annual fire safety statements have been conducted and were available.

Clinical equipment is managed by Chemtronics with two full-time employees on site, with an annual schedule developed to provide asset management and service requirements.

A number of workplace health and safety audits are conducted with an annual workplace and safety plan developed. Each department is required to identify hazards and provide a plan to improve these. There is an impressive record of very low lost time in the past 12 months with a very enthusiastic and supportive workplace health and safety officer being appointed.

Accommodation for patients is based on clinical need and visiting hours are flexible for family or carers if required, although some modification has been required in the past 12 months due to COVID–19.

Norwest has endeavoured to create a welcoming environment through artwork and staff awareness. There is a framework in place to welcome Aboriginal people to Norwest. It is noted that there is a low rate of Aboriginal people attending Norwest at present. The installation of recent Aboriginal Artwork at Norwest is an example of co-design and reflects the journey of Aboriginal people in the local area.

Standard 2 - Partnering with Consumers

Clinical governance and quality improvement systems to support partnering with consumers

Action 2.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for partnering with consumers b. Managing risks associated with partnering with consumers c. Identifying training requirements for partnering with consumers	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring processes for partnering with consumers b. Implementing strategies to improve processes for partnering with consumers c. Reporting on partnering with consumers	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Norwest has a strong commitment to partnering with their consumers. This is evident through executive leadership and as well as the Norwest Consumer Consultants input to patient safety and quality. Three consumers met with the assessors and described in detail their journey to becoming a consumer consultant. All had lived experience of their patient journeys at Norwest. Their level of health literacy and understanding of their role is well developed. It is noted that Norwest has a large cohort of volunteers. These volunteers are not on site during Covid and are contributing to some hospital activities from home.

The consumer consultants provided constructive feedback on their role and experience. They are represented on the Patient Care Review Committee (PCRC) and could articulate their input to this forum. The consumers acknowledged that some patient activities are now virtual, e.g. bookings and pre op screening. Based on consumer feedback the following changes have been experienced: menu change, Patient Experience (PEX), better clinician: patient engagement at the bedside.

During assessment there was evidence of stoma therapy nursing staff partnering with consumers in their care. Similarly, one patient, following complex spinal surgery reported the positive experience of having his physiotherapy outside in the sunshine. Consumers could describe many similar small acts of kindness.

Partnering with patients in their own care

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

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

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

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

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

Not Met	
Not Applicable	

Assessment Team Summary:

Norwest provide patients with a copy of their rights and responsibilities in their bedside compendium. An improvement opportunity is the installation of a copy of the Australian Charter of Health Care rights at each public entrance to Norwest.

Norwest is compliant with Advisory 18/10 regarding financial consent and has conducted a gap analysis and action plan.

Norwest has a system in place for substitute decision makers, there was no patient meeting this criterion in the cohort seen during assessment. There was evidence of patient partnering in goal setting, informed decision making and patients being aware of their options. The Emergency Department (ED) clinicians described the process should a patient request a second opinion.

There is a range of consents in place for surgical procedures and interventional procedures as well as financial consent. Mothers in the maternity consent for confinement and this includes episiotomy. In ambulatory care, consent is obtained for blood transfusion and chemotherapy and the consent is for duration of treatment. There is a policy for withdrawal of consent.

The assessors attended the weekly virtual meeting to review finding of Patient Experience updates (PEX). There were some compelling patient stories and small acts of kindness shared. There is an opportunity to include a consumer at this forum on occasion.

Healthscope developed a reconciliation action plan in 2019. This has a specific component on building relations with indigenous consumers, promoting positive relations, participation in NAIDOC week, cultural awareness training, indigenous workforce and identifying opportunities to improve health outcomes.

Health literacy

Action 2.8	
The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.9	
Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.10	
The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided on discharge	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The consumer consultants and patients interviewed during assessment displayed sound levels of Health Literacy. Norwest has a suite of appropriate patient information pamphlets some developed locally, and some developed by Healthscope Corporate and some are procured from speciality groups such as Cancer Care. Another example of improving health literacy is the ability of mothers booked for confinement being able to access information through calling the midwives if they have concerns.

Partnering with consumers in organisational design and governance

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

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

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

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

Assessment Team Summary:

There is evidence of some involvement of consumers in design. Feedback on the impact of swinging doors and an inclination on consumers in wheelchairs has been rectified. An improvement opportunity will be to include consumers in future planning and design where possible.

There is a framework in place to welcome Aboriginal people to Norwest. Noting a low rate of Aboriginal people attending Norwest at present. The installation of recent Aboriginal Artwork at Norwest is an example of co-design and reflects the journey of Aboriginal people in the local area.

All actions in this standard are rated as Met.

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

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

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

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

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

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

Assessment Team Summary:

Norwest has a well-developed Infection prevention and control system in place, and this was evident through pre assessment documentation, focus groups and rounding. Given the cohort of complex surgical patients, the governance, monitoring and reporting is clearly evident through the hospital. There is a Standard 3 committee chaired by the Director of Nursing (DON). There is evidence that the infection control coordinator, CSSD staff and food safety supervisor have appropriate qualifications.

There are several examples of improved performance relating to infection prevention and control. Examples include Antimicrobial Stewardship (AMS), increased uptake of staff immunisation, introduction of sepsis pathway, improved Hand Hygiene (HH) rates, increase in cleaning staff FTE, upgrade of mattresses and successful food safety audit. As a result of Covid, all patients are now accommodated in single rooms. As a result of an RCA, there is increased focus on sepsis pathway in maternity. As a result of a Staphylococcus Aureus Bacteraemia (SAB), there has been increased surveillance of IVI cannulae. Due to reduced activity during Covid, there was a water quality flag that has been rectified and shower heads replaced.

Covid Response

Norwest responded appropriately and in a timely manner to the Covid-19 Pandemic. An Executive (Incident Command inclusive of VMO representatives) Covid committee was mobilised and took an active lead. Surgical activity was capped to emergency only during the acute phase. Patients are now only admitted to single rooms. An area in ED has been allocated to patients presenting with Covid type symptoms. Significant training has been provided. Regular communication sessions have been held. The current situation and pending risks are closely monitored. Update reports have been generated. Visiting hours were restricted during the acute phase. Due to the impact of reduced visiting, clinicians did additional rounds and noted the risk of social isolation for many patients. Twenty-five (25) Norwest staff have already received the Covid Vaccination.

Norwest has a robust surveillance system in place and monitors and reports on infection rates, water quality and food standards as well as AMS adherence. The cooling tower system is managed by Strata, with results provided to maintenance noting no recent flags.

Infection prevention and control systems

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

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

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

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

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

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

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

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

Action 3.13	
The health service organisation has a risk-based workforce immunisation program that: a. Is consistent with the current edition of the Australian Immunisation Handbook[19] b. Is consistent with jurisdictional requirements for vaccine-preventable diseases c. Addresses specific risks to the workforce and patients	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Norwest standard and transmission-based precautions are consistent with Guidelines for the prevention and control of infection in health care. Of note is the high rate of single rooms, the increase in HH stations as well as increased cleaning staff.

Risks relating to infection are closely managed at the appropriate level at Norwest. This includes patient screening prior to admission. Maternity, orthopaedic and neurosurgical patients are screening for MROs. A system for flagging of MRO is available on PAS. It is noted that there has been no outbreak of transmissible infection since 2017 when six patients were symptomatic. Since then some ward carpet has been replaced with vinyl in some patients' areas and disposable curtains have been procured.

Norwest is reporting >90% with hand hygiene audits. There is a large supply of hand hygiene stations. All relevant hand-scrub basins observed during the assessment have non-touch taps.

Nursing staff complete aseptic technique assessment in operating theatre, ICU and ED. In the ED, clinicians are assessed inserting five IVI cannulae to achieve aseptic technique competency.

Improvement opportunity: That Norwest confirms the cohort of staff that require aseptic technique assessment. Focus on this cohort for assessment and monitoring and thus rate of compliance will reflect this. It is suggested that the particular focus is on critical care areas including ED, Theatre, procedural areas (interventional cardiology) and maternity.

A range of implantable devices are used at Norwest, including cardiac stents, arthroplasty and spinal implants. Of note is minimal use of tracheostomies.

Norwest has a structured cleaning regime in place and this is regularly audited. Rooms accommodating MRO patients are terminally cleaned. An additional cleaning shift has been resourced since Covid and this has received positive feedback.

It is reported that there was a slight increase in sharps / needlestick injuries (NSI) in 2020. This is being monitored and training provided. There is a system in place for first aid for staff receiving an NSI. There is good compliance with immunisation. Hep B is required for clinical support staff, where there is 100% compliance with 50 boosters due this year. This is monitored by IPC coordinator. ED staff provided positive feedback that they were given access to Covid vaccination recently and they report that this made them feel valued.

Sepsis pathway

Norwest has rolled out an evidence-based sepsis pathway for adults, paediatrics and maternity. There was evidence of this during rounding in ED and in discussion with ID physician at MAC. Given the roll out in 2020, Norwest has not yet done a complete evaluation and confirm that this is intended.

Suggestions for Improvement:

An improvement opportunity is suggested that Sepsis pathway is applied to inpatients showing signs of sepsis. Auditing of compliance with sepsis pathways could be included in medical record reviews M&M reviews to embed this change.

Reprocessing of reusable medical devices

Action 3.14	
Where reusable equipment, instruments and devices are used, the health service organisation has: a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying • the patient • the procedure • the reusable equipment, instruments and devices that were used for the procedure	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Reprocessing of reusable medical devices at Norwest Private Hospital.

Norwest Private Hospital performs high volume complex surgery. There is a standalone endoscopy suite. Norwest has an inhouse CSSD. Norwest has a large volume of sterile stock on hand given the range of speciality surgery.

Norwest is well progressed on completion of a gap analysis and action plan for segregation of clean and dirty activities, design of storage areas for sterile stock, replacement with non-compliant cleaning, disinfecting and sterilising equipment and monitoring of water quality.

Norwest attest to the risks associated with this action.

At Norwest there is evidence of executive endorsement of the gap analysis and action plans as well as a commitment to upgrade non-compliant cleaning, disinfecting and sterilising equipment, e.g. hot pan washers have been prioritised in maternity and ICU with the remainder on action plan.

Antimicrobial stewardship

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

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

Assessment Team Summary:

Norwest has implemented an Anti-Microbial Stewardship program. There is a multidisciplinary committee. This was evident through pre-reading, meeting with MAC, rounding and availability of reports. There is access to an Infectious Diseases physician. Therapeutic guidelines are in place and a formulary is available. The clinical pharmacy team play an active role. Results from NAPS audits are circulated to relevant clinicians. Results from audits are provided to appropriate forums including MAC. The vast majority of clinicians are on board with AMS and respond to advice from the ID physician and pharmacists. Areas of focus have been cardiac, orthopaedics and neurosurgery. There is evidence of discussion at MAC of clinician variation with AMS and MAC has taken a lead in improving this. The intent of the AMS advisory is met.

Standard 4 - Medication Safety

Clinical governance and quality improvement to support medication management

Action 4.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management	
Met	
Met with Recommendations	
Not Met	All facilities under membership
Not Applicable	

Action 4.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management	
Met	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Action 4.3	
Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to: a. Actively involve patients in their own care b. Meet the patient’s information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.4	
The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Norwest maintains an active Medication Safety committee with appropriate reporting lines to other relevant committees within the organisation. The medication safety committee is multidisciplinary and includes represented from HPS pharmacy (third party pharmacy provider) who also maintain an onsite Quality Care Pharmacy Program (QCPP) accredited pharmacy.

Policies and procedures are present and reflective of both Healthscope and local needs. It was identified at assessment that poor compliance of medication documentation on the medication chart had been an area of focus, and based on medication charts sighted at assessment this is an ongoing area for attention and improvement to drive consumer safety initiatives related to medication documentation. Furthermore, there are opportunities to strengthen the escalation and action by craft groups to support quality initiatives implementation.

Norwest maintains a high risk medication register, and has processes to review and endorse new medications as appropriate.

Norwest does not support self-medication initiatives, and all medication administration is observed by nursing team members. Medication drawers are located in the consumer rooms with minimal impress on the wards.

S4 and S8 medication storage and management is in accordance with NSW legislation and guidelines. Medication storage is appropriate and there has been a significant focus on medication fridge cold chain monitoring in recent months. The organisation is encouraged to continue this work to ensure sustainable results are achieved.

Consumers are encouraged to participate in care, inclusive of medication management from admission, through admission and through discharge. Consumer Medicine Information (CMI) are provided on discharge, with access to full prescription services through HPS pharmacy services. Medication reconciliation services are provided by HPS pharmacy for high risk consumers.

The day oncology services are supported by Slades Pharmacy, with an onsite pharmacist available to support the administration of chemotherapy, and subsequent medication needs. Chemotherapy is provided by Slades Pharmacy pre-mixed with no compounding occurring on site.

Action 4.1
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Not Met
Assessor Comment: The organisation has systems and processes to manage medication safety, however the policies and procedures have not been fully implemented to ensure safe delivery of medication. This is evidenced by the following: - March 2020 audit results demonstrated 30% compliance in overall completeness of medication charts with limited evidence of the supporting quality plan. - September 2020 the overall rating increased to 76%, no further audits were available following this audit. At assessment a random sample audit of ten records was undertaken inclusive of all inpatient wards. The results demonstrated the need to enhance medication documentation in accordance with local policy across all areas of the chart including labelling, ceasing medication orders, allergies and adverse drug reactions (ADR) documentation, indication for medication (especially for PRN medications) and the numbering of medication charts (e.g. 1 of 2) and telephone orders.
Recommendation:
Enhance the frequency of the audit program to provide increased surveillance with direct links to improvement activities, including education (formal and informal) of the staff as to the requirements for safe medication prescribing and medication chart documentation. The regular audit program should be sustainable to not only measure immediate improvements but also ensure sustainable improvements are achieved.
Risk Rating:
High
Risk Comment:
Some systems are in place, however there is a need to expand these systems to ensure a consistent and safe approach to medication documentation.

Action 4.2
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Met with Recommendation
Assessor Comment:
As highlighted in 4.1 there are evaluation and monitoring systems however the systems need to be strengthened to ensure sustainable achievements are achieved.
Recommendation:
Enhance the medication safety evaluation and monitoring processes to ensure sustainable results are achieved.
Risk Rating:
Moderate
Risk Comment:
Some systems are in place, however there is a need to expand to ensure a consistent and safe approach to medication documentation.

Documentation of patient information

Action 4.5	
Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.6	
Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.7	
The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.8	
The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.9	
The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements	
Met	All facilities under membership
Met with Recommendations	

Not Met	
Not Applicable	

Assessment Team Summary:

Medication history is included in the consumer admission process or upon presentation to the emergency department. This process forms part of the comprehensive assessment where consumers identified at high risk are escalated for pharmacist review.

Pharmacists are available in the clinical areas to support medication reconciliation and to support prescribing needs (including pharmacist interventions).

Adverse Drug Reaction (ADR) reporting processes are in place with Therapeutic Goods Administration (TGA) reporting also being available if required.

Continuity of medication management

Action 4.10	
The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.11	
The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.12	
The health service organisation has processes to: a. Generate a current medicines list and the reasons for any changes b. Distribute the current medicines list to receiving clinicians at transitions of care c. Provide patients on discharge with a current medicines list and the reasons for any changes	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Norwest has processes in place to support medication review, escalation of high risk medication management issues and access to pharmacist support services. This includes use of the comprehensive risk assessment and high risk workflows, with pharmacist review referrals made via the WebPAS system. Pharmacists actively participate in case management meetings and ICU rounds.

HPS pharmacists provide medication clinical interventions, and clinical areas have access to CMOs / registrars/VMOs to support the medication management through inpatient admissions.

A discharge summary is provided on discharge with discharge counselling for all clients on high risk medications or identified as high risk through the risk assessment process. Discharge information is provided to the General Practitioner (GP) and / or the residential aged care facility (RACF).

Medication management forms a component of the nursing discharge information for all consumers at the time of discharge.

Medication management processes

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

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

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

Assessment Team Summary:

eLearning med safe modules are available at Norwest with high levels of compliance in use of these tools. Education is complemented by Pharmacist monthly education sessions, where clinical staff also actively engage in future education topics.

Appropriate reference tools are available to clinical staff including eMIMS, Antibiotic guidelines, and other reference tools.

High risk medicines have been identified and are appropriately managed. Tall Man lettering has also been implemented according to best practice guidelines

Standard 5 - Comprehensive Care

Clinical governance and quality improvement to support comprehensive care

Action 5.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for comprehensive care b. Managing risks associated with comprehensive care c. Identifying training requirements to deliver comprehensive care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.4	
The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify, at all times, the clinician with overall accountability for a patient's care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.5	
The health service organisation has processes to: a. Support multidisciplinary collaboration and teamwork b. Define the roles and responsibilities of each clinician working in a team	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.6	
Clinicians work collaboratively to plan and deliver comprehensive care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The provision of safe Comprehensive Care is directed through National Healthscope evidence-based policies and procedures.

The risk register demonstrates documentation of risks associated with providing Comprehensive Care and mitigation strategies that reduce those risks. Monitoring of events such as incidents, adverse events, and patient feedback are managed through the quality and risk systems, reported to the Patient Care and Clinical Committee and included in the National Healthscope auditing and feedback system.

A range of mandatory training is required for staff, and the compliance rate for all training attendance is quite high.

The quality improvement system was observed to be used when auditing and monitoring comprehensive care with a range of KPIs. There are opportunities for improvement identifying and implementing opportunities for improvement and reporting the results to the Clinical Committee, the workforce and all outcomes from the comprehensive care standard are reported to Healthscope National for analysis and feedback.

The assessors witnessed patient involvement in their care during handover with consistent use of the patient information board. During patient interviews with the assessors they reinforced the communication and actions between patients and staff and active participation and shared decision making in their care.

National policies, plans and procedures support clinicians in developing comprehensive plans and treatment for their patients.

The clinician responsible for overall care is always noted on the patient board as is the nurse for the shift. Throughout the visit assessors noted easy and effective communication between doctors, therapists and nurses that was supported by clinical notations. The provision of safe Comprehensive Care is directed through National Healthscope evidence-based policies and procedures that are reviewed regularly and as needed to ensure the best possible Comprehensive Care is maintained.

Developing the comprehensive care plan

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

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

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

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

Action 5.11	
Clinicians comprehensively assess the conditions and risks identified through the screening process	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

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

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

Assessment Team Summary:

Clinicians are provided with Healthscope endorsed tools that comply with Advisory AS18/14 "Screening and Assessment of Risk of Harm" and ensures comprehensive screening processes are implemented. Documentation audits identify gaps. Healthscope and Norwest have completed the current milestone of AS18/14. The assessors viewed a number of healthcare records and noted effective screening processes throughout the episode of care. Risks identified in the Minimising Harm criteria are addressed.

Healthscope endorsed the comprehensive care plan in 2019 and this was implemented at Norwest in 2019 with education for staff provided.

There is a system in place on WebPAS to enable patients to identify as Aboriginal and Torres Strait Islander with training regarding this being available for staff.

The care plan is informed by the screening processes and developed by the multidisciplinary team in partnership with the patient and family towards meeting the patient's goals. The plan in partnership with the patient identifies and documents the support people who are to be involved in planning and implementing strategies to reflect the patient's individual needs. Plans for discharge are discussed on admission.

Norwest completed an audit tool 'compliance with comprehensive care plans' in 2020 achieving greater than 90% compliance with comprehensive care planning.

Documentation audits demonstrate a mostly high level of compliance with screening, assessment and care planning processes, with confirmation of the results of assessor findings when sighting the clinical records.

Delivering comprehensive care

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

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

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

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

Action 5.18	
The health service organisation provides access to supervision and support for the workforce providing end-of-life care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

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

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

Assessment Team Summary:

All adult patients have cognition assessed on admission and a history is taken regarding their mental state. Staff have undertaken training and patients are assessed as to their behavioural, physical and mental state.

Patients are asked on admission if they have an advanced care plan, and if so to bring it on admission for inclusion in the healthcare record. If not, they are informed of the process, and if they wish are supported by clinicians in the process of documenting their plan.

Documentation audits demonstrate a mostly high level of compliance with screening, assessment and care planning processes, and the results are supported by assessor findings when sighting the clinical records.

Documentation audits demonstrate a mostly high level of compliance with screening, assessment and care planning processes, and the results are supported by assessor findings when sighting the clinical records. There has been a great deal of work undertaken regarding end-of-life care; this includes the Dying to Know Day promotion to increase awareness of end-of-life care, the butterfly symbol is discretely placed on doors to signify that the patient is receiving comfort care and is end of life.

The assessors viewed a number of clinical records that confirmed that the patient had an advance care directive, and their wishes were included in the clinical record, notation was available in the record of the care provided, however no formal review has been undertaken.

Norwest has a draft document to survey patients entitled “End of Life Care Survey for Families” that is yet to be undertaken and it is recommended that this occurs.

Action 5.19
The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Met with Recommendation
Assessor Comment: Norwest Private has systems in place for recording a patient's end of life wishes and to provide this care. A review of the patients' clinical records by assessors showed that end-of-life care is recorded, and that discussion occurs with the family. There has not been a formal review that the patients' wishes align with this. A draft document entitled 'End of Life Care Survey for Families', has been developed, but has not yet been implemented.
Recommendation:
The End-of-Life Care Survey for Families be implemented, and the results of the surveys be regularly collated and provided to staff.
Risk Rating:
Low
Risk Comment:
There is a risk that feedback will not be obtained concerning patients and that their wishes have been implemented.

Minimising patient harm

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

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

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

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

Action 5.25	
The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

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

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

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

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

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

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

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

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

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

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

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

Assessment Team Summary:

Best practice guidelines are used to screen all patients on admission for pressure injury and manage stage one and above pressure injuries and wounds as required. A wound management chart is best practice based and commenced to regularly assess and treat the wound or pressure area effectively. The incidence of pressure injuries for Norwest is 0.001% against the average of Australian hospitals 0.07%. There has been a steady reduction of the incidence of pressure injury over the past three years.

Patients all receive written information and explanation on how to prevent pressure injuries, and all beds are equipped with pressure relieving mattresses. Numerous pressure-relieving devices are available in inpatient areas and operating theatres.

The assessors noted that Pressure areas and wounds are screened, and appropriately managed when stage one or more is noted during the skin inspection on admission, however the need to screen patients for pressure injuries after admission is not clearly identified on the daily care plan. Staff modify each care plan to include regular pressure area screening during the episode of care. The assessors have made a recommendation under Action 5.22 that the Daily Care Plan be reviewed to ensure regular checking of patient pressure areas after admission is included definitively on the Daily Care Plan.

The Falls Risk Assessment Tool (FRAT) is utilised to assess falls risk. A number of strategies are used to manage falls including low/low beds, observing in a room that is closer to the nurses' station, calls bells in reach, always escorting to the bathroom. The incidence of falls is below the industry rate and has remained stable over the past few years. An exercise class is provided by the physiotherapist for patients on the orthopaedic ward. There are a number of falls devices in order to manage falls safely with an increase in the purchase and use of chair sensor mats over the past year. Written falls prevention information is provided to patients and families.

Healthscope has very recently centralised the menu for all its services following well researched dietary advice, with food prepared at Norwest with additional skilled dietary and speech therapy advice where required. Malnutrition screening occurs for all patients on admission and the incidence is reported to relevant Healthscope and Norwest committees and is also reported through HACS; it is below the average. Cognition is assessed initially on the comprehensive risk assessment and if there are two or more risks a CAM Assessment is conducted. A top 5 chart is completed in conjunction with the family to identify triggers and possible solutions to reduce agitation. Care of patients with cognitive impairment and delirium are referenced by the Delirium clinical care standard.

Screening for self-harm and suicide occurs at admission and an alert sheet is completed and an alert placed on WebPAS. Norwest has access to psychiatrists from Healthscope if required and monitoring for the patient.

All staff have had training in Workplace Aggression and Violence Education (WAVE) and use of family experience and/or intervention aid in calming and de-escalating situations.

An emergency code black response procedure which is included in induction. Incidents are reported through the risk management system. Duress alarms are available throughout the hospital.

Should the episode become aggressive or violent the staff enact the Code Black Emergency Policy.

Action 5.22
Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Met with Recommendation
Assessor Comment: The comprehensive care plan very clearly addresses pressure injuries, however there is not a section to record the daily skin integrity check on the daily care plan. If there is a skin integrity breach it is either recorded on the wound chart or under the other section. If there is not a breach the skin integrity check is currently written into the patient's clinical record notes. There is a potential risk that the skin integrity test may not be conducted.
Recommendation:
A system is developed to ensure a consistent approach to recording the daily skin integrity check.
Risk Rating:
Moderate
Risk Comment:
Daily skin integrity checks may not occur leading to the potential for a pressure injury to occur.

Standard 6 - Communicating for Safety

Clinical governance and quality improvement to support effective communication

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

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

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

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

Not Applicable	

Assessment Team Summary:

Norwest has embraced contemporary models for communication and transfer of care to achieve safer patient outcomes. Appropriate policies and procedures are in place to govern communication for patient safety. The communication for safety committee reports to the PCRC.

As a result of an RCA / CSR, a number of changes have been implemented that include strengthening communication for patient safety in particular detection and early intervention in deteriorating patients. From a quality perspective, Norwest gave consideration to waking mothers to enable their participation in the morning handover. After consultation with the mothers, the majority preferred to be woken.

There is consumer representative on PCRC. Patients participate in handover. Patients provided positive feedback to assessors regarding their ability to participate in handover. All patients are currently single rooms, thus no risk to privacy during handover. It is also noted that the nursing team actually went into the patient’s room and conducted the handover at the patient’s bedside and included update on patient care board.

Norwest has made a concerted effort to improve the rate of nursing discharge summaries. In addition, there is a specific communication tool for inter-hospital transfer for patient going to rehabilitation. In discussion with clinicians, there is a low rate of transfer out for higher level care with the exception of acute trauma as Norwest is a Level 5 hospital. It is noted that Norwest has a unique medical record number and patients transferring to other Healthscope hospitals do not have the same MRN.

Correct identification and procedure matching

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

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

Assessment Team Summary:

Norwest has appropriate systems in place to correctly identify patients using at least three identifiers. This is included in the patient wrist band. During assessment, midwives described their practice when a baby's ID bracelet is misplaced. Norwest has recently codesigned their cot cards and have received positive feedback from parents and families.

The assessors observed a TTO in the orthopaedic theatres. This was led by the anaesthetist in the presence of the patient, surgeon and team. This was assessed as compliant. Norwest audit TTO annually. An improvement opportunity is to conduct this audit more frequently given the potential risks of non-compliance.

Communication at clinical handover

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

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

Assessment Team Summary:

The assessors observed a number of clinical handovers and noted the level of compliance with contemporary practice. ISOBAR is the agreed communication tool, and this was noted to be a framework for handover. Bedside patient care boards are updated during handover. Patient identifiers are checked. All patients were given an opportunity to comment on their goals of care and expected discharge date. One patient shared a copy of his x-rays on his mobile phone. It was noted that when nurses are attending bedside handover, they were not disturbed for non-handover related matters.

Some wards have nursing huddle before bedside handover and other wards huddle after handover. These huddles enable an overview of key issues and any risks as well as predicted admission, transfers and discharges.

The NUMs have a virtual huddle with nursing executive every weekday and share ward activity, predicted transfers and workforce requirements as well as any safety concerns. In addition, the duty nurse manager conducts regular rounding.

Norwest has a Neurosurgical registrar and a number of orthopaedic registrars. They conduct regular ward rounds and provide a summary of actions to the nurse in charge.

The two discharge planners conduct regular rounding of complex care patient to enable efficient and effective discharge planning. The nearby Health Scope Rehabilitation Hospital provides an in-reach service to Norwest to assess and plan transfer for complex needs patients.

From a transfer of care perspective, the ED staff described optimal times for ST Elevation Myocardial Infarction (STEMI) cardiac patient getting to interventional cardiology within target time frames. Similarly, the theatre team described the transfer of care to theatre for CAT 1 and CAT 2 patients requiring Lower Segment Caesarean Section (LSCS) within time critical timeframes. Some delays have been reported with delayed transfer of care out of ICU in particular when the hospital is at capacity.

Communication of critical information

Action 6.9	
Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.10	
The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Regular staff huddles are held to update changes to patient’s assessment and goals through the shift. Regular consultant led ward rounds are conducted. Abnormal pathology results are communicated in real time.

Documentation of information

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

Assessment Team Summary:

A sample of medical records was reviewed and there is evidence of contemporaneous recording of patient information.

Standard 7 - Blood Management

Clinical governance and quality improvement to support blood management

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

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

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

Assessment Team Summary:

The organisation maintains current Blood and Blood management policies and procedures that are inclusive of massive blood transfusion policy documents. The blood management committee oversees the management of blood within the organisation and reports to the patient care committee and the MAC as relevant. The committee is multidisciplinary and inclusive of medical, nursing, contracted pathology unit, and wards men to ensure all employees involved in the management of blood are represented on the committee. The committee maintains a holistic approach to the oversight of blood management including prescribing, blood transfusion consent, documentation, policy procedure management, risks, consent, storage and transport, and waste minimisation.

Pathology services are available on site through a third party arrangement with Australian Clinical labs (ACL) who provide a 24/7 onsite service. The ACL services are NATA accredited. ACL is responsible for all blood storage, there are no other blood fridges within the organisation and blood/ blood products are released as a single pack. Additional products can be sort via the blood bank with a delivery time of approximately two hours. Emergency blood is available in the organisation relevant to the acuity needs of the organisation.

Consumer clinical needs are included when prescribing blood, with evidence of clients understanding the risks of blood transfusion and processes are in place for clients that elect not to receive a blood transfusion. The organisation was able to demonstrate the successful outcomes of a Jehovah's Witness client requiring a massive blood transfusion due to a HB of 3.7 – the client was successfully treated with synthetic blood products over a 10-day period with a stabilised HB of greater than 8.0 prior to discharge.

Blood safe eLearning is used to support educational needs. All employees involved or potentially involved in the transport, prescribing, administration of blood are required to complete the blood safe module – currently the organisation is achieving a compliance rate of 94%.

Prescribing and clinical use of blood and blood products

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

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

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

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

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

Not Met	
Not Applicable	

Assessment Team Summary:

The organisation has undertaken significant improvement work to ensure blood is prescribed as clinically warranted. Blood is now released from ACL as a pack at a time (a new initiative commenced in recent months), administration is to commence within 30 mins of release from pathology, and to be completed within four hours of commencement, with evidence to support this has been consistently achieved since the implementation of this policy. The committee will oversee ongoing monitoring to ensure sustainable achievement of results. The organisation in partnership with ACL has processes in place to report transfusion related events both locally and in accordance with the national guidelines.

The organisation has an extremely low blood reaction rate with no reported blood reactions in the last 12 months, despite on average 150-200 units of blood product transfusions per month on average.

All non-urgent blood administration is in business hours, with only urgent blood administered after hours with appropriate safety parameters in place.

Patient risk of bleeding is identified, and blood saver techniques are in use. When blood or a blood product clinical need is documented, and blood transfusion consent is obtained.

Suggestions for Improvement:

To ensure sustainable practice change it is suggested the Blood Committee continue to evaluate the prescribing, consent and administration of blood in accordance with recently revised local policies and procedures.

Managing the availability and safety of blood and blood products

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

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

Assessment Team Summary:

The organisation maintains appropriate storage and transport of blood and blood products. Labelling and tracking of blood and blood products is in place in accordance with guidelines, and NATA accreditation requirements.

Blood waste monitored and has resulted in a quality improvement being undertaken in recent months. This has resulted in platelet and Cryoprecipitate wastage now being below national benchmark. The organisation is undertaking investigation to further reduce waste, whilst maintaining a risk aware approach to ensure adequate emergency stock is on site to support urgent needs linked to the organisation's acuity.

Standard 8 - Recognising and Responding to Acute Deterioration

Clinical governance and quality improvement to support recognition and response systems

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

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

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

Assessment Team Summary:

Norwest has undertaken significant improvement over the last 12 months to enhance use of the MET in accordance with local policies and guidelines. This improvement activity has been multidisciplinary and included all areas of the organisation. Criteria used aligns with the 'between the flags' system in addition to enable a 'worried criteria' to result in a MET call. The MET includes a multidisciplinary team and also supports participation of the ward clinical team, and junior members of staff to broaden knowledge and awareness of the MET activities whilst enhancing communication.

The MET process has been strengthened to include consumer participation and to enhance consumers access to information which has resulted in an increased of client / carer initiated MET calls.

All MET calls are reviewed for lessons learnt opportunities through debriefing activities and formal review process supported by RiskMan. In addition, M&M process partnership with MAC and specialty craft group meetings.

Norwest has qualified employees on site to deliver Basic Life Support (BLS) and Advanced Life Support (ALS) training.

Norwest has undertaken a recent quality improvement activity to enhance the management of resuscitation trolleys. This improvement activity has included a systematic review of equipment to ensure consistency across all clinical areas, whilst also enhancing equipment checking, within significant improvement shown since January 2021.

Suggestions for Improvement:

Continue to drive outcomes of the resuscitation trolley improvement project and the surveillance of checking/ restocking of emergency equipment to ensure sustainable results are achieved and lifesaving equipment is readily available for an emergency should it occur.

Detecting and recognising acute deterioration, and escalating care

Action 8.4	
The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.5	
The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d. Determine the required level of observation e. Document and communicate observed or reported changes in mental state	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.6	
The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.7	
The health service organisation has processes for patients, carers or families to directly escalate care	
Met	All facilities under membership
Met with Recommendations	

Not Met	
Not Applicable	

Action 8.8	
The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.9	
The workforce uses the recognition and response systems to escalate care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Norwest is using the between the flags observation chart that supports clinicians to quickly identify excursions. All employees undergo appropriate training and are supported in escalating care to a MET call. High level of training compliance was evidenced.

The assessment, observation and MET process is inclusive of delirium or changes in cognitive impairment. A new screening tool has been implemented with the supported education / training as part of the comprehensive screening tool. Evidence was provided demonstrated the appropriate use of the MET team for changes in cognitive impairment.

The observation process and MET criteria are readily available and are also available to consumers to actively participate in their care with an escalation of care.

Responding to acute deterioration

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

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

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

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

Assessment Team Summary:

Norwest maintains adequate resources 24/7 to support the MET and acuity of the organisation. The MET is led by the multidisciplinary intensive care team, and supported by appropriately trained specialty teams as relevant (for example women's and children's services) with the ability to provide appropriate and timely support across the campus.

An intensivist is on site between 7am and 10pm, and then available on close call. When on close call an ICU registrar is available for MET calls. Other speciality services are also available on close call after hours to support women's and children's services, with a paediatrician called in for all category (CAT) 1 deliveries or urgent paediatric need.

The organisation has implemented appropriate hand over procedures to ensure consumer safety post a MET call.

Norwest has processes in place to escalate care to other facilities if required, inclusive of Newborn and paediatric Emergency Transport Service (NETS) transfer or other speciality care service requirements. Mental health services are not provided on site and should specialty mental health care be required transfer processes are in place.

Recommendations from Current Assessment

Standard 1

Organisation: All facilities under membership
Action 1.22 : The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system

Recommendation:
The importance of annual performance review be reinforced in order to ensure that each staff member receives an annual performance review.

Standard 4

Organisation: All facilities under membership
Action 4.1 : Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management

Recommendation:
Enhance the frequency of the audit program to provide increased surveillance with direct links to improvement activities, including education (formal and informal) of the staff as to the requirements for safe medication prescribing and medication chart documentation. The regular audit program should be sustainable to not only measure immediate improvements but also ensure sustainable improvements are achieved.

Organisation: All facilities under membership
Action 4.2 : The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management

Recommendation:
Enhance the medication safety evaluation and monitoring processes to ensure sustainable results are achieved.

Standard 5

Organisation: All facilities under membership
Action 5.19 : The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care

Recommendation:
The End-of-Life Care Survey for Families be implemented, and the results of the surveys be regularly collated and provided to staff.

Organisation: All facilities under membership
Action 5.22 : Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency

Recommendation:
A system is developed to ensure a consistent approach to recording the daily skin integrity check.

Rating Summary

Norwest Private Hospital

Health Service Facility ID: 101779

Standard 1 - Clinical Governance

Governance, leadership and culture

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

Patient safety and quality systems

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

Clinical performance and effectiveness

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

Action	Assessment Team Rating
1.28	Met

Safe environment for the delivery of care

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

Standard 2 - Partnering with Consumers

Clinical governance and quality improvement systems to support partnering with consumers

Action	Assessment Team Rating
2.1	Met
2.2	Met

Partnering with patients in their own care

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

Health literacy

Action	Assessment Team Rating
2.8	Met
2.9	Met
2.10	Met

Partnering with consumers in organisational design and governance

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

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

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

Action	Assessment Team Rating
3.1	Met
3.2	Met
3.3	Met
3.4	Met

Infection prevention and control systems

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

Reprocessing of reusable medical devices

Action	Assessment Team Rating
3.14	Met

Antimicrobial stewardship

Action	Assessment Team Rating
3.15	Met
3.16	Met

Standard 4 - Medication Safety

Clinical governance and quality improvement to support medication management

Action	Assessment Team Rating
4.1	Not Met
4.2	Met with Recommendation
4.3	Met
4.4	Met

Documentation of patient information

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

Continuity of medication management

Action	Assessment Team Rating
4.10	Met
4.11	Met
4.12	Met

Medication management processes

Action	Assessment Team Rating
4.13	Met
4.14	Met
4.15	Met

Standard 5 - Comprehensive Care

Clinical governance and quality improvement to support comprehensive care

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

Developing the comprehensive care plan

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

Delivering comprehensive care

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

Minimising patient harm

Action	Assessment Team Rating
5.21	Met
5.22	Met with Recommendation
5.23	Met
5.24	Met
5.25	Met
5.26	Met
5.27	Met
5.28	Met
5.29	Met
5.30	Met
5.31	Met
5.32	Met
5.33	Met
5.34	Met
5.35	Met
5.36	Not Applicable

Standard 6 - Communicating for Safety

Clinical governance and quality improvement to support effective communication

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

Correct identification and procedure matching

Action	Assessment Team Rating
6.5	Met
6.6	Met

Communication at clinical handover

Action	Assessment Team Rating
6.7	Met
6.8	Met

Communication of critical information

Action	Assessment Team Rating
6.9	Met
6.10	Met

Documentation of information

Action	Assessment Team Rating
6.11	Met

Standard 7 - Blood Management

Clinical governance and quality improvement to support blood management

Action	Assessment Team Rating
7.1	Met
7.2	Met
7.3	Met

Prescribing and clinical use of blood and blood products

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

Managing the availability and safety of blood and blood products

Action	Assessment Team Rating
7.9	Met
7.10	Met

Standard 8 - Recognising and Responding to Acute Deterioration

Clinical governance and quality improvement to support recognition and response systems

Action	Assessment Team Rating
8.1	Met
8.2	Met
8.3	Met

Detecting and recognising acute deterioration, and escalating care

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

Responding to acute deterioration

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

Recommendations from Previous Assessment

Nil