NS2.1 Short Notice Final Assessment

Final Report

The Geelong Clinic

St Albans Park, Victoria

Organisation Code: 220997
Health Service Facility ID: 101047
Assessment Date: 17 June 2026

Contents

Introduction

The Australian Council on Healthcare Standards
The Australian Council on Healthcare Standards (ACHS) is Australia's leading healthcare assessment and accreditation provider. ACHS is an independent, not-for-profit organisation dedicated to improving quality and inspiring excellence in health care. We accredit organisations according to either government standards, or our own established standards.

ACHS is approved to accredit the following standards

- National Safety and Quality Health Service (NSQHS) Standards including the Multi-Purpose Services Aged Care Module (MPS Module)
- National Safety and Quality Digital Mental Health (NSQDMH) Standards
- National Safety and Quality Primary and Community Healthcare (NSQPCH) Standards
- National Clinical Trials Governance Framework
- Royal Australian College of General Practitioners (RACGP) Standards for general practices (5th edition) and the RACGP Standards for point-of-care testing (5th edition)
- National Standards for Mental Health Services (NSMHS)
- Rainbow Tick Standards
- EQuIP Standards

Currently there are more than 1,600 healthcare organisations, including their associates, that undertake ACHS assessment and quality improvement programs. ACHS are proud to accredit the majority of all public and private hospitals in Australia.

With representation from governments, consumers and peak health bodies from throughout Australia, ACHS works with healthcare professionals, consumers, government and industry stakeholders to implement healthcare accreditation programs.

ACHS offers a variety of services including accreditation, education and training, data and benchmarking and consulting. We take a partnership approach to continuous improvement, tailored to the needs of individual services and health systems, using our expertise in accreditation, standards development and education.

Australian Commission on Safety and Quality in Health Care
The Australian Commission on Safety and Quality in Health Care (Commission) leads and coordinates national improvements in healthcare safety and quality. It works in partnership with patients, carers, clinicians, the Australian, state and territory health systems, the private sector, managers and healthcare organisations to achieve a safe, high-quality and sustainable health system.

Key functions of the Commission include developing national safety and quality standards, developing clinical care standards to improve the implementation of evidence-based health care, coordinating work in specific areas to improve outcomes for patients, and providing information, publications and resources about safety and quality.

The Commission works in four priority areas:

1. Safe delivery of health care
2. Partnering with consumers
3. Partnering with healthcare professionals
4. Quality, value, and outcomes

The Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme
Under the National Health Reform Act 2011, the Commission is responsible for the formulation of standards relating to health care safety and quality matters. This includes formulating and coordinating the Australian Health Service Safety and Quality Accreditation Scheme (the AHSSQA Scheme), which provides for the national coordination of accreditation processes.

The AHSSQA Scheme sets out the responsibilities of accrediting agencies in relation to implementation of the following safety and quality standards:

- National Safety and Quality Health Service (NSQHS) Standards including the Multi-Purpose Services Aged Care (MPS) Module
- National Safety and Quality Digital Mental Health (NSQDMH) Standards
- National Safety and Quality Primary and Community Healthcare (NSQPCH) Standards, and
- Any other set of standards that may be developed by the Commission from time to time

The National Safety and Quality Health Service (NSQHS) Standards were developed by the Commission in collaboration with the Australian Government, states and territories, the private sector, clinical experts, patients, and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met.

There are eight NSQHS Standards, which cover high-prevalence adverse events, healthcare associated infections, medication safety, comprehensive care, clinical communication, the prevention and management of pressure injuries, the prevention of falls, and responding to clinical deterioration. Importantly, the NSQHS Standards have provided a nationally consistent statement about the standard of care consumers can expect from their health service organisations.

Rating scale definitions

Whenever the NSQHS Standards (2nd ed.) are assessed, actions are to be rated using the rating scale outline below:

Rating	Description
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. If there are no not met actions across the health service organisation, actions rated met with recommendations will be assessed during the next assessment cycle. **Met with recommendations may not be awarded at two consecutive assessments where the recommendation is made about the same service or location and the same action. In this case an action should be rated not met.** In circumstances where one or more actions are rated not met, the actions rated met with recommendations at initial assessment will be reassessed at the final assessment. If the action is not fully met at the final assessment, it can remain met with recommendations and reassessed during the next assessment cycle. If the organisation is fully compliant with the requirements of the action, the action can be rated as met.

Rating	Description
Not met	Part or all of the requirements of the action have not been met.
Not applicable	The action is not relevant in the service context being assessed. The Commission's advisory relating to not applicable actions for the health sector need to be taken into consideration when awarding a not applicable rating and assessors must confirm the action is not relevant in the service context during the assessment visit.

For further information, see Fact sheet 4: Rating scale for assessment

Repeat Assessment

If a health service organisation has 16 or more percent of assessed actions **rated not met and /or met with recommendations**, and /or more than 8 actions from the Clinical Governance Standard not met at initial assessment and is subsequently awarded accreditation, the organisation is required to undertake a further assessment within six months of the assessment being finalised. All actions rated not met or met with recommendations from the initial assessment will be reassessed. The aim of the reassessment is to ensure the organisation has fully embedded the necessary improvements in their safety and quality systems to maintain compliance with the NSQHS Standards. This is a one-off assessment with a remediation period of 60 business days. **All actions must be met when the assessment is finalised for the organisation to retain its accreditation.**
For further information, see Fact Sheet 3: Repeat assessment of health service organisations

Safety and Quality Advice Centre and Resources

The Advice Centre provides support for health service organisations, assessors, and accrediting agencies on NSQHS Standards implementation, the Primary and Community Healthcare Standards, the Digital Mental Health Standards, the National General Practice Accreditation (NGPA) Scheme, the National Pathology Accreditation Scheme, and the National Diagnostic Imaging Accreditation Scheme.
Telephone: 1800 304 056
Email: AdviceCentre@safetyandquality.gov.au
Further information can be found online at the Commission's Advice Centre via https://www.safetyandquality.gov.au/

Authority to act as an Accrediting Agency

I, Dr Karen Luxford, CEO of the Australian Council on Healthcare Standards (ACHS) declare that ACHS has the approval from the Australian Commission on Safety and Quality in Health Care to conduct assessment to the *NS2.1 Short Notice Final Assessment*. This approval is current until 31st December, 2029.

Under this authority, ACHS is authorised to assess health service organisations against the Australian Health Service Safety and Quality Accreditation Scheme.

Conflicts of Interest

I, Dr Karen Luxford, declare that ACHS has complied with Australian Commission on Safety and Quality in Health Care policy on minimising and managing conflicts of interest.

No conflicts of interest were evident as part of this assessment and no Consultants or third parties participated in this assessment.

Assessment Team

Assessor Role	Name	Declaration of independence from health service organisation signed
Lead Assessor	Ann Cassidy	Yes

Assessment Determination

ACHS has reviewed and verified the assessment report for The Geelong Clinic. The accreditation decision was made on 13/07/2026 and The Geelong Clinic was notified on 13/07/2026.

Executive Summary

On 17/06/202617/03/2026, The Geelong Clinic underwent an NS2.1 Short Notice Final Assessment. Below is a summary of the Health Service Facilities (HSFs) that were reviewed as part of this assessment:

Health Service Facility Name	HSF Identifier	Delivery Type
The Geelong Clinic	101047	Virtual

Summary of Recommendations Subject to the Final Assessment

Facilities(HSF IDs)	Initial Assessment MwR	Initial Assessment NM
The Geelong Clinic-101047	1.22, 3.10, 5.01, 5.06, 5.13, 6.05	

Summary of Ratings following the Final Assessment

Facilities(HSF IDs)	Final Assessment MwR	Final Assessment NM	Final Assessment Met
The Geelong Clinic-101047	1.22, 5.06		3.10, 5.01, 5.13, 6.05

The final assessment was conducted for The Geelong Clinic on 17/06/2026. The following report outlines the assessment team's findings.

General Discussion

The Geelong Clinic (TGC) participated in a Final Assessment as described in the ACSQHC Short Notice Accreditation Fact sheet 17. The assessment was conducted virtually by the Australian Council on Healthcare Standards on Wednesday, the 17th of June 2026, by one Assessor.

The TGC team was well prepared for the assessment, with appropriate evidence available for all six (6) recommendations. Throughout the assessment, it was evident that staff were actively engaged in reviewing the processes and systems associated with the recommendations and in identifying and implementing improvement strategies to address and mitigate the risks associated with the variance identified at the Initial Assessment. Conversations with staff and documentation review further validated the progress made since the Initial Assessment. The Assessor was able to validate that the key tasks required to meet four of the six actions within the standards were met. Met with Recommendation (MWR) ratings that related to Performance management (1.22) and multidisciplinary clinical reviews (5.06) were continued.

In the Clinical Governance Standard at the Initial Assessment, action 1.22 (a & c) Performance Management was rated as" Met with Recommendation”. Significant work has been undertaken to review and strengthen the system supporting performance development conversations. This has included, but not limited to, the enrolment of staff in the ELMO database, the management of casual employees and the identification and monitoring of probationary reviews triggered by the HR program.

Compliance has increased to 67%, with the remaining staff either scheduled for review, currently progressing through the process, or identified as exempt. Endorsed action plans are registered in the eQuaMs system, and performance is monitored through regular reporting at the Heads of Department Committee. As these revised arrangements require further implementation and evaluation, the MWR rating has been retained.

One action in the Preventing and Controlling Infections Standard was rated as MWR, relating to hand hygiene compliance rates. Corrective actions, supported by enhanced awareness promotion, surveillance and improved access to hand hygiene products, have contributed to an increase in compliance from 47% to 76%. Hand Hygiene remains an identified operational risk, and continues to be monitored and reported to the Quality and Safety Committee. The intent of the action has been assessed as met.

Three actions in Comprehensive Care relating to Mental State Examination training (5.01), multidisciplinary clinical reviews (5.06) and care plan reviews (5.13) were rated as MWR at the Initial Assessment. Evidence presented at the assessment, as described in the action-specific recommendation commentary, indicated improvements across all actions.

The Healthscope postgraduate Mental State Examination training and competency assessment program has been successfully implemented, with identified staff completing the required training. Casual employees are being supported to complete training and remain under direct supervision until competency is demonstrated. Supporting resources, such as the Writing Progress Note Guide, have been developed to support consistent completion of MSE's. TGChas actively contributed to the development of a National MSE competency framework. The intent of the action is met

A working group has been established to oversee the response to the recommendation in action 5.06 relating to multidisciplinary clinical reviews in the inpatient care setting. Reviews of corporate and local policies, together with consideration of contemporary practice across mental health services, identified variability in both practice and documentation. Early corrective actions, including the inclusion of nursing representation within the eating disorders team, have generated positive reviews from both consumers and staff. An action plan is currently being developed, with progress monitored through the Quality and Safety Committee. Although considerable progress has been made in reviewing current practice, identifying gaps, and implementing early improvements, further work is required to achieve consistent implementation across the various programs. Accordingly, the MWR has been retained.

In response to the recommendation in action 5.13, a range of strategies have been implemented to improve the timely review and documentation of mental health care plans in the inpatient care settings. Conversations with staff and clinical record reviews indicate these measures have been effective, as demonstrated by an increase in compliance to 90%. Performance is monitored through ongoing audits, nursing leadership rounds, and contemporaneous review at clinical handover, with reporting provided through the Quality and Safety committee. It is within this context that the action has been assessed as met.

The recommendation relating to action 5.13 within the Communicating for Safety Standard focused on the use of approved patient identifiers for the storage and use of consumer medicines. Photographic evidence and a review of one medication room confirmed that approved patient identifiers had been attached to inpatient consumer medicine containers stored within medication rooms. The designation of a Medication Safety Champion portfolio and monthly reviews of imprest stock have further supported oversight and medication safety practices. The intent of the action has been met.

Overall, TGC has made excellent progress since the Initial Assessment, and should be pleased with safety and quality systems embedded in the organisation.

Assessor Findings at Final Assessment

Below is a summary of the findings of the assessment team:

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	
Initial Assessment Comments		**Initial Assessment Recommendation(s) / Risk Rating & Comment**
TGC staff's annual performance review completion rates are well below target, and there was no evidence of compliance with the three- and six-month probationary review discussions. In addition, there is limited evidence that identified training needs are systematically incorporated into the organisation's broader training program.		**Rating:** Met with Recommendation **Applicable:** All **Recommendation:** It is recommended that TGC: a. Improve compliance with performance review processes, including annual and probationary review timeframes, in line with policy requirements; and b. Formalise processes to ensure that training and development needs identified through performance reviews are consistently captured, aggregated and integrated into the TGC's training program for all members of the workforce. **Risk Rating:** Moderate
Final Assessment Comments		
Significant work has been undertaken to review and strengthen the systems supporting performance development conversations, with compliance rates increasing to 67%. Refer to the executive summary commentary. As the revised arrangements require further implementation and evaluation to demonstrate sustained compliance and consistent integration of identified training and development needs into training programs, the recommendation has been revised.		
Final Assessment Rating	**Applicable**	**Final Assessment Recommendation(s) / Risk Rating & Comment**
MWR	The Geelong Clinic	**Recommendation:** Embed and evaluate the revised performance development processes to ensure consistent completion of annual and probationary performance development conversations, with identified training and development needs

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	
		documented and integrated into the TGC's training program for all members of the workforce. **Risk Rating:** Low

ACTION	
3.10	The health service organisation has a hand hygiene program that is incorporated in its overarching infection prevention and control program as part of standard precautions and: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with benchmarks and the current National Hand Hygiene Initiative c. Provides timely reports on the results of hand hygiene compliance audits, and action in response to audits, to the workforce, the governing body, consumers and other relevant groups d. Uses the results of audits to improve hand hygiene compliance

Initial Assessment Comments	**Initial Assessment Recommendation(s) / Risk Rating & Comment**
TGC's current Hand Hygiene aggregated compliance rates are at 47%, which is trending below the national target rate for a number of audit periods.	**Rating:** Met with Recommendation **Applicable:** All **Recommendation:** A structured, risk-based approach to hand hygiene compliance be adopted across the service, in accordance with policy, to support achievement of targeted compliance rates and ongoing monitoring. **Risk Rating:** Moderate

Final Assessment Comments
Corrective actions, supported by enhanced awareness promotion, surveillance and improved access to hand hygiene products, have contributed to an increase in compliance from 47% to 76%. Hand Hygiene remains an identified operational risk, and continues to be monitored and reported to the Quality and Safety Committee. Refer to the commentary in the Executive summary. The intent of the action has been assessed as met.

Final Assessment Rating	**Applicable**
Met	The Geelong Clinic

ACTION	
5.01	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

Initial Assessment Comments	Initial Assessment Recommendation(s) / Risk Rating & Comment
5.01c - There was inconsistency with the understanding of, training in and competency of non-specialist mental health nursing staff in completing a mental state examination (MSE). The MSE is a fundamental tool in contemporary mental health service assessments of patient risk, clinical needs, it informs risk assessment, observation levels and care planning and is referred to in HSP and TGC clinical forms and policy and procedures.	**Rating:** Met with Recommendation **Applicable:** All **Recommendation:** Identify the training requirements of non-specialist mental health nursing staff and take action to ensure clinician understanding of and competency in the completion of a mental state examination. **Risk Rating:** High

Final Assessment Comments
The Healthscope postgraduate Mental State Examination training and competency assessment program has been successfully implemented, with identified staff completing the required training. Refer to the commentary in the Executive summary. The intent of the action has been met.

Final Assessment Rating	Applicable
Met	The Geelong Clinic

ACTION		
5.06	Clinicians work collaboratively to plan and deliver comprehensive care	
Initial Assessment Comments		**Initial Assessment Recommendation(s) / Risk Rating & Comment**
The systems for integrated multidisciplinary patient clinical review in TGC bed-based services was inconsistent with the TGC October 2025 Patient Clinical Review Policy and Procedure and this was evidenced by audit results, health record reviews and discussion with clinicians and consumers.		**Rating:** Met with Recommendation **Applicable:** All **Recommendation:** Review the current practice for multidisciplinary clinical reviews in the TGC bed-based services to align it with the current patient clinical review policy and procedure and contemporary mental health practice. **Risk Rating:** Moderate
Final Assessment Comments		
A working group has been established to oversee the response to this recommendation. Although considerable progress has been made in reviewing current practice, identifying gaps, and implementing early improvements, further work is required to achieve consistent implementation across the various programs. It is within this context that the recommendation has been revised to focus on the implementation and evaluation of improvement strategies.		
Final Assessment Rating	**Applicable**	**Final Assessment Recommendation(s) / Risk Rating & Comment**
MWR	The Geelong Clinic	**Recommendation:** Implement and evaluate the identified improvement strategies to support consistent multidisciplinary clinical review practices aligned with policy requirements and contemporary mental health practices. **Risk Rating:** Low

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

Initial Assessment Comments	Initial Assessment Recommendation(s) / Risk Rating & Comment
The HSP/TGC processes for developing and documenting a comprehensive and individualised mental health care plan with a consumer in the bed-based TGC services is inconsistently applied. This was evidenced by audit results, health record reviews and discussion with clinicians and consumers.	**Rating:** Met with Recommendation **Applicable:** All **Recommendation:** Review the current practices across the TGC bed-based services for developing and documenting a comprehensive and individualised mental health care plan with a consumer and align it with current policy and procedure and contemporary mental health practice. **Risk Rating:** Moderate

Final Assessment Comments
A range of strategies has been implemented to improve the timely review and documentation of mental health care plans in inpatient care settings. Conversations with staff and clinical record reviews indicate these measures have been effective, as demonstrated by an increase in compliance to 90%. Refer to the commentary in the Executive summary. The intent of the action has been met.

Final Assessment Rating	Applicable
Met	The Geelong Clinic

ACTION	
6.05	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

Initial Assessment Comments	Initial Assessment Recommendation(s) / Risk Rating & Comment
A review of the medication storage systems and through discussions with staff it was noted the current storage of consumer medications in the medication rooms is inconsistent with best practice use of three consumer identifiers.	**Rating:** Met with Recommendation **Applicable:** All **Recommendation:** Review the storage for consumer medications in the medication rooms at TGC to ensure they comply with contemporary best practice in the use of identifiers. **Risk Rating:** High

Final Assessment Comments
Photographic evidence and a review of one medication room confirmed that approved patient identifiers had been attached to inpatient consumer medicine containers stored within medication rooms. The designation of a Medication Safety Champion portfolio and monthly reviews of imprest stock have further supported oversight and medication safety practices. The intent of the action has been met.

Final Assessment Rating	Applicable
Met	The Geelong Clinic

Summary of Accreditation Status

A summary of the Accreditation awarded is outlined in the below table:

Health Service Facility Name	HSF Identifier	Accreditation Status
The Geelong Clinic	101047	3 years Accreditation