NSQHS Standards Second Edition Organisation-Wide Assessment

Final Report

Mount Hospital

PERTH, WA

Organisation Code: 521765
Health Service Facility ID: 101223
Assessment Date: 20-22 July 2021

Accreditation Cycle: 1

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

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

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

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

A rating report is provided for each health service facility.

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

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

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

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

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

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

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

Executive Summary

Mount Hospital underwent a NSQHS Standards Second Edition Organisation-Wide Assessment (NS2 OWA) from 20/07/2021 to 22/07/2021. The NS2 OWA required three assessors for a period of three days. Mount Hospital is a Private health service. Mount Hospital was last assessed between 10 October and 12 October 2017.

The Mount Hospital is one of Healthscope's 42 national private hospitals. The Mount Hospital is a 224-bed facility and the only Healthscope hospital within Western Australian (WA). The Mount Hospital advocates that they are the main WA centre for Cardiology and Cardiac Surgery also providing other specialties such as orthopedics, neurosurgery, vascular surgery, and general surgery including breast and bariatric surgery, and medical suites. The Mount provides a 24-hour priority admission service for patients on referral or transfer from other healthcare facility.

Significant changes to The Mount Hospital's executive and leader positions over the last 18 months have had a marked influence in the safety and culture of this organisation. Assessors acknowledge the committed executive leadership team which works within the clearly defined strategic and operational parameters required by Healthscope. The feedback from the staff from the Safety and Culture survey provided evidence to support a strong culture of safety and quality within this organisation. Staff believe that they have a good understanding of their roles, and it is evident that there is a good team approach to support the many changes that have recently occurred as a result in the changes to the leadership. There are processes to ensure that during the selection process there is a full assessment of the person to the position, to the team and to the organisation. The leaders/managers interviewed during this assessment were clearly motivated and passionate toward quality and safety with the aim to maintain safe patient outcomes this was validated through the verification of evidence written and observational.

The Mount Hospital Clinical Governance Framework ensures systems and processes are in place to support patient safety and quality. These include policies and procedures, incident, and complaint management (including open disclosure), risk management, information on the diversity of its consumers and higher risk groups and healthcare records. It is evident that a large body of work has recently been completed to ensure policy documents are current. There has been a focus by the organisation on continuous quality improvement of which there are examples mentioned throughout the body of this report against each relevant standard, with positive outcomes relating to patient safety and quality achievements.

The levels of compliance by the Visiting Medical Officers (VMO) to the organisation's mandatory training requirements was an issue; as a result a recommendation has been made to develop an implementation plan to support an increase in uptake by the VMOs as part of their workplace duties.

The Mount Hospital have introduced good systems to support patients to contribute to improve health outcomes. There is good involvement from consumers in the organisation governance structure with a very active Consumer Advisory Council (CAC), the group has proven themselves as dynamically valuable to the organisation in presenting the perspective of consumers and more recently have been involved in further developing partnerships with the Aboriginal community. It was clear to assessors that the Mount Hospital is actively engaged in the principles of patient-centred care.

The Mount's Infection Prevention and Controlling (IPC) of healthcare-associated infections is being managed exceptionally well. This is one area where the change in leadership with the appointment of a new IPC Manager has demonstrated significant changes to the way the IPC is managed across the facility through innovation and enthusiasm which is supported by the Clinical Governance Committee. Antimicrobial stewardship is well done with strong governance and leadership, surveillance data is collected annually however the assessment team would like aspect of this surveillance process to be completed more frequently to ensure a timelier response to issues of non-compliance with reports provided to relevant clinicians and to develop plans from the data for ongoing improvement.

The Medication Safety Management system is well established with good systems processes to support the medication management pathway. This includes the monitoring of policies and procedures, oversight of quality improvements, new systems, processes, therapies their effects and medication incidents.

The issue of safe storage and distribution of Schedule 4 Restricted and Schedule 8 medications is in concordance with the WA Medicines and Poisons Act as well as internal policy and procedure. An issue was observed to the discarding of Schedule 4 Restricted and Schedule 8 medications particularly within procedural areas. The discards are currently captured on the anaesthetic record, but non-compliance with this process. The requirement for two practitioners to observe discards was not routinely adhered to, and documentation was insufficient, with insufficient oversight from a governance perspective. A recommendation has been made to support changes to the practice. The Mount Hospital has acknowledged these shortcomings and produced a comprehensive action plan to rectifying the observed deficiencies

The assessment of Comprehensive Care has demonstrated good systems and processes to ensure that patients are appropriately risk assessed prior to the development of a plan of care that is suitable for the various types of admissions. Care is planned collaboratively between all clinicians and in partnership with the patient. Risk screening tools are used on admission and throughout the patient journey enabling the effective management of risk, prevention of deterioration and the development of individualised care plans, provision for ongoing care, referral to appropriate disciplines and services through to discharge. Patients are screening for cognitive impairments and individual care plans developed.

Policy and processes are in place to identify documentation of Advance Care Directives/Advanced Care Plans/ Resuscitation plans in the clinical notes it was not evident to assessors that this was embedded practice across the organisation. Processes are supported by the Last Days of Life Toolkit.

The Mount Hospital organisation has embedded effective processes to ensure that they communicate effectively to enhance patient safety, with assessors noting positive examples across the hospital. Communication for Safety is well implemented as per the Healthscope and local policy and procedure.

There is and efficient program for the management of blood and blood products with significant work undertaken to minimise the requirement for blood transfusion. Interventions have included routine multidisciplinary pre-operative assessments, optimisation of haemoglobin and iron stores pre-operatively, modification of surgical techniques where possible to reduce the risk of bleeding, the cessation of anticoagulation agents where possible and the routine utilisation of cell-salvage devices. As a result there have been favourable rates of blood product transfusion and wastage when benchmarked against peer hospitals through the WA Haemovigilance surveillance program.

The Mount Hospital has a well-established infrastructure to support timely escalation for emergency assistance. An emergency Code Blue system has been operational for several years, with a single telephone access point and a rapid pager response activated for members of the Medical Response team. The Mount Hospital has a REACH program works developed by the Clinical Excellence Commission to empower patients and their carers to escalate concerns. The assessment team noted strong integration across all hospital areas, with a high level of awareness from healthcare workers and patients. The presence of consumer-friendly promotional material was noted in each bed unit.

During this assessment, the assessment team identified that there has been good progression in developing and achieving the many actions to meet the requirement the Australian Commission on Safety and Quality in Health Care's Advisories within the required time frame. Opportunities for further and ongoing improvement were identified, and suggestions and as mentioned two recommendations have been made within the report related to the Visiting Medical Officer training and medication safety for the disposal of scheduled medications.

The Commission assessment framework for safety and quality systems (PICMoRS) and the application of patient journey and process flow were used to assess each action. Several patients and staff were interviewed during this assessment and local practices monitored to verify compliance to the National Standard. Evidence was sighted of a strong commitment to providing a safe environment for both patients and staff. The assessment team was impressed with the preparation for this assessment.

Summary of Results

At Mount Hospital's Organisation-Wide Assessment two Actions were rated Met with Recommendation across 8 Standards. The following table identifies the Actions that were rated Met with Recommendation and lists the facilities to which the rating applies.

Actions Rated Met with Recommendations

Facility (HSF ID)	NS2 OWA 20/07/2021 - 22/07/2021
	MwR
Mount Hospital-101223	1.20, 4.14

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

Sites for Assessment - Mount Hospital

Site	HSFID	Address	Visited
Mount Hospital	101223	150 Mounts Bay Rd PERTH WA 6000	Yes

Standard 1 - Clinical Governance

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

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	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital has a clinical governance plan which is designed to align with the on Healthscope 2025 Strategy which has two objectives to improve the experience and grow the business. These objectives are strengthened by six elements (pillars) to drive the goal of exceptional patient-centred care and clinical outcomes. Significant changes to the Mounts executive and leader positions over the last 18 months has had a marked influence in the safety and culture of the organisations. Feedback from the staff from the Safety and Culture survey (2012) have identified that there is a strong culture of safety and quality within this organisation. Staff believe that have a good understanding of their roles and there is a good team approach. This is actively monitored as part of the selection process to ensure that there is and full assessment of the person to the position, to the team and to the organisation. The leader/managers interview during this assessment were clearly motivated and passionate toward quality and safety particularly maintain safety patient outcomes. Priorities are clearly established under each of the Clinical Governance Framework pillars.	

Org Name : Mount Hospital
Org Code : 521765

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	
1. Leaderships and culture with the structure that oversees governance and ensuring that there is accreditation against the National standards and a strong safety and quality culture. 2. Partnerships ensure that reconciliation has been processed with the development of a Reconciliation Actions Plan (Action 1.2), the development of relationships with the Valued Medical Officers (VMO) and other stakeholders such as the WA Health Department. 3. Clinical data and outcomes which has been designed around a national and local data set of Clinical Key Performance Indicators (KPI's and clinical indicators (CI) with a focus on clinical incident clinical audit and the development of public reporting through the My Healthscope website. 4. Managing Risk with the National Clinical Risk Management framework with provide the rules and processes for the management of risk and monitoring arranged by the Quality Safety and Risk Team. 5. Quality Improvement which is outlined in the Clinical Governance Safety and Quality Action plan and the identification of opportunities for the improvement of patient care. 6. Evidence based practice through the management of policies, procedures guidelines and opportunities for research. 7. Building capacity through staff training and performance monitoring. 8. Patient Experience, ensuring there is consumer participation, patient surveys and patient feedback processes.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital has developed an Aboriginal and Torres Straight Island Plan to support the needs of the Aboriginal people hospital by monitoring the numbers of Aboriginal people that attend their facility and the types of procedures that these people are admitted for as well as monitoring clinical incidents that have occurred for any aboriginal person and aboriginal consumer feedback. The aim is to improve the cultural competency and seek community feedback to monitor the effectiveness of internal systems and processes. Assessment of the requirements to meet the Commission's Advisory AS18/04: Advice on the applicability of Aboriginal and Torres Strait Islander Specific Actions have been met for Action 1.2.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital's clinical governance framework is very comprehensive and reviewed annually to identify previous achievements. These include an assessment against the National Standards and the required audits, the assessment against others external reviews such as the WA Licensing and Regulatory United inspections. Other new improvements have been the introduction of new information technology systems, monitoring of staff training and identifying new training opportunities,	

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	
monitoring Hospital Acquired Infection (HAI) rates and ensuring that opportunities for improvements are identified and implemented from patient experience surveys.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Mount has implemented several target actions through a review of the local demographic data, clinical incidents, consumer feedback, types of procedures and average length of stay of Aboriginal and Torres Strait islander people. Assessment of the requirements to meet the Commission's Advisory AS18/04: Advice on the applicability of Aboriginal and Torres Strait Islander Specific Actions have been met for Action 1.4.	

Rating	Applicable HSF IDs
Met	All

ACTION 1.5	
The health service organisation considers the safety and quality of health care for patients in its business decision-making	
Comments	**Suggestion(s) for Improvement**
Safety and quality objectives are included as part of the organisations business and strategic plans. There are standardised Healthscope Capital Expenditure forms and templates for the introduction of service development or changes to the clinician's scope of practice.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Mount has a strong leadership model that supports the delegation of safety and quality roles within the clinical workforce and to drive safety and quality improvements. Safety and quality training is evident with a published annual training schedule.	
Rating	**Applicable HSF IDs**
Met	All

<table>
<tr><th colspan="3">ACTION 1.7</th></tr>
<tr><td colspan="3">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</td></tr>
<tr><th colspan="2">Comments</th><th>Suggestion(s) for Improvement</th></tr>
<tr><td colspan="2">A broad suite of policies is in place across the Mount Hospital, ranging from those determined by Healthscope as well as local policy requirements. These are supported by local procedures and clinical guidelines.

All local documents are current, appropriately endorsed, and reflective of evidence-based practice. There is a strong system for policy distribution of new and revised documents which has a tiered approach to make certain appropriate levels of education is undertaken to support policy being embedded into everyday practice. Staff have easy access to policies via the HINT (Healthscope internet) database which is easily accessed from the intranet.

Compliance to policy, procedure and guidelines is monitored via audits, actions are taken to address variance through action plans and quality improvement for example recent changes made to Confidential Waste.

There is a system in place for monitoring legislative compliance.</td><td>Prior to this assessment work was conducted to update clinical guidelines it is suggested that the data base is reviewed to include all local documents and improve the monitoring system.</td></tr>
<tr><th>Rating</th><th colspan="2">Applicable HSF IDs</th></tr>
<tr><td>Met</td><td colspan="2">All</td></tr>
</table>

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		
Comments		**Suggestion(s) for Improvement**
Monitoring of the Mount Hospitals quality improvement system is undertaken through regular reporting at both the Healthscope Board and at hospital level. KPI's for clinical performance have been set by Healthscope, areas that require improvement have strategy plans communicated. There is a formalised audit schedule with reports tabled at both governance and operational meetings. Results are discussed at the staff information session such as safety huddles. Quality action plans are produced to address variances and are monitored at the various committees (including CAC) and meetings for the progression and the completion of activities. Examples of quality activities are staying safe while we medicate and REACH (recognise, engage, act, call, help) program. This process will be further enhanced in September with the implementation of the electronic auditing system: Measurement, Analysis and Reporting (MARS). A safety and quality culture survey has been conducted with positive results, to assist with the Mounts commitment to build a strong safety and quality culture. It is evident that the culture has shifted from reactive and moving towards resilient.		
Rating	**Applicable HSF IDs**	
Met	All	

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		
Comments		**Suggestion(s) for Improvement**
There is a reporting framework set by Healthscope and Mount Hospital which provides an integrated framework for reporting on safety and quality systems including risk. Routine reports are tabled for discussion at the various operation and Healthscope meetings as per Action 1.8. Consumers are informed of safety and quality information via Mount Hospital website, CAC in addition to safety and quality boards in all clinical areas.		
Rating	**Applicable HSF IDs**	
Met	All	

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	
Comments	**Suggestion(s) for Improvement**
There is a Risk Management policy and framework with clear reporting processes and the recognition of risk accountability. Risks are registered into the integrated risk management system RiskMan system which has recently been updated to improve effectiveness. All risks have an assigned owner who is responsible to develop a treatment action plan to address/control and mitigate the risk.	

<table>
<tr><th colspan="2">ACTION 1.10</th></tr>
<tr><td colspan="2">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</td></tr>
<tr><td>Both the heatmap and register is routinely reviewed at the Executive Committee the various committees reporting into this peak committee. Regular reviews include risk ratings, and monitoring of progress of actions to reduce the risks.

Risk scenarios were assessed as part of this assessment of two top risks that were identified from the Risk Register. On review of these risk staff could articulate the required processes to ensure timely assessment, intervention and review of issues were evident. For example, risk reduction strategies made to paediatric resuscitation equipment, admission, and environmental criteria. Nurse Unit Managers (NUM) were able to articulate a good understanding of risk management. The General Manager is alerted to any new risk via an email alert from RiskMan.

Plans for the management of internal and external emergencies are evident. Staff are provided with regular annual training on emergency response. Environmental audits are completed to ensure that emergency equipment is compliant with the regular Australian Standards. Business continuity plans have been updated to align with state requirements. Each area has a delegated fire warden.</td><td></td></tr>
</table>

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
Effective processes are in place to monitor incidents trends at all levels of the organisation via the committee framework, operational meetings including shift safety huddles. Regular memos to the workforce from executive are circulated to communicate incident trends with an educational component to reduce further risks. Incidents rated as Severity Assessment Code (SAC)1 are subject to a Root Cause Analysis (RCA) review, this is guided by WA Health and Healthscope policy A good system is in place to ascertain SAC 1 recommendations are closed off within policy timeframes. The workforce is provided in training at orientation and at subsequent study days on clinical incident management. There are processes to ensure that the patients/consumers are provide feedback on any clinical incidents.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
There is an open disclosure Healthscope policy that is aligned to the Australian Open Disclosure Framework. Open disclosure education is via eLearning modules and is a mandatory training requirement for applicable staff, current compliance is 99%. There is an Employees Assistance Program (EAP).	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
There is a system for feedback for patient experience, on discharge patients receive a letter from the General Manager inviting feedback via a survey based on the new Australian Hospital Experience Set, this provides continuous feedback on experience and outcomes of care enabling prompt review and identifying opportunities for improvements. Reports are provided to senior staff and the Board. There are numerous surveys and workshops conducted to gain feedback from the workforce about their understanding and use of the safety and quality systems. Other approaches include formal debriefing post serious events and information from performance development processes.	

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	
Action plans are developed in areas that require improvement and added to the Safety and Quality plan, an example of an improvement are Education and provision of a resource to ensure care is patient-centred and keeping relatives informed via the pathfinder online portal. The latest results of one of the key questions rating overall rating of treatment and care is at 87.9 %.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Healthscope Policy on Complaints Management outlines the process for the management of complaints. There are numerous access points for the patients to find information on how to provide feedback (complaint) including standardised Mount Hospital feedback forms, patient information brochures and there is accessible information from the Mount Hospital website.	

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	
The RiskMan system is utilised for complaint management. This monitors the number of complaints, the actions taken, and the timeframes taken to close the complaint. Complaints are formally coordinated from the Executive office, with established KPI's related to initial contact and feedback to respondents regarding their complaint. These KPIs and complaint trends are monitored by the organisation on a regular basis and reported to the Board, the executive, governance, and consumer advisory committees. The most recent result for response rate to complaints within 28 days is 86.4% and 16.4% above target. Learnings from complaints are shared with relevant committees and cluster/team meetings and included in Shared Learnings report. Links from complaints are made with the risk management system. Examples of improvements made is the recent change to the admission flow for chemotherapy patients. A review is currently being conducted by the Director of Nursing to ensure complaints are registered in a timely manner, the review of the system occurs with the updating of the policy. Feedback is also provided at operational levels. ward levels inclusive of compliments, examples seen were the Appreciation Tree and Heartfelt Thanks displays.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
As the Mount Hospital receives referrals from across WA there are systems in place to identify the diversity of its consumers and those that may be at high-risk and adapt and prioritise care as required. For example, paediatric and Aboriginal Torres Strait Islander consumers. The Mount Hospital workforce receive training on cultural diversity.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
There are a number of policies and procedures to support the management of the healthcare record that are accessed by the workforce through the HINT system. By-laws for VMO include the obligation for record management. The medical record is paper based, care plans and treatment related documents are available at the bedside, the medical record is audited hospital wide, findings are discussed with managers, action plans to improve variance are developed as required. The Mount Hospital will eventually implement and Electronic Medical record as part of a National Healthscope electronic health record program.	

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	
The Clinical Documentation Specialist (CDS) has facilitated a multidisciplinary clinical documentation improvement program to support the workforce in maintaining accurate complete records. The workforce is educated via an online module on Privacy Awareness on orientation. Documentation champions have been implemented to support and empower peers in maintaining documentation standards. The secure storage of medical records on site complies with the relevant Acts for record storage and privacy. External storage is via and external contractor with processes in place for 24/7 recall. Confidential waste bins are available in all areas and computers are password protected. There is a centralised patient administration system (webPAS) which is a computer health platform involving patient admission and clinic registration. This system will generate the patient registration number, which is a national number and has secure links to integrate with other systems currently in use at the Mount Hospital.	

Rating	Applicable HSF IDs
Met	All

ACTION 1.17	
The health service organisation works towards implementing systems that can provide clinical information into the MyHealth 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	
Comments	**Suggestion(s) for Improvement**
The system for guided by Healthscope Policy - MyHealth Records and User Documentation for MyHealth Record. The Mount Hospital uploads event summaries and nursing discharge summaries into the patient's MyHealth Record. Further work is being conducted to upload the VMO discharge summary. The Mount Hospital uses national patient and provider identifiers and standardised national terminologies into MyHealth Record. A gap analysis and action plan has been completed to comply with the Commission's Advisory AS18/01 Implementing systems that can provide clinical information into the MyHealth Record system for Actions 1.17.	

Rating	Applicable HSF IDs
Met	All

ACTION 1.18	
The health service organisation providing clinical information into the MyHealth 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	
Comments	**Suggestion(s) for Improvement**
The Healthscope Information Technology (IT) department provides access to the MyHealth record database following authorising by the General Manager, there is a process in place for a data breach and an audit is conducted annually of access and uploads. Uptake has increased by 32% since 2018. A gap analysis and action plan has been completed to comply with the Commission's Advisory AS18/01 Implementing systems that can provide clinical information into the MyHealth Record system for Actions 1.18.	

ACTION 1.18	
The health service organisation providing clinical information into the MyHealth 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	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
There are systems in place for monitoring attendances at orientation and for annual mandatory training that aligns with Healthscope policy. Safety and Quality Training is provided to the executive and all clinical and non-clinical staff. VMO receive this as part of the Bylaws and their onboarding process.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital has a comprehensive orientation program for staff as well as an induction specific to the area they are to work. A Mandatory Training program is in place to cover patient safety and quality in healthcare and occupational health, which includes Manual Handling, Basic Life Support (BSL), fire safety and infection control. Staff interviewed demonstrated accountability for their own training and for their competency assessments. All training and assessment rates are monitored by the various committees or operational meetings. Staff participate in performance development annually to discuss individual performance on a one-on-one review. Mandatory Training is also reviewed at this meeting. There was a high level of compliance with mandatory education with current compliance of 92% for hospital employed staff. Further education was available for staff including external education opportunities. Compliance is captured on the MyLearning and Kronos databases and reported under regular Safety and Quality dashboards at Corporate Governance and Education committees. Whilst this framework is applied to the employed and volunteer workforce it was noted by assessors that VMO were not afforded the equivalent program, of particular concern is BLS. The assessment team noted that a large part of the medical workforce were Visiting Medical Officers, who do not have an employed relationship with the Mount Hospital. As such, there is no current mandatory training regimen for the VMO workforce, including a lack of strategy pertaining to ensuring that this component of the workforce undertook training pertaining to the provision of Basic Life Support, hand hygiene and aseptic technique. The Executive team commented that this matter is currently being considered at National executive level.	

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		
Rating	**Applicable HSF IDs**	**Recommendation(s) / Risk Rating & Comment**
MwR	All	**Recommendation:** To develop a gap analysis and implementation plan to ensure that Visiting Medical Officers undertake mandatory training as part of their workplace duties within the Mount Hospital. **Risk Rating:** Low **Risk Comment:** The recommendation is rated as a low risk as limitations to this training will not directly impact on patient safety.

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	
Comments	**Suggestion(s) for Improvement**
Cultural awareness sessions are organised at orientation and ongoing to improve staff awareness to meet the needs of Aboriginal and Torres Strait Islander people. This has been enhanced with the development of the Cultural Protocol in consultation with local a Whadjuk Ballardong and Yued community member to improve cultural awareness and cultural competency of the workforce. The current cultural awareness training compliance is 96%.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
There is a Healthscope Performance Review and Development policy. Staff participate in performance development (PD) three months post appointment and annually thereafter to discuss individual performance on a one-to-one review. Mandatory training is also reviewed at this meeting. Compliance rates have been improved by data cleansing of casual workforce and the implementation of Biweekly report. On assessment the employee’s goals are identified with plans to move forward, goals from the previous year are also reviewed, the line manager is responsible to ensure that goals aligned with the Mount Hospital Clinical Governance Framework. A formal annual review of training requirements is conducted, the annual Safety and Quality cultural survey results also inform the training system.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
There is a multidisciplinary approach at the Mount Hospital for this action that is supported by various policy documents and the Credentialing system.	

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	
The Medical Advisory Committee (MAC) is the responsible body for governing credentialing of any visiting practitioner. VMO are credentialed for a period of five years, with reviews this includes a performance and scope of practice review. Scope of practice is considered in line with the clinical delineations identified for the Mount Hospital. All clinical staff Australian Health Practitioner Regulation Agency (AHPRA) registrations are verified annually. Both credentialing and scope of practice are communicated formally to the organisation from administration to relevant staff, e.g., Operating Theatre who also have read only access to scope of practice. Proceduralists who perform Colonoscopy adhere to the requirements with the Comprehensive Care Standard for recertification and auditing. There is a process in place for review of SOP for new services, technology, or procedures, this is governed by the General Manager and MAC. Scope of practice for allied health and nursing is defined by registration status. A system for clinical competency relevant to job requirements is in place for Nursing. There are no Nurse Practitioners or Endorsed midwives employed at Mount Hospital. The assessors reviewed the processes in place in relation to AS18/12: Implementing the Colonoscopy Clinical Care Standard and can attest that the requirements of Advisory AS18/12 are met.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The assessment team was impressed with the robustness of the current credentialing process to ensure that all practitioners practised within a defined scope of practice. The hospital conducts a series of quarterly audits to ensure that all practitioners are practising within their defined scopes. The last audit demonstrated 100% compliance. The Mount has a system to ensure that deficiencies within performance are identified and considered as part of a practitioner's clinical privileges. Minutes were observed from the last Credentialing Committee verifying decisions taken to impose restrictions pertaining to scope of practice where deficiencies are identified. Restrictions to a practitioner's scope of practice are documented on cGov as well as webPAS to ensure that admitting and theatres teams are aware of restrictions imposed upon a practitioner's scope of practice. The Mount has provided evidence to demonstrate compliance to the AS18/12 Implementing the Colonoscopy Clinical Care Standards for Actions 1.23 and 1.24 Annual audits are conducted annually to ensure VMO are working within credentialed scope of practice with 100% compliance. The assessors reviewed the processes in place in relation to AS18/12: Implementing the Colonoscopy Clinical Care Standard and can attest that the requirements of Advisory AS18/12 are met.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
There is a position description matrix, all employees and volunteers are provided with job description forms (JDF) which are filed in the employee record. VMOs are bound by Healthscope Bylaws. Several JDF were assessed as part of this assessment. Each document has identified safety and quality roles and responsibilities Staff are educated on their roles in safety and quality and staff interviewed at assessment were aware of the Safety and Quality plan and their roles and responsibly in terms of Safety and Quality. An orientation process for agency nursing is in place, this was audited at assessment with high compliance in most components of the process.	Whilst it is noted that nursing agency usage is low (1%), it is suggested that compliance of agency nursing orientation is monitored regularly and added into the audit schedule.
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The clinical workforce is well supported and supervised with escalation processes, Duty Nurse managers After Hours and the provision of On-call Executive support after hours.	
Rating	**Applicable HSF IDs**
Met	All

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		
Comments		**Suggestion(s) for Improvement**
The Mount Hospital, supported by Healthscope, has a strong focus on the delivery of evidence-based care, demonstrated throughout assessment through a broad range of clinical pathways, use of the Clinical Care Standards, and the conduct of programs such the Back to Bedside program. Distribution of these includes the MAC/Clinical Review Committee and Craft Groups e.g. Colonoscopy Clinical Care Standard. There are numerous examples of guidelines (Action 1.7), pathways and decisions support tools that have contemporary references. Clinical Care Standards are well known by workforce, each has had a gaps analysis conducted and all have a comprehensive action plan in place that show good progress. A range of support information is also available to staff electronically through the Healthscope website, with links from the HINT intranet, e.g. to 'MIMS Online and HICMR. The assessors reviewed the processes in place in relation to AS18/12: Implementing the Colonoscopy Clinical Care Standard and can attest that the requirements of Advisory AS18/12 are met.		It is suggested that Mount Hospital review the policy database to include all related policy, guidelines and clinical pathway documents that are in use, this will ensure there is a standardised approach to all documents related to clinical practise.
Rating	**Applicable HSF IDs**	
Met	All	

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	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital monitors variation in practice by submitting data, benchmarking, and analysis. There are number examples of reports to demonstrate active monitoring of variation that are reviewed by the Board and various committees. The most recent hospital acquired complication (HAC) rate was 2.01% this is below the target set by Healthscope of < 4.16%. Clinical variation, HAC and audit data is discussed in detail at the Clinical Review Committee under Qualified Privilege, MAC, and craft groups. The MAC drives improvements regarding variation via peer review processes within the committee meetings. RiskMan system is used to report variation if required with linkages to the risk register. Healthscope Shared Learnings, clinical indicators, HAC rates audit outcomes and incident trends are all used to inform action plans quality improvement and risk management plans. The assessors reviewed the processes in place in relation to AS18/12: Implementing the Colonoscopy Clinical Care Standard and can attest that the requirements of Advisory AS18/12 are met.	

Rating	Applicable HSF IDs
Met	All

<table>
<tr><th colspan="2">ACTION 1.29</th></tr>
<tr><td colspan="2">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</td></tr>
<tr><th>Comments</th><th>Suggestion(s) for Improvement</th></tr>
<tr><td>The Hospital provides a welcoming clean environment for their consumers. Environmental audits are routinely completed (Action 3.11).

There are processes to ensure that there are scheduled maintenance on building and equipment. Any issues that requirement maintenance is registered on the kwiklook (integrated facility management systems) which is monitored weekly via a weekly meeting between facilities and the General Manager. Biomedical equipment servicing is contracted to a third party, with reports to corporate governance.
and monitored via the equipment committee.

New works completed over the past three years include a new cardiac catheter laboratory procedural room and day procedure recovery area.

An external report for building and equipment requirements has been sought and received, as a result there is a business case for a refurbishment plan and works required to make improvements and maintain standards being prepared for the Board meeting in August.

Appropriate processes are in place to manage pandemic outbreak management e.g., COVID-19 from a building perspective.

Food safety audits were reviewed at assessment with demonstrated high achievement in meeting the required food safety standards.</td><td>While currently, there is an informal process for management of equipment/product recalls, it would be pertinent to maintain a register and monitor these, including actions taken to address at either the equipment or corporate governance committees.</td></tr>
</table>

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
There are emergency responses policies and systems to support issues relating to unpredictable behaviour. Training is provided for workplace aggression and violence and code black procedures. Security systems are evident at bedsides and reception areas. Staff are provided with training annually on emergency management and Workplace Aggression and Violence Education (WAVE). Security is available with police back up as required. Night-time lockdown processes are in place, this can be instigated when required by facility management or Duty Manager.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The signage and direction throughout the Mount Hospital facility are clear and meet the needs of the local community and those consumers requiring access to the services. There is an electronic interactive map available in the main foyer however this has been inactivated due to COVID. A Wayfinding project is in progress with further improvements planned.	

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	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
Visiting hours are identified and this information is provided to all consumers. Flexible arrangement as organised depending on the needs of the patient and relatives and potential COVID restrictions.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital has a welcoming environment for Aboriginal Torres Strait Islander people. Artwork is displayed at the reception and various places throughout the hospital. During the assessment, this was enhanced with the unveiling of a new piece of artwork created by an aboriginal Consumer Advisory Council (CAC) member during NAIDOC week in partnership with hospital employees and consumers. Further artwork in the form of a wall mural on the wards is planned as part of the Wayfinding project.	

<table>
<tr><th colspan="3">ACTION 1.33</th></tr>
<tr><td colspan="3">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</td></tr>
<tr><td colspan="2">Aboriginal and Torres Strait Islander flags are raised on flagpole at the entry of the hospital in addition to being displayed on the front reception desk. Collaboration with the local Aboriginal people is evident with the involvement of an Aboriginal consumers member on the CAC, a smoking ceremony by local community members and the development of the Aboriginal protocol.

Activities presented support the compliance of the Mount Hospital to meet the requirements for the Commission Advisory AS/18/04 Advice on the applicability of Aboriginal and Torres Strait Islander specific Actions 1.33.</td><td></td></tr>
<tr><th>Rating</th><th colspan="2">Applicable HSF IDs</th></tr>
<tr><td>Met</td><td colspan="2">All</td></tr>
</table>

Standard 2 - Partnering with Consumers

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

<table>
<tr><th colspan="3">ACTION 2.1</th></tr>
<tr><td colspan="3">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</td></tr>
<tr><td colspan="2">Comments</td><td>Suggestion(s) for Improvement</td></tr>
<tr><td colspan="2">There are a range of policies and procedures to support various processes for partnering with consumers.

The Mount Hospital have developed a Consumer Engagement Plan 2020-2025 in collaboration with consumer consultants. The Mount Hospital has a good record of active consumer engagement through the Clinical Governance, CAC, and Partnering with Consumers committees.

The CAC has appropriate Terms of Reference that include quality and safety outcomes, the minutes reflect that this group is active in all aspects of safety and quality which includes patient experience feedback, incident outcomes, sentinel events, clinical indicators, KPI’s and audits.

Appropriate training programs are in place for consumer representatives both at Healthscope level and at the Mount Hospital.

My Healthscope website informs the community and consumers about the safety and quality performance at the Mount Hospital.</td><td></td></tr>
<tr><td>Rating</td><td colspan="2">Applicable HSF IDs</td></tr>
<tr><td>Met</td><td colspan="2">All</td></tr>
</table>

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		
Comments		**Suggestion(s) for Improvement**
Consumer representatives and volunteers are involved and have input in the quality improvement system via the Mount Hospital governance committees and the CAC. The CAC reviews the patient experience data, incident and complaint trends and has input into strategies to address. The hospital is actively recruiting for volunteers and members of the CAC.		
Rating	**Applicable HSF IDs**	
Met	All	

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		
Comments		**Suggestion(s) for Improvement**
Healthcare rights consistent with the Australian Charter of Healthcare Rights are clearly displayed throughout the facility and available on the website. These are also displayed in the four other languages that have been identified from the annual demographic review.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 2.4		
The health service organisation ensures that its informed consent processes comply with legislation and best practice		
Comments		**Suggestion(s) for Improvement**
The Mount Hospital is guided by Healthscope policies in gaining informed consent. The monitoring of consent occurs through annual audits and the incident reporting system, with identified issues reported to various governance committee. Consent audits are reported to the Clinical Governance, MAC, and Clinical Review Committee. Consent audits have shown 100% compliance to the consent process however some aspects have been identified for improvement such as clinicians printing name. As a result, an action plan has been developed to address these areas in need of improvement. The frequency of the audit has been amended until the required benchmark is achieved. The assessors reviewed the processes in place in relation to financial consent and can attest that the requirements of Advisory AS18/10 are met.		
Rating	**Applicable HSF IDs**	
Met	All	

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	
Comments	**Suggestion(s) for Improvement**
Patients are screened and assessed pre-admission and on admission for cognitive impairment and the capacity to make decisions on their own care. There are processes to support the management for patients that require support from a substitute decision maker, with copies of any signed documents filed within the medical record.	

Org Name : Mount Hospital
Org Code : 521765

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		
Education is provided to the workforce on assessing patient's capacity. There are processes to communicate advance care directives including at safety huddles during handover. This was observed by assessors during assessment.		
Rating	**Applicable HSF IDs**	
Met	All	

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		
Comments		**Suggestion(s) for Improvement**
There are several policies available for staff including the Healthscope policy on Rights and Responsibilities which outlines the requirements to involve consumers in decision making about their own health care and to support the patient to set their health priorities/goals of care (Action 5.4, 5.13). This is also underpinned in the Healthscope Safety and Quality Plan. There are routine audits completed to demonstrate that patients are involved in the decision-making process for planning their care which commences either as part of the pre-admission processes or on admission.		
Rating	**Applicable HSF IDs**	
Met	All	

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		
Comments		**Suggestion(s) for Improvement**
Staff are provided with training to support the development of consumer partnerships and person-centred care processes. There are several initiatives that have enhanced this action including the Back to Bedside project and Care boards. Both documented evidence and the observation of clinical practice throughout the period of this assessment strongly confirm the commitment of staff and consumer representatives of Mount Hospital principles of patient-centred care. Observation of safety 'huddles and handover processes that involve the consumers demonstrated the existence of individual care plans with patient agreed outcomes. This is monitored through formal patient experience surveys that are reported to the various Committees including the CAC. The results show high levels (80% and higher) of responses to questions concerning patient engagement in their care plans. This result was confirmed by a small number of patients happy to speak with assessors about the quality of care being provided and their understanding of treatment plans.		
Rating	**Applicable HSF IDs**	
Met	All	

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	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital diversity profile is reflective of the services provided the predominant language is English. Aboriginal Cultural Awareness training is mandatory for all staff and linguistic diversity of community groups is identified with information available in other languages for four key groups. Further analysis identified 74.1% of patients did not respond to the question 'Do you identify as Aboriginal or Torres Strait Islander on admission. An improvement project inclusive of education was conducted with now only 10.81% of patients not responding. Interpreter service is available and at assessment staff were aware of process and how to access this service.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
There is a strong process in place for involving consumers in the development and review of patient information. All consumers are provided with information is a variety of formats. This information is routinely reviewed by the CAC.	

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	
There is an Aboriginal volunteer who is involved in the review of documents and other processes to ensure they are culturally appropriate.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
Mechanisms have been established to support and enhance the communication processes for consumers. Depending on the type of admission a standardised information pack has collated to ensure that patients are provided with information routinely on every admission. All consumer information has appropriate approvals including consumer approved logo. Information is available in other languages including Aboriginal and Torres Strait Islander appropriate information from the intranet. Clinicians are supported to ensure clinical needs of patients are addressed via a comprehensive suite of policies, education and various trigger charts and clinical pathways. The Back to Bedside initiatives also supports this including clinical handover in consultation with the patient and Patient Escalation of care REACH framework. The Discharge Coordinator is involved from pre-admission through to discharge and has implemented several initiatives and processes to ensure adequate information is provided on discharge.	

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	
The Nursing Discharge summary is provided given to each patient on discharge to patients and General Practitioner (GP) and uploaded into the MyHealth Record where applicable.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
CAC members are involved in several of the governance meetings including a member on Clinical Governance committee. It was evident that consumer engagement and partnerships are an integral part of the Mount Hospital, there were many examples of where consumer consultation occurs, and consumers participate can influence service planning. All areas were keen to partner with consumers as their focus is to ensure that care and services are designed around consumer and needs. An example of an improvement made as an outcome of consumer involvement was the change of oncology patient admission flow; this reduced the time vulnerable patients spent in the foyer mixing with large number of other people whilst waiting on admission. This deceases the risk of hospital acquired complication and increased patient satisfaction.	

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	
Consumers are involved in design, measurement, and evaluation of services through processes including incidents, complaints, patient feedback and survey mechanisms. Consumer and patients interviewed by the assessors stated that they felt they are listened to and are confident that what they say makes a difference in improving the health service. There was evidence of working in partnerships with Aboriginal and Torres Strait Islanders and this has provided an environment for improved health outcomes.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
Appropriate training programs are in place for consumer representatives both at Healthscope level and at the Mount Hospital. EAP is available for volunteers.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.13	
The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs	
Comments	**Suggestion(s) for Improvement**
Collaborative working relationship has been established with local Whadjuk community members, this was noted on assessment with a Welcome to Country, smoking ceremony and unveiling of artwork painted by a ATSI volunteer Liaison Officer for the Hospital. The Healthscope Reconciliation Action plan was published in May 2021 with inclusion in the Mount Hospital Consumer Engagement Plan. Activities presented support the compliance of Mount Hospital to meet the requirements for the Commission Advisory AS/18/04 Advice on the applicability of Aboriginal and Torres Strait Islander specific Action 2.13.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital incorporates consumer experiences into training via numerous strategies including Consumer involvement in the development in the Safety and Quality and Consumer Engagement plans, membership on committees where educational requirements related to safety and quality are discussed and via patient stories at the end of various committee meetings, these shared stories and learnings influence education and training requirements.	
Rating	**Applicable HSF IDs**
Met	All

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

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

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	
Comments	**Suggestion(s) for Improvement**
The Mount has a comprehensive suite of policies and procedures for healthcare associated infections and for their antimicrobial stewardship (AMS) program as outlined by the requirements to meet the National Standards (Action 1.7) and the Australian Guidelines for the Prevention and Control of Infections in Health care. This process is supported from an external Infection Prevention and Control (IPC) Service Provider who supplies the Mount with access to various specialised IPC manuals and IPC toolkits. COVID resources and guidelines are bundled under an easily accessible heading on the Intranet. These policies and procedures are monitored for currency and compliance to State and National infection prevention requirements by the Infection Prevention and Control (IPC)Committee in the first instance then other committees as and additional level of review. Changes to policies are communicated to the workforces through various methods, email, newsletters, and meetings. Policies, procedures, guidelines, and medical records forms pertaining to IPC for example IV Cannulation are accessible on the Healthscope Intranet. A formal Risk Assessment approach has been developed to manage infections. A flow chart has been developed for quick interpretations of the specific WA Health requitements for the management of diseases and multi-resistant organisms (Action 3.2). Staff have been provided with additional training to support the role-out of this process which has included the development of pocket cards for staff to carry while working within clinical areas.	

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	
IPC risks can be identified from clinical incident, hazard, patient complaints and from routine IPC surveillance processes. Daily surveillance monitoring is undertaken as part of the assessment of all new patient's infection status and by the review of pathology results and feedback from staff and patients. These risks are monitored as a routine agenda item by the IPC committee. Hospital Acquired Infections (HAI) are reported as a Healthscope Quarterly KPI and submitted to be benchmarked Nationally with other Healthscope hospitals every quarter. The Mount is currently recognised as being better than Peers. The RiskMan system is used to register all IPC risk and supports the ongoing processes to resolution. Any IPC identified risks are rated according to the required risk assessment framework (Action 1.10). All risk are registered into RiskMan. Once registered these IPC risks are routinely reviewed and reassessed for any residual risk. The Mounts IPC Manager has the has been delegated to review and update risks with compliance monitoring by the quality team. The one remaining high risk continues to be the Pandemic associated with COVID-19. A significant amount of work has been undertaken to support the controls to mitigate any issues of outbreak. These processed are continually reviewed and reported to both management and staff. The management or COVID remains a high risk on the Mounts Risk Register. Routine audits are completed as per the Healthscope Audit Schedule. These results are benchmarked Nationally with other Healthscope hospitals. These audits support the process of risk assessment with deviations of results reported and reviewed to identified risk and opportunities for improvement. There is a Healthscope policy for Mandatory Training (Action 1.20). Staff training is available from the eLearning programs which are easily accessible from the Healthscope intranet. These learning modules are supported by the relevant practice guidelines. Training completion is monitored for compliance against the training schedule which include compliance for completion of competency assessment.	

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	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
There is a very in-depth quality and Safety Plan which is used to monitor the progress which is dated and any linkage with the registered quality improvement activity and risk registration. There is recognition of accountability by either a committee or person with the expected time frame for completion. On assessment of risk such as the rise in Serratia Marcescens in 2020 a working party was established to develop an action plan to address the modified risk (Action 3.4). There have been numerous IPC quality improvement activities registered with 20 completed in 2020 nine completed 2019. Currently for 2021, there are 21 outstanding with two completed. Changes to the IPC portfolio holder members where there has been a rebranding to their role to IPC Area Leads. The aim is to support local IPC audits including Hand Hygiene Australian (HHA) audits. These staff have also been trained as COVID-19 contract tracers as part of the Mounts, Contract Tracing Team,	

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	
The audit schedule has recently been reviewed as part of the IPC plan with increases to the number and frequency of audits. All audit results are tabled at the IPC and Clinical Governance Committee meetings. An action plan is developed following discussion of areas of concern with the responsible person identified to monitor the issue to completion. The Mount participates in the Healthscope Quality Key Performance Indicator (KPI) program by submitting quarterly reports to the corporate office for benchmarking. Recently the IPC had an included Key Performance Indicators (KPI's) surveillance indicators have been expanded to include bacteraemia's. These are benchmarked with the WA Health and the Healthscope Group IPC Committee and with ACHS clinical indicator program with the last ACHS results demonstrating all rates are within the required 99% Confidence Interval.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
Patients are involved in the planning of their care through the admission process and the development of goals and ongoing care (Action 2.3-2.10). Patients are required to complete the Admission Infectious Screening Questionnaire to support the development of their care plans which included history of infection status.	

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	
Discussion on treatment options and infection prevention education commences on admission. Risk identification of infection is required in the patient notes and in medical record alert sheet and webPAS. There is a referral process to the Infectious Diseases (ID) Physician and the IPC Manager. Additional education will be provided depending on the identification of any infection status on admission. Any registered multi-resistant organism (MRO) will currently be reviewed by the IPC Nurse in collaboration with the patient. Documentation of the plan of care is recorded in the patients' medical record with a notation of any relevant education material provided to the patient to ensure that staff are aware of what has been provided to the patient and opportunities for inclusion of additional material later in the admission or on discharge. There are several examples provided as evidence during this assessment of CAC approved brochures that are provide to patients. IPC patient education continues throughout the admission until discharge. A discharge phone call is provided. This process is audited with 100% of patients being satisfied with the education material and with the discussion. Further action is required to support the process for the follow-up phone call as not all discharged patients are provided with service.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
Routine surveillance data is collected by the IPC Team with all exposures recorded and monitored for trends and issues using the RLDatix infection surveillance database to monitor HAI's and tracks trends, and environment issues. There are various surveillance reports required at a local, WA State and National levels. The evidence provided many examples where a review of infection treads including surgical site infection rates during this assessment clearly demonstration a very proactive and mature Infection Control Program. A review of the Mount's Staphylococcus Aureus Bacteraemia (SAB) cases were investigated to ensure compliance with the WA Health policy for the reporting of SAB as a SAC1. The result has been the development of an RCA team to review all SAB cases with the report of the investigations to table at the various committee meetings with a copy of the recommendations to be forwarded to the treatment physician. There have been nil cases of SAB infection for central line bacteraemia. The monitoring of antimicrobial prescribing will be reported under Action 3.15-16.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
Patients requiring transmission-based precautions are identified on admission. This information is obtained through the patient pre-admission questionnaire, the referral letter, previous alert registrations in webPAS and on clinical assessment. Any identified infection issues are referred to the IPC Manager and ID Physician. Newly identified issues are registered as an Alert, recorded in webPAS and transferred to staff through handovers. After hours the hospital manager who identifies infection admission issue must assess the patient for the correct placement for their admission and referred to the HICMR Consultant who provides a 24/7 coverage for IPC related issues. Daily surveillance extracts reported are monitored by the IPC nurses and assessed against the required IPC isolation/precautions and sign cards are placed outside the patient's room. This is supported by the recent introduction of the IPC Patient Management Flowchart to guide clinicians with the required pathology request, isolations precaution types and well as linking in with the required IPC policy (Action 3.1). Any HAI are monitored by the IPC Manager and ID Physician. All HAI are entered RiskMan database follow-up by a clinical review or RCA depending on the issue with high level issues such as SAB blood stream infections reported as a SAC 1 to WA Health (Action 1.11) Department. All outcomes are discussed by the IPC committee and the AMS sub-committee. There are weekly IPC rounds attended by the ID Physician, IPC Manager and pharmacist provides an additional support for monitoring treatment and compliance 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	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
There are several policies and procedures for the management of IPC Infection risk and transmission-based precautions including a Patient Precautions-standard and Transmission based precautions policy and Multidrug Resistant Organism Management policies. Risk management processes are evidence as per Action 3.5. Due to the lack of negative pressure facilities for the management of airborne transmission, patients that require this type of capacity are not admitted to the Mount. These patients require immediate transfer to another healthcare service who can provide the appropriate isolation rooms to care for patient with airborne infections. All patients are risk assessed prior to admission and at the pre-admission clinic. Surgical patients routinely screened for MRSA and VRE prior to major surgery. Auditing of the standard precautions compliance within all clinical areas identities a 98% compliance rate with a similar result with the transmission-based precautions audits.	

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	
Equipment is available to support Infections risks with laminated visual display cards as required by the Commission outside the patients' rooms with other reference cards including the Personal Protective Equipment (PPE) donning and doffing procedures.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
Information on patient's infectious status is routinely communicated as part of the handover process and this was observed by the assessment team to be in current practice. It was also noted during handover that staff were checking the IV cannulation sites for date of insertion and appearance for signs of infection. The transfer of patients policy required written information on the patient's infectious status on transfer. This infection status is included in the Inter-hospital Healthscope transfer form.	

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	
Information on Multi-Resistant Organism (MRO) is routinely documented with the last audit reporting a 100% compliance for information documented in the nursing handover sheet, entered onto webPAS and 100% of MROs noted in the Nursing Discharge summary.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
Hand Hygiene Australian (HHA) auditing is completed as per the audit schedule. The most recent review identified low sampling sizes as a result additional IPC Area Lead Nurses were recruited as HHA auditors to increase the sample size the most recent audits identified that all but one department was above the 80% national benchmark. Professional medical staff rates were below the benchmark (73.5). The action from the low rate has been a communication to the Medical Director with a requirement to target peer-to-peer auditing and escalation of the medical compliance of the low HH rate to the MAC. Hand gel has been attached to the end of the beds in a bracket and available in each room and outside each room with a poster placed above the gel to support the application of hand gel process.	

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		
"Bare below the elbow" audits are completed with an overall compliance rate of 88%.		
Rating	**Applicable HSF IDs**	
Met	All	

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		
Comments		**Suggestion(s) for Improvement**
Healthscope has a policy on aseptic technique. A review of all the clinical protocols across each department has been completed to identify those procedures that require Aseptic technique as part of the clinical management. The ability to identify these procedures supports a greater opportunity to practically assess clinical competency. Aseptic training and competency monitoring as per the mandatory obligations for the clinicians is completed using the ANTT with an overall compliance rate of 97%. Theatre scout, theatre scrub technique aseptic technique is currently 100%.		
Rating	**Applicable HSF IDs**	
Met	All	

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]	
Comments	**Suggestion(s) for Improvement**
A hospital-wide invasive device register have been completed and risk assessed of exposure prone procedures within the clinical areas. Education self-directed learning packages and competency assessment on the invasive medical devices has been completed. Monitoring the length of time of device in situ is evident with the date recorded on all devices observed during this assessment and the related clinical notes. The Mount has a Comprehensive Care Plan Daily IV Access document which is a supplementary document to the Comprehensive Risk Screening Assessment. Auditing of the documentation on peripheral intravenous cannulation is completed with the date of insertions compliance rate of 95% for date/time for insertions and 86% on removal.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Mounts cleaning services is managed by the Hotel Service Manager. The current cleaning of non-clinical and ward areas is completed by inhouse cleaner with all procedural aeras cleaned by an external contracted service.	

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	
Cleaning audits are completed by using a UV Light. A recent audit action plan requested the implementation of Clinell wipes near hand stations within clinical areas to support a more proactive approach to cleaning of equipment within each patient's room. Work instructions for cleaning and environmental cleaning schedules that include the frequency of cleaning. There is a chemical register. Chemical spill kits are available, and MSDS sheets are available on the wards and relevant departments. PPE education is provided at orientation and monitored for the donning and doffing of PPE.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Facilities Manager oversees the hospital maintenance schedules which include the monitoring the HEPA filters - all environmental tests are taken at the IPC meeting Maintenance schedule for annual testing of various equipment monitored by the maintenance manager. The maintenance schedules include HEPA filters, steriliser validation, airflow as per Action 1.29.	

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	
The Mount's linen is externally outsourced. Linen is delivered daily in covered trolleys. There is a water testing plan to monitor for legionella, this is being supported by an external contractor. All refurbishing works conducted and in planning involve the IPC Manager with environmental testing conducted on completion prior to occupation.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
There are policies on workforce immunisations processes which recognise the risk - based category of healthcare workers. Staff are screened preemployment for their immunisation status and if unknown are requested to have serology testing and proof of vaccination. Any new employee serology deficits are follow-up with their GPs prior to being clearance to commence work. This information is stored in the RLDatix database. There has been significant work undertaken to support workforce immunisations, At the commencement of 2021 the rate was 57%. A QI saw the introduction of the 0.4FTE position for IPC Clinical nurses to provide a mobile "Needle on wheels" mobile vaccination station to increase the rate which currently is at 93%.	

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	
Flu vaccinations are monitored with 43.7% compliance and 2.2% refusal rate. COVID-19 compliance is currently 31.1% for the first dose and second dose is 26.7%.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
There are systems for tracing reusable equipment/instruments to the patient, procedure, and the device for the procedure. A reusable medical device register was developed in 2021 to track CSSD (Central Sterilising Service Department) and RMD (Reusable Medial Devices) outside the procedural areas. There is a gap analysis completed to determine the current level of compliance with the relevant national standards for reprocessing reusable medical devices to comply with the Commission's Advisory AS18/07: Reprocessing of reusable medical devices in health service. All the CSSD staff have the required certification, this is routinely monitored by the manager. The Sterilisation department has good security arrangements with controlled access and the area is isolated from the main part of the general hospital traffic area. Door signs are installed on all restricted areas and there is HEPA filtration.	

<table>
<tr><th colspan="2">ACTION 3.14</th></tr>
<tr><td colspan="2">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</td></tr>
<tr><td>The facility is well lighted with both natural and internal lighting. The windows are sealed. Staff have padded mats under set workstations to support longer standing with processing of equipment.

There is good segregation of clean and dirty activities with a unidirectional flow of all processing to support decrease contamination including received and hold trolleys for used instruments awaiting processing to cleaning areas. The receiving areas are well designed to hot and cold-water outlets, steal benches. Hand washing basins are evident.

The sterilising area is separated with an area for cooling of sterilised equipment. The sorting and packing areas is well laid out to support the processes for wrapping, tracking, and sealing of equipment. The sterilising/cooling area is in a one-way flow. Stock rotation is monitored as well as processes for monitoring packages for integrity, labelling and batch control. Monitoring the storage of sterile stock to main the integrity overall compliance is at 100%.

There is a single entry to the Endoscopy cleaning service room which is very small. The room is currently registered on the Mount’s Risk Register for improvement with plans currently progressing. There is a one-way movement of processes from precleaning the scopes to leak testing, manual cleaning to disinfection and sterilisation. The process is that the scopes are cleaned and hung in a cupboard which are high enough to allow for the scopes to hang vertically without coiling. These cabinets have minimal ventilation as a result the scopes are cleaned prior to use. This area and the storage systems for the scopes is currently under review as part of the service redevelopment for theatres planned within the near future.</td><td></td></tr>
</table>

Rating	Applicable HSF IDs
Met	All

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]	
Comments	**Suggestion(s) for Improvement**
There is an AMS policy, procedures, and antimicrobial formulary decisions processes. The Infectious Disease (ID) Physician chairs the quarterly AMS Committee. Access to and ID Physician is available 24/7. There are weekly AMS clinical rounds with the ID Physician, Clinical Pharmacist, the IPC Manager, Ward Managers, and relevant doctors if available to review the prescribing of antimicrobials and collaborate with the team decision based on best practice. If the doctors is not presented, they are contacted by phone. Current results show an 83% satisfaction with the processes and acceptability for the recommendations. Earlier this year a restricted antimicrobial formulary was introduced to support the AMS program. This has included the development of a poster to guide the prescription of antimicrobials according to a restricted processed that is identifiable through a traffic lighted process green for no restrictions to red for restricted requiring formal review and approval. Staff education has been provided as part of the implementation process. AMS usages continues to be monitored by the AMS committee. There recently been the development of an updated list of antimicrobial and a review of the clinical storage of restricted antimicrobials. Patient allergy assessment and the previous assessment of allergies noted in the NIMC, recorded in the patients notes and registered into webPAS. The Australian Therapeutic Guidelines are available in all clinical areas. Compliance to the Commission's Advisory AS18/08 Antimicrobial stewardship is evident. A Gap Analysis has been completed against the AMS Clinical Care Standard.	

Org Name : Mount Hospital
Org Code : 521765

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]	
Rating	**Applicable HSF IDs**
Met	All

<table>
<tr><th colspan="2">ACTION 3.16</th></tr>
<tr><td colspan="2">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</td></tr>
<tr><th>Comments</th><th>Suggestion(s) for Improvement</th></tr>
<tr><td>A review of the current AMS prescribing and Gap analyse has been completed against the Commission Clinical Care Standards. An antimicrobial restricted formulary is evident with a guidance posters to support the medical decision-making process.

An AMS surgical prophylaxis poster has been developed to target key procedures in theatre. There are issues with current prescribing of cephalexin for some orthopaedic procedures where the required dose of 2 grams is not being given as per protocol.

Current audits include the NAPS, NAUPS and SNAPS are completed annually. These reports are monitored by the AMS, IPC and MAC committees. These audits provide an annual overview, and it is suggested that a more frequent audit of issues noted within these reports be considered to target compliance of AMS prescribing outside the required Guidelines. This has been recognised as an issue due to number of changes appointment to the IPC Manager position (three) over the previous two years that has impacted on stability of the AMS program.

IV to oral switch processes – with the development of a poster.</td><td>To review the current AMS audit for Surgical Site Infection compliance to antimicrobial dose according to the best practice guidelines.

The NAPS audit is completed annually however this may not provide a good indication to monitor compliance therefore the IPC/AMS team should consider a better real time audit preferably random monthly audits.</td></tr>
</table>

Rating	Applicable HSF IDs
Met	All

Standard 4 - Medication Safety

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

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	
Comments	**Suggestion(s) for Improvement**
Governance of medication safety is the responsibility of the Mount Hospital Executive Team. This responsibility is delegated to NUMs. The Medication Safety Committee meets monthly and has terms of reference and KPIs which are reviewed annually. The Committee reports to the Clinical Governance Committee which in turn reports to the Executive Leadership Team. This committee has executive representation (Director of Nursing), representatives from each clinical area, the Chief Pharmacist, and other representatives. A VMO is invited to attend as a representative of the MAC. Pharmacy services at the hospital are outsourced to the Mount Hospital Pharmacy. Following meetings of the Medication Safety Committee, an action plan is circulated confirming agreed actions and the person(s) responsible. Committee members report back to their clinical areas on the activities of the committee and information/medication safety alerts/policies/practices are discussed. There is a Healthscope Medication Safety cluster group sharing knowledge and expertise to facilitate quality improvement throughout the company particularly in respect of the medication safety issues identified in NSQHS Standard 4. The Quality and Risk Manager is a member of this cluster group and was for several years the coordinator of this group. Several risks relating to medications have been registered in the hospital's Risk Register with controls in place to mitigate risks. These risks are reviewed either six or 12-monthly depending on the level of risk.	

<table>
<tr><th colspan="2">ACTION 4.1</th></tr>
<tr><td colspan="2">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</td></tr>
<tr><td>Medication incidents are reported on the RiskMan incident reporting system and are closely monitored. They are reported monthly to the various governance committees. Incidents are trended to enable corrective actions to be undertaken.

Critical system/s reviews are undertaken for serious medication incidents and reported to the National Clinical Risk Manager & the State Manager. On a quarterly basis the Healthscope national team provides a report on all medication sentinel events that have occurred within Healthscope and provides 'Shared Learnings' arising from an analysis of incidents which all hospitals are required to implement. The 'Shared Learnings' are reviewed at the Nurse Unit Managers' Committee and actions implemented are reported to the Clinical Governance Committee and are signed off by the General Manager, Director of Nursing and the Quality and Risk Manager. Medication ‘Shared Learnings’ are reviewed by the Committee. There is an audit schedule of medication safety audits addressing all medication safety issues identified in NSQHS Standard 4 Medication Safety Standard. Action plans are developed to address deficits identified in the audits.</td><td></td></tr>
</table>

Rating	Applicable HSF IDs
Met	All

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		
Comments		**Suggestion(s) for Improvement**
The Mount Hospital has a comprehensive and robust system of quality improvement and audit activities to ensure that medication management is optimal, underpinned by a series of national and local policies and procedures to support best medication management. The risk register reflects several medication risks which are continually reviewed, and mitigating action is taken. The current audit suite includes audits pertaining to the NIMC Audit, Schedule 8 Documentation, High-risk Medications, Medication Safety RiskMan Reviews and Medication Safety Self-Assessments. Where deficiencies are identified with the follow-up development of a detailed action plan. Each identified issue has an assigned accountable owner. Issues and outcomes and reported back to the Medication Safety Committee. Medication errors are recorded into the RiskMan database, investigated and benchmarked data is provided to the Medication Safety Committee to monitor for emergent risks.		
Rating	**Applicable HSF IDs**	
Met	All	

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	
Comments	**Suggestion(s) for Improvement**
Patients are actively involved in their care (Action 2.3-2.10). Shared decision making occurs in all parts of the patient journey, including with respect to the provision of information relating to their medication. The health service utilises patient information sheets where appropriate. Consumer engagement is evident with the development of new information sheets where the documents are developed in collaboration with the CAC. Patients are further involved with their medication routinely as part of the bedside handover process. The assessment team observed bedside handovers whereby medication histories were discussed with the patient to ensure congruence with their agreed goals of care.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital has systems in place to ensure that only those members of the workforce (medical practitioners) with the authority to do so can prescribe, dispense, and administer medicines. There is a robust system of credentialing and re-credentialing medical practitioners which ensures that AHPRA registration is checked with no conditions related to prescribing of medications instituted.	

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	
The cGov credentialing system is integrated with the AHPRA database such that limitations with respect to the prescribing of medications are identified on a contemporary basis. Such restrictions are captured on the cGov tool and uploaded to webPAS to ensure that all relevant ward and procedural areas are aware of such restrictions. Only pharmacists dispense medication. Pharmacy services are outsourced to Mount Hospital Pharmacy which has current accreditation from the Pharmacy Guild of Australia. Registered nurses administer medication. The AHPRA registration of all registered nurses is checked, and a database is maintained indicating dates of registered nurses' renewal of registration. All newly appointed registered nurses need to successfully complete a medication competency (MedSafe) before they can administer medications independently and complete a practical assessment. Medication endorsed enrolled nurses also administer medication. Again, the AHPRA database is checked as this will reveal any enrolled nurses who have conditions or notations on their registration preventing them from administering medications.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital has a suite of policies pertaining to the capture of best possible medication histories. All healthcare professionals are aware of their responsibilities with respect to medication reconciliation upon commencement of an episode of care. Patients are provided with patient information booklets informing them of the importance of bringing in a list of medications from their own GPs upon admission. On admission, each patient's medication history is obtained including any known adverse reactions to medications, and documented in their medical record, on an Alert Sheet and documented within webPAS at that time. In addition, all patients are risk assessed as per High-risk Medication Check list with early referral to pharmacist expertise where high-risk medications are identified. The Mount Hospital monitors documentation of best possible medication history through annual auditing of the Medication Management Plan or as per audit outcomes, and the last audit demonstrated 87% compliance.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital has a well-established process to ensure that current medication management strategies are reviewed as part of the review of the patient's best possible medication history.	

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		
On admission the admitting nurse captures the best possible medication history from a variety of sources which are clearly documented in the admitting documentation. This is reconciled by the treating medical practitioner and documented onto the Medication Management Plan. Patients identified as being of higher risk are proactively referred to the pharmacist for further reconciliation and strategies are implemented in a multidisciplinary context.		
Rating	**Applicable HSF IDs**	
Met	All	

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		
Comments		**Suggestion(s) for Improvement**
Patient's allergy status and history of adverse drug reactions is part of the patient admission history and documented in the patients' medical record. Alerts including allergies to medications is recorded on a separate alert sheet and uploaded to webPAS as an alert. The latest audit indicated 100% compliance with this process, and this was verified by the assessment team through the direct observation of medical records.		
Rating	**Applicable HSF IDs**	
Met	All	

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	
Comments	**Suggestion(s) for Improvement**
Any observed Adverse Drug Reactions are recorded within the medical records as well as registered in RiskMan for investigation. In addition, the information is entered into the webPAS database as an "Alert". A red alert identification band is applied if the patient does not already have an alert identification prior to this event. The admitting and/or treating Medical Officer is responsible to provide the patient/family/carer with a letter that the patient/family/carer can retain and provide a copy to any other healthcare professional for ongoing care or treatment, or to assist in future medical situations. This information is reflected in the Discharge Summary to the referring GP.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital has applicable policies outlining when notification to the Therapeutic Goods Administration is required. Such notifications are made by the NUM in liaison with the medical practitioner and captured as part of the Hospital's Adverse Drug Reaction procedures.	

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	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
Current and accurate medicines information and decision support tools are readily available to the clinical workforce when making clinical decisions related to medicines use. A plethora of tools and external references are available for staff, including the Therapeutic Guidelines, MIMS Manual, the AusDI manual and the Australian Medicines Handbook All ward areas further have access to the Australian Injectable Drugs Handbook. Upon presentation, risk factors pertaining to the requirement for earlier multidisciplinary expertise are identified for early referral to a pharmacist for expert advice. Patients requiring medication reviews are proactively identified and escalated to the treating medical practitioner and pharmacist. In addition, there are weekly AMS rounds involve pharmacists and infectious disease physicians to ensure continual best medication practice.	

Rating	Applicable HSF IDs
Met	All

ACTION 4.11	
The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks	
Comments	**Suggestion(s) for Improvement**
Patients are actively involved in their care (Action 2.3-2.10). Shared decision making occurs in all parts of the patient journey, including with respect to the provision of information relating to their medication. The health service utilises patient information sheets where appropriate. Patient information sheets provided have been endorsed by the CAC.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
Medical practitioners, pharmacists and nurses work together with the patient to maintain and generate accurate and comprehensive medicines lists when transferring care. On discharge/transfer to another healthcare facility, medications are reconciled against the medications taken by the patient pre-admission and those prescribed while an inpatient. Upon discharge current medication regimens are communicated to the external pharmacy provider situated on site to produce for accurate outpatient medication dispensation, and medication regimens are communicated through the Discharge Summary to the patient and GP. Compliance with the Nursing Discharge Summary is audited monthly, with the last audit demonstrating compliance more than 98%.	

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	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.13	
The health service organisation ensures that information and decision support tools for medicines are available to clinicians	
Comments	**Suggestion(s) for Improvement**
Current and accurate medicines information and decision support tools are readily available to the clinical workforce when making clinical decisions related to medicines use. A plethora of tools and external references are available for staff, including the Therapeutic Guidelines, MIMS Manual, the AusDI manual and the Australian Medicines Handbook. All ward areas further have access to the Australian Injectable Drugs Handbook.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
Medication fridges and freezers have electronic continuous monitoring and temperature alerts installed. Purpose specific alarmed medication fridges have been installed in all clinical areas. Temperatures are checked and recorded daily as a further safety control.	

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	
Reports are sent in real time to responsible staff to prevent a cold chain breach, and there are well articulated processes with respect to responsible owners and actions in the event of a cold chain breach. All relevant staff have received an appropriate training package pertaining to the maintenance of the cold chain. The Storage and Disposal of Schedule 4 Restricted and Schedule 8 medications is in concordance with the WA Medicines and Poisons Act as well as internal policy and procedure. A Controlled Drug Register is maintained with clear evidence of receipt, transportation, administration, destruction all Schedule 8 (S8) drugs. On receipt of S8 medications from the pharmacy supplier, documentation in the drug register captures date and time, quantity of S8 delivered, count reconciliation with existing S8s. S8 medication are witnessed and signed into the register by two appropriate practitioners, and similarly administered by two practitioners. Controlled medication within ward areas are stored in appropriate locked storage facilities. Discarding of Schedule 4 Restricted and Schedule 8 medications particularly within procedural areas was observed to be ad hoc. Discards are captured on the anaesthetic record, but non-compliance with this process was widely observed. The requirement for two practitioners to observe discards was not routinely adhered to, and documentation was insufficient, with insufficient oversight from a governance perspective. The Mount Hospital has acknowledged these shortcomings and produced a comprehensive action plan to rectifying the observed deficiencies.	

Rating	Applicable HSF IDs	Recommendation(s) / Risk Rating & Comment
MwR	All	**Recommendation:** Implementation of a program of works to ensure the appropriate discard, documentation, and clinical governance of Schedule 4 Restricted and Schedule 8 medications. **Risk Rating:** Moderate

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		
		Risk Comment: This recommendation has been rated as moderate, due to the legal issues associated with the management of restricted medication and the consequences associated with lack of oversight of this process.

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	
Comments	**Suggestion(s) for Improvement**
The risks for storing, prescribing, and administering high risk medicines are regularly reviewed. A list of high-risk medications is in place specific to the Mount Hospital using the APINCH (anti-infectives, potassium, insulin, narcotics, chemotherapy, heparin) acronym as advised by the WA Therapeutics Advisory Group (WATAG). High-risk medications have been separately stored and labelled as high-risk medications. An e-learning education package (APINCH) is allocated to all nursing staff as mandatory education. A series of policies pertaining to the storage, dispensation and administration of high-risk medications have been implemented. The management of high-risk medications are captured on the organisation's risk register. Regular audits are conducted to ensure best practice, and Shared Learnings Reports are produced by the National Risk Manager allows for the Medication Safety Committee to identify and rectify emergent risks.	

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	
Rating	**Applicable HSF IDs**
Met	All

Standard 5 - Comprehensive Care

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

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	
Comments	**Suggestion(s) for Improvement**
Healthscope has developed a suite of policies and procedures to support the delivery of comprehensive care. These documents are supported by local procedures and guidelines which are reviewed by the reviewed by the Comprehensive Care Committee in the first instance, then elevated for review/endorsement by the Clinical Governance Committee and the MAC. Documentation endorsement protocols are as per Action 1.7. Nationally Healthscope have implemented a dedicated committee the Comprehensive Care Cluster which consists of members from other National services. This committee provides overarching governance to the Comprehensive Care standard across all the National Healthscope healthcare agencies. Risks associated with Comprehensive Care are identified through various methods including clinical incident report, patient complaints, hazard notification and following the completions of audits. Clinical Incidents are entered into the RiskMan database (Action 1.11) these, as well as registered risks are routinely monitored by the Quality and Risk Manager. Regular quarterly reported identified issues and trending are tabled at the Comprehensive Care Committee. Action plans are developed to monitor issues and consideration for the development of a quality improvement project, and these will be added to the Quality Plan.	

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	
Regular audits are completed as per the Mount Hospital's audit schedule. The majority are completed annually however it is the Assessments Team understanding that they can be repeated more frequently if there is a perceived issues with the outcome results. Reports on audits are published as part of the clinical performance and health outcomes data which is easily accessible to the public on the My Healthscope website Staff are provided with training on Comprehensive Care to comply with the current Mandatory Training policy requirements which may include a competency assessment.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital has a very robust reporting framework for all the elements of Comprehensive Care. This includes quarterly quality KPI reports of core indicators and audit results which are monitored by the various clinical governance committees (seven in total) and craft groups. These are monitored at a National level by the Healthscope Executive and the Healthscope Board. KPIs are reported quarterly to Healthscope Corporate. These are benchmarked against other Healthscope facilities of a similar size and as well as with the nature of the care provided. Areas identified as being below the required level will required the development of an action plan.	

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		
Any significant quality improvement issues are added to the Quality Improvement Register, and if identified as an ongoing risk registered as a risk on the RiskMan database. Clinical Incidents can be registered by any clinician in the RiskMan database. These are routinely monitored for trends and the level of the incident per Action 1.11.		
Rating	**Applicable HSF IDs**	
Met	All	

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	
Comments	**Suggestion(s) for Improvement**
Consumer participation commencing on the patient admission to the Mount these processes link to Actions 2.3-10). This process will include with development of their plan of care. The Mount's Care plan has a designated area for patients/cares to sign as part of the process for their agreement of their care daily. Care boards by the patient beds provide an opportunity for the patient to be involved in the discussion regarding their daily care with notation for the change of nurse during handover.	

Org Name : Mount Hospital
Org Code : 521765

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	
Feedback from patients’ post-discharge on whether they were involved in their care has a current rating of 91.1%. There is a similar response from feedback from consumers regarding their involved in their decision making regarding their treatment and care.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
Healthscope has several admission policies depending on the clinical treatment requirements of the patients. This is supported by the Mounts admission inclusion and exclusion criteria/s. Mental health patients are within the exclusions criteria as these patients are outside the Mounts capability framework. However, patient with cognitive impairment are admitted. A risk assessment is completed on admission and routinely repeated as per the protocol and these patients may be provided with additional close observation. On referral the VMO will identify the reason for admission, the length of stay and if the patient may require a high level of care and/or specific post-operative care. It is during the pre-admission/admission risk assessment process the patient will be assessed for their suitability for admission and this assessment may result in delay in treatment/surgery and or transfer to a more suitable healthcare facility. The estimated discharge date is recorded in the patient’s medical record, on webPAS and added to the patient journey board in the nurse’s station.	

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		
There is a dictated Nurse Discharge Planning position to support the discharge/ referral process. Routine monitoring is completed for unplanned hospital readmission rates which are currently below the industry rate for 2019.		
Rating	**Applicable HSF IDs**	
Met	All	

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	
Comments	**Suggestion(s) for Improvement**
There are numerous referral systems and routine meetings to support the multidisciplinary approach for planning and delivery of care. Collaboration and teamwork were evident. There is a weekly multidisciplinary meeting for all inpatients which includes Allied Health, the Discharge Nurse, the Wound care Nurse and if available the VMP. A Rehabilitation multidisciplinary case conference form is completed this may require to be as per Action 6.2 for the routine involvement of this form into the bedside documentation and/or care plan.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.6	
Clinicians work collaboratively to plan and deliver comprehensive care	
Comments	**Suggestion(s) for Improvement**
In addition to the process established for Action 5.5 the guidance for care resides with the admitting VMO and the endorsed guidelines and care pathway.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The clinical risk screening processes commences prior to admission. There is an agreed screening approach for all admissions which is an in-depth screening process where a comprehensive risk assessment a documented on a single Healthscope Comprehensive Risk Screening B Tool. The risks recorded cover all the identified National Standards clinical risk assessments. This is risk assessment is primarily completed by the nursing staff within the required expected timeframe. A most recent audit demonstrate an 84% of compliance for risk screening on admission. This assessment now includes the required COVID patient screening questionnaire. There are various clinical policies that relate to core assessment tools. These includes the requirement for reassessment. This process identifies the time frames for repeat screening using a more in-depth screening tool e.g. the Braden Scale assessment/reassessment and intervention plan. Staff are provided with training on risk assessment at orientation with repeated education provided according to the clinical issue.	

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	
Compliance to the Commission's Advisory AS 18/14 Comprehensive Care Standard: Screening and assessment for risk of harm has been assessed for the requirements to meet Action 5.7.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
There is a process to routinely ask patients if they identify as Aboriginal or Torres Strait Islander people during the admission process. Poor results were noted over a two-year period as result additional education sessions were provided to the staff as a result the number of Aboriginal and Torres Strait Islander identified people rose from 1.89% to 10.81% on registration for admission.	

Rating	Applicable HSF IDs
Met	All

ACTION 5.9	
Patients are supported to document clear advance care plans	
Comments	**Suggestion(s) for Improvement**
The Mount followed the WA Health process for the management of Advanced Healthcare Directives (AHCD) particularly relevant with the recent introduction of Voluntary Assisted Dying WA Legislation which is not being considered as a treatment option at the Mount Hospital. It is primarily the patient's GP's role to support the signing of an AHCD and the patient is required to provide a copy for filing on admission. The AHCD copy is placed in the front of the patient's medical record. On review of several of the palliative care inpatient files during this assessment if was noted that AHCD were being filed as per the current protocol.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The screening for risk commences on admission with the patients providing their health history and also completing a COVID screening questionnaire. All information is assessed against the admission criteria, and relevant referral information and previous admission. This progresses to the completion of the Comprehensive Risk Screening assessment which covers the eight-risks outlined by the Comprehensive Care Standards. Interventions are initiated as part of this assessment.	Consider increasing the frequency of the audits for risk screening and expand the report to capture compliance to all parts (A – H) including the completion of the required risk mitigation interventions.

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		
An annual audit is undertaken to check compliance for the completion of the risk assessment. This audit may need to be repeated more frequently following low compliance rates. The current rate is of compliance is 84%. Compliance to the Commission's Advisory AS 18/14 Comprehensive Care Standard: Screening and assessment for risk of harm has been assessed for the requirements to meet Actions 5.10 have been completed as per the requirements date of December 2020.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 5.11	
Clinicians comprehensively assess the conditions and risks identified through the screening process	
Comments	**Suggestion(s) for Improvement**
The Mount's clinical assessment is completed in collaboration with the patient/carer following the assessment of risks and other information such as referral documentation and previous admission history. Opportunities to identify training requirements (Action 2.1) have been identified from various audits, surveys, and consumer feedback processes. Patient-centred care training is provided at orientation and in addition staff are trained on assessing the patient's capacity. Information provided to the patient on the rights and responsibilities for the patient through a variety of methods including brochures and the Mount Hospital website.	

ACTION 5.11		
Clinicians comprehensively assess the conditions and risks identified through the screening process		
Other specific training is provided to staff responsible for the completions of the various risk assessment tools including when to undertake a repeat assessment.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 5.12	
Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record	
Comments	**Suggestion(s) for Improvement**
A comprehensive care plan or pathway of care is developed depending on the reason for admission. The care plan and pathways are routinely audited with a current compliance rate of 85%. Feedback from these audits are distributed to the various departments for feedback at department meetings.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Mount has completed a detailed Gap analysis to address the development of a comprehensive care plan that address the complexity of an individual's admission. The detailed risk assessment (Action 5.10) identified the primary risks to move forward to support the implementation of the patients agreed goals of care and actions for ongoing treatment during the admission. This process is adjusted according to the patient's age and admission diagnosis. This progresses to the development of a detail discharge plan in collaboration with other clinicians (Allied Health, Discharge Planning Nurse, Wound Care Nurse). For inpatients there is a weekly multidisciplinary team meeting support the communication process and documentation of outcomes from this discussion. On assessment the Mount Hospital has met the requirements for December 2020. The organisation has developed a range of policies, procedures, templates for the comprehensive care planning. These have been endorsed by the Comprehensive Care Committee. Staff are provided with training on these tools at orientation. As a result, the requirements to meet the Commission Advisory AS 18/15 Comprehensive Care Standard: Developing a comprehensive care plan.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The care plan is the primary tool for the delivery of care and monitored by each clinician. These plans include the recognition of the patients' goals for their admission (which are reassessed daily) and the development of a plan and inclusion of other staff required following the initial assessment of who should be involved in their care. Opportunities are provided to assess the patient education requitement. For inpatients this process progresses to the development of a Daily Care Plan which is completed at each nursing shift in collaboration with the patient.	

Rating	Applicable HSF IDs
Met	All

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]	
Comments	**Suggestion(s) for Improvement**
The Mount currently uses the Clinical Excellence Commissions the "Last Days of Life Toolkit". These resources are available on the Mounts website. The toolkit provides recognition management and care, medication, information for patients, bereavement, and evaluation Patient/carers are supported through the treatment process associated with end-of-life care. There is an End-of-life management plan to be completed by the treating team.	

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]	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.16		
The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice		
Comments		**Suggestion(s) for Improvement**
The Mount has access to expert palliative care support.		
Rating	**Applicable HSF IDs**	
Met	All	

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		
Comments		**Suggestion(s) for Improvement**
There is a policy and procedure for the collection, recording and filing of Advanced Health Care Directive. Advanced Health Care Directives when obtained from the patient are filed in the medical record with a notation on the patients' alert Sheet.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 5.18		
The health service organisation provides access to supervision and support for the workforce providing end-of-life care		
Comments		**Suggestion(s) for Improvement**
The Mount Hospital staff have a peer support program and access to the Employee Assistance Scheme.		
Rating	**Applicable HSF IDs**	
Met	All	

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		
Comments		**Suggestion(s) for Improvement**
There are process to support the evaluation of the quality of end-of-life care including feedback system, evaluation of documentation, the review of mobility and mortality data.		
Rating	**Applicable HSF IDs**	
Met	All	

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]	
Comments	**Suggestion(s) for Improvement**
The End-of-Life Toolkit provided process to ensure that patients/cares and families are involved in the decision-making regarding end-of-life-care.	

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]		
The treating physician is the accountable person for the documentation of discussion with the patients in the progress noted and developing the goals of treatment.		
Rating	**Applicable HSF IDs**	
Met	All	

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	
Comments	**Suggestion(s) for Improvement**
The is a Healthscope Pressure Injury-Prevention, identification, and Management policy. The Mount uses the Healthscope risk assessment tool for the assessment of skin integrity and pressure injury. All pressure injuries are required in the RiskMan database. Audit trends are assessed to identify contributing factors are reported to the Comprehensive Care Committee. There are not many pressure injuries report the majority are Stage One. The current rate of pressure injuries is well below the industry rate. Any identified pressure injury or skin integrity issues are referred via webPAS to the Wound Care Nurse Consultant as the person for review. This nurse is also available to support all outpatient wound care patients. Some of the Stage One pressure Injuries may have their assessment delayed due to other wound care priorities. All process are reviewed by the Comprehensive Care Committee with reports on the number of pressure injuries per month displayed on the ward/department noticeboards.	

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	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The is a Healthscope Pressure Injury-Prevention, identification, and management policy and skin assessment tool. Routine weekly reassessment are required to ensure ongoing risk assessment is completed during the admission.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
Patient and family education on skin care is provided. This commences on admission and progresses as required through the admission and maybe provide on discharge. The Wound Care Consultant has a range of brochures depending on the issues for patients to review including the management of their wound dressing.	

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		
There is adequate equipment. All mattresses and pressure injury prevention equipment are neatly stored for use as required post risk assessment.		
Rating	**Applicable HSF IDs**	
Met	All	

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		
Comments		**Suggestion(s) for Improvement**
There is a Healthscope Falls Prevention and Management policy. Fall Risk Screening is completed on admission with the plan of care developed for inclusion of the required intervention following this assessment. All falls incidents are recorded in the RiskMan Database. These are reviewed and trended for each clinical area with the overall incidents monitored by the Comprehensive Care Committee. Current trending of falls incidents demonstrate a remarkably decrease in the incident of falls. National trends with the incidents of falls demonstrates the Mount has lower rates recorded in comparison to other Healthscope hospitals. Any high-level falls with complications are reported to the Board. Post falls management process are evident which will include a review of equipment and multidisciplinary review and planning for ongoing care.		
Rating	**Applicable HSF IDs**	
Met	All	

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	
Comments	**Suggestion(s) for Improvement**
Part of the care planning process include mobility support and required assistance. The Mount have available equipment to assist with the prevention of falls, adjustable chairs, specialised beds and walking aides, bed/chair alarms and non-slip socks.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
Patient education commences on admission and continues through the admission. Additional education is available for patients and staff from the Mount's website.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
There is a Healthscope policy and process for nutrition.	

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	
Dietitian support is available. Nutrition assessment if part of the Risk assessment process on admission which covers aspects of malnutrition, weight loss, oral health, special dietary need, and allergies.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
Regular reassessment of the patient's nutritional need is competed as per policy. The care plan is monitored to support staff identification of patient nutritional and feeding requirements including enteral feeds. Other assessments include issues with enteral feeding support for the patient requiring feeding with notification to staff by a red tray placemat.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
There is a Healthscope policy on delirium and cognitive impairment which include the use of medication. Screening for cognitive impairment and delirium are completed on admission. Care planning will depend on this assessment. Patients with cognitive impairment will be allocated to a single room close to the nurse station. Family/carers are encouraged to participate and support the care for the patient, or a Care Special may be required to support and observe the patient during their admission.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
Staff are provided with training to support the process for recognising and managing patients with cognitive impairment and delirium.	

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	
Additional process have been developed to support the care such as the Behaviours Chart which provides an assessment of changes in behaviour. As per Action 5.29 additional support can be provided by using family or care special staff. Education is provided to the patient carer/family during the admission and on discharge.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
Mental Health is risk assessed as part of the risk assessment process on admission. All Mental health risk alerts are document on the Alert sheet and in webPAS.	

Rating	Applicable HSF IDs
Met	All

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		
Comments		**Suggestion(s) for Improvement**
Healthscope has a policy on self-harm and suicide. The Mount Hospital does not admit acute suicide patients as part of their exclusion criteria. Any inpatient that is experiencing these issues are referred/transferred for care in collaboration for psychiatric care.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 5.33		
The health service organisation has processes to identify and mitigate situations that may precipitate aggression		
Comments		**Suggestion(s) for Improvement**
Patients are screened on admission to identify issues of aggression or a history of aggression. Any identified issues are incorporated into the care plan, registered in webPAS as an alert and recorded in the Alert Sheet.		
Rating	**Applicable HSF IDs**	
Met	All	

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	
Comments	**Suggestion(s) for Improvement**
Staff are provided with training to assist with escalation of aggression WAVE training (Action 1.30). Any issues where attempts to de-escalate are not successful then a Code Black emergency response is actioned and registered as an incident in RiskMan.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Mount has a restrictive practice policy and companies with current WA Health legislation. Any mechanical and chemical restraint must be authorised by the VMP and registered in RiskMan.	

Rating	Applicable HSF IDs
Met	All

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		
Comments		**Suggestion(s) for Improvement**
Not applicable and the Mount Hospital is not an authorised mental health facility.		
Rating	**Applicable HSF IDs**	
NA	All	

Standard 6 - Communicating for Safety

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

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	
Comments	**Suggestion(s) for Improvement**
There is a comprehensive policy and procedure framework in place, regulating clinical communication. These policies and procedures are a combination of Healthscope and local Mount Hospital documents. Compliance is monitored through the audit schedule. The standard is governed by the Communication for Safety committee which reports directly to the Clinical Governance. The ISOBAR (Identify Situation Observation Background Assessment and Recommendation) acronym is the agreed process for the flow of information and to standardise the handover process and is incorporated into forms and processes for clinical handover. The Clinical Safety huddle at commencement of handover has been introduced as a process to support communication of risk associated with patient care, safety environmental issues, clinical incidents, and other updates. Clinical Incidents on issues with communicating for safety are monitored following the registration of an issues in the RiskMan system by the Clinical Governance Committee. Staff orientation includes communicating for safety, with several relevant online training modules available to support ongoing education. This ensures clinicians are updated and provide safe care at points of service delivery.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
Several audits relating to clinical communication is completed as per the audit schedule, audit results are monitored via the governance committees, action plans are completed for variance. Trended data from Mount Hospital handover audits show generally high levels of compliance with the policies and processes governing handover. It was noted that clinical incidents reported because of information procedure failure and poor communication were appropriately recorded, investigated and subsequent learnings. There are several quality improvements projects that have actively supported improvements in clinical communication including an extensive handover and mapping points project to streamline and clinical communication rounding and bedside handover. Lessons learnt are reviewed and fed back to staff through operational and the General Managers newsletter or memo from the Quality and Risk Manager. A Clinical Documentation Specialist provides education and support staff to document an accurate account of clinical interventions and outcomes contemporaneously.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital has systems to involve the patient in their care, this has been embedded as part of the Back to Bedside project and includes identification and reviewing patient goals at each handover episode or review. These are documented in the comprehensive care plans and on the patient care boards. Observation of 'huddles and handover processes that involve the consumers demonstrated that patients are actively involved in their own care and shared decision making. This result was confirmed by a small number of patients happy to speak with assessors about the quality of care being provided and their understanding of treatment plans. Discharge planning audit demonstrates 100% compliance with patients/family/carer actively involved in discharge planning processes and 100% compliance with all written discharge information provided at discharge. The patient care board provides information on clinical deterioration and escalation with a REACH phone number clearly visible.	Review opportunities to incorporate MDT involvement within the routine bedside documentation.

Rating	Applicable HSF IDs
Met	All

<table>
<tr><th colspan="3">ACTION 6.4</th></tr>
<tr><td colspan="3">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</td></tr>
<tr><th colspan="2">Comments</th><th>Suggestion(s) for Improvement</th></tr>
<tr><td colspan="2">The Mount Hospital abides by Healthscope policy documents that outline the points of care where procedure matching is required within the Correct Patient, Correct Procedure and Correct Site procedure. Team time out procedures include these principles in addition patient identifiers. Audits demonstrate 100% compliance.

There are numerous policies and procedures that support transfer of care within the Hospital or to another site. Handover processes for handover of care are consistent with the ISOBAR format.

Critical information on risks or changes to care are included in huddles and handover processes and documented in the medical record where appropriate. Risk and alerts are maintained at the front of the medical record.

A good process has been implemented for orderly transport to include identification processes; audit results show 100% compliance of patient identification check.</td><td></td></tr>
<tr><th>Rating</th><th colspan="2">Applicable HSF IDs</th></tr>
<tr><td>Met</td><td colspan="2">All</td></tr>
</table>

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		
Comments		**Suggestion(s) for Improvement**
The Healthscope Patient Identification band policy defines the four approved patient identifiers that are required on registration and admission; when care, medication, therapy, and other services are provided; and when clinical handover, transfer or discharge documentation is generated. There is a suite of policy documents that govern this process.		
Rating	**Applicable HSF IDs**	
Met	All	

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	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital have a suite of policy documents that govern the processes to correctly match patients to their care. The Healthscope Policy Correct Patient, Correct Procedure and Correct site applies to all procedures and is endorsed by the Royal College of Surgeons. Team Time out was observed by assessors checking data entry for the four stages of time out as required. Audits are conducted, showing a 100% compliance.	It is suggested that the Mount Hospital review meal matching processes and include regular monitoring in the audit schedule to ensure the process is fully embedded.

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	
Meal matching has been implemented however it was noted by assessors that it was not monitored on a regular basis.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
There is a Healthscope Clinical Handover policy which covers Department and intra Unit process for handover and recognised issues for the need to transfer the accountability of care. The ISOBAR acronym is the agreed process for the flow of information and to standardise the handover process and is incorporated forms and processes for clinical handover. The standardised processes provide a standardised approach to optimise communication, minimise omission and reduce risk. Clinicians participate in handover at all points of care including bedside handover processes, documentation of handover on transfer forms, telephone handover for interhospital transfer and on discharge. Nursing Discharge summaries are given to patients at the time of discharge with a copy for the GP; they are uploaded in MyHealth Record if the patient is registered.	

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	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
Handover education is incorporated into orientation, videos on HINT and communicating for safety study days. The ward handover processes consist of an initial Huddle of all oncoming nursing staff and the current shift coordinator. This covers all pertinent pieces of information such as relevant risks, change in medications, advance care directives and high-risk patients. A bed-to-bed handover following the ISOBAR format includes goals and preferences and participation of patients and their carer and families. Patient Care boards are paramount in this process. Observation audits are conducted with high levels of compliance with completion of patients Care Boards noted with audit results averaging between 90-100% over the past 12 months.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Healthscope Clinical Handover policy identifies the need to ensure that critical information is communicated, safety checks of equipment occur, and alerts and risk are identified. Staff use the ISOBAR for handover of critical information. There are processes to manage critical information, examples include changes to medication, diagnostic test results, clinical deterioration, change in patient goals food and medication allergies and adverse drug reactions. There is a comprehensive risk screening process, and a critical information alert sheet is located at the front of the medical record and updated on each as required.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
As per Action 8.7, patients and carers have opportunities to communicate critical information and risk about their care, REACH program has been implemented as an escalation process for patients, carers and families should there be concerns related to critical information, this is covered on admission and is on each patient care board.	

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	
Managers attend Huddles to handover critical pieces of information related to patient's safety such as equipment recalls, a daily bed meeting is conducted to communicate issues related to resourcing and patients of concern to After Hours Management.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital have access to numerous Healthscope policy documents and local medical record forms that guide the process for contemporaneous documentation. The healthcare record includes critical clinical information, alerts, risks, re-assessment processes, outcomes, and changes to care plans. A Clinical Documentation Specialist has undertaken a project which included a documentation education program, the specialist supports staff to document an accurate account of critical information, clinical interventions, and outcomes contemporaneously. Medical record audits demonstrate on average 80% compliance to policy which is above Healthscope target.	

Rating	Applicable HSF IDs
Met	All

Standard 7 - Blood Management

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

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	
Comments	**Suggestion(s) for Improvement**
Governance of blood management is the responsibility of the Mount Hospital Executive Team. There is a Blood Transfusion Committee which meets quarterly. The terms of reference includes KPIs and are reviewed annually. The Committee reports to the Clinical Governance Committee which in turn reports to the Executive Leadership Team. It is well represented and chaired by a senior MAC representative and included a haematologists, the Director of Nursing, the Quality Manager as well as scientific representation from two external major blood product suppliers, both located on site (Western Diagnostic Pathology and Clinipath Pathology. Reports are widely disseminated, including to the MAC. Both providers hold NATA (National Association of Testing Authorities) accreditation. A national corporate Transfusion Committee provides further support. This group conducts at least two quality improvement projects a year as well as reviewing best practice and policies and procedures when required. The Mount Hospital has proactive representation on this committee. Several risks relating to medications are included in the hospital's Risk Register with controls in place to mitigate risks. These risks are reviewed either 6-monthly or 12-monthly depending on the level of risk. Reviews of medication risks are referred to the Blood Transfusion Committee. Blood related incidents are reported on the RiskMan incident reporting system and are closely monitored.	

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	
They are reported on a quarterly basis to the Blood Transfusion Committee, Nurse Unit Managers' Committee, Quality and Risk Committee and the Executive. Incidents are trended to enable corrective actions to be undertaken. Critical systems reviews are undertaken for serious and sentinel incidents and reported to the National Clinical Risk Manager & the State Manager. On a quarterly basis the Healthscope national team provides a report on all medication sentinel events that have occurred within Healthscope and provides 'Shared Learnings' arising from an analysis of incidents which all hospitals are required to implement. The 'Shared Learnings' are reviewed at the Nurse Unit Managers' Committee and actions implemented are reported to the Quality and Risk Committee and are signed off by the General Manager, Director of Nursing and Quality and Risk Manager. Medication 'Shared Learnings' are reviewed by the Committee. There is an audit schedule of blood related audits addressing all medication safety issues identified in NSQHS Standard 7. Action plans are developed to address deficits identified in the audits.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital has a comprehensive and robust system of quality improvement and audit activities to ensure that blood management is optimal, underpinned by a series of national and local policies and procedures to support best practice. The risk register reflects a number of risks which are continually reviewed in light of mitigating actions taken.	

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	
The Mount Hospital submits to the following benchmarked ACHS QI indicator suite: • Significant adverse blood transfusion events. • Transfusion episode where informed patient consent was not obtained. • RBC transfusion where Hb reading is >= 100g/L. The hospital performs well with respect to all above indicators. The Mount also a participant of the WA Health Haemovigilance infrastructure and as such monitors blood utilisation, wastage, and transfusion reactions, with strong performance with respect to all indicators. There have been nil blood-related adverse reactions since 2015. Where deficiencies are identified detailed, action plans are developed with assigned accountable owners and reported back to the Blood Transfusion Committee. Blood and Blood product incidents are recorded in Riskman.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital has several underpinning policies and procedures to ensure that consumers are actively involved in all episodes of care as part of a shared decision-making paradigm.	

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	
All patients are proactively consented for the use of blood products. This consent is captured as part of the Consent to Treatment proforma as a separate delineated section. Consent is captured by the medical practitioner considering a holistic patient-centred model of assessment. Consent may be withdrawn at any time. Capturing informed consent is regularly audited; the last audit demonstrated 100% compliance with strong performance. Where individual needs are expressed, these are accommodated. The Mount Hospital complies with Healthscope policy Healthscope Policy "Jehovah's Witnesses and Other Patients Refusing Blood Transfusion Therapy" who may choose not to have blood, or its derivatives transfused. This policy informs staff on the process for Jehovah's Witnesses and other patients who refuse transfusion/administration of blood/blood products and outlines the action to be taken.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital has a program of work to minimise the requirement for blood transfusion, various quality improvement activities have been implemented to support this program of works. Such interventions have included routine multidisciplinary pre-operative assessments, optimisation of haemoglobin and iron stores pre-operatively, modification of surgical techniques where possible to reduce the risk of bleeding, the cessation of anticoagulation agents where possible and the	

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	
routine utilisation of cell-salvage devices. Such interventions have produced strong outcomes as per captured through favourable rates of blood product transfusion and wastage when benchmarked against peer hospitals through the WA Haemovigilance surveillance program. A further quality improvement activity was introduced in 2021 whereby medical practitioners were encouraged to proactively consider Group and Hold approaches in lieu of traditional pre-operative cross matching procedures. The outcomes of this initiative will be monitored via the Blood Transfusions Committee.	

Rating	Applicable HSF IDs
Met	All

ACTION 7.5	
Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital is broadly compliant with a range of national and local Healthscope policies pertaining to the documentation of blood and transfusion management. The HMR 10.8 Blood and Blood Products Prescription and Transfusion Record form ensures a standardised approach to documentation and prescription and must include: • Patient identification details – given name, family name, gender, date of birth, and unique patient identification number (MRN) if available. • Date, time the transfusion is to commence, and urgency of the transfusion. • The type of blood / blood product to be transfused. • The duration over which the blood product is to be transfused. • Special requirements (e.g. CMV seronegative, irradiated).	

ACTION 7.5	
Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record	
• Route of administration. • Number of units / doses of blood product to be given (e.g. number of packs, mL, units, or grams). • Special instructions, e.g., use of blood warmer, medication required before or after transfusion, flushing of line between packs. • Medical Practitioner (prescriber) – legibly written name and signature. • Informed patient / legal guardian consent for blood products. Compliance with this procedure is regularly audited. The last audit revealed high levels of compliance more than 95% pertaining to best prescription practice, with less optimal performance pertaining to documentation of transfusion indications. An action plan has been developed to remedy the gaps identified and will be reported to the Blood Transfusions Committee.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
A series of local and national Healthscope policies and guidelines support clinicians to prescribe and administer blood products appropriately, in accordance with national guidelines. Medical practitioners have access to decision support tools which are readily available to the clinical workforce when making clinical decisions related to blood product use.	

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	
A plethora of tools and external references are available for clinicians, including the Therapeutic Guidelines, MIMS Manual, the AusDI manual and the Australian Medicines Handbook. There is a well-established major bleed protocol embedded within the Hospital. All staff involved in administering blood are required to participate in mandatory training through completion of the BloodSafe eLearning module.	

Rating	Applicable HSF IDs
Met	All

ACTION 7.7	
The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria	
Comments	**Suggestion(s) for Improvement**
The Blood Transfusion Committee reviews adverse events that occur across the hospital, and the Quality and Risk Manager reports these to the Clinical Governance Committee. There is a Healthscope Shared Learning report has shared learnings regarding transfusion events, and these are considered by the Blood Transfusion Committee for local interpretation. The BloodSafe eLearning module instructs staff on how to report incidents related to transfusions. Any observed Adverse Reactions are captured within the medical records as well as RiskMan for investigation and captured on the webPAS alert system.	

ACTION 7.7	
The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria	
Adverse events are closely audited, and the Mount Hospital submits data pertinent to the ACHS quality improvement benchmark related to adverse events. There have been no major adverse events since 2015.	

Rating	Applicable HSF IDs
Met	All

ACTION 7.8	
The health service organisation participates in haemovigilance activities, in accordance with the national framework	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital submits to the following benchmarked ACHS QI indicator suite: • Significant adverse blood transfusion events. • Transfusion episode where informed patient consent was not obtained. • RBC transfusion where Hb reading is >= 100g/L. The Mount Hospital performs well with respect to all above indicators. The Mount participants in the WA Health Haemovigilance infrastructure and as such monitors blood utilisation, wastage and transfusion reactions, with strong performance with respect to all indicators. There have been nil blood-related adverse reactions since 2015. Where deficiencies are identified, detailed action plans are developed with assigned accountable owners and reported back to the Blood Transfusion Committee. Blood transfusion incidents are captured via RiskMan. Wastage rates are favourable.	

ACTION 7.8	
The health service organisation participates in haemovigilance activities, in accordance with the national framework	
Where an adverse individual medical practitioner variation is identified, this is escalated to the General Manager and the MAC for consideration of performance improvement action.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
Since the last assessment, the blood fridge that was on site has since been decommissioned, and blood is now stored within the Western Diagnostic Pathology and Clinipath Pathology laboratories, which are both on site. Both laboratories are National Association of Testing Authorities (NATA) accredited. Each service is responsible for the delivery of blood to the blood fridge. Both pathology practices monitor the blood usage independently and provide separate reports to the Blood Transfusion Committee. The process of transfer of blood products from the laboratory to the bedside is well articulated and governed through appropriate process and regularly audited. A recent quality improvement introduced cold box storage facilities to each ward area to further expedite the passage of blood from the laboratories to the bed side. Low rates of wastage through this process are observed.	

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	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital utilises the services of Western Diagnostic Pathology and Clinipath Pathology Blood Bank for obtaining blood and blood products whenever they are needed including for emergency indication. Blood is tracked electronically using BloodNet. The availability of blood is reflected on the organisation's risk register, and the Mount Hospital has a range of initiatives in place to eliminate avoidable wastage. Where system critical supply issues are identified, this is escalated to the General Manager for consideration of rationalisation of elective activity to reduce the acute demand for blood product usage.	
Rating	**Applicable HSF IDs**
Met	All

Standard 8 - Recognising and Responding to Acute Deterioration

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

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	
Comments	**Suggestion(s) for Improvement**
Governance of recognition and response systems is the responsibility of the Mount Hospital Executive Team. This responsibility is delegated to the Resuscitation Coordinator and Nurse Unit Managers and is overseen by the Medical Emergency and Resuscitation Committee. The Medical Emergency and Resuscitation (MER) Committee meets quarterly and has terms of reference and KPIs which are reviewed annually. The Medical Emergency and Resuscitation (MER) Committee reports to the Clinical Governance Committee which in turn reports to the Executive, with linkages to the MAC. The MER Committee reports annually on its activities. This committee has Executive representation (Director of Nursing and the Quality and Risk Manager) representatives from ICU, CCU, the Catheter Laboratories and the medical /oncology ward, the Resuscitation Coordinator, the Clinical Development Coordinator, the Medical Director/Intensivist, an Anaesthetists, and a Medical Emergency Team (MET) Registrar. An organisation wide MET system has been in existence since 2003. The MER Committee ensures that the Mount Hospital's policies and processes for recognising and responding to clinical deterioration are consistent with the National Consensus Statement and the Australian Resuscitation Council guidelines. The committee oversees the recognition and response systems which are well established at the Mount Hospital. An organisation wide Cardiac Arrest Team has been in existence for many years.	

<table>
<tr><th colspan="3">ACTION 8.1</th></tr>
<tr><td colspan="3">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</td></tr>
<tr><td colspan="2">The MER Committee also reviews and trends all MET and cardiac arrest calls and monitors the effectiveness of processes for the early recognition of clinical deterioration. It ensures that members of the MET and Cardiac Arrest Team maintain competency and currency in Advanced Life Support and managing medical emergencies. In addition, it ensures that all nursing staff are competent in Basic Life Support and could undertake further education in managing life threatening emergencies.

There is a Healthscope Clinical Deterioration Cluster Group sharing knowledge and expertise to facilitate quality improvement throughout the company particularly in respect of the requirements of NSQHS Standard 8 Recognising and Responding to Acute Deterioration.

The Mount has a dedicated Resuscitation Coordinator to provided leadership, facilitate learning and development, audit and evaluation of recognition and rapid response processes and practice.

Identified risks are registered on the hospital’s Risk Register relating to the management of rapid response systems and identifies the controls put in place to mitigate risk.</td><td></td></tr>
<tr><th>Rating</th><th colspan="2">Applicable HSF IDs</th></tr>
<tr><td>Met</td><td colspan="2">All</td></tr>
</table>

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	
Comments	**Suggestion(s) for Improvement**
The MER Committee also reviews and trends all MET and cardiac arrest calls and monitors the effectiveness of processes for the early recognition of clinical deterioration. Whenever a rapid response call is made, an 'Emergency Response Form' is completed. This Emergency Response Form has a section which seeks evaluation of the management of the emergency event. It asks the After-Hours Manager or Nurse Unit Manager, who was present at the event, whether the emergency team responded promptly and whether the event was optimally managed. This information is entered on the rapid response electronic database and is trended and investigated. Following each MET call, staff lodge an incident report on the RiskMan incident reporting system every time a rapid response call is made. They outline the circumstances of the event and its management. They also document the timeliness of the response and can comment on any concerns they may have arising out of the management of the event. A copy of the RiskMan entries is automatically sent to the General Manager, Director of Nursing, Quality and Risk Manager and the Resuscitation Coordinator. The Quality and Risk Manager sends a copy to the Medical Director. Any issues raised relating to the responsiveness of the recognition and response systems are referred to the Medical Emergency and Resuscitation Committee for formal review. The Mount Hospital submits to several Healthscope and ACHS Clinical Indicator programs where it is identified that the Mount Hospital overall performs favourably across these indicators apart from unplanned ICU admissions within 24 hours post procedure, which the committee is currently investigating.	

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	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
Patients are actively involved in their care. Shared decision making occurs in all parts of the patient journey, and consumer engagement with respect to the development of new information sheets is sought via the CAC. The Mount Hospital has recently successfully implemented the REACH program of works developed by the Clinical Excellence Commission to empower patients and their carers to escalate concerns. The assessment team noted strong integration across all hospital areas, with a high level of awareness from healthcare workers and patients. The presence of consumer-friendly promotional material was noted in each bed space, and the Committee is currently evaluating the outcomes of the initiative. The Mount Hospital further has policies and procedures to ensure that patient wishes are integrated into their overall goals of care, especially pertaining to the routine enquiry of Advanced Health Directives and Enduring Power of Guardianships upon admission as part of the overall care plan.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The assessment team noted several national and local policies and procedures governing the processes for ensuring that acute physiological deterioration is appropriately. The Mount Hospital uses a general observation chart the Adult Deterioration Detecting Chart which includes a score. This observation chart complies with the required human factor principles to include the capacity for clinicians to record vital signs and the level of consciousness graphically over a prescribed time. The chart includes thresholds for each of these parameters to include abnormality and other factors to trigger escalation with notation of actions required according to the score. There a several other charts in use that have been designed incorporating human factor principles include the Recovery Observation Chart, the Patient Control Analgesia Chart, Ketamine Infusion Chart, and the Patient Control Epidural Chart. The compliance with this chart and timeliness to response is closely audited and reported to the Committee. The assessment team was able to triangulate that staff felt confident and empowered to escalate concerns pertaining to an acutely deteriorating physiological state.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
Several national and local policies have been developed to embed processes for clinicians to recognise and respond to acute deterioration in mental state, and the Hospital has embedded several systems to support the overriding policy framework. Assessment upon admission to the Hospital includes several pertinent assessment tools, including an assessment of current mental state and a cognitive impairment risk stratification process. Where concerns are identified, more detailed assessment and intervention is undertaken, including an assessment of causative factors of delirium. This is integrated as part of the comprehensive care planning bundle and documented in the medical record on a Behaviour Chart, with a procedure for determining the required level of observation and escalation.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital has well established protocols to support specific criteria to warrant specific indications for the escalation of care, pertaining to acute physiological and mental state deterioration.	

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	
This includes the utilisation of clearly defined Track and Trigger measures with delineated escalation parameters for escalation, as well as the utilisation of well-articulated processes pertaining to acute mental state deterioration. The newly embedded REACH program affords patients and carers the opportunity to directly escalate concerns regarding acute deterioration, and adherences to all the above processes is closely monitored at the MER Committee.	

Rating	Applicable HSF IDs
Met	All

ACTION 8.7	
The health service organisation has processes for patients, carers or families to directly escalate care	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital has recently successfully implemented the REACH program of works developed by the Clinical Excellence Commission to empower patients and their carers to escalate concerns. The assessment team noted strong integration across all hospital areas, with a high level of awareness from healthcare workers and patients. The presence of consumer-friendly promotional material was noted in each bed space, and the Committee is currently evaluating the outcomes of the initiative. The Mount Hospital further has policies and procedures to ensure that patient wishes are integrated into their overall goals of care, especially pertaining to the routine enquiry of Advanced Health Directives and Enduring Power of Guardianships upon admission as part of the overall care plan.	

ACTION 8.7	
The health service organisation has processes for patients, carers or families to directly escalate care	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.8	
The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital has a well-established infrastructure to support timely escalation for emergency assistance. An emergency Code Blue system has been operational for several years, with a single telephone access point and a rapid pager response activated for members of the Medical Response team. Emergency trolleys and bedside emergency equipment is in all clinical areas, and the procedural areas contains a well-equipped difficult intubation trolley for instances of Can't Intubate Can't Oxygenate scenarios. Emergency call bells are in each patient room, with clear health promotional material pertaining to their utilisation, and all patients are acquainted with these systems as part of their admission journey.	

Rating	Applicable HSF IDs
Met	All

ACTION 8.9	
The workforce uses the recognition and response systems to escalate care	
Comments	**Suggestion(s) for Improvement**
The assessment team noted high levels of staff confidence in all areas pertaining to the utilisation of recognition and response systems to escalate care, and a medical records review across multiple ward areas revealed high rates of compliance with all processes pertaining to the use of recognition and response systems. The MER Committee closely audits several outcomes relating to the utilisation of these systems, including with respect to the proportion of patients with a rapid response system attendance within five minutes, and with strong benchmarked performance.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	**Suggestion(s) for Improvement**
All employed staff are required to undertake basic and/or advanced life support training as part of their mandatory training packages. Training was previously provided through internal means but since 2020 has been provided by an external training provider. Compliance is monitored by the MER Committee, and several strategies are underway to enhance compliance. All members of the MET team hold advanced life support training, and advanced paediatric life support training is provided to staff caring for children.	As per Action 1.20

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	
See comments Action 1.20 pertaining to a lack of mandatory training for VMOs including with respect to basic and/or advanced life support training; this risk is mitigated against by the presence of a highly skilled MET team and on site CCU and ICU access.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital has a well-established infrastructure to support timely escalation for emergency assistance. An emergency Code Blue system has been operational for several years, with a single telephone access point and a rapid pager response activated for members of the Medical Response team. Emergency trolleys and bedside emergency equipment is in all clinical areas, and the procedural areas contains a well-equipped difficult intubation trolley for instances of Can't Intubate Can't Oxygenate scenarios. Emergency call bells are in each patient room, with clear health promotional material pertaining to their utilisation, and all patients are acquainted with these systems as part of their admission journey.	

Rating	Applicable HSF IDs
Met	All

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	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital has well established protocols to support specific criteria to warrant specific indications for the escalation of care, pertaining to acute physiological and mental state deterioration. This includes the utilisation of clearly defined Track and Trigger measures with delineated escalation parameters for escalation, as well as the utilisation of well-articulated processes pertaining to acute mental state deterioration. All employed staff receive training as part of the Healthscope WAVE package. The hospital does not have capability to admit patients with a primary mental health diagnosis on an inpatient basis, and patients needing acute transfer are transferred to the Royal Perth Hospital Emergency Department by ambulance transfer with 1:1 nursing escort. The incidences of seclusion and restraints are closely monitored via the submission of RiskMan notifications through to the MER Committee.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.13	
The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration	
Comments	**Suggestion(s) for Improvement**
The Mount Hospital is well equipped to care for patients with acute physiological deterioration. The hospital has an Intensive Care Unit on site with continuous consultant and junior medical officer presence. It also has a Coronary Care Unit with similar consultant and junior medical officer presence.	

ACTION 8.13	
The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration	
In the instance that a Code Blue is activated, senior members of the medical team are in attendance and determine appropriate onward disposition including escalation to either ICU or CCU. Whereby an acute inter-hospital transfer is required, a referral is made to the appropriate tertiary hospital group and an ambulance transfer is arranged with 1:1 nursing and/or medical escort.	

Rating	Applicable HSF IDs
Met	All

Recommendations from Previous Assessment

Nil