NSQHS Standards Second Edition Organisation-Wide Assessment

Final Report

Bellbird Private Hospital

BLACKBURN STH, VIC

Organisation Code: 221884
Health Service Facility ID: 101048
Assessment Date: 22-23 November 2021

Accreditation Cycle: 1

Contents

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

Bellbird Private Hospital underwent a NSQHS Standards Second Edition Organisation-Wide Assessment (NS2 OWA) from 22/11/2021 to 23/11/2021. The NS2 OWA required 2 assessors for a period of 2 days. Bellbird Private Hospital is a Private health service which was last assessed on 30-31/01/2018.

Bellbird Private Hospital (BPH) is a small private hospital with a largely elective surgical casemix and medical transfers from a sister hospital within the Eastern Cluster of Healthscope. A comprehensive self-assessment was provided and assessors visited all clinical areas, met with the BPH leadership team and numerous clinical and non-clinical staff. Assessors also met with the current Chair of the Medical Advisory Committee. Assessors had easy access to policies, procedures and extensive documentation. Assessors noted that the hospital is currently not functioning to full capacity because of legislative requirements to reduce surgical services in order for the state of Victoria to cope with high numbers of Covid patients. BPH has a new leadership team committed to building on its current systems to effectively manage patient throughput and consumer expectations, within an embedded culture of quality and safety.

The organisation's risk management and quality frameworks are robust and the attention to quality and safety is much in evidence. BPH clearly understands the importance of audit and evaluation which have led to ongoing quality improvement across the eight National Standards in Version 2 and assessors note the support provided by Healthscope corporate to achieve the levels of monitoring and high-quality outcomes observed.

A synopsis of standards related commentary is now provided:

Governance at BPH is robust with the active support of HSP through its policies, procedures and monitoring procedures. Risks are closely monitored and managed. There is a strong commitment to patient centred care and partnering with consumers. Quality improvement is embedded, aligned with forcing factors such as action plan reviews. Staff are trained in safety and quality and understand their roles in this regard. Management of credentialling and scope of practice is meticulous and evidence-based care is being given increasing priority. It was pleasing to see clinical indicators monitored, as well as implementation of relevant ACSQH Clinical Care Standards in this regard. A safe environment is maintained. Aboriginal patients are respectfully and sensitively cared for and offered access to local Aboriginal support services if they wish.

Partnering with consumers is done with enthusiasm and commitment. Related systems are well monitored so that improvements can be made. Patients are well aware of their rights, and in giving informed consent. They felt well supported to make shared decisions regarding their own care.

Effective communication processes are in place and information is clear and comprehensive with significant consumer input. The attendance of consumers on governance committees is valued and their views given credence. Several changes arising from their input were noted by assessors.

Infection control is very well managed, supported by Healthscope and HICMR from both a policy and procedural perspective, but also at the coal face should urgent need arise. Assessors observed meticulous cleaning, use of PPE and hand hygiene and staff are well trained. Antimicrobial stewardship is robust in a governance sense, but clinicians continue to need support to appropriately prescribe antimicrobials as compliance with the requirements of the National Standards is progressing slowly on a few key parameters.

VMOs and staff are clear in regard to their responsibilities relating to medication safety and management. Medication errors are low in number and in risk profile. Staff are well trained and reflective of their practice. Safety initiatives are plentiful and each has contributed to enhancing quality and safety. There is an excellent working relationship with the clinical pharmacist and the private pharmacy services provider which means that patients receive high quality management of their medications through the taking of comprehensive medication histories and creation of medication management plans. Consumers feel well cared for in regard to medication information.

Patients at BPH receive effectively planned and delivered, comprehensive care. The introduction of the Healthscope Comprehensive Risk Assessment has facilitated individualised care planning based on patients' identified needs. Patients are complimentary about their involvement in their own care. In regard to minimising patient harm, BPH is very responsive, with robust strategies in place to prevent pressure injury, falls and malnutrition. A lot of work has been done to assist nurses to recognise and respond to cognitive impairment and delirium, and in managing these conditions to keep patients and caregivers safe. End of life care is respectful and in keeping with best practice guidelines.

It was evident that a lot of work has been done in regard to communicating for safety. Policies directing communication are plentiful and all staff were aware of their responsibilities regarding bedside clinical handover, patient identification and procedure matching, as demonstrated by high audit results. Critical information is communicated clearly and comprehensively. Patients and families feel well supported to initiate escalation of care if they notice deterioration.

Transfusions of blood and blood products are low in number and are always an elective procedure at BPH. Staff are well educated and supervised in regard to checking, storage and administration as testified by the absence of any blood related incidents or adverse reactions. Documentation is meticulous and VMOs are compliant in comprehensively completing the prescription form. Two units of O negative blood are kept on the premises for emergencies; a massive transfusion protocol having been developed to manage this resource should the need arise. Blood arrives on a just in time basis and is never discarded. Emergency supplies are rotated by the private pathology provider for use elsewhere keep wastage to a minimum.

As a small hospital BPH is well aware of its limitations regarding support in an emergency and has a wide range of policies and protocols to recognise and respond to clinical and mental health deterioration. Staff are 100% compliant with basic life support training and have systems in place to urgently transfer patients to more appropriate facilities should the need arise. They respond appropriately to deterioration through the MET Call and Code Blue systems, reviewing their performance after each event so that learnings can be applied if issues are identified.

In conclusion assessors noted that staff were uniformly very proud of their organisation and have numerous opportunities for education, training and professional development, where compliance in mandatory training is very high.

It is obvious that Bellbird Private Hospital has worked very hard and there has been steady improvement in systems and processes associated with the eight National Standards, despite the turmoil created by now nearly two years of COVID-19 pandemic. BPH must be congratulated on the way it managed the unexpected transfer of 18 nursing home residents when the aged care facility in which they resided was forced to close due to a massive Covid outbreak, providing expert care, a high degree of compassion and outstanding infection control which saw no spread of disease amongst patients or staff.

Assessors have rated all actions as Met – without recommendations.

Summary of Results

Bellbird Private Hospital achieved a met rating for all facilities in all actions and therefore there is no requirement for a follow up assessment.

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

Org Name : Bellbird Private Hospital
Org Code : 221884

Sites for Assessment
Bellbird Private Hospital

Site	HSFID	Address	Visited
Bellbird Private Hospital	101048	198 Canterbury Rd BLACKBURN STH VIC 3130	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
BPH is part of the Healthscope (HSP) group, which provides healthcare services across 44 sites throughout Australia. Leading the organisation is the Healthscope Board which clearly demonstrates high level commitment to a safety and quality improvement culture standardised across all sites in a One Healthscope strategy. BPH benefits from this approach through an extensive policy support and a robust monitoring framework. Safety and quality is led by the Board sub-committee, the Clinical Quality Committee which oversights activities through a performance dashboard approach. The commitment to partnering with patients, carers and consumers is obvious, with consumers active participants on all relevant committees at both local hospital and corporate levels. There is an extensive network of feedback mechanisms to obtain, and act on, consumer perspectives replicated across all hospital sites in which the Board takes great interest. Consumer partnership is described in policy to assist hospitals to meet their obligations in this regard. The governing body has a clinical governance framework which informs all hospital clinical governance plans, including that of BPHs. All are formally endorsed. As stated, a robust monitoring framework is in place whereby hospitals report monthly against an established set of quality and safety performance indicators, which are compared to benchmarks. Any deviation from benchmarks requires explanation and an action plan which is monitored closely by the Healthscope Clinical Quality Committee. The monitoring process includes assurance that roles and responsibilities of all HSP employees are clearly defined and regularly reviewed. A comprehensive committee structure provides a pathway for monitoring actions taken as a result of analysis of clinical incidents. All sentinel events are reported immediately to the HSP Chief Executive Officer (CEO) who informs the Board in a timely way if required.

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	
BPH adheres to the HEALTHSCOPE Aboriginal and Torres Strait Islander (ATSI) Reconciliation Action Plan with BPH located on the land of the Wurundjeri people of the Kulin nation. BPH contacted the local ATSI Community Health Liaison Officer (HLO) at the Whitehorse City Council for information and support and to discuss ways to ensure that BPH can continue to provide culturally sensitive and accessible health care to Aboriginal and Torres Strait Islander people. In 2020 BPH developed its own reconciliation plan with advice and review provided by the local council HLO regarding accessibility for ATSI people to the service. All patients are asked on admission if they are either Aboriginal and/or Torres Strait Islander with a monthly report tabled at the Quality meeting to review the percentage of Indigenous or "not-stated persons" for admission. There has been as increase of 6% from September 2020 to March 2021 of those indicating their indigenous status from 84% to 90%. BPH meets the requirements of Advisory AS 18/04 referencing the six defined standards that specifically address the needs of Aboriginal and Torres Strait Islander people.	
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	
The service has good governance frameworks including a clinical governance framework that complies and has embedded initiatives that translates BPH expectations and those of the parent company Healthscope into practice. Positive survey results have been achieved around improved communication and an improved management style and leadership. BPH submits quarterly clinical Quality Key Performance Indicators (KPIs) to Healthscope for review by the National Hospital Quality Committee (NHQC) with key issues added to the Executive and Board agendas as required. Healthscope strategic planning ensures meaningful partnerships with consumers occurs. Safety and quality is both high priority and high profile in all Healthscope activities. The Clinical Governance Framework ensures BPH adheres to its systems and processes to maintain and improve the reliability, safety and quality of the healthcare it is providing to patients. The results are monitored to demonstrate that the care is safe, effective, patient centred and is continuously improving. The HEALTHSCOPE Quality and Risk Plan considers the safety and quality of healthcare in business decision making and is aligned to the Healthscope Strategic Plan with BPH demonstrating this in its Safety and Quality and Strategic Plans.	

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	
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	
BPH continues to monitor the strategies in place to meet the very small percentage of those patients currently identifying as Aboriginal and Torres Strait Islander people. NAIDOC Week is celebrated as is National Reconciliation Week. Fundraisers support aboriginal literacy.	
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	
BPH considers the safety and quality of patient's health care in business decision making aligned to the Healthscope Quality and Risk Plan and the BPH Safety and Quality and Strategic Plans. Examples of this were provided to assessors and are reflected in the hospital's facilities and medical/surgical activities.	
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
The commitment to safety and quality by the Executive Team is clearly evident, through discussions with them and clinical staff; and through review of documents including meeting minutes. Safety and quality information is highly visible throughout the organisation and underpins the training/education program. BPH has position descriptions for the workforce which includes responsibility for quality and safety based on the corporate template. These are recorded and tracked in conjunction with staff performance reviews. Medical Officers are bound by Healthscope Bylaws 2019. These Bylaws assist VMOs to operate within a clinical governance framework which is monitored through the Medical Advisory Committee and craft group meetings.

Rating	Applicable HSF IDs
Met	All

ACTION 1.7
The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements
Comments
BPH is governed by an extensive range of Healthscope policies and procedures and where a Healthscope policy is not available or where Healthscope has mandated that a local policy can be developed this is actioned. HICMR policies comprehensively guide infection control policies being the private consultancy oversighting this function in the organisation. The Healthscope Document Controller oversights the policy review process and monitors for legislative, regulatory and jurisdictional compliance. An example of a risk management approach was provided whereby during the first months of the Covid pandemic multiple related policies with frequent amendments were being distributed by the jurisdiction. To ensure that staff kept abreast of, and complied with these many changes, all other policies coming up for renewal were risk assessed and review delayed where this could safely occur. The national document controller issues new or updated policies monthly with these subject to review and distribution by the BPH Quality Manager. In 2020 Healthscope listed its high-risk policies with compliance audited via incident review, near misses and feedback. The national document controller monitors policies for compliance with legislation, regulation and jurisdictional requirements and follows distribution pathways as previously described to ensure all staff are aware of important changes.

ACTION 1.7	
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Rating	**Applicable HSF IDs**
Met	All

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	
A rigorous system is in place to ensure Healthscope hospital use organisation-wide quality improvement systems. Healthscope sets the safety and quality measures, priorities, monitoring and reporting framework with which BPH complies through monthly data uploads to the corporate Clinical Governance (CG) team. The CG team reviews the hospital's data and formats it into the reporting template which contains benchmarked targets. Deviations from benchmark require an action plan from BPH which is monitored by the CG team. Downstream BPH 's action plans are put into place through the Quality Committee which assists clinical staff to make the required improvements and measures the effects through the local audit process. In addition to required performance indicators BPH uses its incident and feedback systems to identify local improvements which it undertakes through the same action plan monitoring process with the input of consumers on the Quality Committee and clinical staff. Several examples were provided to assessors and nursing staff were also able to describe local quality improvement initiatives.	
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
All reporting on safety and quality is timely and reports are provided to the governing body through its sub-committee, the Clinical Quality Committee. Consumers are also represented on the Healthscope Clinical Quality Committee and are members of the local committee at BPH. Quality Boards are located in public areas for consumers to read. Consumers, and other relevant health service organisations can also easily access safety and quality outcomes via the MyHealthscope website. There is an extensive range of quality and safety items/reports discussed at Ward meetings and the Medical Advisory Committee (MAC) to keep staff and Visiting Medical Officers (VMO) up to date with the hospital's performance in this regard.

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
BPH has an integrated risk register located on RiskMan compliant with HSP policies. Risks are reviewed at a frequency according to the level of residual risk or incident occurrence with KPIs in place for extreme risks ensuring monitoring of the percentage and quarterly review of these risks. HSP have two layers of Risk Register- Corporate and Hospital risk registers -The Hospital risk registers are co-ordinated nationally so any new risks arising from sentinel events or other issues are added to all risk registers nationally. BPH reports on risks to the workforce via, HINT Intranet access; National Webex teams; Committees including department meetings and monthly staff forums. The risk management policies and the Risk Management Framework are regularly reviewed to ensure they reflect best practice and they are adjusted to maintain the effectiveness of the risk management system. There are also policies that address specific risks - such as workplace health & safety, fraud prevention, infection control, bullying, and emergency procedures. These policies guide staff on risk identification, assessment, and reporting.

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
There are a range of business continuity and emergency response policies available to the organisation. These policies set out staff responsibilities if their work area is impacted by internal or external issues. The organisation has also played a key role in regard to managing the COVID-19 pandemic through unexpectedly caring for several Covid positive residential aged care patients displaced through a serious outbreak at their facility which constituted a major risk for BPH but which was managed very effectively with no further transmission to Covid negative patients or to staff.

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
The BPH incident management system includes the analysis of incidents, trends over time and relative performance. Incidents are entered into the incident management system (RiskMan) by staff and reviewed at a hospital level. Serious incidents such as sentinel events are elevated via the HSP chain of command to the Board sub-committee, the Clinical Care Committee. All incidents are reviewed and adhere to the requirements of the HSP high level incident policy. Consideration is given through the review process to adding risks identified via incidents to the risk register. Examples of this were provided. Reporting areas of concern by patients, carers and families is encouraged and BPH provides information for patients, carers and families with Rights and Responsibilities posters and brochures displayed throughout the hospital plus there is a HSP website online contact page with any relevant to BPH would be sent to the BPH General Manager (GM) for review. The analysis and recommendations arising from incident management have been used to improve safety and quality and there has been education of the workforce as required. Several examples were provided to support this statement.

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
The workforce is well-supported to recognise and report incidents via a range of mechanisms, including orientation, ongoing training and assistance from the Quality Manager. Staff are able to provide feedback about incident management processes via the annual staff surveys and in turn receive feedback about RCA outcomes and incident trends at ward/departmental meetings. VMO's receive information through the MAC minutes, craft group meetings and general emails. Each clinical area has a board to display data related to their rate of incidents. Recommendations arising from incident reviews are captured and monitored through the Quality Committee to ensure completion through action plans.

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
Any Open Disclosure required is actioned and is consistent with the Australian Open Disclosure Framework as per Healthscope policy. There is training in the general principles of open disclosure for relevant clinical staff and more advanced education for senior staff and VMO who may be called upon to provide formal open disclosure as part of the incident analysis process. Several initiatives have been undertaken to improve the effectiveness of the open disclosure process and include changes to the training/education process, amendments to RiskMan to better capture how/when open disclosure occurred and through the HSP Shared Learnings program.

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
BPH has processes to receive feedback from patients, carers and families. Feedback at BPH is actively sought via survey with regular avenues of feedback encouraged either verbally or in writing directly to the BPH GM and through the formal complaint process. As a quality improvement initiative BPH also participates in the Back to Bedside project which includes provision to obtain, and act on, feedback at the bedside, to avoid escalation through inaction at a later stage. Managers also conduct 'rounds' to gather feedback and similarly act immediately to better manage patient perceptions of their care. All feedback and complaints are formally reviewed, trended and actioned in a timely manner. Trends in complaints are used to improve safety and quality systems and the organisation was able to provide evidence of where this has occurred. BH participates in the Victorian Healthcare Experience Survey process through DoH in order to seek patient feedback regularly and from the types of patients who represent the patient population to ensure that data is reliable and covers the services provided.

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
As stated in 1.13, consumers are encouraged to provide feedback to BPH, including the making of a complaint if systems to address feedback effectively fail. BHP has ascertained that most complaints are now provided through social media. A daily review of social media sites is conducted by the hospital and the RiskMan feedback section is monitored to document, upload and track patient complaints. Response to any complaint is reviewed and can be used for learning and teaching purposes. The Quality Committee, with its consumer representation undertakes this role. BPH compliance to complaint responses are reported vis Quality KPIs and BPH maintain consistency above 100%. Complaints through other sources such as letters and phone calls follow the same process. Feedback on complaints management is fed back to patients and staff through display on Quality Boards prominent throughout the hospital, to the MAC and to the wider public through the MyHealthscope website. Ward staff now have access to the Qualtrics dashboard for the purpose of early response to issues. Complaints are also discussed in detail at ward/departmental meetings where the requirements of the Back to Bedside program are reinforced. The complaint management system has improved over time through amendments to the RiskMan platform to better capture complaint data and through display of complaint outcomes for patients and staff to note.

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
BPH is subject to the requirements of the HSP policy: Diversity and Inclusion and can monitor the diversity of patients using its services by the information sought at admission or the engagement of telephone interpreter services reports. It has identified risk groups and have robust data collection processes which are analysed and used to inform quality activities and planning. Examples of support include assistance for non-English speaking background (NESB) patients through interpreters if required and multi-lingual information is readily available in commonly used languages. Through demographic analysis the hospital has identified patients who are at greater risk of harm, with the age of its potential patient population being a key driver. To illustrate this, nearly one third of patients are aged between 80-100+ years, necessitating comprehensive risk screening and assessment to identify risks and create individualised care plan plans to meet needs. This information converts to changes and updates to service provision through the strategic planning process, and is operationalised through, for example, the provision of numerous aids to reduce pressure injuries, falls, malnutrition and better manage cognitive impairment.

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
BPH has a paper based medical records system that includes both HSP and locally developed forms in accordance with HSP policy. WebPAS is integrated into the paper based systems with forms printed out as required to the medical record. In March 2021 a review was conducted of BPH local forms with the aim to move to standardised HSP forms only. There were at the time only seven local forms and these are in the process of being archived. Following staff education commencement of using the HSP forms is underway.

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
A documentation audit is conducted annually monitoring the documentation standards with outcomes and action plans submitted to the national Health Information Manager (HIM). Documentation standards are generally high and compliant with policy. BPH through HSP has policies which guide staff to protect patient clinical records confidentiality without compromising clinical care. This includes IT security policies, privacy and confidentiality policies, and policies relating to the release ofc confidential patient information. HSP has comprehensive, formal processes for development, review and document control of forms, documents and files that make up the paper healthcare record. Audits of the health record are tabled and discussed at the Quality Committee.

Rating	Applicable HSF IDs
Met	All

ACTION 1.17
The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that: a. Are designed to optimise the safety and quality of health care for patients b. Use national patient and provider identifiers c. Use standard national terminologies
Comments
BPH meets the requirements of Advisory AS 18/11 as it relates to Actions 1.17 and 1.18. In this regard BHP is subject to the HSP approach to this Advisory. A gap analysis has been undertaken on behalf of all sites. Further actions are required after December 2021 and HSP is currently working towards implementing systems that can provide information into the MY Health record (MyHR) and providing information into the My Health record. BPH complies with the HSP Policy 2.66 My Health Record with all HSP hospitals participating in the MyHR. BPH uses standard national terminology. A small amount of data relating to nursing discharge summaries is currently regularly uploaded.

Rating	Applicable HSF IDs
Met	All

ACTION 1.18
The health service organisation providing clinical information into the My Health Record system has processes that: a. Describe access to the system by the workforce, to comply with legislative requirements b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system
Comments
HSP Policy 2.66 My Health Record describes the authorised access to the MyHR and provides guidance for all HSP/BPH employees, contractors and consultants about access to and use of the My Health Record (MyHR) system. The designated person at BPH is the General Manager (GM) with an Action Plan in place for the implementation of the MyHR system by December 2022. Advisory 18/11 has been met as per Action 1.17.

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
HSP has numerous policies which reference safety and quality for all members of the Healthscope team, including the Board and Clinical Quality Committee specifying education and training in this regard from orientation and onboarding through to ongoing education for all clinical staff. Position descriptions for BPH managers and staff outline quality and safety responsibilities with KPIs reported to the HSP Corporate office quarterly - with action plans in place for those not reaching KPI benchmarks. The mandatory training program was reviewed in 2018 resulting in the rationalisation of the volume of mandatory training requirements. The responsibilities of VMOs related to safety and quality is via the HSP By-Laws. These are recorded in the C-Gov eCredentialling system. The By-Laws are scheduled for review in 2022 to enhance current requirements. BPH facilitates clinical placements for Enrolled and Registered nursing students with many learning opportunities in place with the collection of feed-back an important component of their placement.

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
BPH employs an educator to manage all aspects of the hospital's training needs. Included are mandatory training, orientation sessions for new staff, development of an education calendar and maintenance of ELMO, the online training platform for HSP staff. HSP identify any training items required on the Shared Learning Report with these actioned by the hospitals. Quality and safety outcomes which do not meet benchmark become a focus for targeted education, with improvements monitored through the quality improvement process at the Quality Committee. BPH reviews their mandatory training calendar annually which has been adapted to now include ATSI Cultural Awareness training. Compliance with mandatory training is uniformly high, with many modules at 100% completion. Similarly, there is very high attendance at non-mandatory education, indicating that such learning opportunities are greatly valued by staff.

Rating	Applicable HSF IDs
Met	All

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
BPH has strategies to improve the cultural awareness and cultural competency of its workforce in order to meet the needs of Aboriginal and Torres Strait Islander patients. An action plan has been added to the Consumer Partnership Strategy and now includes cultural awareness and cultural competency of the workforce. BPH reviews their mandatory training calendar annually which has been adapted to now include ATSI Cultural Awareness training in accordance with amended corporate policy. To assist in its strategy to enhance cultural awareness, BPH supports displays of HSP commissioned ATSI artwork, the display of the HSP Reconciliation Action Plan throughout the hospital and an acknowledgement to Country is part of all BPH meetings.

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	
The requirements of AS18/04 have been met.	
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	
In accordance with HSP policy, performance review of all BPH staff at conducted at three months post-employment and annually thereafter. Appraisal tools are inclusive of performance priorities (governance pillars), professional goals, educational needs and compliance with mandatory training. Interim appraisals are also conducted on the occasion of unsatisfactory performance and BPH has access to the HSP Human Resources Department for performance issues if required. At assessment all staff in the organisation had undergone a performance review in the preceding 12 months.	
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
HSP has a suite of policies relating to credentialing and scope of practice with which BPH must comply in order to demonstrate effective governance over defining the scope of practice of clinicians. This is closely monitored through the KPI performance monitoring process. VMO credentialling and scope of practice is captured in the online cGov system. Information on credentialing and scope of practice is available to relevant BPH clinical staff (for example staff in the Operating Suite) within WebPAS. The position descriptions of staff denote scope of practice and are subject to review according to a review schedule. No nursing staff operate within an extended scope of practice at BPH. The incident management system provides feedback on both VMO and staff performance with BPH forums for clinical peer review being: Medical Advisory Committee and the Clinical Operations meeting. Clear processes are in place, through HSP policy, to guide the introduction of new clinical procedures and clinical technologies. A range of matters must be considered in any applications for new technology, including credentialling, scope of practice and training requirements.

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
HSP has an online e-Credentialing Application and Management System which is fully implemented at BPH. This is monitored by the BPH credentialing officer. The BPH credentialing audit compliance is sustained at 100%. Although credentialling processes are thorough and well developed, all aspects are kept under review by HSP in recognition of this important element of care.

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
In accordance with HSP requirements, BPH's Safety and quality Plan is aligned to the HSP Safety and quality Plan and outlines the priorities for the year. Staff have access vis the public access drive. The clinical governance reporting lines and relationships outlines the reporting structure for staff. Organisational charts are available via HINT and the HSP Quality Management course is available over a 16 week period. This runs continuously via teleconference throughout the year. allowing staff to attend as often as they wish. All clinical staff have clearly assigned safety and quality roles, including their responsibilities. In discussions with staff assessors found that each staff member was aware of their role in minimising risks to patients through careful assessment and care planning; the importance of incident reporting (and how to do it) and the need to implement quality improvement activities arising from incidents and near misses. The role of clinicians in the provision of safe and high-quality care is emphasised during onboarding, further reinforced during mandatory training, organisational learning and ongoing education. BPH provides staff with training in the completion of incident reports through RiskMan.

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	
Agency/locum workforce requirements are clearly articulated, including an assurance that each person has the appropriate skills to provide safe patient care including an understanding of quality and safety systems in use at BPH. Assessors noted that Quality Boards are displayed across BPH clinical areas. The Boards include information related to quality improvement activities, audits, training data, education programs and the NSQHS quality standards. This reflects the focus that front line clinicians have on monitoring and improving the care they provide.	
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	
Enterprise agreements set out supervisory requirements with departmental Managers accountable to ensure staff receive their required training. There is a register of employed staff and their relevant qualifications. BPH has well developed formal supervision arrangements in place including for student nurses. Given that all care is provided by VMOs providing care in relative isolation (or in leading a multidisciplinary team) nursing staff were able to articulate how they would escalate care in the event that they believed a clinician was in difficulty during a surgical procedure. BPH staff have access to an Executive 24/7 so that someone is always available to provide support and leadership should a significant issue arise.	
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
At BPH clinical staff have access to a wide array of policies, protocols, guidelines, clinical pathways and decision making tools on the intranet (HINT) or via the HSP librarian. Clinical pathways with variance analysis are available on HINT and clinical clusters /teams discuss relevant pathways and guidelines. Clinical guidelines are distributed to the BPH MAC, Clinical Operations and Quality meeting with quick access guides for key guidelines available via the HICMR website (infection control) and to therapeutic guidelines. BPH patients are also provided with personal care plans to meet the individual and differing needs of each patient. Assessors noted that BPH has reviewed the Australian Commission on Safety and Quality in Health Care Colonoscopy and Antimicrobial Stewardship Clinical Care Standards. A significant percentage of surgical procedures relates to colonoscopy, which is subject to the requirements of AS 18/12: Implementing the Colonoscopy Clinical Care Standard. Assessors report that all elements of this Advisory have been met by the organisation.

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
As a small private hospital, BPH has a range of mechanisms to monitor variations in practice which may lead to unexpected outcomes and provide feedback to clinicians via the MAC. It submits data for review to ACHS, reporting hospital wide Clinical Indicator information. Other mechanisms include speciality submissions, additions to registries, Hand Hygiene Australia submissions; Hospital Acquired Complications (HAC) and the Qualtrics web platform to monitor consumer feedback. There are reflective registries of clinical profile and clinical indicator, HAC and audit data. The BPH General Manager engages with medical staff for incident review through the MAC, plays a key role in monitoring clinical outcomes and conducts forums with nursing and allied health staff.

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	
The quality statements described in the Australian Commission on Safety and Quality in Health Care (ACSQHC) Colonoscopy Clinical Care Standard have been incorporated into the management of the BPH colonoscopy service, and antimicrobial stewardship variation is actively managed by the Cluster AMS Committee in line with requirements of the relevant Advisory from the Commission.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.29
The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose
Comments
The hospital is maintained in accordance with HSP policy and BPH also has access to HSP capex templates the HSP Policy 3.03 Capital Expenditure and Equipment and Maintenance/Replacement/ Disposal, which outlines requirements for equipment and fit for purpose needs. The hospital presented in a very neat and tidy condition despite its age. Infrastructure is well maintained as evidenced by maintenance logs and other documentation. Contractors are well managed to ensure safe, quality provision of service. The BPH Disaster Plan is in place and well monitored, with all staff aware of their responsibilities in this regard. BPH capacity includes 53 beds and consulting suites with the hospital recently undergoing a major refurbishment that included the entire ground floor ward space, nurses station and the catering department. Executive walk arounds, incident trends, new legislation, preventative maintenance, infrastructure upgrades and asset replacement inform the detail of the current strategic plan. Biomedical equipment servicing is contracted to a third party. It is the responsibility of Department Heads for ensuring equipment/environment is fit for purpose. BPH has an asset register monitored by the Finance Manager.

ACTION 1.29	
The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose	
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	
Review of incidents at BPH suggest that it is low risk in regard to patients presenting with unpredictable behaviours. However, in 2018 it conducted an Occupational Violence and Aggression Audit and patient violence and aggression is a standing risk on the risk register. Staff are given information on when to call a Code grey and a Code Black. WAVE 1 &@ Workplace aggression and Violence training is in place for staff. Bellbird Hospital strategies to minimise risk include defined night-time lockdown; overnight security patrols' duress alarm buttons in high-risk areas; access to the Employee Assistance Program in the event of incident or near miss, and inter-hospital transfer procedures for disturbed patients. Single rooms are available for a calm and quiet environment and patient lounges afford space for differing use are available. Education and training in the recognition and management of patients with delirium or cognitive impairment have assisted in improving outcomes for these patients, enabling clinical staff to monitor and respond effectively to agitation and/or delirium and/or behaviours of concern and to guide management of a patient's behaviour.	
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
The signage at BPH is clearly visible, illuminated external to the building. Signs are kept clean, and gardens are kept trimmed to maximise visibility on the busy corner where the hospital is located. Ambulance bay parking is identified and designated and lined walking areas into the consulting suites are marked for the safety of pedestrians. The hospital car park is well lit and fire safety maps and evacuation signage assist in egress from the buildings.

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
BPH complies with HSP Policy 2.06 Visitors and HSP policy 0.01 Code of Conduct in regard to visiting hours. Flexible visiting arrangements have information provided on the web-site although during COVID-19 and lockdowns this changed in 2019/2020. Conversations with staff suggest a compassionate response to visitor requests outside the stringent COVID-19 visiting arrangements was applied, especially in regard to the very frail aged care residents who were unexpectedly transferred to BPH following a large outbreak of COVID-19 at their facility. Several patients died as a result of their frailty and infectious status. Families were much appreciative of efforts taken.

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	
BPH acknowledges the Wurrundjeri Peoples of the Kulin nation and there is engagement with the Whitehorse City Council and the Mullum Mullum Community Health Centre ensuring an established contact should it be required. ATSI flags are displayed at the reception desks of the hospital and the consulting suites. For the past four years BPH has acknowledged both NAIDOC and National Reconciliation Week throughout the hospital with various activities. Thoughtful, local Aboriginal artwork is on display throughout the facility. Staff are appropriately trained in cultural competence and provide a welcoming environment to all patients.	
Rating	**Applicable HSF IDs**
Met	All

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.

ACTION 2.1
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for partnering with consumers b. Managing risks associated with partnering with consumers c. Identifying training requirements for partnering with consumers
Comments
BPH complies with HSP policies and procedures Partnering with Consumers with evidence that consumer engagement and input is actively sought and facilitated. This has been interrupted by COVID-19 and lockdown of health facilities in Melbourne but is in the process of reinvigoration. The hospital has developed a Consumer Participation Plan 2020-2023 which has been reviewed and updated in consultation with the local Consumer Consultants. The Consumer Participation plan 2020-2023 describes the vision and direction of the hospital to drive and improve safety promote patient centred care and improve patient outcomes. The objective is to engage consumers at three key levels: Individual level, service department and at organisational level. The consultation process for the plan was to seek feedback from the hospital Executive, Department Heads and the BPH Consumer Consultants and to incorporate feedback received in recent years from patients, which appropriately identifies risks associated with partnering with consumers. One Consumer Consultant has received HSP approved training; the other will complete when it recommences following the lifting of COVID-19 restrictions.

Rating	**Applicable HSF IDs**
Met	All

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
BPH was able to provide evidence of quality improvement in monitoring its processes for partnering with consumers and implementing improvement strategies. The hospital has carefully and thoughtfully created its new Consumer Participation Plan with inbuilt performance indicators to monitor its performance in implementing the plan; and consumer consultants were very positive in their feedback regarding progress in relation to meaningful partnering.

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
Outcomes and activities related to partnering with consumers are monitored through the Quality Committee and reported through the Committee hierarchy to HSP leadership. BPH displays specific quality and patient experience results on Quality Boards throughout the organisation so that everyone can see at a glance the trends relating to quality and safety. This data is also discussed at staff huddles as required. HSP introduced online patient surveys from 2018 and on discharge for all patients who provide an email address to receive an email link to ask about their recent hospital experience. Patient experience responses often reflect the personal side of their care. The survey is based on the Australian Hospital Patient Experience Question set developed by the Australian Commission on Safety and Quality in Health Care.

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
The Charter of Rights and Responsibilities is on display throughout the hospital and is easily accessible for all attending Bellbird Private Hospital. This Charter is consistent with the Australian Charter of Healthcare Rights. This, together with other relevant information, including how to access further support and advice was readily available and displayed, including in patient handbooks and flyers and electronically on the My Healthscope website and the Patient Information Channel. Feedback from consumers and family indicates that patients are generally aware of their rights and where to find out more information.

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
BPH provides informed financial consent by the provision of cost information to private patients including notification of likely out-of-pocket expenses at pre-admission although in some circumstances informed consent cannot be sought for example if a patient is admitted directly from an emergency department. Review of material provided indicated to assessors that current practice meets the requirements of Advisory AS 18/10 - Informed financial consent. Whilst informed consent processes at BPH adhere to required legislation, best practice and in accordance with HSP policy as determined by regular audit, it is not uncommon for a patient to be transferred to the holding bay in the Operating Suite without informed consent being obtained prior as custom and practice. Although there is a clear mechanism to prevent transfer to the operating theatre without a signed consent form via display of a large STOP sign, a suggestion is made that steps be taken to minimise this occurring except in the most urgent of circumstances.
Suggestion(s) for Improvement
Although there is a clear mechanism to prevent transfer of a patient from the holding bay to the operating theatre via display of a large STOP sign, steps should be taken to minimising this occurring except in the most urgent of circumstances.

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
BPH provides clear guidance for staff and patients and their families about how to identify a patient who may or may not have capacity to make decisions about their own care, provides advice on testing and documenting capacity assessments if required and the rights of patients in line with HSP policy. Processes support ensuring the patient has the capacity to make decisions about their own care or that a substitute decision maker is involved in care planning. Additional policy support regarding shared decision-making includes: Discharge Against Medical Advice; Consent to surgical/medical treatment and the use of advance care directives. Nursing staff document the next of kin or substitute decision-maker in webPAS and also in the Patient Health History HMR 4.5.

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	
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	
Patients and carers are involved in their own care at every contact with BPH as identified through formal patient feedback, and in discussions between patients and assessors. There is a commitment to transparency in reporting key indicators of quality and safety with these published on the My Healthscope website. Staff have received education in understanding the meaning of a " patient goal" and how to understand the simplicity of setting a patient goal. Active involvement of patients is facilitated by the use of Patient Care Boards near every patient bedside; bedside clinical handover; and purposeful patient and leadership rounding. Each of these initiatives has demonstrated effectiveness in assisting patients feel involved in their care through the audit process although traction is still slow in getting patients to use the Care Boards rather than just observe them. Work is being undertaken to improve this.	
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
BPH promotes and enables partnering with patients/clients/families through a range of targeted activities which are audited for effectiveness through the regular audit schedule. Patient rounding assists staff to liaise with patients on an ongoing basis and the endorsement by BPH of 'back to the bedside' is a component of the Strategic Plan. Assessors observed several examples of beside clinical bedside handover and noted active engagement between nursing staff and patients. Audits regarding the effectiveness of clinical handover are conducted and suggest that this is a work in progress. Tailored education sessions are provided as required. Purposeful patient rounding has demonstrated at BPH that it facilitates individual patients' engagement with staff and encourages the asking of questions etc. An unexpected positive outcome of the COVID-19 visitor restrictions is that there is much greater engagement between care providers and patients because patients are more available to staff without visitors present for several hours a day.

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
BPH uses communication mechanisms tailored to the diversity of its consumers in accordance with HSP policy and utilises HSP approved publications as a key method. There is a HSP register of all consumer information available with feedback from consumers collated and reported at the relevant committees. BPH consumer consultants in 2020 undertook a project to review the content of handouts given to patient's post-surgery. A stamp was introduced in 2020 ensuring that education is provided and understood by a patient receiving their Medication Profile on discharge and signed by the patient/carer and/or the nurse/pharmacist.

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	
Aboriginal consumers are offered access to specialist support from local Koori organisations.	
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	
HSP involves consumers in the development and review of an extensive range of patient-related information, all of which is available for use by BPH and its patients. BHP also has a small amount of in-house information which has been approved by local consumer consultants. For example, the Consumer Consultants reviewed the handouts given to patients by Allied Health staff via a project in 2020 and also reviewed the Patient Care Boards and reported on any difficulties that patients may be experiencing with these. Assessors noted the digital and hardcopy information available to consumers and agreed that evidence provided supports the effectiveness of the system.	
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
HSP and BPH have focused on providing relevant, accessible and easily understood information to patients so that communication is clear and effective. Evidence was provided, and observed by assessors, that health information needs including method of communication, is established at the point of contact and informs communication needs throughout the patient journey, including at transition of care points and discharge/transfer. Key indicators are displayed on the HSP website to allow patients and carers to make informed decisions aligned with consumer approved patient information given to patients. Clinical handover eLearning is available to staff and webPAS generated nursing discharge summaries are available for patients using clear language in plain English. This also occurs in relation to discharge medications. The Healthscope By-Laws outline VMO responsibilities to support clinical decision making and the development of pathways of care that yield optimal clinical outcomes.

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
HSP has systems to involve consumers in the governance of, and the evaluation of care through consumer consultants being actively engaged at corporate quality level, where a panel of consumer consultants provide feedback and suggestions for all HSP hospitals; and through local membership of the Quality Committee at BPH. BPH acknowledges the value of having Consumer Consultants on all relevant safety/quality committees where they question current practice and processes associated with incidents and where clinical outcomes fall below required outcomes. Examples of their active participation were provided by both the organisation and by the consumer consultants themselves. The BPH consumers are integral to the Bellbird Quality and Risk Management Framework providing feedback on both clinical and environmental services.

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	
The leadership commitment and support for engaging and partnering with Consumers and the community was evident. Feedback mechanisms such as surveys and complaints mechanisms were cited as also being used to inform improvements to communication tools.	
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	
In accordance with HSP policy regarding partnering with consumers, BPH Consumer Consultants are well supported and undertake a comprehensive orientation program which includes key areas that need to be covered and includes both a position description and a confidentiality agreement. Ongoing educational opportunities are also offered. BPH consumer consultants felt that education offered was sufficient for their needs and that additional support was readily available either from the local organisation, or the national consumer consultants.	
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
The HSP Aboriginal and Torres Strait Islander cluster has a senior advisor in Aboriginal policy and community engagement for consultation as required. Relationships have been established with the Community Development Officer for Diversity at the local council. BPH also works increasingly closely with local ATSI support systems to initiate support for consumers with specific health needs. The hospital acknowledges NAIDOC Week and social events raise money for donation to the Aboriginal Literacy Foundation.

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
BPH works with its consumers to incorporate their views and experiences into the training and education of its workforce. Consumers' experiences are included in the Graduate Nurse study program, staff ongoing education, and eliciting the consumer experience is part of manager rounding. Consumer Consultant surveys (when they commence again once COVID-19 restrictions are lightened) will continue to ask about patients' experiences on a wide range of parameters including the cleanliness of the hospital environment, meals, pain management and engagement with staff. All this information is used to educate staff on the patient experience.

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
An excellent governance system for infection prevention, control and surveillance is in place at BPH in collaboration its parent corporation Healthscope and the organisation's expert external providers (HICMR) of infection control (IC) services. A very comprehensive suite of evidence-based policies guide practice; are regularly updated and well monitored through a raft of audit and surveillance processes. The governing body is kept informed on IPC outcomes via a dashboard to which all Healthscope hospitals contribute data. BPH's performance is impressive on all indicators, as one would hope to find in a small, largely elective hospital, where the majority of surgical cases are day cases. An effective Healthscope Webex IC team on which BPH has representation monitors infection rates across all of the corporation, reviews related incidents, ACHS clinical indicators and guides the implementation of policies and procedures at each site via local Infection Control Committees. The risk management system is robust, and BPH is compliant with the Healthscope Risk Management framework and its governing policies. All infection control related risks on the hospital's risk register are regularly reviewed and have individual management plans to reduce/manage associated risks. Management plans are well monitored and assessors noted effective controls, supported by nil/negligible rates of infection. The Eastern Cluster, of which BPH is one of three participating hospitals, manages the risks associated with anti-microbial stewardship and monitors local practices in this regard to mitigate risks. HICMR conducts annual risk assessments of BPH's system and facilities from which resulting recommendations are formally addressed and progress reported to the hospital executive and via the Healthscope hierarchy to the Board. To ensure the risk of infection is reduced to a minimum mandatory training regarding effective prevention and management of infections is in place. This program is very comprehensive and compliance with completion of both the eLearning modules and any accompanying competencies is almost 100%. Additional discretionary modules are available, and all staff have access to HINT, which provides Healthscope Library materials for effective infection control including Australian Guidelines, the Australian Hand Hygiene Initiative; HICMR Policy and Procedure Manual, and audit tools. This broad approach ensures robust, evidence-based information and support is available to staff at all times. BPH has met the requirements of the National Standard Preventing and Controlling Infections 2021 as set out in Advisory AS 21/01.

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
Infection prevention and management is very effectively managed at BPH and considerable evidence was provided to demonstrate how the workforce uses the organisation's safety and quality improvement systems to maintain strict standards and keep healthcare associated infections to zero. BPH has an Infection Control Plan, reviewed annually, to guide its quality improvement process. A detailed audit program is in place across a wide-range of parameters, the data from which may be submitted to external bodies for oversight (e.g. Hand Hygiene date) or to Healthscope corporate for benchmarking against like-sized hospitals. A well-managed surveillance program is in place. Incidents relating to infection control are entered into the organisation's RiskMan database from where they are analysed although such incidents are negligible. Action Plans are developed as warranted from incidents or performance indicators which do not meet the required mark and are well monitored until identified improvements are complete. The effectiveness of the antimicrobial stewardship (AMS) program is monitored via the Eastern Cluster AMS committee comprised of infection control/AMS experts, with active participation by BPH. Data is provided from a number of sources, including the private pharmacy partner, to inform the Committee and its activities. Results of all audits and quality improvement activities are provided to the Medical Advisory Committee (MAC) for review. The hospital was able to provide evidence of numerous strategies it has implemented to improve outcomes associated with healthcare-associated infections and antimicrobial stewardship. A few examples include the introduction of colour-coded medication fridge temperature charts; the removal of ice machines; introduction of Antichlor for cleaning rooms of infectious patients; the standardisation of single use masks across the organisation to negate potential risks from using incorrect masks, and changes to IV cannulas to positive pressure cleanable needleless connectors. A daily list of patients on IC precautions has also been introduced as a communication tool.

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 outcomes of all activities related to the prevention and control of healthcare associated infections, and the AMS program's activities as articulated in the IC Plan are monitored by BPH's Quality Committee, and by Healthscope. Outcomes are displayed for staff, patients and visitors on Quality Boards in each ward/department. Related issues are discussed at regular ward/departmental meetings, and at the MAC. Results are also exhibited on the My Healthscope website – Bellbird Private Hospital.

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
Evidence was provided of examples where clinicians actively partner with patients to involve them in their own care; meet their information needs and share decision making. Assessors attended clinical handovers where interaction took place at the bedside. On admission patients complete the Admission Infectious Screening Questionnaire which forms the basis for individualised care plans during the patient's stay. Decisions based on the information provided in the questionnaire are discussed with the patient. There are appropriate brochures available for patient information. Some brochures outline general infection control principles. Others are specific to an identified risk and clinical staff explain the brochure's content to the patient, obtaining feedback that the information is understood. All new antimicrobial medications are discussed with the patient, who is also given an information leaflet 'Receiving antibiotics in hospital' from the NPS CEC/Quality use of antimicrobials in Healthcare (QUAH). Information on the organisation's corporate and clinical infection risks is available to patients and carers at point of care and via the 'My Healthscope' website. Patients, carers and visitors can access an extensive range of information relating to infection prevention and management, including hand hygiene. Feedback regarding the effectiveness of information material is sought from patients through patient satisfaction surveys.

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	
A consumer actively participates on the Healthscope Infection Control Webex membership, representing patients attending Healthscope facilities.	
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	
BPH has a surveillance strategy for healthcare associated infections and antimicrobial use which includes robust data collection in accordance with Healthscope policy; uses this data to reduce risks associated with such infections and reports its outcomes to its staff, consumers and via the hierarchy to Healthscope and its Board. Surveillance is conducted via the HICMR surveillance toolkit which provides a standardised approach and facilitates benchmarking across Healthscope organisations. Surveillance for collecting HAI data is mandated through VICNISS. The HAI clinical indicators collected include Staphylococcus aureus bloodstream infections, surgical site infections and influenza vaccination rates. Most recently Covid vaccination rates have been included. In regard to antimicrobial stewardship, BHP submits data annually to the National Antimicrobial Prescribing (NAPS). Audits sighted by the assessors demonstrated negligible infection rates, outstanding vaccination rates and improved antimicrobial prescribing. On the rare occasion where an infection is detected or a performance indicator falls short, the Quality Manager was able to describe the immediate action taken to review each case, identify possible contributing factors and manage accordingly.	
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
BPH has processes in place to apply standard precautions and transmission-based precautions in accordance with the Australian Guidelines for the Prevention and Control of Infection in Healthcare. HICMR policies define and describe standard and transmission-based precautions and are readily available to staff in HINT. HICMR also provides a 24hour consultancy service should nursing staff have any questions. Compliance with policy in this regard is well monitored and outcomes show effective application of precautions.

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
Clinicians assess infection risks and use risk-based transmission-based precautions. A risk analysis is undertaken based on the pre-admission self- assessment regarding a patient's infectious status, confirmed by a pre-admission phone call. On occasion a patient's doctor will communicate infectious status. Although standard precautions are applied in every case, decisions regarding the need for transmission-based precautions are dependent on the hospital's capability. The hospital has no negative pressure rooms so the patient may be nursed in a single room (dependent on the mode of transmission) or be cared for in a more suitable facility. Additional factors such as environmental controls; transportation within the facility; cleaning procedures and equipment requirements are taken into consideration. Specific cleaning requirements have been defined and quality improvement activities include product changes to keep abreast of best practice.

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
A quick guide for management of patients in precautions has also been introduced as a quality improvement measure. Appropriate personal protective equipment (PPE) is in use and closely monitored. Environmental controls include the availability of single rooms and a mostly day case elective surgical case mix although the current situation regarding COVID-19 and the common practice of receiving patients from other Healthscope facilities (including from their Emergency Departments) necessitates constant vigilance. Assessors heard a great deal about BPH's response to COVID-19 when in July 2020, with little warning, it was required to admit 18 patients from a nursing home which had been forced to close due to overwhelming infection amongst residents and staff. Urgent assessment and placement of infected patients was a key feature of its pandemic response and the staff are justifiably proud of the fact that there was no further spread of COVID-19 between the nursing home patients or to staff at BPH. This is a testament to robust infection control.

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
Patients complete a pre-admission screening tool which includes a section regarding their infectious status. Sometimes a doctor will inform the hospital of this. On confirmation of infectious status, an Alert is triggered on the Alert form at the front of the medical record, and in the WebPAS electronic alert system. This alert guides the response for the applications of appropriate precautions and patient placement. Signage used for these precautions is clear and specific, and assessors observed high levels of compliance in the use of Personal Protective Equipment (PPE) on occasions when precautions were in place. Terminal cleaning requirements were clearly documented, and audits indicate very high levels of compliance in this regard also.

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	
The patient's infectious status is identified and communicated at clinical handover. The communication when patients need to be transferred in or between facilities is well documented to minimise the risk of exposure. WebPAS generates a nursing discharge/transfer form sent with all transferring patients to another facility or community nursing organisation, and to the patient's general practitioner advising of infectious status. IPC monitors effective management in all aspects relating to care of patients with, or suspected of having, a transmissible infection.	
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	
Hand Hygiene (HH) is monitored as per the Hand Hygiene Australia program and audits are completed as per the audit schedule by qualified auditors. Audits are conducted by moment and healthcare worker designation. Audit reports demonstrate consistently high compliance in recent years, and are higher than national benchmarks, currently near 90% in 2020 and 2021. Visiting Medical Officer (VMO) compliance is relatively high at 77%. Alcohol-based hand rub stations are clearly located and readily available throughout the hospital and the assessors observed that it is consistently used. The IPC team uses a range of innovative techniques to keep hand hygiene high profile and has systems in place to address observed occasions of noncompliance, although these are rare. Staff must complete hand hygiene training, there is signage throughout the hospital advising staff and patients of the importance of hand hygiene and results of audits are on display.	
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	
The organisation has very effective systems in place to monitor aseptic technique in accordance with Healthscope policy 8.38 Aseptic Technique. A risk-assessed audit based on the NSQHS Aseptic Technique Risk Matrix identified all procedures where aseptic technique applied and a training program was developed for relevant clinical staff. The training program includes a competency assessment component. The online component is available on ELMO for all clinical staff. HICMR compliments the Healthscope policy with its own in relation to clinical practices and care bundles for management of therapeutic devices. Training modules, training records and compliance data was presented to assessors in regard to the organisation's aseptic technique program. Records indicate that numbers of trained clinical staff have regularly grown year on year and currently at BPH 96% of relevant clinicians have undertaken both the training module and been assessed as competent. New staff undertake the training on commencement.	
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	
Evidence was provided to indicate that invasive devices are well managed and appropriately used in accordance with the Australian Guidelines for the Prevention and Control of Infection in Healthcare. Healthscope provides easy access to a wide range of policies to guide practice to an extensive array of devices. These policies are regularly reviewed by the Infection Control Cluster to maintain best practice. Medical staff are assessed for competence in the Operating Room in regard to maintaining a sterile field; insertion of PIVC; and spinal/epidural insertion on a randomised basis.	
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
BPH has processes to maintain a clean and hygienic environment in accordance with comprehensive, risk assessed HICMR policies and procedures related to environmental services; food services; maintenance; management of clinical waste and linen. Each policy conforms with jurisdictional requirements, legislation and Australian Standards as warranted. Each element is closely monitored to ensure compliance. Cleaning audits demonstrate very high standards are maintained across the organisation, evidenced by assessors. Corrective action plans are developed and monitored on the rare occasions that variances occur. Cleaning schedules accommodate required frequencies and are responsive to emerging/changing environmental risks. Specialised contractors clean the Operating Suite. Staff are well trained in infection control and in the use of PPE, evidenced during the assessment. All staff have relevant vaccinations in accordance with organisational policy. Support is provided for staff who have difficulties using information technology or where language other than English poses a barrier. Material Safety Data Sheets (MSDS) regarding cleaning chemicals are readily available if needed. HICMR policies and the Transmissible Diseases Toolkit govern outbreak control, e.g. gastroenteritis.

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
BPH presents as a very neat, clean and tidy facility despite its advancing age. Furnishings and fittings are pleasant and well maintained. An effective maintenance and repair program is in place, with input from the Infection Prevention and Control (IPC) team. The program is active and adequately resourced. A risk management plan for legionella is in place and well monitored. HEPA filtration is well maintained on an annual schedule. Linen at BPH is well managed through a private linen provider in accordance with the relevant components of AS3789, including designated areas for clean and soiled linen. The attention to segregating, storing and disposal of all waste meets standards and environmentally friendly systems are used whenever possible. HACCP food services audits demonstrate a safe environment for food handling in accordance with BPH's Food Safety Plan. HICMR conducts rigorous annual environmental service audits and action arising from recommendations are part of BHP's performance indicators. Examples of changes made were provided to assessors. Adequate training is provided to staff to achieve this safe environment. Blood and body fluid exposures are at currently at zero level for staff with excellent systems of control in place. The Theatre Manager in collaboration with IPC and HICMR ensure all products and RMDs used in CSSD and clinical areas are TGA approved for use in healthcare facilities, cleaned and maintained in accordance with HICMR policies.

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
BPH's vaccination program is operated in accordance with Healthscope Policy 4.26 Immunisation for Vaccine Preventable Diseases – Staff; and HICMR policies relating to Staff Health, which includes an Immunisation Waver form for completion by staff who choose not to vaccinate. In accordance with legislative compliance this is not an option for COVID-19 vaccination and all staff at BPH are double vaccinated in this regard. Before employment all staff are expected to provide evidence of immune status against a Healthscope defined list of diseases. If immunisation cannot be established vaccination is offered to staff for a range of infections, including an annual influenza vaccination. Although influenza rates are usually very high, they have been lower in 2021 although it is noted that influenza has been negligible in the community this year. Vaccinations on offer are risk-based and in accordance with the Australian Immunisation Handbook.

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
Reprocessing of reusable devices takes place at BPH in the CSSD which operates under the HICMR Sterilising Services Manual in accordance with the requirements of AS 4187/14. Processes described in the manual are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines. Because of its age capital works are still needed at the hospital for full compliance. Its 4187/14 Gap Analysis and Action Plan are however almost complete with remaining works scheduled for 2022. In the meantime, associated risks are on the organisation's risk register and are currently mitigated to HICMR's satisfaction until the works take place. BPH is represented on the Healthscope CSSD working party. Staff are well trained and undergo annual skills assessment. There have been no incidents relating to CSSD and practices since last Accreditation assessment. Integrity of sterilisation is rigorously monitored and regular microbiological testing occurs in the endoscope cleaning room.

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
Audits confirm processes follow procedure and standards, reinforced by visits from assessors who observed cleaning, disinfecting and sterilising of reusable devices and confirmed that the requirements of the policies and procedures to support the process were met. A manual tracking system called Meditrac Traceability System is used to track all reusable medical devices (RMDs) across all sterilising systems in use at the hospital. These include porous load steam sterilisation and low temperature hydrogen peroxide 'Sterrad' systems. The HICMR tracking form is used for flexible endoscopes and diagnostic probes. Meditrac can track instruments and other RMDs to individual patient should the need arise. BPH currently meets all requirements of Advisory AS18/07. Plans are well advanced to complete outstanding elements of its 4187/14 Action Plan in 2022.

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
The use of antimicrobials at BPH is governed by the Healthscope Policy Antimicrobial Prescribing and Management; HICMR Policy and Procedure: Antimicrobial Stewardship (AMS) and the Healthscope Pharmacy Services (HPS) Antibiotic Stewardship and auditing program which comply with the current National Standards Antimicrobial Stewardship Clinical Care Standard. Healthscope provides access to all its hospitals and promotes evidence-based practice in line with the Australian Therapeutic Guidelines and related resources such as SA Advisory Group Guidelines on Antimicrobial Resistance (SAGGAR) via HINT. BPH participates on the Eastern Cluster AMS Committee which oversights antimicrobial use at four Healthscope hospitals in the area and the Healthscope Infection Control Cluster/Webex IC team The AMS Committee is a multidisciplinary team comprising infection control staff, an AMS pharmacist, VMOs, intensivists and Emergency doctors and can readily access specialist Infectious Diseases support. The Committee monitors the Cluster's use of antibiotics in accordance with its AMS Policy, and other relevant protocols such as the Sepsis protocol and surgical prophylaxis protocols.

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]
A specific antibiotic formulary is in place, visually represented by a customised traffic light restriction program. A strict approval process is in place, and well monitored by the private pharmacy provider who supplies annual antibiograms and other prescribing data. Antimicrobials in the red zone require specific permissions before dispensing can occur. The Bellbird Private Hospital MAC is supportive of, and actively encourages, VMOs to comply with policy. Antimicrobial prophylaxis guidelines are displayed on the anaesthetic trolleys in each theatre. Antibiotic stewardship is high profile throughout the hospital with messages for staff and patients. BPH celebrates Antibiotic Awareness Week each year with a variety of activities promoting judicious use of antibiotics. The requirements of Advisory 18/08 are met.

Rating	Applicable HSF IDs
Met	All

ACTION 3.16
The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy • antimicrobial use and resistance • appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing
Comments
The antimicrobial stewardship program in the Eastern Cluster (on which BPH participates) is comprehensive in regard to Action 3.16 of the National Standards, reporting outcomes through the Committee hierarchy to the governing body. The Committee oversighting the program reviews every antibiotic prescribed in the organisation and may feedback to individual clinicians whenever antibiotic prescribing falls outside the guidelines. AMS surveillance data indicates low but improving levels of compliance at BPH where antibiotic use is relatively low due to its patient cohort. The clinical pharmacist reviews all antibiotic use and often suggests alternatives to VMOs if warranted. Clinicians appear to be very appreciative of advice provided by the pharmacist and members of the AMS Committee and practice will gradually change over time.

ACTION 3.16
The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy • antimicrobial use and resistance • appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing
Surveillance data on antimicrobial resistance is utilised to support appropriate prescribing, with the external pathology service providing relevant information. Monthly antibiograms identify rates of resistant organisms in the Eastern Cluster which are used to communicate local resistance patterns and assist doctors with more appropriate prescribing. Surgical prophylaxis is addressed as part of the AMS program and BPH meets the requirements of AS18/08, Antimicrobial Stewardship, participating as it does in the National Antimicrobial Prescribing Survey (NAPS). Compliance with indicators 6a, 9a, b and c of the AMS Clinical Care Standard has been slowly improving over time. Outcomes of VICNISS and NAPS audits are presented to the MAC, the Operating Theatre/Anaesthetic Committee and to relevant craft groups. The requirements of Advisory 18/08 are met.

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
Quality systems from the Clinical Governance Standard are used by clinicians when implementing and reviewing policies and procedures, managing risks using the risk management system from Clinical Governance Standard and providing staff training in relation to medication management. BPH benefits from a comprehensive list of Healthscope corporate policies covering all aspects of safe, effective medication management which are readily available electronically and maintained by a specific policy document controller. Additionally, BPH has its own specific policies related to local conditions and to which corporate document control policy is applied in regard to monitoring and review. Healthscope maintains a Risk Register which has several medication-related risks. These risks are applied to all hospitals in the group; individual hospitals may add specific risks as required. Risks are regularly reviewed by BPH and by Healthscope. Governance over medication safety is through the Medication Safety Committee (MSC) in turn oversighted by the Quality Committee, monitoring medication incidents and quality improvement activities. Numerous audits are conducted in accordance with the BPH annual audit schedule and should performance fall below benchmark, the MSC oversights the improvement plan. Data is provided to the Board through a linear hierarchy of committees usually in dashboard format unless there is a sentinel event or negative trend which is individually managed. Three key performance indicators are routinely monitored by the Healthscope Quality Team and used for benchmarking purposes. These indicators are medication events in total; medication errors resulting in an adverse event and the Med+Safe Package. Nursing staff at BPH have access to many education opportunities related to medication safety; some of which are mandated by the Healthscope Mandatory Training Policy such as the recently revised Medication Management and Safety training package. The private pharmacy service as well as drug companies also offer drug updates. Pain workshops are regularly held. Assessors were pleased to note 100% compliance with mandatory training and very high attendance at discretionary education.

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
BPH applies the quality improvement system from the Clinical Governance Standard and uses the process to monitor the effectiveness and performance of medication management. Healthscope corporate requires monitoring of key performance indicators for benchmarking within Healthscope hospitals. These indicators include total number of medication related incidents and incidents which result in an adverse event. Sentinel events relating to medication safety are also reportable events requiring comprehensive individual reviews. BPH audits significantly more medication safety and performance related indicators for internal risk management and quality improvement. The MSC develops action plans to ensure improvements to medication management and associated processes. Outcomes are reported through the Quality Committee to the hospital executive team. All medication incidents are lodged in RiskMan, the incident management system, and occur at a rate of 2-3 low level incidents a month. Despite this low number, each is reviewed and nurses involved may be required to complete e-medication safety education as a reflective learning opportunity. Audits include accuracy of use of the National Inpatient Medication chart (NIMC) against a number of parameters. With some areas not meeting expected targets in 2018 and 2020, an action plan has seen some improvement in 2021 due to discussing requirements with the Medical Advisory Committee and resultant changes in Visiting Medical Officer (VMO) compliance. On a more positive note, reconciliation of medications on admission and discharge, plus the creation of medication management plans for defined patients is almost 100%. An excellent relationship with the contracted clinical pharmacist is at least part of the reason for this. The Medication Safety Self-Assessment audit conducted every second year has also shown improvement. Multiple small audits are also conducted in regard to labelling of injectables; bedside drug security; Nurse initiated drug policy compliance and documentation of adverse drug reactions show extremely high compliance at near 100%. Numerous examples of system improvement were provided, including a consumer joining the Quality Committee; the introduction of tamper-proof patient's own medication S8 storage bags; the move to potassium ampoules on the Crash Cart in a separate, clearly labelled location and new Drugs of Addiction books with additional recording requirements to minimise errors and capture discarded medication more easily. Tall man lettering has been introduced since last assessment, as has a Pharmacy Communication Book for ease of communication between ward staff and visiting pharmacists/delivery couriers. BPH also participates in the Healthscope Shared Learnings Program where all hospitals have the opportunity to learn from the mistakes of others before a similar error occurs.

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	
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	
Evidence of the use of processes from the Partnering with Consumers Standard was provided to assessors through conversations with BPH's consumer representatives who assist in producing and reviewing patient information material, and assessors' observation of partnership during clinical handovers, multiple disciplinary meetings, and during the consent process. Consumer feedback is entirely positive in regard to feeling involved in their own care, in shared decision-making, and in information provided. Each of these areas is monitored through the audit process and improved as required and reported via the Medication Safety Committee through the committee system to the Governing Body. Feedback to staff and consumers is evident via Quality Boards displayed in common areas, and through staff meeting minutes. To ensure patients have understood the changes to their medications on discharge, they are asked to sign a stamp on the discharge summary indicating this. The stamp is counter-signed by the pharmacist or discharging nurse, dated and a copy given to the patient.	
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
Healthscope Bylaws, and related policy describe the process for defining and verifying the scope of practice for prescribing, dispensing, and administering medicines that apply to relevant clinicians in specific circumstances. This is supported by the VMO credentialling process oversighted by the BPH Credentialling Committee which is annually audited. Specific authorities are monitored by HPS Pharmacy. Antimicrobial restrictions are also applied in accordance with the Eastern Cluster Anti-Microbial Stewardship (AMS) Committee's directive. There are no nurses who work with an extended scope of practice at BPH.

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
Medication reconciliation commences with pre-admission documentation provided by patients (or their family/carer) listing current medications as requested in, and supported by, the BPH patient information booklet. Additional history may be taken during the pre-admission phone call. The list of medications is reconciled on admission or within 24 hours by the clinical pharmacist in accordance with the Healthscope policy Best Possible Medication History – obtaining the Healthscope Medication Plan Management Plan and the Healthscope By-laws. Assessment criteria relating to medication safety indicate the circumstances under which a Medication Management Plan is required; usually in relation to the complexity of the patient's condition and the number of medications the patient takes. This document remains in the patient's medical record. The patient's doctor then prescribes medications to be administered during the hospital stay on the National Inpatient Medication Chart (NIMC). Reconciliation occurs again when medications are changed during the in-patient episode of care, and a final time on discharge, where the pharmacist explains changes and both patient and pharmacist document confirmation of understanding on the discharge stamp before providing the patient with a copy of the Discharge Summary.

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	
Detailed medication instructions are provided in written form at the same time. The patient's own medications are safely stored while they are in hospital and returned to them on discharge will instructions on how to manage or destroy them.	
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	
Assessors noted that the clinician reviews patients' current medication orders against their best possible medication history and documented treatment plan, reconciling any discrepancies on presentation and at transitions of care. The clinical pharmacist reviews the medication chart to ensure reconciliation with the medication list and information obtained from the patient during the BPMH discussion before making a decision in regard to creation of a Medication Management Plan. The criteria for a MMP are patients over 65 years, more than four medications, high-risk medications and on request of the clinician. Compliance is monitored by the pharmacy service, with results reported to the Medication Safety Committee. In reviewing several patient healthcare records, assessors confirmed the use of the National Inpatient Medication Chart (NIMC) completion of which was compliant with the requirements of the Australian Commission for Safety and Quality in Healthcare (ACSQHC). Evidence sighted in healthcare records and during assessor observation also demonstrates that a BPMH is documented on the Medication Management Plan (MMP) as directed by policy which is regularly monitored.	
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
Processes are in place for documenting a patient's medication allergies and adverse drug reaction (ADR) in the healthcare record on admission. Requirements to do so are referred to in a number of Healthscope policies relating to medication management and to the documentation and management of Alerts. Documentation audits regarding the accurate recording of medication allergies and adverse drug reactions show incremental improvements over three years to its current 100% compliance relating to the Alert Sheet at the front of the medical record; 90% documentation of 'Not applicable' on the Alert Sheet if there are no known alerts; and 90% use of the label/stamp on the NIMC. Assessors noted Alert Sheets in the point of care documentation and in the front of the patient's medical record after discharge. In addition to the Alert Sheet, a Medical Alert sticker is placed on the front of the medical record and medical alerts are entered into webPAS. Patients wear a red identification band if a medication allergy or ADR is known and clinical handover audits indicate that ADRs and medication allergies are handed over to oncoming staff 100% of the time.

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
BPH documents all ADRs in RiskMan, the clinical incident management system where each is individually, are investigated and confirmed by the medical practitioner and pharmacist. The ADR is recorded in the medical record and reported to the Medication Safety Committee where it is included in the monthly dashboard relating to medication safety.

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
The pharmacist at BPH is responsible for reporting relevant adverse drug reactions reported by patients to the Therapeutic Goods Administration (TGA) in accordance with its requirements and dictated by a range of related medication policies; most specifically the Healthscope policy: Adverse Drug Reactions – Reporting to the TGA (Therapeutic Goods Administration). No non-compliance issues have been identified. The private pharmacy provider also distributes medication alerts, safety notices and medication availability to staff as warranted.

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
BPH has processes to conduct medication reviews including requirements for documentation in accordance with Healthscope policies Obtaining the Best Practice Medication History, and the Medication Management Plan. The pharmacy service performs medication reviews for patients in accordance with best practice and evidence based policy and procedures. Medication reviews are prioritised for those patients who are over 65 years old, have more than 4 medications prescribed, are on high risk medication, and on the request of clinicians. When making alterations and notations the clinical pharmacist uses a purple pen to ensure clinicians identify the notations. Any errors noted in medication charts result in the creation of an incident report in RiskMan and managed through the risk management and quality improvement system. Action planning ensures improvements are made. A Pharmacy Referral Book has been introduced to facilitate medication reviews when criteria are met.

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
Patient information sheets from evidence based external sources, and in-house material that has been reviewed by consumers for ease of understanding are readily available to support clinicians in providing their patients with information about their individual needs and risks. This material includes policies regarding administration of Warfarin, oral medications and dispensing of discharge medications. Clinicians also have access to MIMS online (including training on how to locate and use the program) and Healthscope Library resources. The private pharmacy provider is also readily available to clinicians for advice and support, while the Antimicrobial Stewardship (AMS) Committee for the Eastern Cluster specifically supports clinicians in regard to the appropriate use of antimicrobials.

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
BPH has processes to generate a current medications list and provide it to receiving clinicians at transition of care (usually the patient's general practitioner) and to the patient on discharge. The pharmacist produces a reconciled discharge medication list together with any additional relevant written information which is discussed with the patient. The list includes information about new and existing medications including dosage, which may have changed or ceased. On discharge the patient is given a copy of the list. A copy is immediately forwarded to the patient's GP or residential care facility. Should care need to be transferred to another hospital the current medication chart and the Medication Management Plan is included with transfer documentation. Completion of the Nursing Discharge Summary and subsequent forwarding to the post-discharge care provider has been found to be near 100% compliance in recent years against a target of 85% according to monthly audits.

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
To support evidence-based best practice Healthscope provides easy on-line access to a wide range of resources including MIMS Online; TGA; the Australian Injectables Handbook and the Australian Medicines Handbook, plus many more, with centralised control to maintain their currency and a single source of truth. Clinicians also have access to Healthscope Library resources in HINT. As stated, the private pharmacy provider is also readily available to clinicians for advice and support, while the Antimicrobial Stewardship (AMS) Committee for the Eastern Cluster specifically supports clinicians in regard to the appropriate use of antimicrobials.

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
BPH complies with manufacturers' directions, legislation, and jurisdictional requirements for the safe and secure storage and distribution of medicines through a comprehensive range of governing policies maintained and monitored by Healthscope corporate. These policies are referenced to current evidence-based practice and direct the safe secure storage and distribution of medicines, storage of temperature-sensitive medicines and cold chain management, and disposal of unused, unwanted or expired medicines, including controlled drugs. All medications are stored in compliance with the Drugs, Poisons and Controlled Substances Act 1981 and Regulations 2017, and a Controlled Drug Register is maintained and monitored through regular audit. Medication, blood and vaccine fridges are monitored to ensure the cold chain is maintained, with systems in place should an issue arise. Monitoring was observed by assessors to be meticulous. Drugs were observed by assessors to be stored strictly in accordance with policy in swipe carded specific medication rooms with CCTV. Cleaning of these rooms took place under supervision. Completion of the new drug books was also found to be thorough, including the recording of discarded medicine. Tall Man lettering is in use.

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

Assessors observed several interactions relating to medication administration and nurses were found to be compliant with policy on every occasion. This is reflected in very small numbers of medication errors, particularly when two nurses are required to be involved in the process.

The hospital's risk register contains a number of well mitigated risks regarding the storage, distribution, and disposal of medicines.

Patients' own s8 medicines are stored in sealed, tamperproof bags in the drug cupboard – a new initiative at BPH.

Temperature sensitive medications are stored in specific medication refrigerators that alarm in the ward or department if the pre-set temperature parameters are exceeded. The pharmacist decides which, if any medications need to be discarded due to the cold chain breech. All cold chain breaches are documented and investigated with cost of discarded medications reported. A preventative maintenance program is in place to minimise the risk of incidents.

The pharmacist regularly checks imprest medications and re-distributes nearly expired drugs or disposes of them in accordance with policy. There is a receptacle for expired or discarded drugs in each clinical area which is collected by the pharmacist.

Rating	Applicable HSF IDs
Met	All

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

BPH identifies its high-risk medications and systems are in place to store, prescribe, dispense and administer them safely. Medication Safety: Governance is the overarching Healthscope policy guiding the use of high risk medications. The acronym APINCH is used across the entire organisation to guide clinical staff in the recognition of high risk medications. APINCH charts are prominently displayed in each medication room and on the wards as a staff reminder.

Some APINCH medications are subject to specific policies for their safe use and handling and have an alert attached to raise awareness of the associated risks. Other Healthscope policies in HINT specifically guide the management of Warfarin and Potassium Chloride; the storage of controlled drugs; and the security and custody of Schedule 4 drugs.

Any incidents relating to the management of APINCH medications are reported through the RiskMan incident management system, reviewed at the Medication Safety Committee – although no incidents have been reported in years.

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	
Numerous quality improvement initiatives have been introduced in recent years. They include a high-risk antibiotic register introduced in the Ward to monitor their use by the pharmacist; the introduction of Tall Man lettering for look-alike: sound alike medicines; and smart pumps with guardrails have been purchased to administer high risk medications. Codeine has been removed from ward stock storage.	
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
At BPH safety and quality systems have been implemented to support clinicians to deliver comprehensive care and minimise harm, congruent with the Clinical Governance Standard 1. Being a small health service comprehensive care is governed by the Quality Committee which oversights many of the clinical standards. The Quality Committee has clear roles and delegated responsibilities and provides scheduled reports via the Healthscope safety and quality hierarchy until aggregated results reach the Healthscope Board Safety and Quality subcommittee or in rare instances are reported individually as sentinel events. Members of the multidisciplinary workforce at Bellbird Private Hospital have areas of special interests for which they are champions, including pressure injury/wound management and falls prevention/harm minimisation. Healthscope corporate provides extensive support through standards clusters where ideas are discussed, issues raised and policy/procedures formulated. Policy and procedures are comprehensive, easy to locate and readily accessible to staff electronically. Most policies are developed at corporate level and apply to all hospitals in Healthscope; small numbers of local procedures have also been developed. The governance framework as described in Action 1.7 supports the development and control of such documents. Assessors conducted observational audits and had discussions with clinical staff throughout the assessment to validate that staff understand and practice within established policies and guidelines. A small number of risks relating to comprehensive care and patient harm are currently listed on the Bellbird Private Hospital risk register, being the risk of falls (due to its largely elderly patient cohort) and the potential for suicide/self-harm arising from inadequate assessment. These risks are regularly reviewed and are well mitigated, Training is provided to the clinical workforce at orientation to the health service and throughout each staff member's employment with emphasis in recent months on recognising and responding to cognitive impairment and assessing for deterioration in mental health. Such training may be provided through a range of formal and informal learning opportunities, although e-learning has been the most likely modality in the last two years due to limited staff on site due to the Covid pandemic. Stubbornly higher than benchmark falls also necessitates ongoing education so that nursing staff remain mindful of their responsibilities.

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	
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
Quality improvement methodologies are utilised to mitigate risks associated with patient harm and to monitor, respond to and evaluate care as described in Actions 1.8 -1.9. BPH complies with the Healthscope Annual Audit Schedule which is revised each year. Audits conducted, with subsequent results provided to the Quality Committee for monitoring, include the Minimising Patient Harm Audit; Falls Audit, Pressure Injury Prevention (PIP) Audit and the Venous Thrombo-embolism (VTE) Audit, all of which are used to assess the effectiveness and performance of the system. The Minimising Patient Harm audit specifically reviews compliance with completion of the Comprehensive Care Plan, the Daily Care Plan and with risk screening. Results of all audits are very pleasing, with high levels of compliance in completing documentation and very low incidents, with the exception of falls, which, as previously stated are stubbornly intransigent despite numerous interventions. There is a strong reporting culture at BPH in regard to incidents, which are entered in RiskMan, the electronic incident management system which allows individual incidents to be investigated and trended data to inform wider strategies for improvement. The number of patient incidents with serious outcomes has been at zero since 2019. Internal benchmarking occurs across hospitals of similar type and casemix so that comparisons are meaningful. BPH performs better on most Healthscope Clinical Indicator parameters except for falls, which have reduced year on year since 2017 but still remain slightly higher than industry benchmarks. Incident analysis, clinical and mortality and morbidity reviews coupled with patient feedback, are also utilised to monitor and measure the effectiveness of comprehensive care at BPH. Feedback on performance related to comprehensive care is provided through a series of performance quality and safety dashboard reports to the Board, Executive, clinical staff and operational committees. A quarterly Shared Learnings report is issued to facilitate risk management at BPH by applying lessons learned from incidents at other Healthscope hospitals. This allows clinical processes to be thoroughly reviewed and risks identified for active management. A number of quality improvements were provided as evidence of the application of shared learnings; the most notable being the implementation of the Comprehensive risk Assessment, inclusive of mental health history/concerns which was introduced in 2020.

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	
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	
A person-centred approach to care is adopted as referenced in the Standard 2 Partnering with consumer standard guided by several Healthscope policies and processes to involve patients in their own care, including the overarching policy 1.5 Consumers, Partnering With. Patients and their families are actively engaged in their care as evidenced by assessors both in conversations with them and by observing interactions at bedside handovers. Patient experience surveys rate their engagement and care delivery indices above the 90th percentile. A comprehensive education and information system in place, tailored to individual needs. Brochures are provided on a range of subjects; the Patient Information Booklet offers a wealth of information and the patient channel on each television is also a valuable source of support. Evaluation of information provided is conducted on a regular basis so that changes can be made to keep the information, and its delivery mechanism, current. Audit outcomes demonstrate the responsiveness of the system. Interpreters are available as required. Assessors note the invaluable service providing by Greek speaking staff members on the unexpected arrival of several Greek speaking aged care residents at the height of the pandemic in July 2020.	
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
BPH has systems to guide comprehensive clinical care. To support clinical staff in the development, documentation and communication of comprehensive plans BPH currently uses a paper based medical record that is supported by WebPAS. This provides clinicians with access to clinical information related to current and previous admission episodes, outpatient treatments, investigation results and alerts. Care assessment and planning documentation was observed to be used at bedside handover, in collaboration with the patient, to advise oncoming nursing staff of changes in patient condition or requirements as documented in the plan. An admission and exclusion policy, supported by pre-admission clinical review and assessment manages risks regarding safe care provision and ensures BPH operates within its capability. COVID-19 assessment is rigorous to avoid inappropriate admission. BPH has a ward structure that facilitates the accommodation of inpatients in two clinical areas that best meet their physical and other needs in a combination of single, double and four bedrooms with ensuite toilet and shower facilities. One ward is currently closed associated with COVID-19 restrictions. The rooms are bright and airy, allocated in accordance with patient wishes, where this can be accommodated, or in relation to clinical need, whether due to the need for transmission-based precautions or a calm, quiet and private environment. Day surgery structure allows for privacy in regard to taking of clinical histories and preparation for surgery, and for close observation during the recovery phase. Referral to specialist healthcare services is directed via local policies and facilitated through the comprehensive assessment process in collaboration with the patient's admitting medical officer. Every patient admitted to BPH has a clearly identified medical officer recorded in WebPAS who has overall accountability for their care, notwithstanding a team approach to the provision of patient care.

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
Multidisciplinary collaboration and teamwork are actively supported and evidenced across the organisation for those patients whose assessment profile warrants this approach. This is usually conducted as multidisciplinary meetings and case conferences with the active engagement of the patient and/or family. Clinicians work collaboratively, within the private health sector environment, in a primarily elective surgical facility to build and strengthen a strong team approach to the provision of comprehensive shared care when required. Assessors noted the range of structured interdisciplinary communication tools and processes in use at BPH that were supportive of teamwork. These included but the surgical safety checklists; structured clinical handovers, assessment processes and multidisciplinary meetings, the relevant elements of which are appropriately audited, and compliance noted to be near 100% in regard to conduct of Time Out, use of assessment tools and clinical handovers. The Patient Care Board at each bedside facilitates communication between patients and multidisciplinary care providers. The role and responsibility of each multidisciplinary team member is clearly defined.

Rating	Applicable HSF IDs
Met	All

ACTION 5.6
Clinicians work collaboratively to plan and deliver comprehensive care
Comments
Assessors observed clinicians working collaboratively to plan and deliver comprehensive care in accordance with processes outlined in 5.5a. and b. Patient engagement and shared decision-making was also evident, reinforced by very positive patient feedback in this regard.

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
A suite of policies governs the hospital's processes relevant to patients using the service, and services provided for integrated, timely screening and assessment. Policies address individual screening and assessment requirements for minimising patient harm. Supporting these policies is a raft of forms for documentation of screening and assessment outcomes, which trigger certain actions in accordance with the specific risk factor. COVID-19 screening has been routine since March 2020. Patients self-assess via an admission questionnaire, the Patient Health History, in the first instance; this is confirmed or amended by the pre-admission nurse for patients whose self-assessment points to higher clinical risk at a pre-admission clinic. All other patients are contacted on the night before admission for surgery where the after-hours coordinator can address any health concerns. Comprehensive screening and assessments by the VMO and the admitting nurse complete the admission; ongoing assessments occur dependent upon outcomes at the initial assessment phase in line with policy directives. Assessors were advised of a number of improvements made in regard to systems to screen and assess patients. They include management of oral hypoglycaemic agents and pre-admission ceasing of SGLT2 inhibitors for diabetic patients. Alerts are entered on the Alert Sheet at the front of the history and in webPAS. Action 5.7 is the subject to the ACSQHC advisory - AS18/14 Comprehensive care standard: screening and assessment for the risk of harm. At assessment all requirements for this Advisory have been met.

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	
Processes have been implemented to ensure all ATSI persons are identified at point of entry into the service and documented into the electronic clinical and administrative datasets. Compliance with documentation is very high through routine measurement of this indicator, increasing from 84% in 2020 to 93% in 2021. All staff undergo education to improve cultural competency and to explain to patients the reason for asking ATSI originality of everyone. Staff also have access to the Commission's resources in this regard via direct link on the Healthscope Internet. Support is available for those who identify as ATSI should they require it for complex care needs.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.9	
Patients are supported to document clear advance care plans	
Comments	
Healthscope policy 2.56 Advanced Care Directive can be accessed via HINT on the Intranet to support patients in documenting clear advance care plans. BPH has an additional local policy informing staff on how to manage patients who already have an ACD. Information is provided as a brochure 'Advanced Care Directive' located in the Patient Information Display Board in each clinical area, and in the Last Days of Life toolkit. Patients can be referred to a social worker should they wish to develop an ACD while an in-patient. ACDs are located in the medical record behind the Alert Sheet, on which its presence is identified. If a patient has a Met Call or Code Blue whilst in hospital, ongoing treatment in accordance with their wishes (and the ACD if present) is documented on the Medical Orders for Life Sustaining Treatment (MOLST) Form to guide ongoing care.	
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
At BPH clinicians screen patients on contact with the hospital for elective surgical procedures and on presentation in the case of transfer from other local hospitals. Screening includes both physical parameters, and a range of cognitive, behavioural and mental health issues. Social and other circumstances which may impact on care are also interrogated. The requirement to screen and the circumstances under which this occurs is defined in a series of policies specific to each screening process. Policies identify when to screen and follow up required and relate directly to policies on care planning and care delivery. Screening commences on entry in accordance with Healthscope policy 2.65 Admission of a patient – Acute Medical/Surgical Hospital which comprehensively covers taking of a patient health history, screening requirements and physical examination. Results are recorded on the various tools which contain decision support in regard to the need for, and parameters of further assessment. Compliance with policies guiding admission screening and assessment processes as identified on the regular audit schedule has grown in recent years to almost 100%.

Rating	Applicable HSF IDs
Met	All

ACTION 5.11
Clinicians comprehensively assess the conditions and risks identified through the screening process
Comments
Comprehensive assessment for conditions and risks identified during the screening process is undertaken in response to a series of defined triggers which flag that more detailed review is required. As in screening, clinical assessment is clearly defined in extensive policies, and a new comprehensive screening tool, released in 2021, now brings all assessments into one document which makes initial screening and assessment much more streamlined. Decision support arising from assessment findings clearly define ongoing assessment and care planning/delivery requirements, as well as referral to appropriate care providers. Assessments are structured, multidisciplinary where required, and information generated from the assessment is used to determine patient's individual, risk-based healthcare needs and appropriate treatment options. Reassessment occurs at predetermined intervals although audits show that when regular re-assessment is required e.g., Weekly for patients in hospital for lengthy periods of time, nursing staff are less likely to complete the assessment as per policy. Nevertheless, despite this remaining below benchmark, year on year improvement is noted and new assessment tools now in use highlight the need for re-assessment more effectively.

ACTION 5.11
Clinicians comprehensively assess the conditions and risks identified through the screening process
Elements of these process are individually evaluated in accordance with the clinical audit schedule which is very comprehensive. Audit results are reported and actioned at the Quality Committee through formal action plans if outcomes fall short of expected performance. Training is provided to the clinical workforce at point of entry into the health service and throughout the period of employment. Such training is provided through a range of formal and opportunistic learning opportunities and is ongoing. Most recently education has concentrated on screening and assessment of cognitive impairment, including delirium, behavioural and mental health issues. Action 5.10 is subject to the ACSQHC advisory - AS18/14 Comprehensive care standard: screening and assessment for the risk of harm. Assessors found that requirements for meeting AS 18/04 have been met.

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
Clinicians document screening and clinical assessment findings, including any relevant alerts, in the medical record. The audit plan identifies several key points for audit to monitor compliance with the broad range of policies referring to screening and assessment. Audit outcomes relating specifically to documentation of findings are consistently high at present, being at or near, 100% compliance across most parameters associated with concerted educational efforts. Areas for continued effort include completion of malnutrition risk screening, documentation of name/signature of nurse completing the assessment, and weekly re-assessment, which falls short most significantly, but shows year on year improvement. Nursing staff expressed general satisfaction with the enhanced utility and simplification of the screening and assessment system.

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
Clinicians use processes for shared care decision making to develop and document a comprehensive and individualised care plan. Care planning at BPH commences at pre-admission and is based upon assessment of the patient from which an individualised care plan is commenced. Pro forma documentation (the Healthscope Patient Care Plan) is used to guide comprehensive care in accordance with Healthscope policy Care Planning and Evaluation and local BPH supporting policies. A case management approach is adopted for patients with more complex needs through a twice-weekly multidisciplinary case-mix meeting. Family meetings are also used to facilitate effective care planning. Throughout the assessment period it was noticeable that patients and their nominated support persons are actively engaged in their care. Patient feedback indicates that patients feel very well informed about their care and are involved in decisions made about treatment and care. Discharge planning commences prior to or on admission in collaboration with the patient's VMO and includes documentation of the patient's expected length of stay, discharge destination and referral to additional discharge support services as required. Assessors observed that discharge is actively managed across the care continuum and all patients who spoke with them were aware of their expected discharge date. Agreed goals of care, including functional and clinical goals, are clearly defined. Assessors note an improvement activity in this regard arising from poor compliance with completing this section of the care plan where staff were provided with education on 'What Matters to Me' together with a new tool to capture patient goals more effectively. The care plan includes referral to a range of post-discharge specialist or support services as warranted. Action 5.13 is subject to the ACSQHC advisory AS18/15 Comprehensive Care standard: Developing the Comprehensive Care Plan. Assessors noted that actions addressing the requirements for the January 2021 timeframe have been completed and the Advisory is considered met.

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
At BPH nursing staff complete education care planning and care delivery, most recently in regard to the introduction of the new Healthscope Comprehensive Care Plan, and the extensive list of Healthscope policies related to care planning and provision, including clinical deterioration. These policies articulate the key components of individualised care planning and staff members' responsibilities to provide care in partnership with patients and their families. In order to assess the provision of comprehensive care at BPH assessors attended each clinical area, spoke to a range of patients and several staff and observed a number of clinical interactions. Several medical records were also reviewed. Patients were united in their view that they were always consulted regarding their care plan, their goals of care, and the care delivered. The key clinical communication tool supporting the development and monitoring of comprehensive care plans is the paper based medical record, specifically the newly introduced Healthscope Comprehensive Care Plan. Documentation in the medical record includes clinical history, physical examination, risk assessment, treatment plans (inclusive of patient goals) and discharge planning. Progress notes are used by clinicians to record changes in the patient's condition or wishes and any modifications to the treatment plan. Monitoring the effectiveness of the comprehensive care plan for individual patients occurs in several ways at BPH. Review occurs during the VMO's round; bedside clinical handovers, hourly rounding, multidisciplinary meetings and family meetings, in addition to regular assessment of the patient's condition through the taking of clinical observations and conducting and repeated risk assessments. Information collected on Patient information Boards at each bedside may also communicate important information. Incidents relating to patient care delivery are recorded in RiskMan where they are analysed. Any recommendations arising from analysis of individual incidents or in trends are monitored through the Quality Committee via Action Plans. Patient observations are recorded and monitored using standard adult observation charts in track and trigger format to recognise early signs of clinical deterioration. Changes detected as part of regular observations and rounding, in response to patient/family concerns or a clinical incident such as a fall, may escalate care to a MET call A review of the care plan occurs following an escalation in patient care that results in a clinical review or a MET call. A review also occurs where there are changes in the patient's clinical condition or following a clinical incident, such as a fall. Abnormal or unexpected pathology or medical imaging results or clinical observations also trigger a review of the patient's condition and possible alterations to the care plan. Processes to escalate care where the patient has mental health or behavioural issues are also in place and nurses are now trained to detect changes through the various assessment processes and to escalate care appropriately, although careful pre-admission screening means that this is a very unlikely risk.

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
Assessors found that BPH has well established systems in place to monitor the clinical care that patients receive, and to adapt comprehensive care plans as warranted by changes in condition or patient wishes.

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
Healthscope has comprehensive processes to identify patients who are at end of life consistent with the National Consensus Statement: Essential elements for safe and high-quality end of life care which extends across all of its hospitals articulated in the Last Days of Life Care toolkit, which contains beautifully presented resources for use by patients, families and the clinical workforce, and references work undertaken by the Clinical Excellence Commission. Comprehensive policies, assessment forms and related audit tools underpin end of life care and are used to monitor outcomes through the Quality Committee. All deaths in the organisation are reviewed through the Morbidity and Mortality Committee. There is a strong commitment to the education of staff through direct care conversations, and unit-based education sessions. Clinicians support consumers and carers to make decisions about end of life. Systems are in place to support staff in the event of a death. While deaths at BPH are uncommon, 2020 saw 18 aged care residents unexpectedly transferred to hospital care where several patients died, testing this support system and how the hospital cares for patients at the end of life.

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	
Assessors observed that BPH has processes in place for clinicians to access specialist palliative care advice through Healthscope policy and its Last Days of Life Toolkit, which provides care and treatment guidelines. A number of palliative care specialists in the local area are also available for referral. Additionally, a social work service which can be accessed at any time is available to address any concerns a patient or family member may have, including creation of an Advance Care Directive (ACD). Healthscope policies also reference voluntary assisted dying via Policy 8.98 which assists patients in making end of life decisions and referral to palliative care experts if requested.	
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	
Processes are in place to ensure current advance care directives (ACD) can be received from patients as described in Healthscope policy 2.56 Advance Care Directives. ACDs are placed in the medical record behind the Alert Sheet, where their presence is acknowledged so that staff are aware. This is also communicated at each clinical handover. Social workers are readily available to assist patients in developing an ACD should they wish.	
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	
The clinical workforce has access to supervision and support through the Healthscope Employee Assistance Program (EAP). Team debriefing sessions and social work counselling sessions are also available to staff who care for dying patients.	
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	
BPH has processes for routinely reviewing the safety and quality of end of life care provided against planned goals of care where all deaths in the organisation are reviewed in accordance with the Healthscope Risk Management policy. Identified failures in care are evaluated through RiskMan, the incident management system, while routine review occurs via the annual mortality audit which considers contributing factors, clinical care provided, end of life decision-making conflicts and whether the medical order for life sustaining treatment (MOLST) was in place to guide care in accordance with the patient's wishes.	
Suggestion(s) for Improvement	
Assessors suggest that after a period of time BPH contacts the family of deceased patients and elicits from them whether their loved one's death met their and the deceased person's wishes regarding a perceived good death.	
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
Clinicians support consumers, carers and families to make shared decisions about end-of-life care through the use of the Healthscope Last Days of Life Care Toolkit which references the Clinical Excellence Commission, the Guys and St Thomas NHS Foundation Trust Amber Care Bundle and is consistent with the National Consensus Statement. Whilst formal evidence of this is lacking, every patient who spoke with assessors indicated they felt very involved in their care and in regard to shared decision making which is supported by formal customer feedback in this regard.

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
Governance of pressure injury and prevention management is through the Healthscope policy: Pressure injury – Prevention, identification and management of, together with policies regarding diet and nutrition and consent for photography in the event that photos are taken of wounds for monitoring of healing. Evidence based guidelines are in use to guide staff in the care and management of patients at risk of pressure injury, or who are admitted with an existing pressure injury using validated age-related screening and assessment tools. The system is well structured, comprehensive and accessible to staff. The use of, and compliance with the requirements of the policy are monitored through a range of scheduled audit activities Outcomes are reported to the governing body via a performance dashboard and BPH is currently at zero hospital acquired pressure injuries in 2021 ytd. Pressure injury prevention is monitored by the BPH Quality Committee through the audit process and through review of incidents in RiskMan due to a requirement to record all breaches of skin integrity whether identified on admission or are hospital acquired. Audit outcomes are displayed on Quality Boards throughout the organisation in patient areas where they can be seen by patients, visitors and staff. A highly regarded wound management nurse collaborates with the patient's VMO and provides support and advice in the ward and further expert advice is available through the Healthscope Eastern Cluster.

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	
Nurses providing care to patients at risk of developing a pressure injury are required to comply with Healthscope policy relating to compliance with completion of screening and assessment tools (including re-assessment) including skin inspections. Time frames and frequency are prescribed in the policy. Assessors note increasingly high compliance with completion of the Healthscope Risk Assessment tool which is now above benchmark requirements. The system has been strengthened through a range of improvement initiatives which include staff education in wound care; ongoing training in recognising the loss of skin integrity classification and management, and increased awareness of pressure injury staging.	
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	
Comprehensive education is provided to patients and carers regarding the importance of skin integrity and preventing pressure injury. This is provided conversationally at point of care across the care continuum, through the provision of printed materials in the patient information booklet, on the Healthscope TV channel and the My Healthscope website. Assessors learned from patients that staff were diligent in reinforcing pressure injury prevention information and felt very involved in their own care.	

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	
A wide range of pressure relieving products, equipment and devices is available and well used to prevent pressure injuries at BPH. Audits on inventory are regularly completed and new products purchased as required. An example of the purchase of new air mattresses was provided to illustrate ongoing investment. Storage of equipment is regulated and easy to access. Staff are trained in its use. Assessors noted that equipment appeared plentiful, was well maintained and in use extensively in the ward.	
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
Organisational response to falls prevention and minimising harm from falls mirrors that of pressure injury prevention and management. Comprehensive policies and assessment tools guide evidence-based practice and are designed to support staff in the prevention and care of persons at risk of falling. Age related validated screening and assessment tools are commenced on admission and used across the care continuum as described in the policy. Careful patient history is taken either before or on admission, with involvement of the patient and family in establishing the level of risk of falling, supported by application of the falls risk assessment section of the new Comprehensive Risk Screening tool. Numerous initiatives are in place to minimise risks from falls. BPH is represented on the Webex Fall Prevention Team which is a rich source of helpful interventions for fall reduction, and it participates in falls prevention research. There is early referral to physiotherapists when a high falls risk is identified. High falls risk patients are admitted to specified High Falls Risk rooms which can be closely observed by nursing staff and where low level beds are in use. Unexplained confusion or disorientation is investigated for underlying cause and medication review takes place. Sensor mats are in place. Regular rounding is meticulous with frequent toileting. Assessors note many additional improvement initiatives implemented throughout 2020 and 2021 as the hospital continues its efforts to reduce its fall rates. Every fall no matter how minor is entered into RiskMan and comprehensively investigated. Local learnings from such investigations are applied as warranted; additionally, Healthscope Shared Learnings are incorporated into local practice where relevant. When a patient falls careful assessment for injury is performed and the care plan amended in consultation with the patient, family and VMO.

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	
Compliance with policy is monitored through a range of scheduled audit activities including bedside safety audits. Audit outcomes inform BPH's clinical performance dashboard which is monitored by the Quality Committee and reported regularly to the governing body. The board takes great interest in this particular indicator because harm from hospital acquired injuries such as falls remains a significant risk to the organisation and investment in falls reduction strategy is high. Assessor observations during the assessment period confirmed active application of falls prevention strategies in accordance with planned 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	
A comprehensive range of falls prevention equipment and devices is readily available on the ward and all staff are aware of their availability and trained in their use. Environmental adjustments are to mitigate the patient's risk of falling as required. Bed maintenance is the responsibility of the maintenance service and is undertaken on an annual basis. Patient mobility aides, and sensor mats are available for use. Physiotherapists are active in all cases where a falls risk has been identified.	
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
As with pressure injury prevention, comprehensive education is provided to patients and carers regarding the importance of falls prevention and harm minimisation. Nurses reinforce good practice in conversations at point of care across the care continuum, information exchange occurs through the provision of printed materials in the patient information booklet, on the Healthscope TV channel and the My Healthscope website. Assessors learned from patients that staff were diligent in reinforcing falls and falls injury prevention information and felt very involved in their own care. All patients were aware of initiatives such as the need to use mobility aids; wearing of grip socks and to call for assistance when getting out of bed or ambulating if they are a designated falls risk. Educational opportunities such as April Falls Day are promoted to patients and staff.

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
Healthscope supports the hospitals in its fleet to appropriately manage nutrition and hydration in accordance with best practice through its policies: Diet and Nutrition-adult patient; Fluid Balance Charts and Enteral feeding via PEG and supporting screening and assessment tools in the Comprehensive Screening Tool. Decision support arising from screening and assessment triggers referral to a dietitian so that an individualised nutrition care plan can be introduced and its effects monitored. These policies provide operational support for staff optimising nutrition and hydration to promote wellbeing, recovery and the prevention of malnutrition and metabolic disorders, and are informed by Best Practice guidelines. A local policy relating to the management of dysphagia is also in use. All patients are screened before or at admission using the Healthscope Malnutrition Screening tool (MST) alongside a comprehensive history regarding food allergies, sensitivities and cultural preferences. Relevant information is transferred to the Alert sheet and webPAS. The catering manager is advised of specific dietary requirements at the daily bed meeting and conducts a round to discuss special needs with individual patients.

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
Referral to a dietitian occurs when triggered by the MST so that an individualised nutrition care plan can be developed. Compliance with completion of the MST by nursing staff is excellent and there have been no incidents of malnutrition in recent years. In fact, during the COVID-19 pandemic in 2020 when several residents from a residential aged care facility transferred to BPH unexpectedly, their condition and malnutrition assessments improved during their stay. The only area of concern relates to continued weekly re-assessment and BPH is actively managing this indicator through a monitored action plan. A dedicated kitchen with a current food safety certification prepares fresh meals for all patients and dietary requirements. Food and nutrition services are provided by appropriately trained staff with clear roles and responsibilities assigned according to role delegations and scope of practice. Skills development training sessions are attended on a needs basis on components of the food and hydration system.

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
The system supporting nutrition and hydration is monitored through a range of performance measures, incident analysis, clinical reviews and patient feedback. All patients are screened before or at admission using the Healthscope Malnutrition Screening tool (MST) alongside a comprehensive history regarding food allergies, sensitivities and cultural preferences. Relevant information is transferred to the Alert sheet and WebPAS. The catering manager is advised of specific dietary requirements at the daily bed meeting and conducts a round to discuss special needs with individual patients. Referral to a dietitian occurs when triggered by the MST so that an individualised nutrition care plan can be developed. Compliance with completion of the MST by nursing staff is excellent and there have been no incidents of malnutrition in recent years. In fact, during the COVID-19 pandemic in 2020 when several residents from a residential aged care facility transferred to BPH unexpectedly, their condition and malnutrition assessments improved during their stay. The only area of concern relates to continued weekly re-assessment and BPH is actively managing this indicator through a monitored action plan.

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
A dedicated kitchen with a current food safety certification prepares fresh meals for all patients and dietary requirements. Food and nutrition services are provided by appropriately trained staff with clear roles and responsibilities assigned according to role delegations and scope of practice. Skills development training sessions are attended on a needs basis on components of the food and hydration system. Nutrition related incidents are reported in RiskMan from where they are analysed and action taken to improve where appropriate. No events have been identified in recent years, but it is expected that results would be communicated across the organisation through meetings and quality displays. Several improvement Initiatives to improve the nutritional status and reduce the incidence of malnutrition of persons have been introduced. Fasting times in theatre are actively managed to minimise risks of lengthy fasting and cooks have had allergen training. Consumer feedback of the service and food quality is very positive, reinforced by conversations with patients during the assessment.

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
Systems are in place to identify and manage persons with cognitive impairment or who are at risk of delirium. The system comprises policies, screening and assessment tools, preventive strategies and management, all of which are aligned to the Delirium Clinical Care standard. Primary risk assessment for cognitive impairment (CIRAT) is part of the new Comprehensive Risk Screen which requires application of the 4AT Assessment Test for Delirium and Cognitive Impairment if indicated by initial screening, for all overnight patients. An Alert is entered in WebPAS and on the Alert Sheet in the front of the medical record to inform staff at the point of care. Family/carer consultation takes place to gather enough information to provide safe care as they may know both trigger points and de-escalation measures which will calm and reassure the patient. Family members may assist in clinical care and activities of daily living if they choose.

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
Information relating to this consultation is recorded on the Family/Carer Consultation form to guide staff when the family is not available. A Behaviour Chart is also part of effective care planning and delivery to objectively monitor the degree of impairment and interventions in place. In some instances, patients may be required to have close supervision 'specialling' for which the Specialling Care Record is completed. Clinical staff are well trained in regard to recognising and managing delirium and cognitive impairment via the Cognition and Delirium Clinical Management Toolkit and learn to de-escalate situations where there is a risk of aggression and violence through compulsory WAVE training. A Delirium Education package was delivered this year to all clinical staff. Audits demonstrate high compliance with completing the CIRAT and 4AT assessment. Incidents related to cognitive impairment are reported in RiskMan where they are analysed and changes made to processes if required. The use of psychoactive and antipsychotic medications is well managed in accordance with legislation. A medication risk assessment is taken on admission and patient taking these classifications of drugs are referred to the pharmacist in conjunction with the VMO. A multidisciplinary approach is taken to monitor patients in regard to their medications and pharmacists are available to provide staff with education in this regard.

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	
Assessors observed nursing staff using the system for providing care for patients with cognitive impairment. All patients over 65 were screened, and the 4AT risk assessment completed for those with two or more positive indicators on the CIRAT. Behaviour charts were in use, informed by Family Carer Consultation forms. Specialling was in place and the Specialling Care Record completed. Nurses indicated they felt much more prepared to care for patients with cognitive impairment following the education provided, and the guidance provided by the toolkit and flowcharts. Initiatives to improve the management of persons with cognitive impairment and reduce harm associated with cognitive impairment were in evidence in the ward. These included regular rounding with reorientation, music therapy, environmental adaptation, and the use of diversion and distraction aids with individualised Diversion and Distraction Boxes available. Nursing staff collaborate with patients, carers and families to understand the patient and implement individualised strategies to minimise distress. These are documented on the Family/Carer Consultation Form. Comfort items may accompany the patient and assessors observed staff being very accommodating in regard to this. In the event of an episode of aggression or violence associated with cognitive impairment or delirium, the patient's VMO is notified to conduct a clinical examination for contributing factors. Referral is available to a geriatrician or social worker. The Healthscope Cognitive Impairment Brochure is available for patients, families and carers if their understanding of the condition is low.	
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
BPH has systems to support collaboration with patients and carers in regard to risks of self-harm and suicide, and to respond to patients who may be at risk. While comprehensive Healthscope policies govern this area of concern BPH does not provide mental health services and has local policy relating to Admission Exclusion criteria (whereby only low risk patients can be admitted to the facility) and a Medical Emergency policy to assist staff in emergency management should a patient express self-harm or suicidal ideation. Mental health screening is part of the pre-admission/admission process so that only patients with a low risk of mental health deterioration are admitted. If a patient is under the care of a psychiatrist, contact details are recorded. This is also recorded as an Alert on the Alert Sheet in the Medical Record and in webPAS. In the very rare event that a patient expresses self-harm or suicidal ideation the Medical Emergency Management Policy is followed whereby the patient, in consultation with the VMO, is transferred to a facility for care in a safer, more suitable environment with expert mental health professionals available. Clinical staff undergo training in regard to workplace aggression and violence and emergency procedures. Assessors suggest that given the increasing level of mental illness in the community staff may also benefit from further education to increase awareness and capability in the identification and management of persons at risk of self-harm or suicide should a patient experience a sudden deterioration in mental health or who is awaiting transfer.
Suggestion(s) for Improvement
Assessors suggest that given the increasing level of mental illness in the community staff may also benefit from further education to increase awareness and capability in the identification and management of persons at risk of self-harm or suicide should a patient experience a sudden deterioration in mental health or who is awaiting transfer.

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	
BPH does not provide care for patients who are acutely unwell from mental illness. In the event that a patient receives care for a surgical procedure, the hospital may facilitate follow up care such as referral to a social worker, or discharge home or to residential aged care to a familiar environment as soon as can be safely arranged. In the rare event of acute deterioration, the Medical Emergency policy may be followed. A MetCall may be instituted to rapidly review the patient and in collaboration with the patient's VMO arrange transfer to an Emergency Department with mental health facilities or an alternative environment. The event is reported in RiskMan for analysis and review to examine the circumstances and care provided.	
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
BPH has processes to identify and mitigate situations that may precipitate aggression. Healthscope policies guide processes which include careful patient selection through the hospital's capability framework – Admission exclusion criteria, whereby only patients at low clinical risk are admitted; and through comprehensive screening through the Comprehensive Screening Tool to identify patients with cognitive impairment or who are at risk of delirium and patient history taking as per the Healthscope Admission of Patients – Acute Medical/surgical hospital policy. Staff are trained to screen for specific risks and predictive factors, which include previous history of aggression and violence, intoxication and withdrawal of substances including tobacco and cognitive impairment. The identification of potential aggressive and/or challenging behaviours identified during preadmission screening, on admission or through the episode of care and are recorded on the Alert Sheet and in webPAS. A newly developed Alert symbol is displayed near the patient's room to warn staff of a previous episode of aggression or violence. All staff are mandated to complete Workplace Aggression and Violence Education (WAVE) and the hospital has an active complaints response process and a range of security measures in place. Staff are trained in de-escalation to reduce risks in situations where violence and aggression are possible. Training rates indicate 100% compliance.

ACTION 5.33	
The health service organisation has processes to identify and mitigate situations that may precipitate aggression	
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	
The hospital has processes to support collaboration with patients, carers and families to identify patients at risk of becoming aggressive or violent, implement de-escalation strategies and safely manage aggression. The identification of potential aggressive and/or challenging behaviours identified during pre-admission screening, on admission or through the episode of care and are recorded on the Alert Sheet and in webPAS. Carers and family are actively engaged to develop a care plan which best meets the patient's needs including the use of diversional therapies (see 5.29). As per 5.33 all staff complete Workplace Aggression and Violence Education (WAVE) and are trained in de-escalation to reduce risks in situations where violence and aggression are possible. Training rates indicate 100% compliance. In accordance with the Restrictive Practice policy, in the event of an episode of aggression or violence, the VMO is notified to conduct an examination to identify a contributing factor, the treatment of which may reduce the risk. Referral may be made to a geriatrician, social worker, or rarely, the police who are quick to respond.	
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	
Healthscope policy 8.95 Restrictive Practices – Patient Restraint governs BPH management in this regard. The policy calls for minimisation of restrictive practice, defines the practices authorised and the mechanism for reporting and monitoring. Episodes of restraint must be documented in RiskMan where they are reviewed against policy 8.95. Incidents of restraint are negligible attesting the effectiveness of alternative nursing care practices.	
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	
Bellbird Private Hospital is not a public gazetted Mental Health facility and does not have seclusion rooms or use seclusion.	
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	
BPH uses safety and quality systems in regard to communicating for safety oversighted by the Quality Committee. Healthscope (HSP) policies are comprehensive and guide a standardised approach to effective clinical communication. Local standard operating procedures (SOP) supplement corporate policies to suit local circumstances. Policies are regularly updated and are easily accessed through HINT on the intranet. Assessors were provided with examples of how risks with clinical communication are managed. Risks associated with clinical communication are included on the risk register. Of particular importance to BPH is the fact that there are many transfers between the hospital and the large acute partner hospital in the Eastern Cluster where clear communication is essential to safe care. Training and education in regard to communicating for safety is comprehensive, commencing at orientation and ongoing thereafter. Emphasis has been placed on ensuring the ISBAR tool underpins clinical communication and on strengthening bedside handover. Compliance with related education is 100%.	
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
BPH applies quality improvement processes in relation to communicating for safety. Effectiveness is monitored through a range of observational audits, documentation reviews and examination of the use of various communication tools. Audit outcomes show steady progress in compliance with the various policies, especially relating to clinical handover, where emphasis has been placed in recent months. Compliance with completion of the Surgical Safety Checklist (SSCL – 'Time Out') in the Operating Suite consistently shows almost 100% compliance. Nurses were able to describe several quality improvement projects related to communicating for safety. They included introduction of Patient Care Boards near each patient's bedside; projects concentrating on each element of bedside handover such as patient identification; and telephone orders. BPH also has a number of safety tools in place including Inter Hospital transfer forms. Any incident relating to Communicating for Safety are reported into RiskMan for investigation and analysis. All clinical incidents are reviewed to identify whether ineffective communication was a factor in the incident occurring. Incidents and trends are discussed with managers and at ward/department meetings and are referred upwards through the HSP hierarchy via the safety and quality dashboard for trended data or via the clinical review process when a serious incident has occurred. The educator develops and rolls out training as a result of any learnings from clinical reviews or incident reporting. Review of meeting Minutes and quality improvement action plans and reports, together with assessor observations of clinical handovers and Team Time Out verify that this action is met.

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
BPH communicates effectively with patients, carers and families especially during high-risk situations. Poignant examples of this were provided in regard to the unplanned transfer of 18 residents (some of whom were infected with COVID-19) from a hastily closed down aged care facility in July 2020. These patients arrived with little notice and without any information. Families were frantic trying to track down their loved ones who had been moved without consultation to multiple hospitals across Melbourne. BPH developed a plan to assess patients and communicate extensively with family members, who expressed profound gratitude for this. Particularly relevant was establishing the end-of-life plans for these residents, some of whom died during their stay at BPH. In general, BPH complies with several HSP policies relating to partnering with consumers and communicating for safety. Especially relevant to patients are those relating to bedside clinical handover, use of patient care boards and how to communicate clinical deterioration. Formal feedback from patients indicates that these elements are very effectively communicated and that patients feel actively involved in their care. They expressed satisfaction with the amount of information provided, and that shared decision-making took place. Assessors observed a number of interactions supportive of these positive feedback outcomes. BPH encourages carers/families to participate in bed-side handovers (although this has not been possible in recent times). Current clinical information is communicated to maintain continuity of care with the patient's knowledge and consent.

Rating	Applicable HSF IDs
Met	All

ACTION 6.4	
The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes	
Comments	
BPH has clinical communication processes to support effective communication in compliance with related HSP policies,15 local policies and medical record tools. Assessors witnessed a number of bedside clinical handovers where patient Identification in accordance with policy occurred. Observation of a patient journey by assessors noted several touch points where effective communication occurred; from day surgery admission, to holding bay; from holding bay to the operating theatre; from theatre to recovery, and from recovery to discharge. In this situation all staff and VMO's followed established handover procedures, and were able to demonstrate the requirements of the policy and protocols regarding communication. Procedure matching, and site marking appeared to be an embedded practice. Patient identification was meticulous. BPH uses ISBAR methodology as its primary communication tool which is particularly useful in communicating critical information as is frequently required when patients are transferred from the large acute partner hospital nearby. Audits demonstrate that transfer documentation follows policy and is comprehensively completed. An example of effective communication occurred through comprehensive transfer documentation when aged care residents returned to their facility after some weeks in July 2020.	
Rating	**Applicable HSF IDs**
Met	All

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	
HSP has a suite of policies to govern the patient identification system supported by local policies together with numerous HSP forms to assist with BPH patient identification requirements. Compliance with these polices is subject to audit and noted to be very high. The webPAS Patient Information System prints the arm band labels with four patient identifiers. Patient identification audits include both observational and retrospective audits with BPH Time Out audits in 2020 and 2021 demonstrating 100% compliance. The Consumer information video was noted to include information patient identification and procedure matching processes. Assessors found that patients, family and carers could verbalise the rationale for why they are asked the same questions numerous times and the safety reasons why. Assessors also witnessed clinicians using the approved identifiers whenever care, treatment or medication was provided. Assessors followed a patient journey through the operating suite for correct identification and procedure matching. During the patient journey, three approved identifiers were used from admission to the service and throughout the numerous clinical handovers, to ensure the patient received the care intended for them. The Surgical Safety Checklist was observed and utilised appropriately for time out before the procedure, with all team members attending and listening throughout.	
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
Processes to match patients to their car and the documentation required are in place with BPH monitoring compliance to policy within the annual audit schedule. Any audit result not achieving target requires an action plan and the audit is then rescheduled. The HSP Patient Identification Policy outlines the requirements regarding the types of identification required during clinical communication and the use of approved identifiers prior to administering medication or commencing therapy, intervention, investigation or procedure, including diagnostic and interventional areas. Processes for Team Time Out by the surgical team through the Surgical Safety Checklist are in place and assessors had the opportunity to witness this in practice. The ISBAR format was in use at all handovers and observed in practice. During all stages of the process observed, there was thorough checking and effective clinical handover practice to ensure that correct identification and procedures took place.

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
BPH complies with HSP policies with the Clinical Handover framework identifying the participants to be involved in handover and the 13 occasions for handover. The clinical handover follows a standardised approach using ISBAR methodology to optimise communication minimise omissions and reduce risks. The clinical handover communicates the transfer of a minimum data set that includes but not limited to clinical diagnosis, relevant past history and current clinical and risk status. Policy encourages family members and carers to contribute to the clinical handover if the patient wishes. Unfortunately, the COVID-19 restrictions currently in place hamper this taking place but the organisation acknowledges its value.

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
The structured clinical handover at BPH ensures that preparation and scheduling of clinical handover is regulated and that relevant clinicians are present. Clinicians provide support for all patients, carers/families to be present when this is possible and to be involved and contribute. The observational audits that are conducted measure all aspects of the formalised clinical handover and what is required to be handed over when transferring the responsibility and accountability of care to another group or clinician. Patient goals are communicated in collaboration, where possible, with the patient, and confirmed on the Patient Care Board which is updated as required. The process is guided by policy and tools standardised across HSP.

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
Staff have access to both HSP and local policies relating to communication of critical information, and to supporting tools such as the intra-hospital transfer form. HSP Bylaws 2018 section 232 states that: Each Accredited health practitioner is responsible for the care and treatment of their privately admitted patients. All clinical staff are aware that the VMO is responsible for making decisions regarding care in accordance with the wishes of the patient and family. A system is in place if this process fails due to unforeseen circumstances. Medical records are available at the point of care for contemporaneous entries to be documented to effectively communicate when any change/s are made. In regard to clinical handover of critical information, short and concise safety huddles are performed at the beginning of the shift to transfer critical information to the whole team. This is followed up by a more specific bedside clinical handover between direct carers which includes feedback or concerns raised by patients, family or carers. Documented alerts and allergies are checked and noted by staff. Risks such as falls, skin integrity and nutritional requirements were also observed to be discussed at the bedside.

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	
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	
BPH ensures that there are communication processes for patients, families and carers to convey critical information and risks about care to clinical staff. The hospital has a robust bedside handover process, which incorporates clinical introduction, shift to shift communication, checking of charts, medications and equipment and checking in with the patient, family or carer if there are any issues. Mechanisms are verbally explained to the patient, carers/families on admission and are provided in written format in the patient bedside information folder and displayed in public areas throughout the facility. Assessors observed these mechanisms reiterated at each clinical handover.	
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	
BPH clinical staff have access to many HSP policies and receive ongoing education to ensure there is continuous quality improvement in the documentation of appropriate information in the medical record. Document requirements include critical information, risks and alerts, outcomes of ongoing re-assessment and changes to the care plan. BPH participates in the mandated annual HSP documentation audit with this audit tool currently under review. Action plans are developed for those sites that have identified areas of non-compliance. BPH audit results were available for the assessment team for 2019/2020 with some areas for improvement identified in regard to the outcome of ongoing re-assessment.	
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	
At BPH clinicians use quality systems from the Clinical Governance Standard when implementing and reviewing evidence-based policies and procedures, managing risks through the risk management system and providing staff with access to training which enables to perform their clinical roles safely and effectively in regard to blood and blood product management. Five related policies provide a governance structure for the management of blood and blood products; an overarching Blood Transfusion policy and a number of specific policies guiding practice in regard to massive transfusion; blood fridge management; Jehovah's Witnesses and blood transfusion; and emergency transfusion of uncross-matched blood. The primary policy is most often used as in almost every instance blood is electively administered at the rate of 2-3 units per month. No massive transfusion events have ever been recorded but attention is regularly drawn to the flow chart so that staff can rapidly respond should this rare emergency ever arise. Several risks related to transfusion of blood and blood products are recorded in the organisation's risk register; All are regularly reviewed and well mitigated. One risk relates to failure of compliance with policy regarding bedside checking of blood products at another facility. BPH has responded to the event by introducing a strategy where blood must be checked by a registered nurse on the ward and a defined senior staff member. This sometimes delays commencement of the transfusion and assessors suggest the organisation reviews this practice and audits compliance with policy. Almost 100% of nurses have competed the Bloodsafe eLearning transfusion package and are enthusiastic up-takers of any other related education opportunities. At corporate level, BPH is represented on the Blood Transfusion Cluster and Transfusion Webex team to remain abreast of current developments.	
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
BHP demonstrates application of the quality improvement system from the Clinical Governance Standard and use of the audit process to monitor and evaluate the effectiveness and performance of blood and blood product management. The Quality Committee monitors the attainment of relevant performance indicators; any incidents which may arise, and related action plans to ensure improvements to the management of blood, blood products and associated processes. Review of incidents shows no events since the last accreditation assessment three years previously. Similarly audits related to blood management show high levels of compliance with all elements of policy. Examples were provided to assessors demonstrating incremental improvement, particularly relating to documentation, which is now of a high standard. The safety and quality chain can be traced from the local Quality Committee through to the Healthscope Board for continuance of clinical governance. Quality improvement support is provided as required by other hospitals in the Eastern cluster and Clinical Laboratories at Knox PH which oversees blood/blood product availability and local Blood Bank services, including haemovigilance activities and waste minimisation. As an excellent quality improvement initiative BPH also participates in the Healthscope Shared Learnings program where all hospitals are made aware of incidents and near misses at other sites so that steps can be taken to avoid a recurrence.

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
Clinicians use organisational processes from the Partnering with Consumers Standard to ensure patients are actively involved in their own care (resulting in shared decision-making) and have sufficient information to provide informed consent. demonstrated in documented involvement of consumers at both corporate and local level in the production and review of patient information. Assessors observed several interactions with patients, including clinical bedside handover and found authentic interaction in regard to the provision of information for patients. This was augmented by a process review relating to observation of an iron infusion and a conversation with the recipient who indicated that she felt very well supported in regard to education. The Patient TV channel also provides information on blood transfusion as does the My Healthscope Website. Specific consent for blood and blood products is obtained. Almost all blood transfusions are elective for treatment of chronic conditions. Under these circumstances consent is obtained for a twelve month period and then renewed, provided circumstances have not changed. If this has happened a new consent process takes place to ensure patients remain well informed. Clinicians involve consumers in the decision of suitable products or blood product alternatives such as iron infusions. Consumers provide input into corporate policies and processes, as well as local policies and procedures at Bellbird Private Hospital to ensure patients have access to suitable information in both content and the manner in which it is presented. Related processes are monitored, improved where indicated and reported through the Quality Committee.

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
Care is taken at Bellbird Private Hospital to optimise and conserve patients' own blood where possible. In almost all cases blood and blood product administration is elective and arises from chronic conditions, necessitating regular infusions of specific blood products. The pathology service supports clinicians to manage the need and minimise the inappropriate use of blood and blood products by advising clinicians of the alternatives to using blood and blood products. Because of careful patient selection associated with the hospital's capability, and clear admission criteria, it is very rare that there is a risk of surgical bleeding requiring blood or blood products. A massive transfusion protocol is in place in the case of emergency, and two units of O negative blood are held for this purpose, re-allocated by the private pathology provider if not used in the time window. In regard to optimising and conserving a patient's own blood however, the single use policy is strictly applied at BPH. A haemoglobin check is undertaken between units to confirm need for a second transfusion. These processes are monitored to ensure appropriateness of transfusion, and there is evidence of a high level of compliance, with resultant ultra-low levels of blood wastage and inappropriate use of blood and blood products.

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
Assessors examined healthcare records of patients who had been transfused with blood or blood products and found no incidents of non-compliance with recording decisions relating to blood management, transfusion history, or transfusion details. The use of the HMR Blood and Blood Products prescription and transfusion record form rather than the intravenous fluid order form has been a quality improvement initiative designed to strengthen documentation associated with recording of clinical indication for transfusion and a transfusion history. Audits conducted by the organisation confirmed that correct use of the correct form is now a much more regular practice.

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	
Assessors noted that corporate policies and procedures are linked to blood management guidelines provided by the National Blood Authority (NBA). Locally developed massive transfusion protocols are also based on the NMB critical care and critical bleeding modules. To support policies and guidelines Healthscope has also developed a series of medical record forms based on the requirements of the NBA to strengthen accurate and comprehensive documentation. Use of the guidelines is monitored using the incident and risk management systems to analyse non-compliance but no examples of non-compliance have been identified in recent years.	
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	
All adverse events related to blood and blood product management are required to be reported through the RiskMan incident management system and individually investigated. No adverse events within BPH have been recorded in recent years but policy directs investigation through the Quality Committee. Patients with known reactions have this recorded as an Alert on the front page of the health record. BPH submits ACHS clinical indicator data in Hospital-Wide Version 13 relating to significant adverse blood transfusion events. Information describing how Healthscope hospitals are preventing adverse transfusion events is available on the My Healthscope website.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.8	
The health service organisation participates in haemovigilance activities, in accordance with the national framework	
Comments	
Results of haemovigilance audits at Bellbird Private Hospital are excellent, with 100% compliance over three years for recording of comprehensive documentation; timing of transfusion (8am-8pm); haemoglobin level < 100 pre-transfusion and information regarding clinical indication for transfusion. No adverse reactions occurred over the same time period. Two units of O negative blood held on site for emergency use are re-directed in a timely manner by the private pathology service. Blood fridges are well monitored with excellent systems of control in place should the cold chain be at risk.	
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	
Excellent processes are in place to safely store and manage blood and blood products in accordance with manufacturer's and relevant legislative requirements. BPH has a 'just in time' approach to blood transfusion, with blood stored in the designated blood fridge until use is imminent. Blood is initially transported by courier to the hospital from the private pathology provider blood bank (a NATA accredited facility) nearby. It is checked into the hospital's blood fridge, which is regularly monitored in accordance with protocol, on the day of, or day before transfusion. The patient is prepared for transfusion before the blood is sourced from the blood fridge. Observations have been recorded and cannulation has already been performed. At the last minute the blood is collected and checked at the bedside by two registered nurses (one a designated senior nurse) with the patient, against the blood prescription form and crossmatch slip. Two units of 0 negative blood are available in purpose built blood fridges compliant with AS3864.2-2012 on site for use in an emergency. The fridge alarms loudly in the ward should the temperature vary from pre-set parameters. A procedure is in place to guide staff in what to do in this situation.	

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
Staff have been trained in their role regarding storing, distributing and handling blood and blood products safely and securely with 100% of clinical staff having competed the Bloodsafe eLearning transfusion package. Tracing is documented using donation or batch number, against the prescription and issue reports with 100% compliance. demonstrated. The assessors confirmed compliance with this action through observation of a blood product journey and review of documentation in the healthcare record.
Suggestion(s) for Improvement
Arising from a serious incident at another Healthscope hospital two years ago a process was introduced whereby of two staff checking blood at the bedside before commencing a transfusion, one had to be a defined senior nurse. This sometimes delayed commencement of the transfusion while awaiting the senior person's arrival. Assessors suggest that whilst the two-person checking mechanism should remain, it should be sufficient for checking to occur between two registered nurses in the ward, with audits undertaken regularly to monitor compliance.

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
Blood and blood products are readily available from the private pathology blood bank a short distance away where a courier service delivers blood in a timely manner. Two units of 0 negative blood are always available on site if needed urgently, and a protocol linked to National Blood Authority is in place for managing massive haemorrhage should it occur. There is little or no wastage at Bellbird Private Hospital. O negative blood stored for emergencies is regularly rotated for use elsewhere by the private pathology provider to avoid expiry.

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	
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
Healthscope (HSP) review their many policies related to recognising and responding to acute deterioration as required with the HSP Document controller recording all interactions and updates. The BPH Quality Manager distributes policies to the relevant clinical departments for review and feedback prior to general distribution with revised policies ratified by the appropriate committee meetings. Managers are required to table policies at departmental meetings with the information placed in the department communication folder. Risks are reviewed regularly in regard to recognising and responding to deterioration, through analysis of related incidents, Met Call response outcomes and performance indicator results. BPH has mitigated risks on the risk register related to clinical and mental health deterioration. BPH places a strong focus on recognising and responding to clinical deterioration across clinical areas visited by the assessors. Staff were able to articulate the process for the management of acute physical and mental deterioration and how escalation of care would ensue. BPH takes its responsibilities regarding training in recognising and responding to deterioration very seriously given that it has no on site medical support and is a very small facility. Nurses receive training at orientation and during their employment to ensure an appropriate response. Such education is mandated and compliance is high. There is also 100% compliance in both theoretical and competency-based basic life support training with senior nursing staff completing advanced life support practical training.

Rating	Applicable HSF IDs
Met	All

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
BPH applies quality improvement systems to recognising and responding to deterioration through elements in its quality action plan located within the HSP KPI reporting tool. The current recognition and response system is well monitored. All incidents relating to deterioration resulting in a Met Call are individually reviewed through RiskMan, the incident management system. Changes are made to the system if review outcomes suggest improvements could be made. These are managed through action plans overseen by the Quality Committee. HSP has a requirement that all hospitals in its fleet report outcomes of mortality reviews and response to clinical deterioration. BPH performs well in both areas although outcomes below benchmark in the third quarter 2021 for responding to deterioration have warranted an action plan currently underway. As a result of incident reviews BPH have introduced the following improvements, including installation of the Operating Suite IN/OUT sign for visual awareness of when operating theatre staff are on site to assist in the escalation of care; the Met call or Code Blue to be announced 24/24 seven days a week as a public address announcement and the addition of new speakers for Code Announcements hospital wide.

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
Patients at BPH contribute to the development of the patient care plan with this subject to review at each nursing clinical handover and updated with any change in condition of the patient. Patients/carers are provided with information on how to escalate care via the information provided by the Acute Deterioration brochure and the individual Patient Care Board and an information flyer is available in public areas such as waiting areas. Assessors spoke with patients who indicated that they were aware of how to escalate care and felt they were actively involved.

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	
BPH related reports are reviewed for trends and one component is 'who escalated the response" patient, family, VMO or staff? Examples of patients and family members using the system were noted by assessors. All Met and Code Blue calls are entered into RiskMan with a clinical extension of data identifying if an Advanced Care Directive is/was available. This data is also reported at the MAC.	
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	
BPH complies with the related HSP policy in providing a standardised approach to recognising and responding to clinical deterioration to ensure prompt and effective action. Minimum observations are documented on the SAGO Standard Observations Chart - track and trigger forms which are evidence based and subject to HSP review. BPH audit of the Observation chart tool is reported as a KPI to HSP as part of the annual mandatory audit schedule. Appropriate use of the track and trigger observation chart appeared well embedded in clinical care observed by assessors. Consistent processes were reflected in clinical practice. Chart audits demonstrate high levels of compliance. Functionality exists within the forms for temporary variation in parameters to accommodate expected outcomes by VMOs. Compliance with related policy is regularly reviewed.	
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
There are processes in place for clinicians to recognise acute deterioration in mental state that require monitoring, escalation and support for patients at risk. HSP has done a lot of work in this regard through gap analysis, action plan creation and now implementation of the plan in accordance with the relevant ACSQHC Advisory. This Advisory AS19/01 – recognising deterioration in a person's mental state (8.5 & 8.6b, c, d and e) has been satisfied, as a process has been implemented to recognise and respond to delirium and to the deterioration in a person's mental state. At BPH the hospital's capability framework is such that people with serious mental illness are not suitable for care. All admitted patients are screened initially and assessed for their mental health history and for any psycho-social behaviours that may require additional planning. If the patient is known to be cognitively impaired this includes recording of early warning signs and trigger points. All nursing staff have access to the related policies and tools such as the use of the cognitive impairment risk assessment tool. Patients identified as at risk of delirium and/or cognitive impairment are entered on webPAS and an Alert sheet is kept at the point of care. The required level of observation is established; in some instances, a 'special' is required to support vulnerable patients. Any patient identified on high-risk medications is referred to pharmacy for review of their Medication Management Plan.

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
The HSP Comprehensive care Cluster has a forum via Webex with a Clinical Deterioration Working Party to support the review of HSP policies and procedures relevant to this standard with BPH protocols for escalation of care a component of the quality and document control system. Protocols used across HSP include agreed vital sign parameters, including in mental state, together with agreed indicators for calling emergency assistance via either Met Call or Code Blue. Consideration is also given to pain and distress which cannot be managed using available treatment and to worry or concerns expressed by the patient, family, carers and the workforce regarding acute deterioration. The protocol's effectiveness is monitored through incidents entered into RiskMan where a clinical extension also provides additional data identifying the reason for activation of a Code Blue and Met Call for which the BPH QM provides a monthly report to HSP. BPH has observed that there is year on year increase in the reporting of clinical deterioration episodes suggesting that staff are recognising and effectively responding more often than in the past.

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
BPH has processes in place for patients, carers and families to directly escalate care. Patients contribute to the development of their individual care plan as they are questioned regarding their concerns at each nursing clinical handover, where the plan is updated with any change in condition of the patient, and at hourly rounding. Patients/carers are also provided with information on how to escalate care via the Acute Deterioration brochure and the individual Patient Care Board on admission. An information flyer is available in public areas such as waiting areas. Patients are also provided with the contact details of the Nurse Unit Manager should they wish to raise a concern. Information is also provided on the hospital TV channel.

ACTION 8.7	
The health service organisation has processes for patients, carers or families to directly escalate care	
Assessors spoke with patients who indicated that they were aware of how to escalate care and felt they were actively involved. They believed they would feel comfortable using the process if they thought it was necessary.	
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	
There is an Emergency Procedures Manual in place with staff having access to the initial response procedures at every telephone site throughout. The mechanisms for staff are the "first response actions", policies cited and available for use via the public address system and the escalation of care and response for emergency assistance mechanisms. When clinical deterioration is identified nurses can call a Met Call or initiate an emergency response by activating the emergency assist button. Protocols are in place to collect the emergency trolley; staff check it regularly and are trained in its use. In the event that a visitor is unwell, a Code Blue response is called. BPH nurses could clearly articulate the mechanisms to escalate care and call for emergency assistance (when, and if required). Training on how to trigger emergency activation and escalation processes commence at orientation and continuing education sessions are held regularly throughout the year. Escalation of care is integrated into BLS and ALS competencies.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.9	
The workforce uses the recognition and response systems to escalate care	
Comments	
The workforce uses recognition and response systems to escalate care. All nurses undergo training on emergency procedures at orientation with mechanisms in place to escalate care and call for emergency assistance. The number of Met Calls entered into RiskMan have increased over time as nurses feel more comfortable using the system. Assessors spoke with nurses, including a graduate nurse, who had all escalated care through the Met Call process and were able to describe the process. The graduate nurse felt that the SAGO chart with its track and trigger mechanism allowed her to escalate care without feeling that she may have been incorrect in her assessment and felt very confident in using it to provide better care for her patients. VMOs with tenanted consulting rooms are issued with emergency procedure information.	
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	
BPH nursing staff could articulate clear processes that support timely response by clinicians. All nurses were aware of emergency numbers to call, and how to initiate emergency care while awaiting assistance through the provision of basic life support. Every nurse at BPH is currently up to date with BLS training. Whilst clinicians have supports and timely response mechanisms in place a concern was noted in the Operating Suite where nursing staff appeared unclear of the procedure to follow in the rare instance that a patient deteriorated significantly in the Operating theatre when no additional VMOs were on site to provide support.	
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
Clinical staff at BPH are able to provide basic life support in the case of emergency. More advanced support is provided by Ambulance Victoria with response times less than five minutes by Mobile Intensive Care Ambulance (MICA) due to the close proximity of several MICA stations. Managers from both BPH and AV have met to coordinate this emergency response. During operating periods an anaesthetist with advanced life support skills is also available in an emergency. Where necessary external education is provided for speciality resuscitation CPR and simulation training.

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
In the rare event of acute deterioration in mental health status patients will be assessed and transferred to a facility where specialist assessment or interventions are required. Relevant information is relayed to the receiving service and to the AV/Paramedic staff attending to the transfer. Clinical handover occurs with the with the VMO if available and the transporting team. Such incidents would be entered into RiskMan for analysis and changes made to systems if issues are identified relating to missed signs and symptoms so that learning can occur.

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	
If a patient cannot be safely cared for, they may be subject to transfer out to another facility where the required specialist assessment and intervention can be actioned. Transfer is affected through Ambulance Victoria. All transfers out are entered on RiskMan and any local incident if appropriate can be reviewed and discussed and may inform part of the HSP Shared Learning report. The clinical handover to both the receiving service/s and AV/paramedics is well established.	
Rating	**Applicable HSF IDs**
Met	All

Recommendations from Previous Assessment

Nil