NSQHS Standards Second Edition Organisation-Wide Assessment
Final Report

The Hills Private Hospital

Baulkham Hills, NSW

Organisation Code: 125984
Health Service Facility ID: 101031
Assessment Date: 2-4 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

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Executive Summary

The Hills Private Hospital underwent a NSQHS Standards Second Edition Organisation-Wide Assessment (NS2 OWA) from 02/11/2021 to 04/11/2021. The NS2 OWA required two assessors for a period of three days. The Hills Private Hospital is a Private health service. The Hills Private Hospital was last assessed on 19th – 21st September 2017.

The current assessment was conducted by two on-site assessors over a three-day period in early November 2021. Over the previous year the organisation had undergone considerable changes with three different people each occupying the positions of both General Manager and Director of Nursing. At time of assessment a Healthscope reorganisation had resulted in the General Manager position being filled as a joint appointment between The Hills Private Hospital (THPH) and Lady Davidson Hospital.

Active recruitment was underway for a permanent appointment to the Director of Nursing position.

The previously mentioned vacancies were the result of internal promotions of previous occupants to other positions within the Healthscope organisation. Whilst the role of the Hills Private Hospital is one providing rehabilitation and mental health services the organisation was required to provide an aged care Covid ward for several months. Whilst this service is no longer required and the ward has reverted to its original rehabilitation, function, valuable lessons and enhanced service capability will enable a reopening of the Covid ward with minimal additional planning, should this be required in the future.

The Hills Private Hospital is a unit of the Healthscope Group. The new owners of this corporate entity, Brookfield Asset Management places a strong emphasis on safety and this is reflected in the practices sighted by assessors during this review. There is strong clinical governance with an active reporting of key performance indicators both to the corporate level and to staff and the public by way of informative quality and safety boards. Staff interviewed during this review demonstrated practices and knowledge suggestive of a good understanding of the spirit and intent of all components of the standard for clinical governance. All actions associated with the Commission's Advisory Note As18/04 have been satisfactorily addressed.

Whilst a small organisation, with only two defined service areas - rehabilitation and mental health, the organisation has well established practices to promote the Partnering with Consumers Standard. Appointed consumer consultants and volunteers provide service in a variety of ways which assist in ensuring the consumer voice is represented. Assessors had the opportunity to attend a "patient forum'" which gave both inpatients and former patients the opportunity to provide commentary on their Hills experience and to offer suggestions for improvement. Consumer goal setting and achievement is strongly promoted and reflected in care planning documentation, reality checks at the time of nurse handover, on the patient care boards in patient bedrooms and during individualised therapeutic sessions with staff.

There is a strong system to ensure The Hills Hospital is compliant with the requirements of the infection Prevention and Control standard. A multidisciplinary team provides oversight, surveillance and audit activity results demonstrate effective processes.

There is a very well-developed antimicrobial stewardship system which is well supported with two infectious diseases physicians and a microbiologist. Over the past year the organisation has successfully converted a rehabilitation ward into a ward to temporarily accommodate the needs of the elderly with Covid. Outcomes from this experience include significant organisational and individual staff capacity to respond to any future demands from the Covid pandemic.

THPH has in place systems to ensure appropriate governance in relation to medication management and safety. A comprehensive medication history including allergies forms part of the admission and discharge process. Medication management plans were evident in the medical records viewed by the assessors. Medication incidents are reported via the RiskMan system and reviewed by the appropriate committee and regular medication chart audits are undertaken by the pharmacist.

Overall, the assessors felt the intake, assessment, care planning and discharge process to be of high standard underpinned by appropriate policies and guidelines. There was a clearly demonstrated commitment by all staff to provide a patient-centred therapeutic journey for each patient that included family and carers. Advanced care directives are discussed with patients on admission and documented in the patient's medical record. Good systems ae in pace to escalate care for patients at risk or those who suffer an unexpected deterioration in either physical or mental health status. A range of standard measures are used to understand any changes in the patient's presentation during inpatient admissions and participation in the group programs. Patient clinical records are well maintained and secured. They are routinely audited and any areas for improvements re identified and acted upon.

Processes for structured clinical handover are used to effectively communicate about the health care of patient. These include the bedside handover and patient care boards that were evident in each patient bedroom. Routine safety huddles are held in each unit. These provide an up-to-date review of incidents and concerns that staff need to be aware of.   Staff focus on supporting the development of individual goals for recovery and support the development of skills that enable patients to achieve those goals. Care plans were developed in collaboration with the patient However, evidence of their involvement and also the nominated family/carers need to be strengthened. It is suggested that both the patient and family carers sign the care plan, if appropriate and this is documented in the patient clinical record.

The patient identification and procedure matching system include the use of the three nationally approved identifiers for inpatients and outpatients. There is a policy regarding the use of patient ID bands that are replaced weekly due to the chorine in the hydrotherapy pool removing information.

The inpatient bands are consistent with the national standard. Patient identification and procedure matching are well understood and given appropriate attention by all staff. Mental health uses photo identification for all patients in the medical record and on each patient's medication chart.

Only about 10-12 blood transfusions occur annually. Whilst there was no opportunity to observe an actual transfusion during this review, assessors were impressed with the systems and staff training in place to ensure the safe delivery of blood. This hospital is fortunate to have a nursing staff member who has had extensive blood transfusion experience in a tertiary referral hospital.

Recognising and responding to acute deterioration is well managed at THPH and ensures that acute deterioration is recognised promptly and appropriate action is taken. Acute deterioration includes physiological changes as well as acute changes in cognition and mental state. Patients and their families are provided on admission with information on how they are able to escalate care if needed.

Advance Care Directives are discussed with patients on admission and this is documented in their medical records.

The outcome of this assessment is two Met with Recommendations related to Scope of Practice documentation for senior medical staff and ensuring a more formalised process of performance reviews for career medical officers.

Summary of Results

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

Actions Rated Met with Recommendations

Facility (HSF ID)	NS2 OWA 2/11/2021 - 4/11/2021
	MwR
Hills Private Hospital, The-101031	1.22, 1.23

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

Sites for Assessment
Hills Private Hospital, The

Site	HSFID	Address	Visited
Hills Private Hospital, The	101031	499 Windsor Rd BAULKHAM HILLS NSW 2153 Australia	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
The Hills Private Hospital Clinical Governance Plan reflects the OneHealthscope 2025 strategy with the two major objectives of growing the business and improving the experience through the delivery of exceptional patient care ad clinical outcomes, building a workplace that grows people., careers and culture and supports VMOS and other partners to excel. There is a strong emphasis on monitoring outcomes with a formalised system for indicator measurement against each of the National Standards.

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
The Aboriginal and Torres Strait Islander Reconciliation Plan first task is identified to identify and address the needs of indigenous people. This is achieved by working with community and leaders to set safety and quality priorities. The organisation has appointed an Aboriginal liaison officer (ALO) from within its existing staffing profile. This person has facilitated linkages with local elders to help establish community needs and create a welcoming environment. Assessors noted indigenous art works throughout the organisation and small copies of the Aboriginal flag on display at reception counters. The indigenous REACH poster is displayed.

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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	
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 Clinical Governance Framework is the same for all Healthscope entities with an emphasis on the provision of exceptional patient care and clinical outcomes through processes of monitoring, improving and evaluating. The associated framework pillars are focused around leadership and culture, partnerships, clinical data and outcomes, managing risk quality improvement, evidence based practice, building capacity and patient experience.	
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	
Ninety-six percent (96%) (233) of staff have completed the online "working with respect" training course, and the script for "welcome to country" was written by an elder. These achievements are consistent with the third action item in the RESPECT section of the Reconciliation Action Plan.	
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
Through minutes and the content of the strategic plan evidence was sighted of the organisation considering safety and quality for health care for patients in its business decision making. In the context of preparing to face the challenges associated with Covid, the organisation was able to convert a ward to safely provide care for elderly Covid patients. Three air locks and 23 air scrubbers have been purchased to enable sections of the hospital to be segregated. Whilst the Covid ward established last year is no longer clinically required, it can be repurposed should the need arise. The organisation is currently researching an alternative supplier of N95 masks, as the current supplier cannot be relied upon in the future.

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
Job descriptions all contain statements requiring participation in quality and safety activities. In addition, many staff carry specifically assigned "portfolio" responsibilities. For example, one Allied Health staff member also has the designated role of Aboriginal Liaison Officer. Two nursing staff members provide oversight of standard seven related to blood. Each ward has a nurse with an infection control portfolio. The quality and safety boards which are displayed in public areas of each ward contain meaningful performance outcome data, providing a daily reminder to staff of quality and safety issues.

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
Assessors were able to confirm the ready availability of Heathscope corporate policies electronically. Similarly, locally produced policies are available to staff on the L drive. Relevant staff are invited to be involved in the development and review of policy. The Quality and Risk Manager is responsible for oversight of policy management, including review, updating, and development. An example of a new policy was that related to a policy on patient photography produced after a near miss when a patient with dementia went absent without leave. A flow chart outlining policy processes was sighted.

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
There is a formal audit program with reportable KPIs reflected against performance targets. These are linked to relevant National Standard actions. Data provided in many instances listed numerator and denominator values. This gives greater confidence to the validity of the measure. For example, the figure of 97% of staff being immunised resulted from a numerator of 231 and a denominator of 238. Data is reported both to local management and to Corporate Office. Healthscope has an established practice of "shared learnings", ensuring that lessons learned from incidents across the different sites of the Healthscope organisation can be shared across all sites. An example provided during this review, was lessons learned from another site related to the risks associated with the drug hydromorphone. Safer storage arrangements have been put in place. Assessors noted records of interviews with a patient who was willing to share her experiences.

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
An established audit program provides the data to build timely reports on safety and quality. Assessors were provided with data showing KPI reporting inked to each of the National Standards. Indicators are assigned a target level. Reports sighted showed data presented in successive quarters thus enabling trending analysis. Numerator and Denominator figures are provided for each indictor. In the absence of favourable result against target, action plans are developed. Audit results are provided to the Medical Advisory Committee and Healthscope Corporate Office. Benchmarking against peer hospitals occurs. Quality and Safety boards are strategically placed in public areas of each clinical area Information displayed includes information related to measures such as patient falls and pressure injures.

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
The organisation currently uses the RiskMan tool to log risks. At time of this review the organisation was looking for an alternative product with the intention of better differentiating between corporate and local risks. Assessors were provided with documentation confirming that risks are being actively managed. Plans to respond to emergencies were sighted.

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
Incidents are logged in RiskMan. All staff have access to enter an incident. Automatic notifications of issues such as work health and safety are sent to the general manger and WHS manager. Most common incidents are falls, medication safety, discharge against medical advice (mental health patients failing to return from leave), and pressure injuries (usually present when patients transferred from another hospital). Serious incidents are reviewed by a multidisciplinary panel of staff who were not involved in the actual incident. It was noted that in the event of a "never event" incident occurrence, the organisation must wear the cost, as the contracts with private health insurers do not cover associated costs.

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
All staff are required to complete the e learning open disclosure training. Data provided to assessors suggest that 97% of staff have completed the training (Healthscope target 92%). Whilst VMOS are not required to complete the training, they have been provided with copies of the policy.

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
A variety of strategies are employed to seek feedback from patents and staff about their experiences. These include patient forums and data collected by patient consultants from their interviews with patients. The patient compendium invites patients to provide feedback. Assessors sighted the patient questionnaire which is provided to all relevant patients inviting feedback after receiving blood transfusion. Assessors noted display boards in clinical areas where "thank you" cards from former patients were displayed. Practices of bedside handover, hourly rounding and executive rounding are other methods by which patient feedback can be obtained.

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
Complaints re lodged in the RiskMan system. KPIs for complaints management are monitored and reported.

Rating	Applicable HSF IDs
Met	All

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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
The pre survey documentation provides information about the demography of the neighbouring local government area together with statistics related to the patient population. Self-identification of indigenous status is noted to be very low, with only 2-3 patients per year (ranging .26 – 0.40% over the past three years). Assessors noted patient pamphlets and publications available in community languages - Chinese, Arabic and Filipino. The data provided shows 95% of patients reporting English as the primary language with 78% identifying Australia as the country of birth.

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
Heath care records at The Hills Private Hospital are kept in paper format. They are available at the point of care. Old files are securely stored and there is an active archival process consistent with legislation. Medical records staff have an annual audit process which reviews entries against defined criteria. The audit result for 2020 showed a compliance rate of 93%.

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
A gap analysis for the introduction of clinical information into the My Health record was completed in 2019. An action plan was developed to address issues. A subsequent report to the quality committee focused on encouraging patients to activate their e- Health. Clearer patient information brochures have been developed, placed in welcome packs and the process is explained at time of admission. The organisation reports there is limited patient interest in the process. The plan is to continue to provide patient information so that consumers may become better informed.

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
The systems for providing information into My Health Record are in place. This occurs electronically through corporate systems. The organisation is compliant with the relevant Commission Advisory on this subject.

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
Locum medical staff receive an individualised orientation to the hospital, provided by the on duty after hours nurse manager. It was noted that there are three career medical officer positions. Occupants are employed under contract through an agency. These individuals however have long standing relationships with the hospital, with one being recognised through the organisation's star award employee program. A recommendation related to these positions is contained in action 1.22. On the rare occasion locum nursing staff are used, an orientation checklist is used. The Director of Allied Health reported allied health locums are never used.

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
Staff of the Hills Private Hospital are required to complete training on fire, basic life support, manual handling hand hygiene, code of conduct and privacy. The acting Director of Nursing who has a background in intensive care conducts basic life support training. Whilst she is advanced life support trained, the organisation's response in such situations would be to seek ambulance assistance. In addition, the Director of Nursing conducts mock exercises in MET response. After hours Nurse managers complete DETECT Training. All staff have training in use of the automatic defibrillator.

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
Records were sighted showing that 97% of staff had completed the cultural competency training e learning program. The Healthscope target for this target is 92%.

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
Performance reviews are conducted using a template provided by Healthscope Corporate. A guide is provided on the intranet to assist managers in the conduct of performance reviews. Emphasis is placed on review of last year's goals and setting of new year goals. After a probationary period, performance reviews are conducted annually. The organisation has three career medical officers. For the past five years they have been employed as "contractors" through a recruitment agency. As such, they are not subjected to any formal documented review although assessors were informed their performance is monitored and it was noted one of the CMO's recently received recognition through the Healthscope Star Awards. Lack of formalised performance review for these individuals who are recognised as making a valued contribution to the organisation represents a missed opportunity for professional mentoring, growth and professional development.

Rating	Applicable HSF IDs	Recommendation(s) / Risk Rating & Comment
MWR	All	**Recommendation:** The conditions under which CMOS are employed be reviewed to ensure that they experience regular formalised performance review. **Risk Rating:** Low

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
Healthscope By-laws provide the framework and formal processes underpinning the appointment of medical staff. Original appointments are for 12 months with the option of then appointment for a five-year period. There is a requirement that at least 12 patients must be admitted during the first twelve months. Several senior medical staff have appointments as consultants, without admitting rights. E.g., infectious diseases physicians. The MAC is the committee at which appointments of medical and visiting allied health staff occur.

Clinical practice monitoring occurs through for example quarterly case review meetings in the Rehabilitation Department, incident reviews (for serious events conducted by multidisciplinary teams of clinicians who were not participants to the incident) and Morbidity and Mortality meetings.

Assessors were provided with a Hills document titled scope of practice. Random sampling of the document highlighted some medical clinicians (psychiatrists) being granted scope of practice privileges for services not provided at The Hills - (e.g. ECT and TMS). It is possible that this document reflects cross credentialing to other Healthscope facilities which do provide such services. In its current format the document is misleading. |

Rating	Applicable HSF IDs	Recommendation(s) / Risk Rating & Comment
MWR	All	**Recommendation:** Enhance the clarity of documentation outlining privileges which can be conducted at The Hills Hospital which are granted to medical staff. **Risk Rating:** Low

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
Outcomes of an April annual Healthscope audit of clinical staff files against nine criteria showed 100% compliance. This review confirmed currency of professional registrations, indemnity insurance and credentials.

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
Job descriptions outline staff responsibilities related to quality and safety. During this review it was clear that across the service individual staff members at ward level, assume responsibilities for specific issues associated with quality – e.g. infection control.

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
Assessors had the opportunity to meet with some senior medical staff including the chairman of the Medical Advisory Committee. It was confirmed that there is a supportive culture and expectation within the organisation with nursing staff comfortable to phone a consultant directly if there are any concerns about a patient welfare. There is always a senior nurse manager on duty 24 hours a day. Examples were provided of inexperienced staff being appropriately supervised prior to their assuming responsibility for clinical task (e.g. nurses must have a mentoring/observational experience prior to caring for patient receiving a blood transfusion. There is formal new graduate program supported with nurse educator.

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

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
Staff have access to the Australian Therapeutic Prescribing Guidelines. The Healthscope Corporation maintains a virtual library service to which clinicians can access and order articles. Throughout this assessment it was clear that many documents and key performance indicators are referenced to the relevant actions of the National Standards.

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
Variation in practice monitoring occurs through discussion at the Medical Advisory Committee which has multidisciplinary representation. Key performance data is reviewed and unexpected outcomes discussed. Assessors were informed that a change in culture has resulted in clinicians now voluntarily bringing forward cases for review. Quarterly Rehabilitation department meetings provide an additional forum for rehabilitation review. The organisation submits ANROC data and all patients are assessed against FIM scores at time of entry and exit to the service. It was not clear that similarly focused approach to monitor variation to practice in mental health is in place. The Healthscope organisation has a well-developed system of sharing "lessons learned " from other organisations. This was a standard agenda item on minutes of several meetings noticed during this review.

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
Suggestion(s) for Improvement
Enhance multidisciplinary systems to monitor variation to expected clinical outcomes the mental health department.

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
A newly appointed State manager for Work Health and Safety has been appointed. There is a proactive approach to supporting staff, standardising documentation. An environmental working party meets monthly. Environmental safety checks are conducted, and lessons learned from other facilities shared. Safety is strongly emphasised by the new owners of Healthscope Brookfield, and staff are encouraged to benchmark safety practices against other industries which are not health related. Healthscope managers have been put through a leadership program offered by Du Pont. This includes understanding the concept of "safety walkarounds". Every member of the executive staff has a KPI related to a safety action.

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
The organisation has reviewed the clinical environment of the mental health ward to eliminate where possible sources of ligature points and self-harm. In the event of increasing concerns about patients' potential for self-harm, transfer to a nearby public hospital mental health facility would be arranged.

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
Access to the hospital is clearly signposted. Vehicle entrance is facilitated by "slipways" on the busy road outside the hospital. The organisation has changed the name of its mental health ward, to minimise the risk of confusion with a nearby private hospital which also offered mental health services. A visitor guide and hospital map clearly outline the position of each patient bedroom and way finding throughout the hospital. Patient bedrooms re numbered according to the floor level. The map also shows positioning of nurses' station and lifts and stairs.

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
Pre Covid the organisation visiting hours were stated to be from 1000 until 2000 hrs. Restrictions associated with Covid have resulted in periods of no visiting, however during this time staff facilitated access to patients through the use of phones and electronic communication devices.

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
Through the work of the Aboriginal Liaison Officer, the organisation has been able to engage with local indigenous community and elders. Small indigenous flags were noted at key reception desks throughout the hospital, as were indigenous art works. Welcome to country (scripted by a local elder) form an introductory part of key meetings.

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
The Standard Two committee provides oversight of the requirements of this standard. The committee is chaired by the consumer liaison coordinator. There are Healthscope policies related to partnering with consumers, patient experience surveys and admission of patients and informed consent. The Consumer Partnership plan is a detailed document which clarifies the concepts of bedside handover, rounding, patient-centred are and consumer participation in patient focused literature preparation. The document also identifies strategies for 2020 2023 - back to the bedside consumer workforce, cultural competencies, commitment to stories, looking after families, beautifying spaces, and partnering with community services. In addition to seeking feedback and advice from consumers of the service, an important contribution to effective achievement of the goals of this standard is the contributions of consumer consultants and volunteers whose work will be referred to throughout this standard.

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
A variety of strategies are employed which contribute to monitor, implement and report on issues associated with partnering with consumers. Assessors had the opportunity to attend a "patient forum" during this review. Attendees included both inpatients and former patients as well as volunteers. The meeting was chaired by the consumer liaison coordinator. It provided a structured opportunity for consumers to reflect on their own experiences in treatment provided by The Hills Hospital. Most commentary was very positive. Constructive suggestions on how experiences could be improved were also tabled.

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
Assessors were provided with examples of patient literature which had been passed through the standard two committee for review, prior to publication. An example includes the booklet produced to support patients who have had hip and knee replacements.

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 Australian Charter of Healthcare Rights was on display in public notice boards throughout the hospital. The charter is also featured in the patient handbook.

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
There are a variety of Healthscope policies associated with informed consent processes. There are consent forms in the patient admission packs. Individual consent forms were noted for procedures, Ellis disclosure, blood and financial consent. Appropriate explanatory information is also available. The medical records audit process includes confirmation of the presence of appropriate consents.   The organisation complies with the Commission's Advisory note AS 18/10 related to informed financial consent.

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
Specific policies guide staff under circumstances where there are questions about a patient's capacity to provide informed consent and an alternative decision maker is required. When necessary, printed copies of required consent are expressed post to next of kin.

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
Assessors were impressed with the emphasis on patient participation in goal setting and therefore being active participants in their care planning. This was manifested in a variety of ways. The patient communication boards at every bedside have a section for daily goals. Assessors noted the status of goals was checked with the patient at the time of nursing staff handover. At the morning community group in the mental health ward, each consumer was asked to identify their goals for the day. Individualised therapy sessions with allied health staff provide another opportunity for goal setting. Family and case conferences, where family member attendance is encouraged are another venue where patient goals can be identified, and reality checked.

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
The Patient Information directory has an explanatory section on National Standard Two with an emphasis on "how we include you and your family in your care", consumer consultants, advanced care planning and directions and an explanation of "what is the person responsible".   Hourly patient rounding and Executive rounding are additional strategies by which partnerships with patients can be further created. The "primary nurse" model in the mental health ward fosters a closer therapeutic relationship between nurse and patient.

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
Demographic statistics of The Hills Hospital show that whilst 38 % were born overseas, the primary language spoken at home is English for 95% of the patient cohort.   The organisation however has systems to respond to effectively communicate with all patients. During survey several references were made to the availability of interpreter services and brochures advertising the service were noted in patient pamphlet racks. In the Blood pack, which is available on every ward, explanations about blood transfusion are provided in Arabic and Chinese, as well as English. During this review, it was noted that a "border" was mentioned at the morning quick review of patients. This is a local term used to describe the situation where a relative is permitted to stay overnight, to assist with communication between patient and staff.   Evidence was sighted of acknowledgements of special cultural events such as Chinese New Year, NAIDOC week and International Women's Day.

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	
A Healthscope Corporate policy is focused on consumer approved publications. One of the tasks of the Standard Two committee is the review of any literature prepared for patients. It was noted that one of the consumer consultants has an education background, so this review process is particularly thorough. The committee was also involved in the review of the patient care boards, situated in each patient bedroom. An outcome was the boards were made bigger, to make it easier for patients to read the information.	
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	
The patient communication boards, mentioned in action 2.9 have been reviewed by consumers to ensure they meet patient needs. Family attendance at case conferences and involvement of both family and patient in care planning and goal setting assist in ensuring patients have information which meets their needs. All patients receive a nursing discharge summary which is tailored to ensure patient understanding of ongoing care and medication requirements. Hourly rounding and executive rounding are other practices which may assist in identifying patient needs.	
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
Assessors noted photographs of appointed consumer consultants (one for rehabilitation and one for mental health - both with lived experience) and volunteers. These images suggest a strong mix of individuals from differing backgrounds and cultures. Public notice boards have large posters explaining the role of volunteers and consultants. The 'yes survey' given to patients on discharge from the mental health unit provides feedback on their hospital experience. There was evidence that feedback from the survey had been used to guide service delivery.

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
Assessors sighted the Healthscope consumer orientation template and the audit of consumer participation against 20 questions. A quarterly meeting "pizza lunch" is held with volunteers which provides a two-way forum for exchange of information and commentary on governance. A guest speaker is also scheduled. The Consumer Consultant's Toolkit provides an overview of roles and responsibilities, a background to the hospital and an introduction to the national standards. Concepts of cultural diversity and the Consumer Engagement Plan are introduced. Consumer training is focused on person centred care, defining roles in committee membership and reviewing policies and publications.

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
Assessors were provided with details of how engagement with local Aboriginal and Torres Strait Islander community and elders has occurred. This has culminated in February 2021 with a visit to the hospital from Leanne Watson, a Darug woman and Chair of the Darug Custodians Aboriginal Corporation.

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
Documented Information obtained from the consumer consultant who interviews patients "in the corridor" is shared with the workforce through written reports of patient feedback.

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
There is an infection control committee with multidisciplinary membership which meets every three months. A gap analysis reflecting the changes to the standard has been conducted. There is an Infection Control Management Plan. The organisation has used the services of a HICMR consultant for six hours a month, however with the increased demand of associated with Covid, this has been increased to one day a week. Locally there is a Nursing Unit Manger with assigned responsibilities for infection control education, ward audits and hand hygiene surveillance. Many of the HICMR audit tools are used. The Hills Quality Manger is also an active member of the committee. Staff have access to the full range of Healthscope and HICMR policies.   A significant achievement over the past couple of years was the conversion of a ward to provide accommodation for elderly patients with Covid. Throughout this report there are repeated references to the system, policy and staffing changes which enabled this to occur. At time of this review the ward had reverted to its original role of providing rehabilitation, however there is now a strong corporate knowledge and capacity to repurpose back to a Covid ward should this become necessary in the future.

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
Assessors were provided with a range of performance measures related to infection control. Many of these are based on HICMR audit templates. Healthscope has a range of Key Performance indicator reporting requirements with many of these linked to the relevant National Standard. Data was sighted related to hand hygiene compliance, implementation of recommendations from HICMR audits, staff immunisation and aseptic technique. Audit results for The Hills Private were consistently above the nominated Healthscope targets. A 19-page Infection Control Quality report outlined achievements in 2020.

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
Following patient feedback, soap dispensers have been placed in the bathrooms and privacy curtains around the bedsides are now disposable. The glossy patient compendiums contain detailed information about hand hygiene, IV cannulation with a full page dedicated to aseptic technique, clearly explaining the process, and inviting patients to contact the Nursing Unit Manager if they have any associated concerns.

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
Whilst rates of infection amongst the patient population are very low, minutes of the infection control meeting showed evidence of routine surveillance for urinary tract infections, blood stream infections, pneumonia and surgical site infections. The minutes also included records actions taken in response to any identified infection. In the reporting quarter data sighted there were no incidents of MRSA being reported.

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
There are a variety of Corporate Healthscope and HICMR policy and procedure documents to assist staff in the management of standard and transmission-based precautions. An Infection control resource folder is available for staff reference in every ward. This folder contains copies of relevant signage which can be utilised in the event specific precautions need to be followed for any patient. There are posters outlining required responses for standard and transmission-based precautions. Enlarged copies of these posters were also noted on display in public corridors.

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
The patient admission forms provide questions to encourage patients to declare any potential for exposure to MRSA, Covid and exposure to CJD. During this review, assessors were provided with detailed information about changes made to the hospital environment, which impacted on people traffic, entry and exits points, transfer of patient delivery points, staff change areas, creation of three air locks, installation of additional air filtration devices and the segregation of the hospital into "red" and "green" areas. Increased checking systems ensured that staff were correctly practising donning and doffing of protective personnel equipment.

All patients are screened for Covid prior to admission. Any person entering the hospital is required to demonstrate registration with the NSW QR code, confirm a series of Covid related screening questions and wear a mask. |

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
Any relevant infection related information is included in patient discharge documentation.

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
Data was sighted showing an active hand hygiene program consistent with the National Hand Hygiene Initiative. Audit results show the organisation exceeding the targets established by Healthscope Corporate office. Results for the three 2021 audits were 90, 90 and 92% respectively. To facilitate compliance, hand gel is now available at every patient bedside in the rehabilitation wards. In the mental health ward, staff carry individualised hand gel supplies. One of the hospital career medical officers is on the committee and very positive medical staff compliance is reported.

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
There is a Healthscope Corporate policy related to aseptic technique. Cannulation, wound dressings, in indwelling catheters and administration via intravenous lines have been identified as the procedures at The Hills Hospital where aseptic technique applies. Training has been provided. The eLearning report for 2021 shows that 89% of staff have completed the aseptic technique program. Results from the surveillance programs indicate strong compliance with aseptic technique.

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
There are policies covering clinical skills associated with, for example, insertion of indwelling catheters, wound dressings and peripheral Intravenous catheter lines. Aseptic technique is practised. Each ward has a nurse with an Infection prevention portfolio. The patient handbook contains a full page clearly written explanation of aseptic technique with an invitation to patients to contact the Nursing Unit Manager if they have any concerns.

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
Assessors were very impressed with the overall presentation of the hospital from a cleanliness perspective. The cleaning staff have a daily 0800 huddle to confirm issues and priorities for the day. Patients who require special precautions are identified and checks are made that appropriate equipment and personal protective equipment is available. They are clearly valued members of staff. Cleaners' cupboards reviewed during this survey were well organised with appropriate arrangements for minimal handling of detergents. Hard copies of material data sheets were sighted. There are cleaning schedules for different parts of the hospital. Environmental rounds and HICMR audit results were on display. Records of water quality testing in the hydrotherapy pool were sighted. Cleaners' trolleys were well equipped with personal protective equipment.

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
Linen is supplied by an external contractor – Spotless. It is decanted from trolleys and stored into trolleys on delivery. A certificate of compliance by the contactor with AS/NZS 4146:2000 was sighted. Shortly prior to this review, the hospital has moved to a contracted maintenance service, with a representative from the company being on site. Processes for logging maintenance requests and responding to more urgent calls appeared appropriate. It is too soon for formal evaluation of the new arrangements.
Suggestion(s) for Improvement
1.   In the context of any future refurbishments, consideration be given to adopting a system of clean linen replacement which avoids the need for manual handling through the transfer of linen from trolleys onto shelves. 2.   As a quality improvement initiative, conduct a formal evaluation of the services provided by the maintenance contractor, ensuring any such review has input from departmental Managers.

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
Records provided to assessors showed that about 94% of staff are fully vaccinated. These records detailed the status of individual staff members with regards covid, influenza, Hep B, Pertussiss and Measles, Mumps, Rubella. The organisation has strict screening procedures for any individual entering the hospital. It was noted however that visiting medical staff have been given until the end of November 2021 to demonstrate their Covid status.

Rating	Applicable HSF IDs
Met	All

Org Name   :   Hills Private Hospital, The
Org Code   :   125984

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
A Gap analysis against AS 4187 was updated in 2020. This organisation does not reprocess reusable critical or semi critical devices. The organisation is compliant with the Commission's advisory AS 18/07.

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
There are policies and established routines underpinning the Antimicrobial stewardship program. Oversight is provided with input from the Director of Medical Services, a pharmacist contracted from HPS, the private pharmacy provider, a Nursing Unit Manager and the HICMR consultant. Two infectious diseases consultants and a microbiologist are accredited to the hospital, to provide advice as necessary. There is a "stop light" system with "amber ": and "red" prescriptions reviewed by the infectious diseases physician or microbiologist. The antimicrobial stewardship system is integrated with the Healthscope Norwest acute hospital, as this is a primary referral source for many of the orthopaedic patients who come to The Hills for rehabilitation. Staff have access to the Australian Therapeutic Guidelines for antibiotic use.

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
Monthly ward reports are produced following pharmacist lead surveillance. Feedback is provided to wards and prescribing clinicians. A change to clinical documentation has included notations such as "not for antibiotics" when this clinical decision has been made. This is a useful communication for ward staff and the career medical officers.

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
THPH has systems to ensure appropriate governance in relation to medication safety. Healthscope corporate policies are reviewed and modified as required by a local medication safety committee. All policies are available to staff via the intranet and staff are notified by email of any updated policies relating to medication safety. Medication incidents are reported via the RiskMan system. Medication incidents are reviewed by the Medical Advisory Committee, the Medication Management Committee and the Quality and Safety Committee. Trended medication error reporting is available for review. The Pharmacist who visits 4 times a week reviews all aspects of medication management and provides education for both staff and patients. Training of staff in medication management is ongoing and commences as part of the orientation program. A "shared learnings" report is distributed across the Healthscope hospitals that includes medication incidents and controls that may impact on medication incidents. This incident reporting and "shared learnings" are used to support both online and local educational activities.

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
THPH was able to demonstrate and provide evidence on a number of systems and processes used to promote and support medication safety during the two-day assessment. Some of these included policies and procedures that are referenced and reviewed in line with policy guidelines, medication safety alerts in the medical record, recording of best possible medication history (BPMH) and appropriate storage of medications. Monitoring the performance and effectiveness for medication safety includes review of medication incidents, complaints and appropriate audits. Signage on the treatment room doors in the mental health unit advise of medication times and the need for appropriate distancing

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
Patient medication charts are part of a compendium of charts that are included in the daily bedside handover ensuring the patient is included in a discussion on their medication and any concerns are able to be identified and addressed. On discharge patients who provide an email address on admission are sent an online survey that includes feedback on their medication experience. This approach, however, means that those patients without access to an email address or who do not provide an email address do not have an opportunity to provide feedback. This lack of opportunity may be further compounded by difficulties that some patients may have completing online surveys. The exploration of alternative approaches to survey distribution could be explored to overcome these identified limitations.
Suggestion(s) for Improvement
It was noted by the assessors that there was no opportunity for patients to provide feedback on their hospital experience including medication management during their stay.

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
It is suggested a system such as 'suggestion box' be provided to obtain de identified comments/suggestions from patients and their families/carers that could be addressed in a more, timely manner if appropriate.

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
All VMOs are credentialed and listed on webPAS which is accessible by senior nursing staff. Nursing Position Descriptions for Registered Nurses and Endorsed Enrolled Nurses detail scope of practice and medication management. Nursing registrations are checked annually. THPH ensures that there are always two registered nurses on duty to fulfil legislative requirements for medication management and administration.

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
During the admission process patients and carers are involved in development of the Patient Care Plan that includes medication management. Any change to medication is documented in the medical record and the Medication Management Plan. There is a system in place to ensure more detailed medication reconciliation activities are undertaken as required.

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

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
Medication charts are checked at each handover between nursing staff and at bedside handover to ensure prescribed medication has been administered and orders in the medication charts have been entered correctly. Medication reconciliation is monitored by annual audits of the MMP. The audits indicate high compliance with medication reconciliation on transfer and discharge of patients. The discharge summary provided to the patients General Practitioner contains information about the care provided, changes to medications, current medication lists, medication management plans, and ongoing monitoring requirements.

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
Any known allergies and adverse drug reactions are highlighted on medication chart and the patient's medical record. Red arm bands are used to alert staff to allergies and there is an associated arm band audit.

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'
Medication incidents are documented in the patient's medical record entered into RiskMan and reviewed at appropriate committees. Serious incidents are tabled and reviewed at the MAC meeting. Patients and their family/carers are informed of any identified adverse drug reaction or allergy.

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
Any suspected drug reactions are reported to the Therapeutic Goods Administration (TGA) via their website. There have been no adverse drug reactions requiring reporting to the TGA for five years.

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
A best Possible Medication History is obtained on admission. Medication reviews are prioritised based on patient clinical need at pre-admission and can be triggered during their hospital stay for reasons that may include routine review, change in condition, transfer, and requested by the patient or their family/carers.

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
Nursing and medical staff are available to discuss medication management with the client and their family/carer including any associated risks to help ensure they are able to make informed choices regarding treatment options. The Pharmacist also provides information and education on medication in either a group or individual setting in both the rehabilitation and mental health wards.

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
The Pharmacist completes medication profiles on high-risk patients that are sent to the referring GP and given to the patient on discharge. Medication profiles for all patients are included on the medical discharge summary. Patients transferred in an emergency are provided with a copy of their current medication chart and Emergency Management form to ensure the receiving facility has the most up to date medication information.

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
Medication management forms part of staff orientation and staff were able to demonstrate and provide evidence to the assessors on several systems and processes implemented to promote and support medication safety. There is ready access to decision support information for clinicians that is updated as required by the Healthscope librarian. Electronic and hard copy reference literature is available and easily accessible to support medication practice. The medication error reflection form exists and is actioned as a non-punitive tool designed to help staff identify strategies that may avoid similar medication errors in the future.

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
THPH has clean and secured medication rooms with clear work benches. Schedules 8 and 4 restricted medications were appropriately stored, and the registers maintained and audited. Medication management plans were evident in the files viewed by the assessors. Medication fridges are monitored to ensure appropriate temperature control and there are guidelines to be followed if the temperature deviates from the required range. There are good practices in place to guide storage and return of patients' own medications. On discharge patients own medication not currently prescribed is placed in a red plastic bag and current medication in a green plastic bag. This easily differentiates current medication that is to be taken at home.

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
Resuscitation trolleys are locked and checked daily. Patients on high-risk medications are reviewed by the Pharmacist and have a medication profile. Although few patients are prescribed Clozapine there are systems in place to ensure appropriate administration and 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
There is a raft of Healthscope policies pertaining to this standard complemented by THPH locally developed policies. All local policies are discussed at the Partnering with Consumers Committee meeting and Consumer Consultants are able to contribute to these policies. THPH participates in a comprehensive care cluster enabling a comparison of performance in relation to comprehensive care. An analysis on Healthscope practices was conducted and any identified gaps actioned. THPH Comprehensive Care working party address any education that is required by staff. Multidisciplinary approaches to all aspects of care across the hospital were evident that align with current policies, procedures, and guidelines. On admission THPH utilises a standardised suite of clinical assessment forms. The assessment process is comprehensive commencing with the information received on admission and then followed by medical, nursing and allied health input. Clinical information is documented in the medical record and communicated via huddles, patient rounding, team reviews, and clinical and bedside handovers and forms the basis for ongoing treatment, ensuring patient needs are understood and considered in the planning and delivery of care. The clinical governance system is inclusive of a risk register, which is monitored on a monthly basis and a Quality Management Plan that outlines priorities and actions identified through peak committees. Terms of Reference, attendance, minutes and actions arising demonstrated that the governance structures within THPH are sound.

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
THPH utilises a standardised suite of comprehensive clinical assessment forms that determine ongoing treatment and care planning ensuring patient needs are understood and considered. All patients admitted are routinely screened for falls and pressure areas and additional risk assessments are conducted if the patient's health status changes. There was evidence in the medical records viewed by the assessors that patients have routine observations to monitor their physical health and risk assessments were regularly reviewed and updated. Comprehensive care is monitored through the review of audit results, incidents and patient feedback and the results are reported to appropriate committees. An exhaustive audit schedule is in use outlining the frequency of each audit according to risk level and previous results. Action plans are implemented to improve outcomes. The Risk Register is also updated with appropriate actions and controls that have been put in place Audit results and trends contribute to overall quality improvement activities.

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
Information on Patients' Rights and Responsibilities is displayed throughout the hospital and included in the Patient Information Directory given to patients on admission. The Directory also outlines how patients can be actively involved in their own care. Assessments and care plans are completed with the patient, and when relevant their family/carer. However, evidence of their involvement was not always evident and documentation should demonstrate either by signature or entry in the medical record that care planning has been done in conjunction with patients and if appropriate, families/carers. Family members or interpreters can be used to support consumers when any communication is required. Mental Health patients and their family/carers are part of the recovery-based care plan that is reviewed and updated throughout the patient journey. Patient rounding, bedside handover and patient care boards provide daily opportunities for patients to be involved in their care and have concerns or issues addressed or clarified.

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
The Patient Experience Survey completed on discharge is also used to determine patients' level of satisfaction in their care delivery.

Suggestion(s) for Improvement
Strengthen systems to demonstrate that patient and the family have been included in the care planning process.

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
The mental health unit has a 21 day group therapy program that all patients are expected to participate in as part of their treatment. At the end of the program outcome goals and behavioural changes are evaluated. THPH has dedicated discharge coordinators that include a social worker to ensure discharge planning begins on admission. The discharge process is coordinated with the multidisciplinary team throughout the patient's journey to ensure referral systems are in place to support patients and their families when they leave the hospital. A nursing and medical discharge summary is given to the patient for external care providers including the GP.

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
Position descriptions include a description of quality and safety responsibilities with annual staff review linked to these responsibilities with the objective to ensure that all clinicians are appropriately credentialed and working within their scope of practice. Separate processes are in place to ensure that compliance is achieved for non-registered professions (e.g. Social Work) which includes minimum qualifications and affiliation with the relevant professional body.

Rating	Applicable HSF IDs
Met	All

ACTION 5.6
Clinicians work collaboratively to plan and deliver comprehensive care
Comments
During the assessment the assessors attended the virtual morning Head of Department team meeting where patient, staffing and environmental safety issues were discussed. Bed allocations were seamlessly organised according to patient requirements at pre-admission screening. The information from the meeting was collated and sent to all staff via email and updated throughout the day. As well as the identified routine clinical handover processes, weekly case conferences are held for all patients during their admission. All members of the multidisciplinary team attend and contribute to determine the patients' current status, goals and discharge planning. Stickers easily identified which discipline had documented in the medical record.

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	
THPH uses the Comprehensive Risk Screening tool when patients are admitted that was designed with consumer input to align with this Standard. The form is completed again every 7 days or if there is a change in a patient's condition. Education was provided to staff on the importance of completing all domains on the form that provide the foundation for a comprehensive care plan. Mental Health also complete a similar Comprehensive Risk Screening tool. These forms were evident in the medical records viewed by the assessors the rehabilitation and mental health wards.	
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	
On admission all patients are routinely asked if they identify as Aboriginal or Torres Strait Islander. This information is entered into webPAS. THPH has an Aboriginal liaison officer from within its existing staffing profile to support cultural needs. Staff also receive cultural competency training.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.9
Patients are supported to document clear advance care plans
Comments
The admission process includes a section on the presence of a current Advance Care Directive and this is discussed and information provided to the patient and their family/carers if appropriate.

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
Risk assessment screening tools are completed on admission and at regular intervals to identify any potential risks during the patient's journey. The patient and their family/carer are important contributors to this process to provide any background information or any known triggers that can exacerbate a change in presentation.

Appropriate referrals are made to the multidisciplinary team members following the screening process. It was noted that the OT reviews every patient admitted to the hospital. |

Rating	Applicable HSF IDs
Met	All

ACTION 5.11
Clinicians comprehensively assess the conditions and risks identified through the screening process
Comments
Assessment tools and resources are available at point of care for clinicians and education is provided on the use of the assessment and screening tools. The annual documentation audit identifies any areas of noncompliance with documentation of the screening and assessment process and areas of noncompliance are identified and an action plan formulated. It was pleasing to note outcome measures formed part of the routine assessment and identification of risk.

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
Following screening and clinical assessment any alerts or risks are documented in the medical record on the alert sheet and the patients care plan updated as required. Alerts are included on the care board for inclusion and review at bedside handover. Alerts are included in the clinical handover sheets that are used by clinicians at change of shift.

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
Advisory notice AS18/15.: Evidence was sighted of a completed gap analysis and implemented action plans to comply with this standard in relation to comprehensive care plans. There was evidence that the December 2021 targets were also met in relation to the advisory. A comprehensive structured patient assessment is completed on admission and identified risks are documented and updated as required. The comprehensive care plan includes a nominated support person to be involved in decision making regarding care and an identified goal documented as an outcome of the admission to hospital. The medical records viewed by the assessors included medical and nursing assessments, changes in clinical state, care provided and pertinent patient information to support the multidisciplinary team to deliver care. Documentation education is provided to staff and regular documentation audits are done to ensure the medical records meet legal and professional requirements. Discharge planning was seen to commence on admission to THPH and included anticipated health care needs on discharge to help ensure a safe transition from hospital that includes the patient and family in the discharge process.

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
The comprehensive care plan is completed on admission. The daily care plan is reviewed each shift and formulated from information obtained about the patient's health history, comprehensive care plan and risk assessments.

Assessment outcomes are cross referenced with the patient's goals to monitor the effectiveness of the comprehensive care plan.

Any identified changes in a patient's behaviour, cognition or mental state are updated in the care plan and reviewed at the multidisciplinary case conference. |

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
Patients who become medically compromised and who are at end of life can be transferred to more appropriate facilities.

However, patients who are at end of life can nominate to remain at the hospital. The Last Days of Life Resource informs staff about the process for end-of-life decisions.

The assessors were touched by the empathy and compassion displayed by the staff when they spoke of the care and end of life quality they were able to provide. |

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
Healthscope policies and guidelines are available to staff including the End of Life Toolkit. An accredited specialist with palliative care expertise is also available if needed for support and advice. Staff are aware of counselling support services for family/carers.

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
On admission Advance Care Directives (ACD) are discussed and information provided. If a patient has an ACD this is documented in the medical record, the alert sheet and on webPAS.

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
Support is available if needed for staff providing end of life care that includes team debriefing, counselling and the 24 hour employee assistance program (EAP).

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
The Medical Advisory Committee reviews clinical incidents including morbidity and mortality.

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
Any decisions concerning end of life care are made in consultation with the patient and their family/carers and the agreed management plan is documented in the medical record to ensure all staff are aware of treatment to be withdrawn or withheld.

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
Prior to admission to THPH patient mobility is discussed during the initial pre assessment as the building structure requires a level of mobility and activity. The assessment also contains information pertaining to current pressure injuries or wounds and includes any history of recent infections. The Waterlow Pressure Injury Prevention/Treatment assessment tool forms part of the admission screening process.

Routine Rounding by staff helps ensure patients are mobile and active and partake in all activities that form part of their treatment program. |

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
Managing pressure injuries includes the use of appropriate mattresses/equipment, wound management and review of nutritional requirements. Healthscope shared learnings include pressure injury and prevention that require policy review, risk register action or improved processes.

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
All patients have a routine pressure area risk assessment on admission that is updated daily and a final assessment completed on discharge. Pressure injury screening was evident in medical records viewed by the assessors. All pressure injuries and other skin related injuries identified on admission or hospital acquired are recorded on RiskMan and investigated. Staff when interviewed were clear on the process for pressure injury care and this is reflected in the low rates of reported pressure injuries within the hospital. Although patients admitted to the mental health unit are generally ambulant and there have been no instances of pressure injury in past years routine pressure area risk assessments are still completed.

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
Patients their families/carers are provided with relevant information specific to the prevention and management of pressure injuries on admission, during their stay and upon discharge. This information includes patient brochures. All patients see the OT on admission where any pressure injury prevention and management strategies are discussed and implemented. Staff receive education in pressure injury identification, prevention and management.

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
The assessors were impressed with the work that had been done in relation to the management of falls underpinned by Healthscope Policies and Procedures.

Falls screening commences on preadmission by the intake officer and this information is provided to the executive and assists in appropriate bed allocation. All patients admitted are routinely screened for falls that is included in the comprehensive care plan. The care plan is reviewed every 7 days and if there is any change in a patient's health status. All patients admitted to the rehabilitation ward are assessed by the Allied Health Team. Falls information is recorded in the medical record, alert sheet and in WebPAS.

The nursing discharge summary includes an overview of past and current mobility status and includes information regarding falls risk and associated management strategies. Although patients admitted to the mental health unit are mobile falls screening is still conducted and audited for compliance. |

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
Falls prevention equipment to help reduce the rates of falls within the THPH is readily available. There have been a number of quality initiatives to assist in the reduction of falls and falls with harm including; patient rounding, bedside handover and falls safety huddles. It was noted the introduction of sensor mats had decreased the falls incidents.   The clinical handover process includes discussion of patients identified as a high falls risk. Patients can be allocated a bed near the nurses' station if needed for greater observation.   Ongoing review and monitoring of falls data is reported at appropriate committees and forms part of Healthscope's shared learnings.

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
During the admission process information is provided on falls in the consumer approved Patient Information Directory. Families are also advised on what items from home can assist patients who are at risk of falls during their hospital stay.   The Physiotherapist and Occupational Therapist are involved in assessing patients and providing advice to both patients and caregivers of interventions and prevention strategies that can be used in hospital and when going home.   Patient care boards indicate for staff and family and carers the level of assistance and any walking aids that are necessary.

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
Food allergies and any cultural dietary restrictions are documented in the patients' medical record. THPH if required has a referral service to speech pathology who are able to assess patients and if indicated recommend food consistency and feeding options. The dietitian provides education sessions to inpatient and day program patients on nutritional advice specific to their individual needs. All staff who are involved in the preparation of food have completed the online food safety handling training course.

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 comprehensive risk screening tool completed on admission and weekly includes height, weight and appetite and the scoring determines if a nutritional intervention is needed. All patients are weighed every Friday. Food and fluid charts are commenced to monitor intake if needed. THPH has protected patient mealtimes to help ensure patients are not disturbed and patients are assisted with eating and drinking if necessary. Patients have the opportunity to provide feedback on food and menu options via the feedback section on their menu or the web site on discharge.

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
If two or more risk factors for delirium are identified the 4AT assessment for delirium and cognitive impairment is completed. Patients identified at risk of delirium or cognitive impairment have this information included in the alert sheet at their bedside and entered into WebPAS Family and carers play an important role in providing staff with information about the patient and how they normally present. The medication risk assessment completed on admission identifies patients that are taking high risk medications including antipsychotic medication. The patients are then referred to the pharmacist for ongoing management and review.

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
There are policies and guidelines to manage patients who have cognitive impairment. Family and carers are valuable in obtaining a past history and identifying any de-escalation strategies that may be useful to support the clinical staff in management and care for the patient. Helping family members and carers understand the diagnosis, the possible future and their own caregiving role can be important as they may be providing care on discharge over an extended period of time.

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
There was evidence THPH has established protocols for escalation of care. Risk assessments are completed daily on patients in the mental health unit that determine the level of observation needed. There are duress buttons located in patient bedrooms and staff carry personal duress alarms that can be activated for an emergency response. Patients in the rehabilitation wards who have mental health issues are reviewed by the mental health team and can be transferred to the mental health unit or a psychiatrist for specialised care. If necessary, patients are located near the nurse's station and provided with 1:1 care for close observation to ensure their safety. All episodes of self-harm are recorded in RiskMan and included in the Quality risk management framework.

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
The medical and nursing discharge plan identifies any episodes of self-harm and if the patient has been referred to any outside agencies. A discharge follow up phone call is made to the patient after 7 days to ensure patient safety.

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
All staff are trained in Workplace aggression and violence and attend emergency procedures training that includes de-escalation strategies.   The indicators for calling for emergency assistance are included on the track and trigger charts.   Staff from the mental health unit are available if needed to see patients in the rehabilitation ward.

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
THPH has strategies to identify patients at risk of becoming aggressive or violent.   If de-escalation is not possible, they are transferred to a more secure facility.

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
Restraint is not an accepted practice at THPH.   If restraint is clinically indicated police or ambulance are called to transport the patient to a more secure environment.
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	
This action has been rated Not Applicable. There are no seclusion facilities at THPH which is not a gazetted MH facility.	
Rating	**Applicable HSF IDs**
N/A	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
There are a variety of systems within THPH to ensure timely and effective communication and documentation that support safe and coordinated care for their patients. There is a clear process to facilitate identification, reporting, escalating and controlling risks and staff demonstrated an understanding of their role in minimising risk and contributing to safety and quality in their delivery of care. Effective communication is governed by the Communicating for Safety Committee and supported by appropriate policies and guidelines. All incidents and complaints are reported through RiskMan. Open disclosure policies are in place, with staff receiving training on how to implement the intent of the policy. The after-hours nurse manager handover is a useful communication tool providing continuity of care relating to staffing, patient safety, and any issues of concern.

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
Clinical staff receive education in Clinical Handover that include training videos. Introduction, situation, background assessment recommendation (ISBAR) is used for all transfers of care including handovers, transfer to another provider and discharge. Transfer of care is well documented and regular audits occur on all aspects of clinical communication.

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
Incidents relating to communication are entered into RiskMan and staff receive education on the RiskMan system during orientation.

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
The bedside handover in all wards between the AM and PM shifts demonstrated a systematic approach to the handing over of patient information including medication management, treatment planning, goal setting and discharge plans.

The bedside handover is an ideal opportunity to involve patients and if appropriate family and carers in ongoing care planning and receive feedback on how the recovery journey is progressing for them and an opportunity to ask questions and have any concerns clarified.

Patients described to the assessors a high level of satisfaction with being included in the handover process. Care boards were in all bedroom areas and information was seen to be updated during bedside handover.

Patient rounding is another way THPH is able to meet patient care needs, ensure patient safety, and decrease the occurrence of patient preventable events, and proactively address problems before they occur.

There are resources available that inform patients of their rights, inclusive of being involved in day-to-day care and decision. |

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
Clinical communication is included in regular staff huddles, shift-to-shift handovers, bedside handover and the afterhours nurse manager handover and includes correct patient identification. Appropriate guidelines are in place to continually check that patients are matched to their intended care and treatment. Any variation to this process is recorded and reviewed through RiskMan. The revised Rehabilitation case conference form includes specific sections to document the disciplines involved in the case review.

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
Patient identification and procedure matching is well understood, and it is given appropriate attention by all staff. The patient identification and procedure matching system include the use of the three nationally approved identifiers for inpatients and outpatients. A white identity wrist band listing the three patient identifiers is attached to the patient unless the patient has an alert when the band is red. The inpatient bands used are consistent with the national standard. Patients are made aware of the protocol that staff are required to follow to establish correct personal identification. Appropriate guidelines are in place to continually check that patients are matched to their intended care and treatment. Any variation to this process is recorded and reviewed through RiskMan. ID bands are checked during bedside handover each day and replaced weekly. All patients admitted to the mental health units have identification photos attached to their medication charts and medical record and these were seen by the assessors to be large and of good quality. Consent forms for photo identification also were evident in the medical record.

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
Sound identification practices were in place for the transfer of patients to and from other providers.

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
During survey three patient identifiers were observed by assessors to be used at clinical handovers, medication administration and treatment procedures. There is a comprehensive audit schedule on patient identification and action items were available for any areas of non-compliance.

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
THPH has policies that specify that information shared as part of the handover process contains relevant, accurate and current information about a patient's care guided by the ISOBAR structured communication tool.

There was evidence on the assessment of monitoring of compliance with handover policies through clinical audit.

Relevant multidisciplinary staff attend clinical handovers that can include patient/family/carers if appropriate. |

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
Bedside handover time is isolated to minimise any disruptions.

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
Communication was seen to embrace all aspects of care and across all domains verbal and written. From a governance perspective, there are a range of policies, guidelines and procedures to support the clinical handover process. Clinicians use a structured framework, ISOBAR and there is evidence of actions to increase the effectiveness of clinical handover using contemporary practice. The care boards in bedroom areas contained information on each patient including goal setting, diet, risk alerts and possible discharge dates and was updated as necessary and complimented the shift-to-shift handover process. The assessors attended several clinical handovers and were impressed with the multidisciplinary patient centred approach to the handover of ongoing care. Clinical handover sheets used at shift handover contained diagnosis, past history, risk investigation and any discharge plans.

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
THPH has identified the importance on the use and monitoring of effective clinical handover/s. The situations where and when clinical handover should and do occur are clearly identified with resources available to facilitate a structured communication process. Whether it is a nursing or multidisciplinary handover there are defined roles and responsibilities of clinicians and the involvement of the MDT in handover is well established. Alerts and risks are included in the verbal handover sheets used by clinicians, documented in the medical record and are included in the regular huddles, bedside handover and patient rounding.

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
The Patient History Form completed on admission is an opportunity to advise staff of any critical past medical history or alerts. There are multiple systems in place for patients and their families/carers to communicate information and risks to clinicians including REACH, bedside handovers, emergency duress and family conferences. Patients and their families are also encouraged to contact staff at any time if there are concerns about any aspect of patient care. Information on the complaint process is available with complaints trended and responded to within 28 days.

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
Assessors reviewed a number of medical records that were available at point of care, and found them to be well structured and integrated, and suitably organised to facilitate various regular audits of progress notes, patient pathways, management plans and alerts to cite a few. A comprehensive structured patient assessment was completed on admission and identified risks were documented and updated weekly and as required. Mental health patients have a preventing relapse and care plan started on admission that is reviewed regularly, and goals are generated collaboratively with patient and carers (where applicable).

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
The Hills Private Hospital only provides about 10- 12 blood transfusions per year. The organisation however is well prepared to ensure the risks associated with blood transfusion are managed safety. Governance of the Standard is provided by a team lead by a senior nurse manager and a senior nurse with extensive experience in blood management from a tertiary referral Hospital.

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
Following each occasion of blood transfusion, a formal audit is conducted providing oversight of all aspects of the transfusion procedure. The post procedure audit incudes a detailed 10 item patient questionnaire, inviting feedback on issues such as being provided opportunity to ask questions, consent confirming risks discussed ad information provided.

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
Consumers are provided with the "iTransfuse Fact Sheet" which addresses the question of "what happens when I receive a blood transfusion?". This document is produced by the Australian Red Cross Blood Service. There is a dedicated consent for blood transfusion/ blood product administration which requires patient signature. The document requires that the patient is informed of associated risks including non-serious common reactions, uncommon serious reactions and the rare possibility of infections such as Hepatitis B and C and HIV/AIDS. The patient information is available in different languages.

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
The organisation is risk averse and would not provide blood to patients with significant underlying health conditions. The hospital is not equipped to optimise use of patients own red cells, haemoglobin and iron stores.

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
The health care record contains comprehensive documentation associated with blood transfusion. The Blood transfusion documentation checklist, identifies the required information which includes: indication, patient has received information, consent signed by patient and doctor, cannulation details, type of blood product, start and finish tie, observations , before, during and after transfusion, volume of blood product to be administered, adverse reaction details and medications administered.

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
Each ward which might administer blood is equipped with the Blood Bank Australian Blood Administration Handbook, together with a "Blood Transfusion Pack" which contains copies of the relevant documentation which will be required for a transfusion. Registered nurses are required to complete the relevant eLearning course. The on-site nurse educator provides practical education and nurses unfamiliar with blood transfusion management are required to observe the process as it is conducted by two experienced nurses.

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
There are systems in place to ensure that any transfusion-related adverse event is reported in accordance with national guidelines and criteria.

Rating	Applicable HSF IDs
Met	All

ACTION 7.8
The health service organisation participates in haemovigilance activities, in accordance with the national framework
Comments
Whilst reactions to blood transfusion are documented and reported to the transfusion service provider, the low number of annual transfusion events mitigates against the organisation participating in haemovigilance activities.

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
Procedures regarding transport and cold chain maintenance ensure that blood is handled and administered in accordance with legislation and best practice guidelines. The Healthscope Blood and Blood products prescription and transfusion record is detailed documented with red "stop" points to ensure that appropriate decisions, documentation and checks are made prior to a transfusion occurring. The document also provides direction on required transfusion observations and instructions on steps to be followed in the event of a transfusion reaction.

ACTION 7.9
The health service organisation has processes: a. That comply with manufacturers' directions, legislation, and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer

Rating	Applicable HSF IDs
Met	All

ACTION 7.10
The health service organisation has processes to: a. Manage the availability of blood and blood products to meet clinical need b. Eliminate avoidable wastage c. Respond in times of shortage
Comments
As blood use is minimal, supplies are only ordered when a decision to transfuse has been made. There are therefore no wastage issues.

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
Advisory AS19/01 relating to Actions 8.5,8.6 and 8.12 have been addressed and implemented and a gap analysis completed. THPH are on track to meet the December 2021 targets. There are a raft of policies relating to deteriorating patients and these are reviewed by the Recognising and Responding to Acute Deteriorating working party and the executive team. THPH has an agreement with Norwest Private Hospital that patients who deteriorate clinically can be transferred by Ambulance for ongoing investigations and treatment. Quarterly data on acute clinical deterioration is reported to Healthscope and forms part of Healthscope KPIs that are reviewed and benchmarked. There are screening and assessment policies to recognise physiological changes as well as acute change in cognition and mental state. Patients who are unable to be safely managed in the mental health unit can be transferred to a local mental health facility if required. Education on recognising a 'Medically Deteriorating Patient' in the rehabilitation setting is provided to clinical staff by the consultant geriatrician.

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
There is a Shared Learning Report every 3 months provided by Healthscope that outlines near misses or serious events from other hospitals and uses the recommendations to review current systems to reduce the risk of similar occurrences. The Shared Learning Report is provided to all Department Managers for implementation at a ward level, if appropriate, and included in the THPH Quality Action Plan. All MET calls are entered into RiskMan and collated and investigated and there was evidence of improvement strategies following serious incidents. This information is communicated to staff via appropriate meetings and email.

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
As part of the admission process Advanced Care Directives (ACD) are discussed with patients to explore the option of documenting the type of health care they may or may not wish to receive if they become seriously unwell or unable to make informed decision for themselves. The 'Last Days of Life Care' pack comprehensively outlines for both the patient and their families/carers information on supports needed if the patient goes home, such as medication management and practical advice on preparing for end of life. There is a multidisciplinary approach to planning and partnering with the patient, carers and their families to ensure shared decision making and involvement in delivered care. The assessors were informed some palliative patients had opted to remain on the rehabilitation wards to be cared for by staff they knew in a familiar and caring environment. Large bedrooms were available for family/carers to stay with the patient if needed. End of life care is managed sensitively and supported by appropriate policies and guidelines.

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

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
Patients are routinely screened on admission for past and current history that includes cognitive or mental health issues. Routine observations are charted daily, are were evident in medical records seen by the assessors. Observation charts are included in the medical record audit. Cognitive screening is conducted on admission to THPH and routinely throughout the patients stay. This provides a baseline to identify any decline in cognition that may be due to delirium, dementia or depression. There is a pathway for staff to follow for a deteriorating patient that includes escalation, documentation, communication and transfer procedure if required.

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
All patients have a mental health comprehensive care plan that includes early warning signs and triggers relating to acute deterioration, including mental health and delirium. Family and carers play an important role in providing staff with information about the patient and how they normally present. Patients in the rehabilitation wards who have mental health issues are reviewed by the mental health team and can be transferred to the mental health unit or a psychiatrist for specialised care. If necessary, patients are located near the nurses' station and provided with 1:1 care for close observation to ensure their safety.

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
There was evidence THPH has established protocols for escalation of care and identified the importance on the use and monitoring of effective clinical handovers. Patients are discussed at daily clinical handover, huddles and are included in bedside handover. Standard Adult General Observation (SAGO) form is used to monitor and track deterioration in physical health. Patients at risk of delirium and cognitive impairment are entered on the alert sheet and this alert is included at bedside handover. Risk assessments are completed daily on patients in the mental health unit and this determines the level of observation required by staff. All staff complete Aggression and Violence Education that includes recognition and de-escalation of disruptive behaviours. The indicators for calling for emergency assistance are included on the track and trigger charts.

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
REACH is actively promoted in all units including mental health. There was evidence of posters and information on REACH including telephone numbers displayed in the hospital and in the patient information directory. They outline how patients and their families/carers can escalate concerns regarding changes in a patient's mental or physical condition. As part of the orientation process patients and their family/carers are also provided with information on the use of the wall mounted emergency buzzers located in the bedroom areas.

ACTION 8.7
The health service organisation has processes for patients, carers or families to directly escalate care
Patients, carers/families are also encouraged to contact the treating team either from home or at the hospital at any time if they are worried or concerned. During bedside handover staff ensure any family/carers present are aware of the escalation of care process.
Suggestion(s) for Improvement
REACH posters currently displayed have small print and phone numbers and information not easily identified. It is suggested the REACH posters in patient areas be enlarged and laminated so they are easy to read.

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
All staff receive training in BLS. However, during survey, the percentage of staff having completed BLS training was under 90% in some wards. It was explained to the assessors it was not a true representation as staff on extended leave were still counted in the numbers. Emergency trolleys and defibrillators were located in each ward and were checked and securely stored. It was noted due to lack of storage in the mental health unit the emergency trolley was kept in the small staff tea room. There are duress nurse call buttons for rapid response to an emergency situation. The ambulance or police are called for any situation that is unable to be managed safely by staff. Escalation of patient care can also be made to the appropriate treating VMO who is on call after hours.

Rating	Applicable HSF IDs
Met	All

ACTION 8.9
The workforce uses the recognition and response systems to escalate care
Comments
THPH staff have an Emergency Procedures Guide that is colour coded and provides guidance when there is mental or physical patient deterioration. All staff receive annual fire and emergency training and attend mock evacuation drills. There was signage throughout the hospital advising of duress alarm locations and the 222 the emergency response number.

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
There is a range of policies that outline the required skills and management of episodes of acute deterioration. There is a CMO on site during routine business hours who responds to episodes to acute deterioration. The CMO is on call after 4 pm.

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
Two senior nurses have been trained in advanced life support and have advanced skills in medical emergencies. All staff are trained annually in BLS and the use of the defibrillators. There is an in house response team that immediately attends a duress alarm. If an ambulance is called staff request, if necessary, a Priority one (lights and siren) response. All response times are included in the Riskman incident report.

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
Procedure documents outline the need to assess patients for any deterioration in their mental state including risk of self-harm or suicide were readily available. The documents included an identified risk assessment tool and the associated need for self-monitoring as required. These policies also identified the need to transfer patients to a local mental health unit by ambulance for stabilisation if patients were unable to be managed safely at THPH. Patients in the rehabilitation wards have access to a mental health clinician to assess patients who become unwell. There are systems to ensure that consumers or carers can escalate care as needed, particularly for those at risk of suicide or self-harm. Staff receive training in de-escalation techniques, including respecting personal space, making verbal contact, and identifying the patients' wants and needs. Patients are able to be nursed in an area that enables higher levels of staff observation or additional staffing input. During the assessment, it was noted that the workforce had access to and used personal duress equipment. Incident reporting included identification of self-harm and suicide, and this incident monitoring was used to identify opportunities for improvement.

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	
Rapid Response Activation Criteria is used for acute physical deterioration of a patient. The Medical Emergency Team (MET) respond to signs of deterioration in patients and provide immediate assessment and appropriate and timely management. All MET calls are reported via RiskMan. Patients needing higher levels of care are transferred to Norwest Private Hospital by ambulance.	
Rating	**Applicable HSF IDs**
Met	All

Recommendations from Previous Assessment

Nil