NSQHS Standards Second Edition Organisation-Wide Assessment

Final Report

Northpark Private Hospital

Bundoora, VIC

Organisation Code: 220686
Health Service Facility ID: 101097
Assessment Date: 13-15 December 2021

Accreditation Cycle: 1

Contents

Preamble

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

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

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

A rating report is provided for each health service facility.

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

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

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

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

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

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

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

Executive Summary

Northpark Private Hospital underwent a NSQHS Standards Second Edition Organisation-Wide Assessment (NS2 OWA) from 13/12/2021 to 15/12/2021. The NS2 OWA required three assessors for a period of three days. Northpark Private Hospital is a private health service. Northpark Private Hospital was last assessed between 23-25/10/2017.

Northpark Private Hospital (NPH) is part of the Healthscope Group, a leading private healthcare provider in Australia. Healthscope has an overarching Board and Chief Operating Officer.

NPH is located in Bundoora 16kms northeast of Melbourne CBD. It has 145 operational beds for Surgical, Medical, Obstetrics and Gynaecology, an Emergency Department and Mental Health. Mental Health offer voluntary subacute care and the VMOs are mindful of the selection criteria.

The Assessors had onsite access to policies, procedures and other relevant documents. All relevant clinical areas were visited, including pathology and radiology services to determine the effectiveness of the interface between.

The Assessors found the organisation was well prepared for the assessment and participated enthusiastically with knowledge of their hospital, patients and staff responsibility.
There were no recommendations arising from the previous review.

The Leadership Team has had numerous changes in management in recent times. The Team reported the Leadership Bus now has the “right people in the right seat”. Assessors identified the Team promote the Healthscope’s four Safe Values of “We care, We do, We strive, We’re a team”. All work together to lead quality, safety and risk through reporting structures, membership of committees, relevant frameworks and reporting mechanisms. This was noted through Committee minutes and risk registers at all levels.

Incidents, complaints and risks are reported, collated, trended and addressed both individually and systemically through the Committee structure utilising the RiskMan quality, safety and risk reporting tool. This is maintained by a small but active quality and safety team who are supported by the Healthscope National Quality Improvement - Quality & Risk department.

The health record system is managed by the health information department and there is ready access to paper records.

Quality, safety and risk expectations are documented in position descriptions, orientation and training, occupational health, safety and wellbeing, performance review, credentialing and scope of practice.

The organisation was noted to be well prepared and had trained for internal and external disasters.

Diversity and cultural competence are addressed through relevant symbolism, a cultural safety framework and formal interaction with community groups. NPH has well established processes that support the credentialing and defining the scope of clinical practice of its medical, nursing and allied health clinicians.

NPH has established effective partnership systems with consumers. Consumers play an active role in the clinical governance processes. Assessors observed evidence of engagement and partnering with consumers in all clinical departments.

NPH's workforce utilises Healthscope's quality and safety systems to ensure effective prevention and control of healthcare associated infections. Full access to HICMRs policies and procedures and other tools further enables the workforce to monitor, manage and reduce healthcare acquired infections.

There has been significant resourcing and education of clinical and nonclinical staff in the prevention of COVID entering the hospital. However, NPH needs to improve the documentation and monitoring of antimicrobial usage and the monitoring and cleaning of expressed breastmilk fridges and freezers.

Medications are managed well at NPH with accountability and collaboration on the needs of the patient. Among the strategies to monitor practice are audits and oversight by clinical managers, nurses and the pharmacists. Quality activities occur along with education for staff in medication safety.

Monitoring of any medication related incidents is managed with risk mitigation strategies and staff education. The pharmacist and other clinical staff meet with consumers individually to discuss and inform them about medication.

NPH, as part of Healthscope, has undertaken a considerable amount of work to ensure that it has systems and processes to provide effective comprehensive care across its range of clinical services.

The NPH Quality and Risk Management Committee plays a key governance oversight role. The Committee monitors and reviews the wide range of comprehensive care related activities that are being undertaken throughout the organisation. NPH demonstrated a strong culture of teamwork and patient-centred care, which is exemplified by the back to bedside initiative and the development of the Steps Towards Recovery booklets. NPH also places an emphasis on risk minimisation and the provision of high-quality care. NPH has a strong staff education and training program that includes a range of compressive care related topics.

There are well-established policies and procedures to ensure effective clinical communication in the various clinical settings. Engagement of consumers in planning of their care is embedded in the clinical handover process. There is an opportunity to review the Corporate Patient Identification Bands policy to ensure that it meets current NSQHS Standards Requirements.

The management and administration of blood and blood products is a strict process that commences with the ordering of blood, collection of specimens and through to the pre and post transfusion checklist.

Informed consent includes explanation of the risks and benefit and information leaflets for the patient.

The prescribing and use are documented and follow best practice principles for ordering, collecting, administering and monitoring for adverse reactions.

NPH has effective systems and processes to respond to patient physical or mental deterioration. This includes the activation of rapid response teams that are made up of well-trained clinicians. The NPH Quality and Risk Management Committee plays a key governance oversight role in relation to all aspects of recognising and responding to acute deterioration. The Mortality and Morbidity Committee also plays an important monitoring role.

Summary of Results

At Northpark 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

Facilities (HSF IDs)	NS2 OWA 13/12/2021 - 15/12/2021
	MwR
Northpark Private Hospital -101097	3.16, 4.2

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

Sites for Assessment
Northpark Private Hospital

Site	HSFID	Address	Visited
Northpark Private Hospital	101097	Cnr Plenty & Greenhills Road BUNDOORA VIC 3083	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
Northpark Private Hospital (NPH) is part of the Healthscope Group, a national private hospital operation and healthcare provider. There is an overarching Healthscope Board and Chief Operating Officer with NPH providing regular reports and KPIs. There have been significant changes to NPH management and the General Manager (GM) and Director of Clinical Services (DCS) are quite new to the hospital. The Assessors observed strong leadership from the Leadership team who are very engaged, set the requirements for all quality and safety initiatives and ensure there is rigorous reporting of key performance indicators. They regularly visit the clinical areas and have developed a culture of openness. Healthscope has a Strategic Plan and from this NPH has developed their own. The plan is reviewed annually. The NPH endorsed Clinical Governance Framework and Safety and Quality plan reflects the OneHealthscope 2025 strategy. Workshops were conducted with staff at NPH to develop an "Above the Line Behaviours and Below the Line Behaviours" chart with examples of the behaviours. Assessors observed these displayed throughout the hospital and staff reported they are used to promote teamwork and accountability. The Committee Structure allows for the monitoring and review of all quality matters and reports KPIs to the Quality and Risk Committee and on to the Leadership Group.

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 self-identified Aboriginal and Torres Strait Islander population who present to NPH was recorded as 0.6% and the Assessors observed initiatives to ensure their health needs are identified. NPH has an Aboriginal and Torres Strait Islander Engagement Plan 2021-2022 to outline its commitment to reconciliation and engagement. Aboriginal Awareness is included in staff orientation and training. NPH is committed to providing a culturally safe environment to meet their health needs. The intent of Advisory AS18/04 for the governing body setting safety and quality priorities for Aboriginal and Torres Strait Islander people has been met.	
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 Plan includes the Clinical Governance Framework that has eight key pillars for exceptional patient care and clinical outcomes. The framework drives quality and safety measurement and reporting across the eight pillars. The Visiting Medical Officers (VMO) were consulted during development of the framework. The accompanying committee structure contains the reporting lines to the Leadership Team on safety and quality. There is an extensive audit program to monitor achievement of targets and is supported by systems and processes for policies and procedures, risk management and ensuring quality and improvement. Although the COVID-19 pandemic placed considerable strain on the hospital, audit of key activities continued, and outcomes remained within defined parameters on most indicators. Themes and trends in the data is discussed and action plans developed and reviewed for progress.	
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	
The Aboriginal and Torres Strait Islander Engagement Plan 2021-2022 has action areas to ensure the strategies are implemented are monitored. NPH has a local Aboriginal cultural advisor providing support. The intent of Advisory AS18/04 for the health service organisation implementing strategies and monitoring safety and quality priorities for Aboriginal and Torres Strait Islander people has been met.	
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	
The Healthscope Board has responsibility for Corporate Governance and business decision-making. NPH has taken patient safety and quality into consideration, both in recent decisions, and in planning future new services. As NPH are expanding their services to include the La Trobe Private Hospital Bundoora, business decision-making for the safety and quality implications for patients was included.	
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	
Quality and safety have prominence at NPH with training for staff provided. Education is provided at orientation and through the mandatory education requirements to keep staff updated to their roles and includes reference to how it informs the organisation's approach to safety and quality. Quality and safety reports are available to staff once they have been reviewed by the relevant committee. Responsibilities are clearly identified in staff position descriptions.	
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	
NPH uses the HiNT database to make policies and procedures available to all staff. There are Healthscope policies and where required local policies are developed. Policy documents are reviewed by the Corporate Document Controller for a standard format and to record approval and review dates. Healthscope are undertaking a Reconciliation Policy Project for a risk and quality review of all site policies. Policies are monitored and there is a Healthscope process for "Shared Learnings". Policies are referenced to include legislation, regulation and Health Department directive where appropriate.	
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	
The Clinical Governance Framework and Safety and Quality plan provides the process to effectively monitor and report on performance against agreed indicators. Information provided through the planned audit schedule identifies areas for improvement and is used for quality improvement. KPIs are monitored and reviewed by the Quality and Risk Committee, reported to the Leadership Group and to Healthscope Board. NPH is moving towards the MARS (Measurement, Analysis & Reporting Systems for Healthcare) system to allow state and national benchmarking.	
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	
The hospital ensures timely reports on safety and quality systems and performance are provided to the governing body, by internal monitoring and reporting to the relevant committees, including the departmental committees. Safety and quality boards are on view in all wards and departments for visitors and the local community to view.	
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
NPH has a Risk Register integrated into the RiskMan Integrated Incident Management system. Risk is identified using a variety of inputs including reported incidents, complaints, audit reports, trended data and external reports. There are controls and a control hierarchy for residual risks and tolerance level. Each risk has a detailed action plan and Assessors viewed the risk management system and it is appropriately maintained and monitored. The Risk Register is linked to the Healthscope Shared Learnings Report where outcomes of high or extreme risks are documented. Reports are reviewed by the MAC Craft Groups and VMOs have had training on the risk system. Risks are discussed at the Consumer Consultant Committee and Ward meetings. NPH has a Disaster Management and Recovery Plan with contingency plans for both internal and external emergencies. NPH liaises with the Department of Health and local public hospitals, especially during COVID. The Business Continuity Plan is regularly updated, available throughout the hospital and has a designated Emergency Coordinator.

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
Incident management is comprehensive and used as an opportunity to improve patient and staff safety. NPH uses the electronic incident reporting and management system, RiskMan. Staff are educated in the use of the system for logging and following up reports. There is feedback to wards and departments on outcomes of investigations. Automatic alerts are sent to relevant managers and the executive. Investigation of incidents is undertaken by a combination of staff including the department manager and the Quality team. Consumers are involved in investigations where appropriate. Data from incidents is collated, trended and detailed reports are provided to Leadership weekly and monthly to the Quality and Risk Committee. The Healthscope Shared Learnings report is also used for incidents.

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	
Serious incidents are investigated, reported through the appropriate processes, committees, the Craft Groups and ward and department meetings.	
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	
NPH has an open disclosure policy and the GM, DCS and VMOs have received training in this process. The National Safety manager is available if required. Open Disclosure is used for any serious clinical event and documented as part of the review and investigation process. This is monitored and identified improvements are used to refine the process. There is weekly follow-up contact and more often if indicated. The Open Disclosure policy and process reflects the Australian Open Disclosure Framework.	
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	
Patients are encouraged to provide feedback on their care and experience. The Back to Bedside project has improved feedback as the communication, rounding, bedside handover and the patient care boards allows more proactive interaction between staff and patients. An electronic post discharge survey is also sent to patients. Feedback from consumers is consistently above 80%. Staff are routinely able to provide their direct feedback on the safety culture through the Employee Experience Survey. All feedback is reported to the Quality and Risk Committee and the Leadership Group. The GM and DCS conduct regular meetings with staff and managers and respond to the comments provided by staff and patients.	
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	
NPH sees complaints as a way to improve care. Complaints may be received through patient surveys, personal contact or reported at department level. There are policies available on HiNT for the management of complaints. There is an organisation wide complaints system using RiskMan and each complaint is recorded, investigated and reported to the Quality and Risk Committee and on to the Leadership Group. Closure and feedback are provided at ward level on outcomes. Complaint resolution meets the timeframes. Action plans are implemented with feedback to ward level to assist with improvements.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.15	
The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher risk groups into the planning and delivery of care	
Comments	
There is recognition of diverse groups and their needs in planning and delivery of care. The hospital is inclusive of all sexualities, genders, identities, and cultures. Although NPH provides low risk care, some patient cohort may be deemed high-risk and there are numerous policies to provided safe care.	
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	
Comprehensive integrated health care paper-based records are available and used by clinicians at point of care. Patient charts are available at the bedside and used at bedside handover and documenting provision of care. Periodic audits of the healthcare record are undertaken to assess documentation and provision of care. The current and secondary storage of records meets regulatory and privacy requirements. The paper records reviewed by assessors were well maintained. The records for partnership, e.g. The Northern Hospital are copied and sent their Health Information Management (HIM) Department.	
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	
Patient demographics are being collected to ensure NPH is working towards alignment with each patient's Individual Healthcare Identifier (IHD). These are used to ensure secure access to healthcare records. Terminology is standardised and reflects relevant requirements. The requirements of Advisory AS18/11 - Implementing systems that can provide clinical information into the My Health Record system have been met for Actions 1.17 and 1.18.	
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	
NPH has completed a Gap Analysis on My Health Record with an action plan. Information provided to the My Health Record system is entered by the HIM staff who have education on the process. The specific requirements of the entries are guided by the Healthscope My Health Record Policy and as per patient consent. The "My Health/My Record" booklet is given to patients.	
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	
There is a formal orientation program for all staff, including the governing body and consumers, which includes presentations on the quality and safety systems. The mandatory education requirements to keep staff updated to their roles includes reference to how it informs the organisation's approach to safety and quality.	
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	
Mandatory training is defined by the Mandatory Training Policy and a booklet provided gives an overview, orientation which is on-line, and ongoing online and face to face requirements. The Mandatory Training program and numerous policies describes the mandatory training requirements and is available on Learning Management System (LMS). NPH has hospital wide training and ward/discipline specific training, e.g. Mental Health or Birthing Suite. NPH has undergraduate and post graduate students who provide feedback on the training program. Training results show most completion is above 85% with systems for improvement and completion.	
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	
NPH has one employee who identifies as Aboriginal or Torres Strait Islander origin and are working to have a consumer representative. An eLearning module on cultural needs is mandatory as is “ask the Question” training. NPH are meeting with the “Local Mob” to explore cultural training, a food garden and ideas to improve cultural awareness.	
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	
All staff undergo an annual review. Position descriptions include the organisation's expectations of staff performance. Medical staff reviews are undertaken as part of the credentialing process and per the Bylaws. If there are practice concerns with VMOs the process is documented in the Bylaws and may be escalated to the Craft Group and the MAC Chair. There is a tool for appraisals relevant to the position. At appraisal ongoing development in safety and quality is discussed.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.23	
The health service organisation has processes to: a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan b. Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered	
Comments	
VMO scope of practice is defined in the credentialing process. The certification and recertification for colonoscopists is also part of the credentialing process. AS 18/12 Implementing the Colonoscopy Clinical Care Standard has been met and compliant for Action 1.23 and 1.24.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.24	
The health service organisation: a. Conducts processes to ensure that clinicians are credentialed, where relevant b. Monitors and improves the effectiveness of the credentialing process	
Comments	
NPH uses the comprehensive Healthscope e-Credentialing system for medical staff that is supported by the Medical Bylaws. VMOs have access to the electronic application to complete applications and for new VMOs an account is created. This acts as a data repository for all aspects of the credentialing process including AHPRA registration, letters, education, and review notes. Medical officers are credentialed for a period of three years, subject to satisfactory performance. Nursing staff registration is checked by their Nurse Unit Manager after sighting the AHPRA certificate and entered into KRONOS. Allied Health (AH) professionals are credentialed as per AHPRA obligations, and those AH professional groups who are not required to register with AHPRA must present affiliation with their governing body. NPH maintains close monitoring of its credentialling processes, including any incidents that may occur, at the Leadership level. There was evidence that relevant credentialing principles had been used when new clinical procedures had been introduced.	
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	
Communication to the workforce on the importance of safety and quality roles and responsibilities is through the various quality and safety committees and at clinical unit level. Training about safety and quality is provided at orientation and induction on how to provide information, strategies and assistance in meeting the quality and safety requirements.	
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	
There is a clinical structure to ensure there is always a designated in-charge role. The GM and DCS do regular walkarounds to all departments to talk to staff, observe and address issues of concern. New staff in clinical areas have a designated team member who provides support. Assessors observed the patient centred care at NPH, and the commitment to provide a safe and quality clinical service for patients. There is an HMO rostered on overnight. Supervision and advice are available after hours when required.	
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	
NPH staff have access to Clinical Care Standards and Clinical Practice Guidelines and these include the Acute Coronary Syndrome, Acute Stroke and Delirium Clinical Care Standards. Certification and Recertification for VMOs who perform colonoscopies is defined in their credentialing and scope of practice. A copy of the GESA Certification and up to date Logbook to demonstrate the requirements are met must be presented as per the credentialing process and standards. NPH is compliant with AS 18/12 Implementing the Colonoscopy Clinical Care Standard for all requirements for this action.	
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 clinical practice is monitored through the Quality and Risk Committee, the Leadership Group, Craft Groups and MAC and feedback provided on outcomes. The ACSQHC mandated Clinical Care Standards, such as the Colonoscopy Clinical Care Standard and Antimicrobial Stewardship Clinical Care Standard provide reviews of variation in clinical practice with patient outcomes being monitored, audited and reviewed. The ACHS clinical indicators collected by NPH and Assessors noted very good results across all data.	
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 preventative maintenance system records the organisation's building and equipment assets and ensures the scheduling of preventative maintenance including testing of relevant equipment occurs. All management of these assets is at a local facility level by a third party provider, BGIS, with group contracts arranged for large items e.g. imaging equipment from GE, Siemens and Philips. Repairs identified at a facility are recorded in the system and corrective maintenance is arranged by the Facility Management Staff. Urgent repairs are arranged and triaged according to priority and cost. The organisation's Emergency Management details are listed on the Intranet, provide access to Site Emergency Numbers, Manuals and Protocols, First Aid Instructions, Major Incident directions, and other emergency response information requirements. The Assessors identified issues pertaining to the traffic flow on entering via Greenhills Road. These issues posed a risk to staff and equipment. It was suggested to the organisation they needed to act to establish safe speed limits for the laneway, relocate the waste disposal bins, the accessing of these bins and the improved design of the loading bay. The organisation quickly responded in the relocation of the waste disposal bins and implementing a zebra crossing to access these bins. Additionally, a redesign of the loading bay was to be submitted by 20 December with works to commence in January 2022. Furthermore, speed limit signs will be installed.

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
Patients are risk-assessed as part of the admission process and any risks identified are documented. In the case of the mental health unit, access to inpatient and outpatient areas is restricted to authorised visitors only. Any incidents that occur at NPH are managed in the RiskMan incident Management system and are discussed at a local management level initially and referred to the Corporate Office where appropriate.

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	
Where Patient Experience Surveys indicate issues relating to the environment, including any perceived risk to patients, these are considered by local management and action taken to avoid any risk or harm to patients and/or staff. Workplace aggression and violence prevention training (WAVE) is undertaken by key staff and high levels of completion were observed.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.31	
The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose	
Comments	
The assessors determined that in the main, external and internal signage shows clear directions across the NPH with restricted entry wherever appropriate, e.g. operating theatres. NPH provides direction to the hospital on the NPH website. There is also information provided at the reception desk at the main entrance and information is available in the waiting room on Pathfinder (real-time patient locator) as well as on admission.	
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	
The organisation has policies and protocols in place to ensure that there are flexible visiting arrangements in place in hospitals. However, during COVID the NPH has adhered to the DHS guidelines for the accessibility of visitors to the hospital. All staff are vigilant in their management of patients and in the provision of patient care. If an incident occurs, an incident report is developed, and a risk is raised on the risk management system and discussed at relevant committee meetings.	
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	
NPH Aboriginal and Torres Strait Islander Engagement Plan 2021–2022 details the hospital's initiatives to recognise the land on which the hospital resides and creating a welcoming environment for all people. Furthermore, the plan details actions taken to ensure culturally appropriate and relevant information is available for Aboriginal and Torres Strait Islander people in the Emergency Department.	
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	
Healthscope Safety and Quality plan and Strategic plans include feedback from partnering with consumers. NPH in addition to complying with the Healthscope Consumer Partnership Plan 2020–23 has developed its own safety and quality plan. The NPH Consumer Partnership plan was developed in consultation with Consumer consultants. Assessors observed active engagement of consumers in strategic planning and at the Consumer Consultant Committee review of key clinical indicator information. The terms of reference of the Consumer Consultant Committee (CCC) indicates they meet at least four times a year. The consumers articulated to the Assessors they had active engagement in the Patient Care Board improvements and provided input into the Back to Bedside project. The Back to Bedside project included patient centred care training.	
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	
This action is achieved through the Healthscope safety and quality plan and the Healthscope consumer partnership plan 2020–2023 that discusses performance KPIs for monitoring processes for partnering with consumers. This system includes audits which are benchmarked with similar size organisations within the Healthscope group. The NPH Safety and Quality plan discusses performance KPI's and audit outcomes for monitoring processes for partnering with consumers and was approved by the Consumer Consultant Committee. The NPH Consumer Consultant Committee is provided with safety and quality data for review at each of their meetings.	
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 is displayed as posters and is available in brochure form in other languages, an animation, and there is a consumer guide and summary guide all readily accessible. The Assessors have verified with patients they interviewed they are aware of the Rights publications and can access them. The complaints management system is very proactive, designed to improve the consumer/family experience by meeting their expectations rather than escalating their issues. Nevertheless, all complaints and compliments are logged on RiskMan and reported monthly.	
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	
Consent documentation is audited, and compliance is high – when consent is not documented a RiskMan report is raised and an investigation is conducted. The Advisory AS 18/10 outlines the requirements for Informed Financial Consent. The assessors confirm NPH meets the requirements, having confirmed with document review, staff, and consumer interviews. The action is achieved by the Corporate and Local Administrative team, with protocols for pre and within admission communication with insurers and compensation funders, and the consumer on several scenarios, including full hospital cover, no insurance, cosmetic procedures, exclusions, and other variations which differently apply to maternity versus acute and rehabilitation patients. Appropriate paperwork is completed, and the patients report they are communicated with proactively throughout the episode of care.	
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	
NPH has access to a suite of Healthscope policies that assist in identifying patient capacity. These documents include advance care directives, ECT consent and consent to surgical/medical treatment. Furthermore, staff receive training on assessing patient's capacity. Along with training there are tools and risk assessments which include cognitive impairment tools, and mini mental health assessment.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.6	
The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care	
Comments	
The Assessors determined that NPH has well established processes meeting this action. The Assessors observed these processes in action in the Early Parenting Unit where both the mother and partner were actively involved in the care of their child/baby including discharge planning. There is considerable support to the parents in the Early Parenting Unit.	
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	
NPH supports the workforce to form partnerships with patients and carers through training and monitoring. Such support included the Back to Bedside project and education on ensuring active involvement of the patient in the bedside clinical handover process. Quality data provided demonstrates that patient involvement in decision-making has remained high since 2018.	
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	
NPH meets this action through the provision of brochures for Aboriginal and Torres Strait Islander people and is working towards Rainbow Tick National Accreditation for the safe and inclusive practice for LGBTQI people.	
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	
Assessors observed that Healthscope consumer approved publications were available. Healthscope had undertaken a consumer approved publication project which was initiated by the corporate consumer and the consumer feedback tool was reviewed by the consumer.	
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	
There has been significant work undertaken by clinicians to provide information to consumers in ways that meets the needs of patients and the consumers. Utilising information and brochures that has been endorsed with the organisation's consumer tick for approval means this information is easy to understand and use for consumers. The assessors visited wards and spoke to patients and families about the communication between themselves and staff. Positive responses on the approach to care included that they were asked about their needs, kept informed during their stay and were involved in discharge planning and ongoing care. An adjunct to shift-to-shift bedside handover is the patient care whiteboard that is adjusted daily to reflect the patient's expressed goals and schedule.	
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
The Assessors spoke with consumers who are both consumer representatives and consumer members of committees, as well as volunteers (many of whom hold dual roles). The consumer representatives represent the diversity of the local community. The team noted that COVID-19 constraints have meant fewer on-site interactions with Consumer Advisors, who report they are well supported and included via virtual meeting modes and keep in contact via phone. Additionally, there are no volunteers currently working day-to-day.

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
There is a register of volunteers and of consumers, representing their diverse patients, ex-patients, and carers. NPH intentionally attempts to proactively engage the consumers best matched to the issue that is being addressed, in a co-design methodology, for the development of information and services. Each participant receives a Consumer Consultant Toolkit to assist in understanding Healthscope, NPH and their role, and a senior staff contact person. NPH consumer consultants have reviewed the patient care boards and some publications. Any new publications reviewed and approved by the consumer consultants have a consumer approved logo applied to the patient information. These publications were observed by the Assessors.

Rating	Applicable HSF IDs
Met	All

ACTION 2.13	
The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs	
Comments	
The hospital meets the action by identifying the Aboriginal patient population profile annually and collaboration with the Aboriginal community. The Assessors noted that the Wurundjeri People were acknowledged in the patient information folder. In 2021, the hospital developed the Aboriginal and Torres Strait Islander Engagement plan.	
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	
Assessors observed compliance through the review by the Consumer Consultant Committee of policies and procedures that included admission of day procedure unit patients and paediatric patients in a mixed ward.	
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	
Governance structures and processes are in place to support infection prevention and control. NPH is part of Healthscope corporate subscription to HICMR which includes full access to HICMR policies and procedure manual (electronically and downloadable) order tools, educational materials and brochures and ongoing contact for advice. As part of the Level 3 agreement a HICMR consultant works at the hospital 16 hours a week. This role works collaboratively with a part time infection prevention and control coordinator. NPH has a HICMR infection control management plan which is updated annually. The infection control team provides relevant reports to the quality and consumer committees, medical advisory committee and other relevant committees. Assessors observed the ACHS clinical indicator data that was submitted by NPH. There are many education and training programs available to staff to ensure that they are skilled and up to date with infection control and prevention practices with these commencing at the time of orientation to the service (Nursing Orientation and Medial Workforce Orientation), along with specific teaching sessions available for antimicrobial prescribing practices. The assessors observed significant signage and information relating to the COVID pandemic including PPE correct order, visitor masks guide posters and coronavirus prevention measures. NPH as part of Healthscope is a member of the Hand Hygiene Australia. Data submitted for 2021 indicates high levels of compliance with the required Hand Hygiene Australia standard. Healthcare acquired infections are reported by NPH on the RiskMan incident reporting system. No areas of concern were identified by the Assessors. A CSSD redevelopment was undertaken in 2019 and meets compliance with AS/NZS4187.	
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	
Clinical leads interviewed could describe how the quality improvement systems are used when monitoring, implementing strategies and reporting on the outcomes of prevention and control of healthcare-associated infections, and the antimicrobial stewardship program. Several examples were provided how the organisation monitors the performance of systems for prevention and control of healthcare associated infections e.g., Hospital Acquired Infections Surveillance reporting, Hand Hygiene Australia audits, Annual ANTT audits, Occupational exposure rates via RiskMan, water and air testing reporting and Sterilisation /disinfection reprocessing records. The Assessors were provided with many examples of strategies implemented to improve outcomes associated with the prevention and control of health care associated infection, including: COVID-19 Response, Reducing Occupational Exposures and Improving Follow up and changes to processes and systems within the environmental services. Evidence of reporting of outcomes was available through committee minutes, with reporting to the Leadership Group Committee, Executive Operations Committee and the Medical Advisory Committee. There was evidence of performance data related to infection prevention and control at ward level on Safety and Quality Boards. Staff were able to discuss and interpret this data on ward walk throughs. Antimicrobial stewardship is now an Agenda item at the MAC. Antimicrobial audit results will now be reported to the Medical Advisory Committee.	
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	
There is Consumer representation on the Infection Prevention and Control Committee. The organisation where possible uses patient information that has already been produced from a validated source. Brochures and pamphlets on Multi Resistant Organisms (MRO) and infectious diseases available within the clinical areas and also through the point of care information management system within the patient room are accessible to each patient at the bedside. Members from infection Control team or the VMO or an ID Physician are involved in discussions with all patients that have a new MRO diagnosis. Theme days are held to raise awareness to the members of the community (along with staff) of particular infection related issues i.e., Hand hygiene.	
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
Surveillance for collecting HAI data is undertaken. The HAI clinical indicators collected include Staphylococcus aureus bloodstream infections and surgical site infections – hips, knees LUSCS, and occupational exposures. Audits sighted by the Assessors demonstrated that these infection rates are low and well below the benchmark. All HAIs are entered in to RiskMan and reviewed by the Infection Control Nurse with feedback to staff. These are reported through the relevant Committee structure. The reporting of VICNISS mandatory reporting data provides for the real time monitoring and reporting of process and outcome indicators. The report is monitored by the Infection Control Committee with reporting to Leadership Group Committee, Executive Operations Committee and the Medical Advisory Committee Interviews with clinical leads verified the surveillance strategy for healthcare- associated infections and antimicrobial use is in place and could describe specific actions taken to address areas of variation noted or where an in-depth review had been undertaken.

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	
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	
The organisation has systems and processes to ensure the application of appropriate precautions. The infection control team undertakes a review of any pathology results, provides guidance on relevant precautions and monitors appropriate practice implementation at local level. Staff interviewed during the assessment were aware of the infection control precaution requirements as relevant to different cohorts of patients. Further verification was undertaken during inspection of a ward and operating theatre environment. Access to standardised signage was available at the point of care and appropriately used. Additional guidance, and more tailored protocols were developed during the COVID response, further optimising transmission-based precaution requirements.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.6
Clinicians assess infection risks and use transmission-based precautions based on the risk of transmission of infectious agents, and consider: a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated when clinically required during care b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs to manage infection risks d. The need to control the environment e. Precautions required when the patient is moved within the facility or to external services f. The need for additional environmental cleaning or disinfection g. Equipment requirements
Comments
Infection risks are identified and recorded in the patient records as well as the patient management system. Regular documentation audits are undertaken to monitor compliance. As observed during the assessment (day of surgery patient journey) nursing staff re-assesses the infection risks of patients during the pre- admission process. This is additional to the infectious status confirmed the day before during an admission phone call. Additional training was implemented during the COVID response to further support staff and raise awareness of transmission-based precaution requirements across clinical and non-clinical groups. During COVID all staff who have direct patient contact are required to wear a mask and PPE when appropriate. Environmental, facility maintenance and nursing staff interviewed during the survey demonstrated a good understanding of cleaning and disinfection requirements, including for equipment and in-build/high access fixtures. The hospital does not have any negative pressure rooms but uses single rooms for either SCOVID or infectious diseases patients.

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
Handover process and documentation captures infectious status, as does discharge and transfer information. Documentation audits are undertaken to monitor compliance. Some of the records sampled during the assessment indicate compliance with the requirements. In the Emergency Department (ED) extra precautions have been implemented for patients identified with or at risk of COVID. In ED it was noted the use of N95 masks and other relevant PPE equipment. Clinical and nonclinical staff interviewed clearly articulated the process for caring for a potential COVID case and precautions taken for transferring the patient to a COVID receiving hospital.

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	
The organisation has a hand hygiene program that is consistent with the National Hand Hygiene Initiative. The Hand Hygiene (HH) Protocol provides guidance and support for clinicians. A mandatory training program is available online to all staff (clinical and non-clinical). Gold Standard Auditors and HH Auditors undertake audit of compliance, as per the NHHI auditing schedule timetable against the hand hygiene initiative. It was noted that measures had been undertaken to address areas where Health Care Workers (HCW) HH was lower than benchmark. Overall, 2021 data showed compliance above the benchmark. Alcohol based hand rub were readily available to HCWs at the point of care with clear signage regarding the appropriate use of the HH product.	
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	
An Aseptic Technique Protocol provides guidance and support to clinicians. All clinical staff who perform aseptic technique procedures must be trained in aseptic technique and complete the Aseptic Technique e-learning package annually. The issue of VMO training compliance for the undertaking of aseptic technique training has been identified and remains an area of ongoing discussion by the Infection Control Committee. This issue remains on the agenda while a solution that meets all concerns has been implemented. It is noted that the organisation's HAI rate is low for the reporting period first half 2021.	
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	
A risk assessment of clinical areas for asepsis in invasive devices has been undertaken. This has been supported by the development of a list of invasive medical devices in use across the organisation and where they are used. Competency packages have been developed and are in place to support all invasive medical devices available for use across the organisation. These have been matched to roles, delegation and location within the organisation. Training and compliance are assessed through an annual Aseptic Technique Audit to evidence workforce compliance with processes for selection, insertion, maintenance and removal of devices.	
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	
Cleaning protocols and schedules are in place outlining frequency and the required regime for each clinical and non-clinical area across the group. Regular cleaning audits are conducted internally and by an external provider with action taken to address any identified gaps. Environmental services staff interviewed during the assessment demonstrated a detailed understanding of the different cleaning regimes and their requirements, including access to relevant equipment, solutions and consumables. Staff are trained in the appropriate use of PPEs and regular auditing of compliance is undertaken. During COVID this was further enhanced with the introduction of the PPE 'spotters', COVID-19 - PPE guidelines, online training modules and easy access to necessary supplies. COVID attestation stations were in place at entry to each of the sites and high degree of vigilance applied to the appropriate application of masks and regular hand hygiene.	

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	
The Assessors noted that on the Early Parenting Unit that the temperature monitoring and cleaning of the Expressed Breast Milk (EBM) fridge and freezer was inconsistent. By the end of the assessment an improved process and auditing system had been implemented and communicated to relevant staff.	
Suggestion(s) for Improvement	
Improved daily checking and cleaning of the EBM fridge and freezer be undertaken.	
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	
HICMR policies and protocols provide guidance for assessing, monitoring and addressing risks relating to infection prevention and control. The organisation evaluates infection risks associated with new or existing equipment, devices and products as part of its annual Infection Prevention Risk Assessments conducted at local/clinical area levels. A Risk Assessment protocol has also been developed to guide requirements during upgrades to building, fixtures and fittings. A planned maintenance schedule is available at each site and a mixture of internal and external contracting arrangements are in place to support implementation. Management of water quality including ice machines, water fountains and hydrotherapy pools is informed by regular, specialist maintenance and microbiological testing regimes. Ventilation including replacement of filters and duct cleaning is also captured by the planned maintenance schedule. Temperature of medication and food fridges and freezers are monitored daily at a local level. Routine linen services are provided through an external provider, and this includes the laundering of re-usable mop head.	
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
NPH utilises Healthscope program and policies such as Immunisation for Vaccine Preventable Diseases to provide direction regarding access to Immunisation and records management. The policies are based on the Health Care worker (HCW) vaccination requirements based on the Australian Immunisation Handbook recommended vaccinations for all healthcare workers. The immunisation is recommended and based on staff risk of exposure and the risk to others that they care for or work with. Immunisation is to be provided for every disease listed under the staff members applicable Immunisation category (i.e. category A, B or C). Challenges exist in regard to the Health Services Amendment (Mandatory Vaccination of Healthcare Workers) Bill 2020 (VIC) that was passed last year in Victoria. The Bill introduces reforms which enables enacting of mandatory vaccinations for health workers in Victoria. Action has been taken by Healthscope and NPH to adhere to the new COVID vaccination requirements for HCWs. Staff influenza rates for first half of 2021 indicated rates 53% with a benchmark set of 80%.

Rating	Applicable HSF IDs
Met	All

ACTION 3.14
Where reusable equipment, instruments and devices are used, the health service organisation has: a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying • the patient • the procedure • the reusable equipment, instruments and devices that were used for the procedure
Comments
The organisation has undertaken a gap analysis of all areas involved in the reprocessing of reusable devices and developed action plans to address compliance with the Standards Australia of AS/NZS 4187:2014 Reprocessing of reusable medical devices in health service organisation. NPH has completed the construction of a AS/NZ 4187:2014 compliant CSSD. An external infection control provider (HICMR) is engaged to support the organisation with the original gap analysis review regular monitoring of compliance, including action plans progress.

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	
Regular training and competency assessments are in place for staff involved in the reprocessing of instruments, including semi-critical devices. There is a manual system for the tracking of reusable equipment, instruments and devices during reprocessing. The traceability systems identify the equipment, instruments and devices and has the ability to identify the patient, procedure and equipment used for the procedure.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.15	
The health service organisation has an antimicrobial stewardship program that: a. Includes an antimicrobial stewardship policy b. Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing c. Has an antimicrobial formulary that includes restriction rules and approval processes d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard[20]	
Comments	
The Antimicrobial stewardship program is well established across the Healthscope group. An overarching policy addresses core elements, recommendations and principles of the Antimicrobial Stewardship Clinical Care Standards. Clinicians are supported with information about appropriate prophylactic antimicrobial therapy for patients undergoing surgery. Information on management of antimicrobials is available and provided to patients and/or their carers, as relevant.	
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
AMS is represented and provides regular updates at the Infection Control Committee and MAC. The organisation participates in the National Antimicrobial Prescribing Survey (NAPS), Surgical NAPS and the National Antimicrobial Utilisation Surveillance Program (NAUSP). Surgical prophylaxis compliance is monitored and reported in terms of drug, dose, time and duration. Monitoring of antimicrobial usage and appropriateness of prescribing inform the ongoing risk assessment for the AMS program. At NPH the Assessors noted a lack of compliance on AMS in particular Advisory 18/08 Indicator 6 (a) Rate of documentation of clinical reason or indication for prescribing antibiotics. By completion of the assessment NPH had improved the audit tool and process to ensure that a de-identified report is provided to MAC. The ID physician will follow up with those VMOs that do not provide a clinical reason or indication in their prescribing. Furthermore, AMS has now been added to the MAC committee agenda. As of 17 December 2021, the new Infectious Diseases position has become a member of the MAC.

Rating	Applicable HSF IDs	Recommendation(s) / Risk Rating
MWR	All	**Recommendation:** Ensure improvement is undertaken in the documentation of antimicrobial usage in accordance with AMS in particular Advisory 18/08 Indicator 6 (a) Rate of documentation of clinical reason or indication for prescribing antibiotics. Routine monitoring is required to ensure compliance with this Advisory and action is taken to address any lack of compliance. **Risk Rating:** Low

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	
NPH has a number of policies and procedures providing governance for medication management and these have been reviewed and up to date. The Healthscope National Medication Safety Webex Team communicates through an online forum and NPH has a representative on the team. There is feedback to the NPH Quality and Risk Committee and the Medical Advisory Committee. NPH has made the decision to reform the Pharmacy Committee to ensure the safe and effective use of medicines and will report to the Quality and Risk Committee. Medication risks are entered in to RiskMan and regularly reviewed. Medication safety training (including drug calculations for nurses) uses the eLearning online module.	
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
NPH undertake a series of medication safety audits in accordance with the annual audit schedule to monitor the effectiveness and performance of medication management. Audit results are reported to the Quality and Risk Committee. This monitoring of medication safety assists with quality improvement and safety. The NSMC National Audit and the “Mini” Audit demonstrated inconsistency with complete documentation of all the components associated with the NSMC. This included indication, patient identification completed correctly on all pages and adverse drug reactions. A review of the committee minutes showed discussion on audit results and action plans to improve outcomes. Strategies have been implemented to improve the outcomes and will require close monitoring.

ACTION 4.2		
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management		
Rating	**Applicable HSF IDs**	**Recommendation(s) / Risk Rating**
MWR	All	**Recommendation:** Review the feedback process for medication safety to provide assurance that low levels of compliance are monitored, reviewed and outcomes reported in a timely manner. **Risk Rating:** Low

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	
The Assessors met with patients and discussed medication management along with other aspects of their care. The patients felt included in their care and were provided with adequate information including medicines and side-effects. There is a range of information regarding medicines available for consumers that have been reviewed by consumer groups. The pharmacist and nurses provide education to patients as required and when commencing any new medicine.	
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	
Clinicians prescribe, dispense and administer medication in line with their scope of practice and their qualifications are verified. There is a list for approved Nurse Initiated Medicines.	
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	
The Best Possible Medication History (BPMH) Policy describes the process to obtain and document the actual medicines the patient is taking before presentation to hospital. The BPMH is usually taken by the nurse and the medications are documented on the Medication Management Plan (MMP) that provides a comprehensive, formal and systematic process. Patients booked for elective admission usually document the medicines in the preadmission documentation. The MMP may be completed by pharmacists and nurses depending on the patient's risk status.	
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
The patient's current medicines orders are reviewed against the BPMH by the nurses or pharmacist who reconcile these with the patient's own medicines, family, GP referral, or the patient's local pharmacy. There is a clinical pharmacist available for the medical ward and other patients over 65 years, on 4 or more medications or present a risk. Pharmacists aim to see all patients within 48 hours of admission. The reconciled list is used to prescribe and administer medications on the NSMC. Audits for current medications documented and reconciled at admission compare favourably with ACHS Clinical Indicators and within Healthscope. The nurses check the NSMC for completion at handover and patients are asked if they have any questions about the medicines that have been prescribed.

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
Known allergies and Adverse Drug Reactions (ADR) are identified on admission and documented on the NSMC and an alert summary in the medical record. ADRs are also entered into WebPAS. Patients with an allergy wear red armbands as a cue for clinicians to ask the patients if they have any allergies at administration of medications. The annual medical record documentation audit shows NPH complies with documentation.

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	
Should a patient experience an Adverse Drug Reactions during admission it is documented in the medical record and a RiskMan is completed. The patient is informed of the allergy and given information about what happened and what to report in future admissions.	
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	
There is a process for reporting a suspected ADR to the Therapeutic Drugs Administration (TGA). If the incident is considered reportable it is reported through the TGA adverse event reporting system. Education is provided to clinicians by the pharmacist on ADRs.	
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
There is a process for a formal review by the pharmacist based on clinical need and/or high risk and documented in the medical history. The Assessor spoke with the pharmacist from the third-party provider, HPS Pharmacy. The HPS electronic "Clinical Pod" has a complete pharmacy history for all patients who have a medication review. These reviews are discussed with the patient. Actions from the review are documented on the NSMC and if necessary, the medical record.

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	
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	
Patients are provided with information about their medications in a way that is understood, appropriate to their needs and timely. This provides the patient and/or family with information to allow informed choices.	
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 generates the patient discharge medication profile for selected admitted patients, especially if the profile contains new or high-risk medications, such as, APINCH. For other patients the nurse explains the profile and gives explanation. A discharge medication summary is part of the medical summary sent to the patient's GP.	
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	
NPH has information and decision support tools available electronically at the point of care and nurses were able to demonstrate their access and indicated they are used regularly. These include the Therapeutic Guidelines, Antimicrobials Guidelines, MIMS and the Injectable Handbook. Ongoing education is provided and NPH conduct a Medication Management Awareness Study Day.	
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	
NPH is diligent in the safe and secure storage and distribution of medicines. The nurses maintain the imprest stock in the medication rooms and there is a system for reordering stock. Medicines are stored in a locked room with secure and limited access. Each ward has one access key for S8 and one key for S11 medications with access only available for pharmacists, RNs and EENs. There are S8 and S11 count checks three times a day. Medication fridges are monitored to ensure cold chain compliance. Each ward has a receptacle for unused, unwanted and expired medicines and this is returned to pharmacy for destruction.	
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	
There are policies to direct how high-risk medicines (controlled substances) are safely managed, stored, distributed and administered. The practices for the management of Schedule 11 and 8 drugs complies with policy and audits confirmed storage and Drug Register compliance consistently above Healthscope benchmark. The APINCH acronym is used at NPH to identify these medicines. Ongoing education is provided when required with pharmacist input.	
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	
NPH has an array of policies to guide staff members in the provision of comprehensive care across its range of clinical services. Most of the policies are Healthscope wide, with some being NPH specific. Overarching guidance is provided by the Healthscope Comprehensive Care Plan Policy. Approved policies are readily accessible to staff members via the Healthscope intranet, HINT. Assessors noted that each policy document has a section that clearly describes the key elements of the policy. NPH has a well-established risk management monitoring system, both at the corporate level and within NPH. The Quality and Risk Management Committee plays an important role in monitoring NPH specific risks. NPH also has an audit schedule in place covering several aspects of comprehensive care. NPH has a strong focus on training and ongoing education which commences at orientation and induction. This includes through online training modules and training that are relevant to the comprehensive care standard. The training program covers for example, falls, pressure injury, skin integrity, organisation violence and aggression, cognitive impairment, mental health risk assessment, mental state examination and acute deterioration in mental state. NPH also provides an ongoing in-service education program, for example in falls management and malnutrition management conducted by allied health clinicians. The NPH training and education program is very well managed and is monitored by the Quality and Risk Management Committee and the Education Committee. NPH undertook a significant change management program with the introduction of the integrated risk screening documents. Also, nurses providing care in the High Dependency Unit were provided with training provided by Medcast. Staff training was also provided in relation to the NPH Back to Bedside initiative. Assessors noted that Healthscope has established a series of Webex online clinical special interest groups. This includes for example related to falls prevention, diabetes management, clinical deterioration and behaviour and cognition. Webex enables an exchange of ideas amongst clinicians and supports the provision of evidence-based patient-centred care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.2
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care
Comments
The NPH Quality and Risk Management Committee meets quarterly and provides governance oversight of the comprehensive care standard. Membership of the committee includes key senior clinical staff. The committee also has consumer representation. The Quality and Risk Management Committee reports to the Leadership Group and has close links with the Medical Advisory Committee. Assessors noted that Quality and Risk Management Committee agendas and minutes are comprehensive and detailed. Detailed Quality KPI (Key Performance Indicator) reports are monitored. Mandatory training reports, clinical incident reviews, policy changes, hospital acquired complications, quality improvement activities and the risk register are also monitored. NPH also closely monitors ACHS Clinical Indicator data and CHBOI (core, hospital based outcome indicators). In addition, an update specific to each of the national standards is provided at each meeting. Any Healthscope wide shared learnings are also considered. The business arising section of the minutes is essentially an action plan that describes actions to be undertaken, by who and by when. Progress is monitored at each committee meeting. Information flow to and from the VMOs is through the Medical Advisory Committee and specialist craft groups, although many informal information channels are also in place. Comprehensive care related matters are also reported to nursing staff through ward clinical meetings and via staff emails. Key audit results and staff training levels are also displayed on ward quality boards. Assessors noted that comprehensive care related clinical incident rates and trends, for example related to falls and pressure injury, compare favourably with other Healthscope sites and peer health services. NPH has undertaken an impressive amount work in the development of gap analyses and action plans related to the Comprehensive Care Standard ASQHC Advisories. Progress has been substantial and is clearly documented. Progress is monitored by the Quality and Risk Management Committee. Assessors noted that NPH has undertaken several quality improvement initiatives across all clinical areas related to the provision of comprehensive care. The multifaceted Back to Bedside initiative and the development of the excellent Steps to Recovery booklets with consumer involvement are just two examples.

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
Shared decision making and goal setting are emphasised in comprehensive care related policies across each of the clinical disciplines provided at NPH. Care planning documentation also incorporates shared decision making and the ongoing consideration of patient goals. NPH has well established processes to engage with its patients during their care. This includes through admission assessments, ward rounds, patient rounding, the use of patient care boards and where relevant, family meetings. Various multidisciplinary team meetings and huddles are also regularly held. Assessors observed well conducted bedside handovers which included good engagement and communication with the patients. Assessors noted the NPH Back to Bedside initiative which has several elements supporting patient-centred care. This includes for example the use of ward patient care boards which display a range of relevant information and regular patient rounding. The NPH Patient Information Directory contains a host of information and is available to patients and their families through the NPH website or via QR code. A range of information brochures are also available to patients and their families. The Directory and brochures include the Consumer Approved Publication logo. The provision of verbal and written information to patients to support their involvement in decision making often commences prior to admission, for example for elective surgical and maternity patients. NPH, through Healthscope, has either developed or has accessed a wide range of high quality consumer resources. Assessors spoke to a number of patients who each provided very positive feedback regarding the level of information being provided, their involvement in decision making and the level of care they were receiving. Similar positive feedback from NPH patients is also received in Qualtrics patient experience surveys.

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
NPH currently uses a paper-based health care record. A variety of well-designed Healthscope forms are used by NPH clinicians to document all aspects of patient care across its range of clinical services. Whilst some forms are generic, others are tailored to meet the needs of specific speciality clinical areas. NPH has a ward structure that provides appropriate accommodation for patients based on their clinical needs, for example mental health, maternity, special care nursery, high dependency, day surgery and early parenting. NPH employs several allied health clinicians from a range of disciplines. Some work primarily in the acute setting, whilst the majority are involved in the provision of clinical care in the mental health ward. Every patient admitted to NPH has a clearly identified VMO who has overall accountability for their care.

Rating	Applicable HSF IDs
Met	All

ACTION 5.5
The health service organisation has processes to: a. Support multidisciplinary collaboration and teamwork b. Define the roles and responsibilities of each clinician working in a team
Comments
NPH has a variety of processes to support multidisciplinary collaboration, teamwork and care planning. This includes through VMO ward rounds, multidisciplinary team meetings, family meetings, allied health/nurse in charger huddles, daily bed meetings, daily operating theatre team meetings and post fall huddles. Twice weekly Mental Health ward "community meetings" are also held. These involve allied health and nursing clinicians and patients who wish to attend. The Comprehensive Care Plan, the Mental Health Comprehensive Care Plan, the Comprehensive Care Plan – Daily and the Progress/Variation/Outcome Notes are used by the clinical team to document clinical assessments and care plans. A large range of supporting documents are also available, depending on the clinical circumstances.

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	
The clinical handover process, including bedside handover, provides the nursing team with concise and relevant information related to patient care matters. Handover sheets printed from webPAS are used to support nursing clinical handovers. Assessors were advised that there is close operational liaison between the nurse in charge in each ward and the relevant VMOs.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.6	
Clinicians work collaboratively to plan and deliver comprehensive care	
Comments	
NPH demonstrated a team approach to planning, documenting and delivering of comprehensive care, as described in the commentary in Action 5.5.	
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
NPH clinicians use a series of risk screening and assessment tools and documents, covering the risks of harm listed in the minimising patient harm criterion. Policies and procedures to support this are in place. NPH has undertaken an impressive amount work in the development of gap analyses and action plans related to the Comprehensive Care Standard ASQHC Advisories. Progress has been substantial and is clearly documented.

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	
Healthscope has developed and implemented a range of risk screening and assessment tools and forms that are evidence based, logical to use and are applicable to the range of clinical services provided. The range of Healthscope documents are in use at NPH. The NPH Comprehensive Risk Screening form and the Mental Health Clinical Risk Assessment form provide summary information related to identified patient risks along with resultant actions. A specific Comprehensive Risk Screening – Obstetrics form has also recently been developed. Processes to assess surgical risks pre-operatively are also well established. Important risks other than those listed in the minimising patient harm criterion are also considered. This includes for example risks related to social situation, continence, substance withdrawal, medications, COVID 19 and other infections, venous thromboembolism and allergies. Further assessments and risk mitigation actions are undertaken, depending on the results of risk screening. Risk screening is also a key part of the provision of Transcranial Magnetic Stimulation (TMS). and Electroconvulsive Therapy (ECT). NPH has developed processes and specific forms that support risk and safety screening and the pre-treatment assessment of patients undergoing TMS or ECT. Assessors agree that the current requirements of the ASQHC Advisory AS18/14 "Comprehensive Care Standard: Screening and assessment for risk of harm", which is applicable to Actions 5.7 and 5.10, are met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.8	
The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems	
Comments	
The NPH administration staff who undertake patient registration advised that asking the Aboriginal and/or Torres Strait Islander identity question is routine practice. The response to the question is entered into webPAS. Aboriginal and Torres Strait Islander status is also documented on the health record patient front sheet.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.9	
Patients are supported to document clear advance care plans	
Comments	
The Advance Care Directives Policy provides guidance in relation to the management of Advance Care Directives and Advance Care Plans. Where an inpatient seeks to further discuss the completion of an Advance Care Directive or to develop an advance care plan, general advice is given. Patients are encouraged to discuss the matter further with their treating VMO. Information on Advance Care Directives is also provided in the NPH Patient Information Directory.	
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
The admission process for all NPH patients includes an overall clinical assessment of physical and mental health conditions the patient may have. Medical, nursing and often allied health assessments are undertaken. Assessments also consider any other factors that may contribute to the overall health of the patient, for example the patient's social and family circumstances and ability to self-care. The assessment also includes a check for known allergies. The Patient Health History form completed by patients prior to their admission includes questions relevant to various risks the patient may have. A series of forms and documents are used to facilitate comprehensive risk screening and assessment during patient admissions. Forms to facilitate specific risk screens are also used, for example the 4AT Assessment tool. Potential behavioural and cognitive risks or needs are also considered. Where admission screens identify specific risks, processes, tools and pathways are in place to further assess the risk and to implement risk reduction strategies. Additional or repeated screening may need to be undertaken during admissions, either scheduled, or as result of a change in the patient's condition. Well established processes are in place to minimise surgical and anaesthetic risk, both at the time the Theatre booking is made and also on the day of admission.

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
Maternity risk screening is undertaken by the obstetrics VMOS and is also considered during NPH antenatal booking in. Assessors agree that the current requirements of ASQHC Advisory AS18/14 “Comprehensive Care Standard: Screening and assessment for risk of harm”, which is applicable to Actions 5.7 and 5.10, are met.

Rating	Applicable HSF IDs
Met	All

ACTION 5.11
Clinicians comprehensively assess the conditions and risks identified through the screening process
Comments
VMOs document admission information and nursing staff complete relevant risk screening and care planning documentation. Where relevant, allied health clinicians also assess patients and document their findings. Where admission screens identify specific risks, processes, tools and pathways are in place to further assess the risks and to implement risk reduction strategies. Clinical assessment processes cover the range of clinical services provided by NPH. The clinical evaluation of patients is supported by an onsite pathology collection service and ready access to a comprehensive medical imaging service.

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
NPH has a paper-based health care record. The health care record includes an appropriate range of forms to support the documentation of clinical assessments, risk screening, care plans and patient clinical progress. Alerts are documented in the health care record and an entry is made into webPAS. An entry is also made on the NPH Alert sheet.

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
A range of NPH comprehensive care plans and daily care plans are used to document the ongoing clinical status of patients and changes to clinical treatment that may be required. Investigations and discharge planning are also documented. NPH has well established internal and external referral processes Patient goals of care are included into the care planning documents. Patient goals are also documented on the patient care boards in the ward rooms. NPH ensures that there is appropriate family involvement in the patient's care, subject to the patient's wishes. The various care planning forms document patient and family involvement in care. NPH has access to a range of allied health clinicians, specialist nurses and other therapists to support patient assessment and management. This includes a music therapist, an art therapist and more recently a yoga teacher. NPH also employs a lactation consultant. Assessors noted that NPH has arrangements with private home support service providers in place to deliver home rehabilitation for elective major joint replacement cases. NPH also liaises closely with other Healthscope facilities, for example in relation to inpatient rehabilitation.

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	
Assessors noted that a follow up phone call is made to surgical cases on the day after their discharge. Should any issues be identified, further care arrangements can be made. Assessors agree that current requirements of ASQHC Advisory AS18/15 "Comprehensive Care Standard: Developing the comprehensive care plan" are met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.14
The workforce, patients, carers and families work in partnership to: a. Use the comprehensive care plan to deliver care b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care c. Review and update the comprehensive care plan if it is not effective d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur
Comments
The paper-based health care record is a key clinical communication tool that supports the development and monitoring of comprehensive care plans at NPH. Documentation in health care records includes clinical history, physical examination, risk assessment, treatment plans, patient goals and discharge planning. NPH monitors the progress of the care plan for inpatients in a variety of ways, including through VMO ward rounds, bedside clinical handover, multidisciplinary team meetings, post fall huddles, allied health/Nurse Unit Manager huddles, repeated or additional risk assessments and ongoing clinical observation. A review of the care plan occurs where there are unexpected changes in the patient's clinical condition or following a clinical incident, such as a fall. A review of the patient's condition and possible alterations to the care plan is also triggered by abnormal or unexpected pathology or medical imaging results. Episodes of escalation of patient care also prompt a review of the care plan. Assessors agreed that NPH has well established systems in place to monitor the clinical care that patients receive, and to adapt care plans as relevant.

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	
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	
NPH provides inpatient end-of-life/palliative care on a very occasional basis in its West (medical) ward. Assessors were advised that this amounts to about two cases per year. There is no specific palliative care room. However, all rooms in the medical ward are modern and a single room can be adapted for the provision of end-of-life care. Healthscope provides a comprehensive range of end-of-life resources through its Last Days of Life Toolkit which is accessed through the HINT intranet site. The Last Days of Life Care and Management Policy provides clear guidance for NPH staff. The Policy references the National Consensus Statement: Essential elements for safe and high-quality end-of-life care and incorporates the essential elements outlined in the consensus statement. The policy emphasises the need for joint decision making in the development of individualised holistic end-of-life care plans. The policy also describes decision making processes surrounding the identification of patients who are near the end of their life. The Initiating Last Days of Life Management Plan – Adult document also includes a section on the recognition of dying. The Medical Orders for Life Sustaining Treatment (MOLST) document is completed in partnership with the patient and/or person responsible. The MOLST document includes the patient's wishes regarding the escalation of care that is to be provided during the last days of life along with other treatment preferences.	
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	
End-of-life care is provided by General Physician VMOs. They can access advice from a Palliative Care Physician VMO.	
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	
Patients are asked whether they have an Advance Care Directive during the admission process. If they do, a copy is requested for filing in the health record. A record of the presence of the document is made in webPAS, on the Alert Sheet and in the patient's progress notes. The presence of an Advance Care Directive is also recorded on bedside handover sheets.	
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	
NPH staff can access support from Healthscope's Employee Assistance Program which is provided by Converge International. Support from managers is also provided and debriefing by a psychologist can be arranged.	
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 provision of end-of-life/palliative care is evaluated on a case by case basis and reviewed by the NPH Mortality and Morbidity Committee. Feedback from patients and their families is also monitored.	
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	
The Last Days of Life Care and Management Policy highlights the need for joint decision making regarding all aspects of end-of-life care. An excellent range of consumer resources are available through the Healthscope Last Days of Life Toolkit.	
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
The Pressure Injury – Prevention. Identification and Management of Policy is a key document that provides guidance to clinicians regarding pressure injury risk assessment, prevention and management. The policy is detailed and references a variety of evidence based resources. Pressure injury risk screening and assessment is recorded on the NPH comprehensive risk screening forms, including the mental health and obstetrics versions. The Waterlow screening tool is used to assess pressure injury risk. Interventions are based on the Waterlow score and are recorded on the comprehensive risk screening forms.

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	
Daily comprehensive care plan forms are used to monitor ongoing pressure injury risk and the interventions that are in place.	
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	
Skin assessments are a routine component of pressure injury risk screening and risk minimisation. Skin assessments are documented in the skin integrity assessment section of the comprehensive risk screening forms. Whenever there is a skin breach that requires dressing, a Wound Care Assessment Plan is completed. Subject to patient consent, wounds are photographed to assist in the monitoring of wound management and healing.	
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	
Pressure injury prevention and management involves discussions with the patient and where appropriate with the family and carer. Nurses and allied health clinicians are involved in the prevention and management of pressure injures, including the provision of patient education. Patient information resources are available through HINT, the Healthscope intranet site. The NPH Patient Information Directory also includes information related to skin care and the prevention of pressure injuries.	

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	
NPH has a range of equipment and aids on site to assist in pressure injury prevention and management. Staff training in the correct use of the aids and equipment is provided.	
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 Falls Prevention and Management – Patient Policy provides guidance to clinicians regarding falls prevention and management. Falls risk screening and assessment is recorded on the NPH comprehensive risk screening forms, including the mental health and obstetrics versions. Several routine falls reduction strategies are implemented for all inpatients. Should the risk screen and assessment identify that the patient has a higher falls risk, a range of additional falls risk reduction strategies are implemented. Physiotherapy referral occurs for all patients who have a high falls risk. Daily comprehensive care plan forms are used to monitor ongoing falls risk and the interventions that are in place. Falls and balance group education classes are provided by physiotherapists in the mental health ward. This was instituted following a review of a cluster of falls earlier in 2021. Falls and balance groups aim to lessen the falls risk in a cohort of patients who often have a number of factors contributing to a high falls risk. The falls and balance groups also aim to minimise patient deconditioning during their admission. Following a fall, a RiskMan form is completed, an entry is made in webPAS and an entry is made on the Alert sheet. NPH has implemented falls huddles following any patient fall. A falls huddle sticker has been developed for placement in the patient's progress notes.	
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	
NPH has good access to a wide range of equipment and aids on site to support patient mobility and to assist in the prevention of falls. NPH can access additional equipment if required through the company Aidacare. Patients are provided with options for them to access falls reduction equipment and mobility aids for use at home following discharge.	
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	
NPH has patient information resources to supplement discussions with patients and their families regarding falls. This includes the Healthscope Preventing Falls Patient Information brochure. The brochure includes the Consumer Approved Publication logo. The NPH Patient Information Directory also includes information related to falls prevention.	
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
The Diet and Nutrition – Adult Inpatient Policy provides detailed guidance regarding the management of the nutrition of NPH patients. A series of supporting policies are also available to NPH clinicians. This includes regarding enteral nutrition, fluid balance charts, the use of naso-gastric tubes, the management of expressed breast milk and bariatric patient management. The policy documents are well referenced, and evidence based. The NPH comprehensive care risk screening documents include the Malnutrition Screening Tool (MST). The documents also outlines the actions to be undertaken depending on the MST score. This may include referral to the dietitian. Where there are concerns regarding dysphagia, speech pathologist referral also occurs. Assessors noted the very good cooperation between the catering service, the dietitian and the speech pathologist regarding the management of nutrition and where necessary specialised food supplements. NPH has implemented the International Dysphagia Diet Standardisation Initiative (IDDSI) framework.

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
NPH undertook a major menu review several months ago to coincide with NPH resuming the preparation of fresh meals on site. The menu review involved collaboration between catering staff, the dietitian and the speech pathologist. The review also had consumer involvement. A new menu that includes more food choices was introduced. A range of special dietary requirements are accommodated, and various food supplements are available. Processes to safely manage patients with food allergies are also in place. Assessors noted that the NPH catering team have a great deal of pride in their work and strive to provide a positive "Private Dining" experience. NPH has implemented protected mealtimes to ensure that patient meals are not missed or unduly delayed. Nurses monitor the nutrition and hydration status of their patients, including whether assistance or supervision with feeding is needed. This is documented on the daily comprehensive care plan forms.

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	
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	
The Delirium and Cognitive Impairment Prevention and Management Policy provides guidance regarding the screening, assessment and management of patients with cognitive impairment and delirium. The focus is on prevention, early detection and prompt management of delirium and cognitive impairment. Patients presenting to the NPH Emergency Department or admitted to NPH undergo an initial screen using the Cognitive Impairment Risk Assessment Tool (CIRAT). For Emergency Department patients, a CIRAT sticker is placed in the Emergency Department Observation Chart. For inpatients, the CIRAT results are recorded on the Comprehensive Risk Screening forms, either the general or the mental health version as applicable. Depending on the result of the CIRAT screen, a 4AT assessment test may be undertaken. A Behaviour Observation Chart may also be commenced. Many of the VMOs appointed to NPH are general physicians, geriatricians or psychiatrists. A high level of expertise in delirium and cognitive impairment assessment and management is thus readily available. The Delirium and Cognitive Impairment Prevention and Management Policy, along with the Restrictive Practices – Patient Restraint (Non-Mental Health Facilities) Policy, provide guidance regarding the use of psychotropic medication. Psychotropic medication is only used as a form of restraint at NPH in very limited and urgent situations and is subject to close monitoring and auditing.	
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
The Delirium and Cognitive Impairment Prevention and Management Policy includes a delirium screen pathway. The pathway provides guidance to clinicians on the screening, assessment, diagnosis and treatment of patients experiencing delirium. The pathway also provides advice on discharge planning and follow up care. Patients who have cognitive impairment or are at risk of delirium are closely monitored by NPH clinicians, including through the use of Behaviour Observation Charts. There is close liaison with the patient and family members with regards to delirium and cognitive impairment. The consumer approved Cognitive Impairment Patient and Carer Information brochure is used to support discussions with patients, family members and carers.

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
NPH has a series of policies that provide guidance to clinicians in the management of patients at risk of self-harm or suicide. This includes in both the mental health ward and in other ward and clinical areas. The Self-harm and Suicide (Threatened, Attempted or Completed in a Non-Mental Health Facility) Policy in one of the key policy documents. Patients admitted to the NPH mental health ward undergo detailed mental health risk assessments, including relating to self-harm, suicidality and aggression. The Mental Health Daily Risk Assessment chart is used to document ongoing assessment of self-harm, suicide and aggression risks.

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	
VMO psychiatrists monitor patients in the NPH mental health ward. They also provide consultation and advice regarding patients in other clinical areas who are experiencing thoughts of self-harm or suicide. A rapid response team call is made should clinicians need to urgently escalate care.	
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	
Patients who have expressed suicidal ideation or are at risk of self-harm and who cannot be managed safely at NPH may require referral and transfer to an acute mental health service for further assessment and management. Generally, this would involve the Northern Hospital which is part of the North Western Mental Health Service. Ambulance Victoria provides the patient transfers, with Police escort if needed. The NPH psychiatrist VMOs can follow up community-based patients in their private consulting rooms.	
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
The Occupational Violence and Aggression (OVA) Incident Management Policy provides guidance to NPH staff regarding the management of aggression or threatening behaviour. The importance of prevention, early identification and de-escalation of potential aggression is highlighted. The policy also emphasises personal safety, appropriate staff training and the use of code black alerts where required. The risk of aggression is a routine part of the pre-admission, admission and ongoing assessment of mental health patients. Patients admitted to other clinical areas, including maternity, are also screened for mental health, behavioural and substance abuse risks. This is documented on the comprehensive risk screening form. Patients considered to be at risk of aggressive or unpredictable behaviour are closely monitored. Behaviour Observation Charts are used where appropriate.

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
NPH emphasises the importance of family and carer involvement, where appropriate, in the management of patients exhibiting difficult or threatening behaviour. There is a focus on working together to develop a management plan to prevent or to rapidly de-escalate threatening behaviour and aggression. Workplace Assessment Violence Education (WAVE) training is mandatory for all NPH staff. At the time of the Assessment, over 90% of staff had completed the training module. The training focusses on predicting, preventing and de-escalating aggressive behaviour. Assessors were advised that the mental health ward is planning to implement the Safewards program during 2022. Should an episode of aggression occur, NPH has processes in place to support staff and where necessary patients, family members and carers. This may include a code black response and support from the Police. NPH reportedly has 1-2 code black activations per year.

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	
NPH also has fixed and mobile duress alert systems in place. When a duress alert is activated, a private security company receives the alert, and an initial call is made the Hospital Coordinator. Emergency Department staff can also contact the security firm directly if necessary.	
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	
The Restrictive Practices – Patient Restraint (Non-Mental Health Facilities) Policy covers physical, chemical and environmental forms of restraint. Physical or chemical restraint is very infrequently used at NPH and only in circumstances where all less intrusive methods have failed. Patients who require or may require chemical, physical or environmental restraint are usually promptly transferred to a more appropriate facility. There are strict documentation and reporting requirements should restraint be used.	
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	
Seclusion is not permitted and is not undertaken at NPH.	
Rating	**Applicable HSF IDs**
NA	All

Standard 6 - Communicating for Safety

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

ACTION 6.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication	
Comments	
NPH demonstrates the importance of effective and coordinated communication and its role in safe, coordinated, and continuous care. At assessment it was evident this communication occurs across the continuum from admission to discharge. There is a suite of policies and procedures readily available for communicating for safety. Risks associated with clinical communication are entered in to RiskMan and the outcomes were sighted by assessors with appropriate actions identified. Orientation and ongoing education are provided to meet the needs of the workforce. Healthscope Quality KPI's are reported quarterly and include orders and incidents pertaining to clinical handover. Assessors noted that areas assessed include nursing discharge/transfer summary, correct patient correct procedure correct site and completion rates and in mental health/OR for ECT correct procedure, correct site and completion rates.	
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	
NPH demonstrates the importance of effective and coordinated communication and its role in safe, coordinated, and continuous care. At assessment it was evident this communication occurs across the continuum from admission to discharge. There is a suite of policies and procedures readily available for communicating for safety. Risks associated with clinical communication are entered in to RiskMan and the outcomes were sighted by assessors with appropriate actions identified. Orientation and ongoing education are provided to meet the needs of the workforce.	
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	
Partnering with consumers has been an ongoing focus for NPH and a review of patient satisfaction surveys demonstrates a high level of patient satisfaction. This process uses a broad approach to measure outcomes with these results demonstrating the engagement process meets the expectations of the Consumers. Patients are encouraged to participate in clinical handover and the assessors observed the staff inviting their involvement. During assessment the assessors observed engagement with patients, carers, and families. The team was impressed with the respect and care evident when observing the clinical handover process. The interaction with family and carers in all areas, clinical and non-clinical, was apparent and patients were encouraged to engage in handover processes and be a partner in their care journey. Each patient has a Patient Care board in their room, which includes a range of information such as the nurse on shift, any risks: such as needing assistance with mobility, questions from the patient or visitors etc.	
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	
All staff across the organisation were able to demonstrate the requirements of the procedures and protocols regarding communication and when identification and procedure matching occurs. Within the sharing of clinical information there is written and verbal communication regarding risks and changes to any condition or management plan. Clinical communication occurs when a patient is transferred within the hospital, between clinicians and on discharge and was observed when the assessors visited clinical areas. Clear processes are in place for procedure matching and the expectation of this process for all clinical areas.	
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
Assessors observed clinicians using the identifiers whenever care, treatment or medication was provided. The organisation uses a number of standard forms for transfer of care and clinical documentation, including discharge summaries. Full patient identifiers are used through the application of an identification label on hardcopies. Examples of the electronic medical record reviewed and noted to have the appropriate identifiers. In the mental health service, patient have photographic identification on their medical record. The Assessors has noted that the corporate policy and procedure for patient identification bands includes four identifies. One of the Identifiers is gender. The policy is dated 2017.
Suggestion(s) for Improvement
As it is now 4 years since the policy was last reviewed it is suggested to NPH and Healthscope Clinical governance team that it is timely to review this requirement for four identifiers and ensure there is alignment with current NSQHSS requirements.

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	
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	
NPH has a suite of policies that guide processes to correctly match patients to their care. Processes for team time out by the surgical team are in place and assessors had the opportunity to observe this in practice. Assessors had the opportunity to follow several examples of a patient journey, including one from admission, through to theatre, recovery and ward and several clinical handovers. At all stages of every process observed, there was a thorough checking and clinical handover to ensure that correct identification and procedures took place.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.7
The health service organisation, in collaboration with clinicians, defines the: a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines b. Risks relevant to the service context and the particular needs of patients, carers and families c. Clinicians who are involved in the clinical handover
Comments
The ISOBAR tool was observed to be well used in the bedside shift: shift handovers which aligned with best practice requirements. The audit reports on clinical handover were discussed at meetings and improvement strategies implemented and revaluated. The assessors observed several handovers, which included confirming any adverse reactions and allergies, and noted that work has been done to educate staff regarding this. Assessors were informed that there were several improvement projects including standardising the clinical handover document in the Healthscope ED and development of a telephone triage form (for patients calling after discharge).

Rating	Applicable HSF IDs
Met	All

ACTION 6.8
Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care
Comments
The clinical handover policy is comprehensive and guiding structured handovers inclusive of patient goals discussed with the patient and a multidisciplinary approach through morning team handovers. This policy is supported by the allied health and nurse shift: shift clinical handover policies. The assessors followed several patient journeys on sites and found the flow of information and documentation to be relevant, accurate and timely. Transfers of care along the patient journey were observed to be well done including transfer forms from ward to theatre, ED to wards and transport of patients.

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	
The surgical and procedural safety checklist was observed to be aligned with best practice at assessment. Clinical handover incidents rates overall have decreased over recent years. Patient goals and preferences are discussed and reinforced during handovers and documented in the patient history and on the patient care boards in patient rooms.	
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	
Clinical handover policies outline critical communications requirements. Alerts for allergies and risks such as skin, falls, nutrition requirements were observed to be handed over at the bedside and alerts noted on the patient care board. Patient discharges were observed during the survey and the patients were given relevant information. A discharge summary was provided to the patient and sent to the GP.	
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 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. These methods of consumer involvement and clinical risk assessment identification was confirmed by assessors who spoke to many patients and families. They said any concerns were listened and followed up with feedback and shared decision making.	
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	
The medical record supports documentation requirements and expectations in a systematic manner. Alerts are consistently recorded in the medical record with staff aware of checking for alerts in the patient journey. The medical record system provides clarity of communication with regular review of the documentation process of effective communication to those documenting care. Clinical risks are documented with information gathered from the patient and carer where needed. Risks then generate action and referrals. Deviations from expected outcomes are reported or identified through audit. Care plans are changed and documented according to the clinical need of the patient.	
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	
There are Healthscope and NPH policies and clinical guidelines for safe blood management. The NPH policies are available for the safe administration and management of blood and blood products, especially for maternity complications. The Healthscope Blood Safe eLearning program is mandatory training for all staff who participate in blood and blood product management. Approximately 10-15 blood transfusions are required per quarter. Blood product related risks are adequately risk-rated and monitored through the Quality and Risk Committee. Should there be a clinical incident reported it is entered into RiskMan and managed, mitigated and where relevant quality improvement projects are initiated. The clinical decision for transfusion is prioritised and monitoring of the single unit use is positive.	
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	
NPH monitors the performance of all blood transfusions with the audit proforma completed after every transfusion. The Assessors reviewed ten histories for patients who had a blood transfusion. It was observed the compliance with completing parts of Blood and Blood Products Prescription and Transfusion Record 1. Right to Transfuse and 2. Right Documentation and Pre-Transfusion sections were not completely filled in for at least 30% of the histories. After discussion with the Leadership an email was sent to members of the leadership team for this to be tabled and discussed at departmental meetings with extra audits.	
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 who receive red blood cell transfusions are informed of the risks and benefits. The type of blood product, reason and patient and medical practitioner signatures are documented on the Consent for Blood Transfusion and/or Blood Product Administration form. The consent may be for this treatment or ongoing. If there is no signed consent, no blood is administered except in emergency situations. There are information brochures available and these include Blood Matters Blood Transfusions Patient Information handout. Audits confirm these are given to the patient and explained for every transfusion. Part of the Blood and Blood Products audit includes a consumer section and results were all 100%.	
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 clinical need for blood products is monitored and documented to avoid unnecessary blood transfusion. NPH has incorporated the 3 Pillars of Patient Blood Management - optimise red blood cells, minimise blood loss and detect/treat anaemia and iron and this is being implemented. The Blood and Blood Products Prescription and Transfusion Record form identifies the clinical indication and any transfusion history. There are 4 units of O neg blood kept in the blood fridge at all times as maternity patients, or others, may be at risk of bleeding. The NPH Massive Blood Transfusion Activation Protocol has been used following post-partum haemorrhage. Post activation reviews showed the process was followed with a good outcome.	
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	
There is documentation of relevant health conditions, risk factors, treatment dates and treatment plan in the medical history. Blood and Blood Products Prescription and Transfusion Record incorporates the Right to Transfuse, Right Documentation and Pre-Transfusion, Right Patient, Right Blood Product, Right Pack, Right Time and the Blood Prescription.	
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	
The Blood and Blood Products Prescription and Transfusion Record identifies the clinical indication and any transfusion history. Blood for cross matching is collected by pathology staff. The blood prescription is also ordered on this form. The checking process, that is, correct patient, correct blood type and group and cross matching is referenced with the crossmatch form and blood bag label by two nurses. All these procedures are then signed as correct. Assessors noted some elements were not completed and there is a suggestion to conduct observational audits for all blood transfusions with real time feedback to improve compliance in documentation. Observations are recorded as per protocol and include recognising and reporting signs of adverse reactions.	
Suggestion(s) for Improvement	
Conduct observational audits for all blood transfusions with real time feedback to improve compliance in documentation.	
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	
Transfusion Reaction Reports have not identified any adverse events for a considerable time. A near miss reported into RiskMan occurred during the checking process for Right Time, that is, date and time on crossmatch and product not exceeded. The laboratory was contacted and the discrepancy corrected.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.8	
The health service organisation participates in haemovigilance activities, in accordance with the national framework	
Comments	
Haemovigilance is maintained appropriately in accordance with reporting requirements. ACHS Clinical Indicators are collected and reported to the Quality and Risk Committee, Consumer Consultant Committee, Infection Control Committee and the Medical Advisory Committee.	
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
Blood products are stored in the blood refrigerator located in the Operating Theatre suite for all patients requiring a red blood cell transfusion. The blood fridge is monitored for temperature control and if there is a breach alarms are sent to the appropriate personnel. The risks associated with the traceability, receipt, storage, collection and transport of blood are constantly reviewed and monitored through RiskMan. Audits confirms they comply with standards and policy.

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	
Blood is supplied through the Australian Clinical Labs who ensure blood is available and manage their inventory levels. Cross-matched blood is also provided by Dorevitch Pathology Service. There is 0% recorded wastage as red blood cell bags are ordered, cross matched and delivered on request and if not used are returned to the laboratory. The O neg blood stored for emergency use is replaced prior to expiry and returned to the main laboratory for rotation.	
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	
The NPH Quality and Risk Management Committee meets two monthly and provides governance oversight of the recognising and responding to clinical deterioration standard. NPH has an array of policies to guide staff members in recognising and responding to acute deterioration in the variety of clinical situations that are relevant to NPH. Most of the policies are Healthscope wide whilst some are NPH specific. Overarching guidance is provided by the Healthscope "Clinical Deterioration, Recognising and Responding to" Policy. The approved policies are readily accessible to staff members via the Healthscope intranet, HINT. Assessors noted that each policy document has a section that clearly describes the key elements of the policy. NPH has a well-established risk management monitoring system, both at the corporate level and within NPH. The Quality and Risk Management Committee plays an important role in monitoring NPH specific risks. NPH has a strong focus on training and ongoing education which commences at orientation and induction. Basic Life Support (BLS) training is mandatory for all clinical staff. The training covers both adult and paediatric BLS and also response to clinical deterioration. Adult and Paediatric Advanced Life Support training is also mandatory for defined groups of clinicians. This includes Nurse Unit Managers, Hospital Coordinators and Emergency Department clinicians. Maternity clinicians also receive neonatal resuscitation training. NPH has recently trained seven clinicians to be Resus4Kids trainers. Midwifery staff undertake several K2 perinatal training modules, including foetal electronic surveillance and management of post-partum haemorrhage. All staff members are required to undertake annual Emergency Preparedness/Codes training. At the time of the Assessment, NPH had a very high level of compliance with mandatory and clinical discipline specific training.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.2
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems c. Reporting on effectiveness and outcomes of recognition and response systems
Comments
The NPH Quality and Risk Management Committee reports to the Leadership Group and has close links with the Medical Advisory Committee. Assessors noted that Quality and Risk Management Committee agendas and minutes are comprehensive and detailed. Quality Key Performance Indicator reports, mandatory training reports, clinical incident reviews, audit reports, policy changes, hospital acquired complication reports and quality improvement activities are reviewed and monitored by the committee. The committee also monitors the NPH the risk register. Updates related to each of the national standards are reviewed and Healthscope wide shared learnings are considered. The business arising section of the minutes is essentially an action plan that describes actions to be undertaken, by who and by when. Progress is monitored at each committee meeting. NPH uses its clinical incident reporting system, RiskMan, to identify all episodes of escalation of care. Every rapid response activation is reviewed by the Mortality and Morbidity Committee as well as the Quality and Risk Management Committee. The Mortality and Morbidity Committee also reviews each death that occurs at NPH. Assessors noted that the NPH hospital standardised mortality ratio (HSMR) is reported in funnel plot format and compares very favourably to other organisations.

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
Shared decision making and goal setting are emphasised in comprehensive care related policies across each of the clinical disciplines provided at NPH. Care planning documentation also incorporates shared decision making and the ongoing consideration of patient goals. NPH has well established processes to engage with its patients during their care. This includes through admission assessments, ward rounds, bedside handover, patient rounding, the use of patient care boards and where relevant, family meetings. Various multidisciplinary team meetings and huddles are also regularly held.

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	
Qualtrics patient experience data along with verbal feedback provided by patients to Assessors indicate that patients have a high level of satisfaction with the amount of information they receive and their involvement in decision making throughout NPH. The NPH Patient Information Directory contains a host of information and is available to patients and their families through the NPH website or via QR code. A range of written information resources are also available to patients and their families, for example the "Your Rapid Response Process" brochure. The Directory and brochures include the Consumer Approved Publication logo.	
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	
NPH uses a range of track and trigger observation charts. All use colour coded track and trigger methodology, with corresponding escalation responses clearly described on the charts. The Standard Adult General Observation Chart is commonly used. NPH however also uses specific neonatal, maternity, mental health, emergency department and a series of age specific paediatric observation charts. Assessors reviewed several charts of inpatients and noted that they are being used appropriately. Nurses commented that they find the charts straightforward to use and provide a clear picture of the patient's physiological status.	
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
The Healthscope Delirium and Cognitive Impairment Prevention and Management Policy is the key resource that guides clinicians in the management of delirium and mental state deterioration. The policy includes a concise delirium screen flowchart. NPH has a series of mental health risk screening and assessment tools that are in regular use. This includes the Cognitive Impairment Risk Assessment Tool (CIRAT) and the 4AT assessment test. Individual patient management depends on the risk assessment and clinical findings. A Behaviour Chart is used when indicated. The presence of an inpatient mental health unit along with credentialed VMO Psychiatrists enables mental health expertise to be readily available across all of the NPH clinical areas. Clinical advice can be obtained from the VMO Psychiatrists. Assessors agreed that NPH meets the requirements of the Australian Commission on Safety and Quality in Health Care (ACSQHC) Advisory "AS19/01: Recognising and Responding to Acute Deterioration Standard: Recognising deterioration in a person's mental state". This is applicable to Actions 8.5, 8.6 b, c, d and e, and 8.12.

Rating	Applicable HSF IDs
Met	All

ACTION 8.6
The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration
Comments
The Healthscope Clinical Deterioration, Recognising and Responding to Policy provides key guidance to clinicians regarding escalation of patient care. The principles outlined in the policy are applicable across the range of clinical services provided by NPH. A number of supporting polices, for example related to mental health and pain management are also available. The combined resource documents cover escalation of care related to physiological, mental state or behavioural deterioration. The documents emphasise the importance of thorough documentation in the health care record and the use of the appropriate track and trigger observation charts. The importance of liaising with the patient and family members following any rapid response team activation is also highlighted. NPH clinical staff maintain regular ongoing engagement with patients, and where appropriate, their families, in a variety of ways. However, should patients or family members have unresolved concerns, they are able to escalate care, including through directly activating the rapid response team. Ward patient care boards include information on patient/family escalation of care. In addition, the NPH Patient Information Directory has a section that describes patient/family escalation of care including through the triggering of a rapid response team call. The NPH “Your Rapid Response Process” brochure also describes how the patient or family member can activate the rapid response team. NPH clinicians are guided by Advance Care Directives and Medical Orders for Life-Sustaining Treatment in relation to escalation of care. These documents ensure that the wishes of patients are clearly recorded and acted upon. Assessors agreed that NPH meets the requirements of the Australian Commission on Safety and Quality in Health Care (ACSQHC) Advisory “AS19/01: Recognising and Responding to Acute Deterioration Standard: Recognising deterioration in a person's mental state”. This is applicable to Actions 8.5, 8.6 b, c, d and e, and 8.12.

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	
The Healthscope Clinical Deterioration, Recognising and Responding to Policy includes a provision for a patient or family member to directly activate a rapid response team. This is reflected in the NPH Patient Information Directory which includes a section that describes how patients/family members can escalate care, including through the activation of a rapid response team call. The “Your Rapid Response Process” brochure also describes how a patient or family member can activate the rapid response team.	
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	
The NPH workforce can call for emergency assistance through emergency call buttons located in inpatient ward and other clinical care areas. Activation of the rapid response team or code blue can be made at any time through calling 888. Assessors were advised that the rapid response team is activated once or twice weekly on average. Assessors were also advised that code blue calls are very infrequent, with two activations occurring in the last two years. NPH has a fleet of resuscitation trolleys located throughout the organisation. Although the trolleys are largely standardised, Theatre and the Emergency Department have manual defibrillators rather than AEDS. Resuscitation trolleys in relevant areas also include paediatric resuscitation equipment. A regular resuscitation trolley checking regimen is in place. Weekly checks are conducted, with plastic ties placed to secure the resuscitation trolleys after each check has been completed.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.9	
The workforce uses the recognition and response systems to escalate care	
Comments	
Assessors spoke to several NPH staff members all of whom were aware of the process escalate care. Escalation of care is well covered at orientation and also during induction to specific clinical areas. This supplements policy guidance which is accessible to all NPH staff members via HINT, Healthscope's intranet site.	
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	
BLS is classified as mandatory training for all NPH clinical staff. Nurse Unit Managers closely monitor BLS training compliance in their clinical areas. Compliance rates are also recorded on ward quality boards. At the time of the Assessment, compliance with BLS training was well over 90% throughout the various clinical areas. Paediatric and neonatal specific resuscitation is also provided to clinicians working in relevant clinical areas. Assessors noted that NPH has recently trained seven clinicians to be Resus4Kids trainers. Maternity staff undertake several K2 Perinatal Training modules, some of which relate to the management of obstetric emergencies.	
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	
Adult and/or paediatric Advanced Life Support (ALS) training is provided to senior nursing staff, including Nurse Unit Managers and Hospital Coordinators. The overnight Career Medical Officer and Emergency Physicians working in the Emergency Department are also trained in the provision of adult and/or paediatric ALS.	
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	
NPH has established policies and procedures to manage patients with deteriorating mental state. This includes patients in the NPH mental health unit and also those in other ward or clinical areas. Activation of the rapid response team may be required along with an urgent Psychiatrist review. On occasions, referral to the public North Western Mental Health Service for further management under an assessment order may be appropriate. Generally, this would involve transfer of the patient to the Northern Hospital. Ambulance Victoria provides the patient transfers, with Police escort if needed. Assessors agreed that NPH meets the requirements of the Australian Commission on Safety and Quality in Health Care (ACSQHC) Advisory “AS19/01: Recognising and Responding to Acute Deterioration Standard: Recognising deterioration in a person's mental state”. This is applicable to Actions 8.5, 8.6 b, c, d and e, and 8.12.	
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	
Patients who require higher level clinical care are transferred to an appropriate health care facility. This may be a public or a private facility depending on the nature and severity of the clinical condition and patient /family preference. NPH clinicians indicated that Ambulance Victoria provides a prompt response to 000 calls. The Perinatal Emergency Retrieval (PIPER) service is also available for urgent patient transfers. NPH uses the Patient Inter Hospital, Facility and Service Transfer Summary form to assist in the provision of all relevant information to the receiving health service.	
Rating	**Applicable HSF IDs**
Met	All

Recommendations from Previous Assessment

Nil