NSQHS Standards Second Edition Organisation-Wide Assessment

Final Report

Nepean Private Hospital

PENRITH, NSW

Organisation Code: 120314
Health Service Facility ID: 100980
Assessment Date: 9-11 November 2021

Accreditation Cycle: 1

Contents

Preamble

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

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

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

A rating report is provided for each health service facility.

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

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

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

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

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

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

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

Executive Summary

Nepean Private Hospital underwent a NSQHS Standards Second Edition Organisation-Wide Assessment (NS2 OWA) from 09/11/2021 to 11/11/2021. The NS2 OWA required three assessors for a period of three days. Nepean Private Hospital is a Private health service. Nepean Private Hospital was last assessed on 17-19/10/2017.

STANDARD 1

The focus on safety and quality at Nepean Private Hospital (NPH) demonstrates a robust quality performance program with data collection, submissions and analysis systems. Peer review programs are used to benchmark key performance indicators internally through the corporate structure and clinically with the ACHS Performance and Outcomes Service.

The Reconciliation Action Plan (RAP) contains strategies to implement and improve policies to enhance services to meet specific health needs of the ATSI people.

The Clinical Governance Plan incorporates the Safety and Quality Plan and the OneHealthscope 2025 strategy. The redevelopment plans for new theatres, Endoscopy Unit and CSSD have been implemented and discussed and is declared to be one of the most exciting projects for NPH as not only extensions of their services but upgrades in space, equipment and delivery of services to meet current healthcare facility guidelines and Australian Standards.

Strong leadership guide staff and consumers in a collaborative approach to safety and quality, evident in the many improvements over time. Incident reporting is through the electronic Riskman platform and reports are submitted to corporate and the relevant committees for discussion and analysis.

Cultural diversity is appreciated and orientation, mandatory and ongoing education provided to staff to meet consumer expectations and reflect the vision of Healthscope and NPH.

Consideration has been given to implement strategies and programs to enhance partnering with Aboriginal and Torres Strait Islander People through representation on the Consumer and Volunteer Committee that meets quarterly and links with the national Consumer Advisory and State Advisory Groups.

A range of comprehensive corporate and local policies and procedures are readily available on the intranet for staff information. All staff interviewed at the time of clinical observation and assessor visits to the departments demonstrated genuine commitment to safety, quality and patient care.

A comprehensive data base records all details and reminders when renewals and re-applications are due.

The roles and responsibilities of staff members, consumer representatives and volunteers at NPH were clearly defined in their position descriptions. Performance review processes were in place to guide practice. All staff receive a comprehensive orientation program and ongoing education supported by competency-based assessment to monitor skill levels.

The Risk Register is detailed covering clinical and business risks, with a risk rating and mitigating strategies to minimise any risks to the business. There is a clear documented process for root cause analysis for sentinel events as legislated.

The Medical Advisory & Credentialling Committee, Clinical Quality and Patient Safety Committee, Executive and Operational Review Committees are the main forums to provide leadership to develop a culture of safety and quality improvement through a clinical governance framework. Other committees as described throughout the report are established to cover all the NSQHS standards and service provision of each department

Policies and procedures, organisation chart, committee structure, strategic and business/clinical risk profiles, meeting schedules and audit schedules, terms of reference for committee meetings with standardised agendas covering the NSQHS standards, letters of appointment and credentialing were all found to be appropriate for the range of services and business strategies conducted by NPH, some of these through the corporate framework.

There is evidence of support for staff attendance at conferences, external and in-house education sessions and on-line training. Awards of recognition are given to staff that are exceptional and a national survey provides feedback from staff for further improvement projects.

STANDARD 2

Policies and procedures regarding partnering with consumers are readily available and supported by orientation and training programs. Consumer activities are documented in the minutes of Consumer and Volunteer Committee (NPH) and the national with reporting to clinical and executive meetings.

Effective partnerships exist through collaboration and monitoring of consumer activities and planned projects.

Legislative requirements for obtaining and documenting consent processes are well managed and monitored for compliance. The risk of con-compliance is identified in the corporate risk register with mitigating strategies. The Australian Charter of Health Care Rights are supplied to each patient/carer.

The relationship between staff and the consumer is clearly visible and valued, facilitating ongoing projects to better involve consumers in service provision and care delivery. The responses from staff that were spoken to on the assessment days were very positive and enthusiastic about their support for education and training and were complimentary about the assistance for ongoing education and awards received from Healthscope.

The Consumer and Volunteer Committee (NPH) and the Healthscope Consumer Consultant Committee play important roles in contributing to changes to the services and care delivery of the hospital, building projects, patient and family services, information for patients and care delivery.

Patients and their relatives who access services also make comments and suggestions through formal surveys, dropped in a comment box at each nurses' station and informally to the nurse providing services. They are involved in making suggestions and comments from consumers attending meetings and completing satisfaction surveys on specific services.

There is clear evidence, particularly in the areas with a larger ATSI population, that training is provided to staff to expand their understanding of the culture and sensitivities of ATSI people and the exchange of information has benefited clients.

STANDARD 3

Infection Prevention and Control is well managed at NPH by the teams that meet at regular IP&C Committee meetings. Policies and evidence-based systems are used to prevent and control healthcare associated infections. All areas of NPH are clean and hygienic, well maintained by a cleaning contractor as scheduled and verified by environmental audits conducted as part of the safety and quality program managed by an IP&C Coordinator and HICMR. Action plans are developed for any non-compliance areas for improvement.

Systems are in place to support and promote prevention and control of healthcare associated infections. Evidence-based systems are used to prevent and control healthcare-associated infections.

Patients presenting with, or with risk factors for, infection or colonisation with an organism of local, national, or global significance are identified promptly, and receive the necessary management and treatment. Hand hygiene is a focus for all staff patients and visitors and posters and products to highlight the importance of hand hygiene is displayed throughout the hospital.

A staff immunisation program is well established and maintained according to current standards.
The reprocessing of reusable equipment, instruments and devices is consistent with relevant Australian standards, and meets current best practice. Full compliance in the reprocessing of reusable medical devices according to the AS4187: 2014 Gap Analysis and comprehensive IP&C audits and reviews undertaken by the Consultant for HICMR is acknowledged as an excellent tool for the redevelopment building program which includes a new CSSD.

Staff undertake a number of competency-based assessments, including hand hygiene, aseptic technique and invasive devices as per current standards. Food services is of a high standard and all staff have certification required for their work in the Catering Department. It is pleasing to note that the regular inspection by the NSW Food Authority (26 /10/2020) demonstrates full compliance with standards.

NPH has systems for the safe and appropriate prescribing and use of antimicrobials as part of an antimicrobial stewardship program with assistance from an on-site Pharmacist.

STANDARD 4

This area is well covered by relevant and up to date policies and procedures. Documentation is well done and all legislative requirements for prescribing, dispensing and administration covered. One good outcome in this area related to the COVID-19 evacuees who all returned to their home with a comprehensive medication review and up to date medication listing.

The use of the pharmacy sticker as a memory jogger for medication review is a good strategy and works well.

STANDARD 5

Clinical polices, guidelines and pathways across Comprehensive Care are evidence based, freely available and known by staff.

Risk screening tools are used on admission and throughout the patient journey enabling the effective management of risk, prevention of deterioration and the development of an individualised appropriate care plan, provision of ongoing care, referral to appropriate disciplines and services through to discharge.

Processes to identify risk and escalate findings for further in-depth assessments are in place and activated.

Pressure Injury, Falls, Nutrition, Delirium, Dementia, and escalation of care are all managed well with systems in place to ensure all patients on admission are screened. Any incidents are entered into RiskMan.

STANDARD 6

Proactive leadership is demonstrated through the clinical governance framework, the multidisciplinary committee and the many evaluations and improvements ensuring safe and effective communication.

Audits, reviews and internal benchmarking activities as well as clinical indicators through the ACHS Performance and Outcomes Service are documented and reported as noted in the overall Quality Plan and schedule.

The identification of patients is well managed by the multidisciplinary team with clinical handover and Time Out procedures carried out routinely and documented in the clinical record, meeting current standards and regulations. Non-compliance of these procedures are part of the risk register and audits monitor and report incidents.

Critical information and risks are communicated with patient and carers wherever possible and observed at admission, discharge and transfer to another health facility. Healthcare records are audited yearly with very good outcomes that are presented at clinical committees as evidenced in minutes.

STANDARD 7

Blood transfusion management is well done with all policies, procedures, and processes in place to ensure patient safety with audit results of over 90%. Staff are well trained, and established processes ensure there is no blood wastage.

STANDARD 8

Nepean Private Hospital has Healthscope and NPH policies and procedures to support the recognition and response systems for the deteriorating patient. Policies are consistent with the 'National Consensus Statements for physical deterioration, high-quality end-of-life care and mental state deterioration' as well as the 'Delirium Clinical Care Standard'. All patient incidents related to recognising and responding to deterioration are recorded, managed, investigated and analysed.

At NPH REACH signage are displayed in the patient waiting areas and treatment areas and outline instructions on how to escalate care, with a pathway on escalating care included in the Patient Information Directory. Staff are well trained in BLS and ALS and a MET team responds to critical medical emergencies. Emergency carts are available in each ward and are well stocked and regularly closely monitored for completeness.

Patient deterioration is well managed as evidenced by a high-risk scenario of a bleed by a post-tonsillectomy child being re-enacted by staff and assessors with successful outcomes. Appropriate risk identification and responses and mitigating policies and procedures have been developed as evidenced in the Risk Register. Information on the minimisation of exposure to risks is readily available for patients and carers.

Summary of Results

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

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

Sites for Assessment
Nepean Private Hospital

Site	HSFID	Address	Visited
Nepean Private Hospital	100980	1-9 Barber Ave KINGSWOOD NSW 2747	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
Healthscope is one of largest providers of medical and surgical private health care in Australia. Nepean Private Hospital (NPH) in Penrith NSW has provided healthcare services to the Penrith Community and satellite suburbs for more than 20 years. NPH is comprised of 109 beds and incorporating 8 operating theatres, a hybrid theatre, CSSD, Endoscopy unit, Maternity unit and a Day Surgery Unit. Delivering high quality care and meeting the needs of the community with the focus on ensuring safe, personal, connected and effective service delivery, a range of specialties are delivered. Leadership is evident in the corporate structure, organisational chart and committee structure. Each ward has a Nurse Unit Manager who works collaboratively with staff and the executive team providing support and partnership with quality and safety initiatives and corporate systems and programs. The NPH "Call To Action" to receive residential care residents from a Hawkesbury Living Residential Home during the COVID-19 outbreak is commended and a sign of strong leadership and a community focus. Excellence in care and service provision embraces the NSQHS standards (second edition), legislative requirements and the Clinical Governance Framework which encompasses the Safety and Quality Plan. There is a distinct culture of safety and quality improvement through a clinical governance framework supporting comprehensive services. The Strategic Plan 2019 – 2021 defines the strategic objectives for those years which includes the growth of services, business goals and consumer engagement. Plans state that everyone has a specific part to play in providing direct care and in partnership with stakeholders. The Nepean Private Hospital Business Plan for 2022 – 2026 details further growth, redevelopment and the top 10 quality initiatives for 2022. Committee structures are established to monitor the effects of the quality improvement program.

ACTION 1.1	
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The roles and responsibilities of employees are defined in their position descriptions that are acknowledged and signed by each staff member and monitored through performance reviews and competency-based assessments. Consumer representatives and volunteers also have their roles clearly defined in position descriptions. A monthly risk report is generated and submitted to Corporate Office via RiskMan. Incident reports are detailed and includes a mechanism for a RCA to be undertaken on notifiable reportable events as per the NSW Private Health Facilities Act 2010 and Regulation 2017.	
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 demographic profile of the patient population in the catchment areas indicates that the number of Aboriginal and Torres Strait Islander people is relatively low (3.8 %). Regardless of this, strategic directions are to incorporate a culture of diversity and acknowledge and promote Aboriginal and Torres Strait Islander People culture as a core objective in strategic directions, now and for the future. The Aboriginal and Torres Strait Islander Engagement Plan defines Healthscope's purpose to 'work together for better care' which is portrayed in the Healthscope original ATSI artwork, "Coming together" displayed at Head Office, at NPH and in publications.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.3
The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality
Comments
The Clinical Governance Framework drives improvements in safety and quality and is comprised of clinical and non-clinical policies, procedures and quality and risk management programs that are easily accessible by staff electronically. The implementation and monitoring of strategies and programs to not only meet goals but exceed safety and quality goals and programs of Aboriginal and Torres Strait Islander people. Clinical and non-clinical data within KPIs are collected, collated and reported monthly with discussion by NPH and corporate executive teams. A range of ACHS clinical indicators are also collected and benchmarked.

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
Diverse culture training and education for staff continues to improve through orientation, mandatory education sessions and on-line modules. Feedback from the consumer representatives at Consumer meetings provide advice and initiatives for safety and quality strategies to improve services and care delivery to ATSI people. Staff have enhanced knowledge and appropriate values instilled with reference to Healthscope values and mission. On-line training modules are mandatory and accessed by staff. The focus on the implementation and monitoring strategies to meet safety and quality priorities for ATSI is demonstrated by the development and implementation of the Reconciliation Action Plan (RAP) and the Aboriginal and Torres Strait Islander Engagement Plan 2021. A review of the RAP, Innovate Reconciliation Action Plan - October 2021 – October 2023 is in draft form.

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
There is a noticeable culture of person-centred care and striving for best practice as expressed by patients and staff on the days of assessment. Integrated into the core values of every ward is evidence that the patient and family/carer is the focus of all activities of the services. Business decision-making is a collaborative process between corporate office, state managers and executives, VMOs, staff and consumers who expressed their views and input into changes and improvements with the assessment team. Strategic and business planning is developed as a result of safety and quality outcomes and clients, suggestions and recommendations from consumer committee meetings and patient experience surveys. Business decision making is also evidenced in the current Strategic Plan 2019 – 2021.

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
It is evident that staff are employed on their educational portfolio and their skills, matching their specific roles and responsibilities. They abide by the health, safety and wellbeing goals set by Healthscope. Discussion with managers and other staff show a high level of enthusiasm and knowledge base for their roles. Defined in their position descriptions and following a comprehensive orientation and training sessions that includes a 'buddy' system, face to face and on-line training modules, staff are able to perform their delegated roles and responsibilities. There was evidence of staff participation along the continuum so as to achieve the highest standard of safety and care delivery. Staff operate within the defined clinical governance framework which is articulated to all staff at orientation and referred to in performance assessments.

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
At the assessment it was apparent that evidence-based policies and procedures were utilised with formatting and the content of policies are reflective of standardised best practice and these are accessible to all staff. Compliance with legislation is well managed with corporate policies by Healthscope and local policies available on the intranet and acknowledged by managers and staff. Review dates are documented and compliance in the timeframes acknowledged. The assessors noted that there is ongoing engagement with consumers to provide appropriate safety and performance information and that some policies were discussed and feedback provided on the development of new policies and revision of current policies and procedures. Minutes of Consumer meetings at the local land corporate levels were presented and discussed as evidence. Non-compliance of policies and procedures are documented and reported in Riskman and is included in the overall Risk Register with strategies in place to mitigate non-compliance.

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 NPH Quality Improvement Plan includes clinical and non- clinical services. The clinical audit schedule ensures regular audits are undertaken in all services. Should results fall outside predetermined parameters a red flag alerts the quality team. The Quality Manager assists services plan and executes quality improvement activities. These may arise from unfavourable audit results or a quality and safety initiative. All link back to the vision and clinical governance framework. Wherever possible a consumer is included in the team to ensure the actions taken are considered from the consumers perspective. Incidents reported in RiskMan often identify opportunities for improvement. The quality improvement activities are recorded in MARS. The NPH KPI Report is sent to all governance committees and the Dashboard displayed on the “Quality Boards”.

ACTION 1.8	
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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	
KPI results are reported on monthly. Routinely collected process and outcome data, the monitoring of the data for trends and reporting clinical alerts including HAC (Hospital Acquired Complication) data, assists the organisation realise its performance and outcomes. NPH reports metrics as part of regulatory requirements, those measuring safety, clinical effectiveness, and patient experience. The MAC and EXCOM (Executive Committee) receive a comprehensive suite of KPI reports and quality presentations which are also available for the workforce via RiskMan. Minutes of departmental meetings demonstrate that these KPI's are discussed and ideas for improvement realised.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.10	
The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters	
Comments	
The Healthscope Audit Risk and Compliance Committee is the primary governing committee. An in-depth review of Risk Management was undertaken in 2019 and a new Risk Framework developed. This included a review of the Risk Register at local level which currently includes risks that have not been reviewed for some years. Staff are trained on the Fundamentals of Risk at Orientation. Risk appetite is discussed at EXCOM and MAC.	

ACTION 1.10
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The EXCOM and OPSCOM (Operational Review Committee) act as the foundation of the organisation having developed policies and procedures that define the organisation's vision, principles, objectives, practices, responsibilities, resources, and how outcomes will be measured in accordance with the risk framework. The organisation actively encourages and supports staff, consumers, and other stakeholders to report potential or actual risks. Risk audits are regularly conducted and monitored. Education on risk management is ongoing. An in-service- "Clinical Risk Overview- A Matter of Concern "was delivered in 2020 and focussed on clinical safety and quality. The Emergency Procedure Manual was reviewed in November 2020. Codes are tested and BCP reviewed in response to debriefs from code exercises. Evacuation Procedures are placed strategically across the facility.
Suggestion(s) for Improvement
Review the fifteen risks that are past review date and consider the consolidation of some risks identified in the register.

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
There is a culture of reporting incidents with an average of 500 per month. Common contributing factors are analysed for Incident Severity Rating (ISR's) 1-4/. SAC. Following ISR one and two investigation and a clinical review is developed. Morbidity and Mortality (M&M) are conducted where required. Trends and opportunities for improvement are acted upon. Action plans are developed and closely monitored. Each incident is managed appropriately from a clinical perspective ensuring the provision of safe, high-quality care including open disclosure if appropriate. Incident KPI's are reported to the MAC, EXCOM, staff, and consumers.

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	
Summation of these results are displayed on the Quality Boards located in the foyer and in each ward/unit. Risks identified in the analysis of incidents are added to the Risk Register with controls and accountability included.	
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	
99% of staff completed the Open Disclosure Learning Package in 2020-2021. This program is consistent with the Australian Open Disclosure Framework. It is evident from reading incidents that Open Disclosure is used as appropriate. There is a system in place for monitoring compliance with the Open Disclosure Framework. NPH leads a “just culture” marked by openness and constructive learning from mistakes.	
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	
The organisation is passionate about receiving feedback from consumers and their carers. Patient Experience Surveys are conducted routinely. Patients can complete survey in their own time using a QR code for those who would like to respond via mobile. There is also a specific email address for feedback. It was apparent from reading the survey results that feedback is used as a catalyst for quality improvement. The Patient Experience Dashboard displays results of the 16 questions of the patient survey.	
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	
The Quality Manager reviews complaints. The Complaint Management Framework defines roles, responsibilities and accountabilities of relevant individuals and committees. Staff attend training on what to do if they receive a complaint. It was encouraging when reading the complaint data to see that even small issues are investigated. Complaint data is analysed identifying trends and opportunities for improvement. The organisation acknowledges receipt of a complaint within three days. Complaints are linked to NPH open disclosure, risk management, credentialling/scope of practice and quality improvement systems.	
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
Periodic audits of the administrative data system demonstrate that the diversity of consumers of the NPH is not wide. Regardless, small pockets of some cultural groups have been identified and these are considered in the planning and delivery of care. Cultural safety and insight training and workshops are conducted to upskill staff of specific ethnic communities. As previously reported the specific health care needs of Aboriginal and Torres Strait Islander People are addressed. There has been a small increase in the number of Aboriginal and Torres Strait Islander presentations. This appears to be as a result of an increase in confidence of this cohort of consumers and the close working relationship with the Aboriginal Health Unit in the public hospital which is adjacent to NPH and shares site. The health outcomes of the specific ethnic groups are closely monitored.

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
Healthcare records are paper based. The Health Information Manager conducts an informing and practical session at orientation on health record management including confidentiality and privacy. Audits are routinely conducted. Audits of unique patient identifiers demonstrate that patient identification is managed well with very few multiples/errors. Records are secured and secondary storage is both onsite and offsite with appropriate retrieval times. Quality Improvement initiatives include a BAM (Baseline, Action, Measure) on health record forms. There is a rigorous system in place to obtain a medical record ensuring security and privacy.

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	
The Health Information Manager (HIM) is responsible for the organisation's preparation for implementation of "My Health Record". The assessors viewed the required gap analysis and the detailed plan. The intent of Advisory AS 18/11 has been met.	
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	
Processes are in place for staff to comply with legal requirements regarding access to the My Health Record system to input clinical information, and to ensure accuracy and completeness of this information when uploading into the system.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.19	
The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation	
Comments	
NPH has established a comprehensive onboarding and orientation program for all staff members. Healthscope Corporate Orientation is followed by local NPH orientation. Much of the orientation is provided online. Department specific induction is also provided. NPH position descriptions refer to the importance of the provision of high quality, safe person-centred care and working in a team environment. A detailed Welcome to Nepean Private Hospital Handbook assists in the orientation of new staff. The Agency and Locum Orientation ensures assists in providing consistent high quality, patient focused care. The VMO Training matrix ensures new VMOs are aware of what is required of them when working at NPH.	

ACTION 1.19	
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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	
NPH has a strong ongoing education and training focus with oversight and support provided by the Nurse Educator. The NPH "Mandatory and Organisation Specific Requirements for Education and Training" policy outlines the mandatory and organisational training requirements for staff members throughout the organisation. The onboarding and mandatory and organisational training requirements applicable to each clinical and non-clinical staff work group, including volunteers, have been determined. A one-page onboarding and training matrix that clearly describes the training requirements for each of the NPH work groups has been developed. Much of the training is delivered through e-learning modules, even more so since the COVID-19 pandemic commenced. Learning modules are readily accessed by staff members via the Education hub. The NPH education calendar is also accessed through the Education hub. The NPH Training Calendar provides a summary of educational courses, workshops, and other educational activities. Comprehensive electronic dashboard training reports are monitored by department heads, with oversight provided by the OPSCOM. Assessors were advised that the increased production of recorded training sessions, such as in-services has been a positive consequence of the move to online learning due to the COVID-19 pandemic. A range of recorded sessions are available for staff members to watch at a time that best suits them. Assessors noted that current overall compliance with mandatory training for NPH is 86%. There have been significant staffing and other challenges created by the COVID-19 pandemic. Notwithstanding these difficulties, NPH has continued to closely monitor and support the completion of mandatory training and is striving to achieve a higher level of compliance.	
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 a highly motivated and skilled Aboriginal Consumer Representative who is well regarded throughout the organisation. Aboriginal and Torres Strait Islander Cultural Insight training "Share our Pride" is provided online as part of the NPH onboarding program. Cultural competency training sessions are also provided on a regular basis, including during evenings to accommodate evening/night duty staff. There has also been an emphasis on developing role models/champions across the organisation. 91% of staff have received cultural training which they indicated has been enthusiastically received.	
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	
The performance management requirements for NPH are described in the P&D Framework. Other documents cover specific matters such as performance management and senior medical staff performance development and process. The NPH Performance Development Process (PDP) program has a strong emphasis on the provision of high-quality patient centred care. PDP is included in the training matrix for each work group and compliance levels are reported through the training dashboards. The PDP program is closely linked to the organisation's education and training system. Assessors noted that the overall current PDP rate is 80% compared to 67% in 2020. NPH is striving to further improve the current compliance rate which has been impacted by the significant disruption to the organisation caused by the COVID-19 pandemic.	
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
NPH has well established processes supporting the credentialling and defining the scope of practice of its medical, nursing, midwifery, and allied health clinicians. The "Credentialing and Scope of Practice" policy provides overarching guidance. This is supported by policies and protocols specific to medical, nursing and midwifery staff. The policies and protocols also cover expanded scope of practice for enrolled nurses and allied health clinicians, including those applying for advanced or extended scopes of clinical practice. Management of the credentialling, defining the scope of clinical practice and the appointment of senior medical staff is supported by eCredentialling and WEBPAS software. Capability framework documents such as those related to surgical services, anaesthetic services and maternity services assist in the alignment of clinician scope of clinical practice with NPH service capability. Theatre management staff have access to scope of practice information related to proceduralists via an excel spreadsheet. Escalation processes are in place should there be any issues or queries related to planned procedures. The "Chain of Command" Policy outlines staff responsibilities in reporting any process outside a clinician's scope of practice. The detailed "Introduction of New Clinical Services, Procedures and other Interventions" protocol provides guidance related to the introduction of new clinical procedures and clinical technologies. The protocol includes a detailed checklist that covers the many relevant issues that need to be addressed, including credentialling and staff training requirements.

Rating	Applicable HSF IDs
Met	All

ACTION 1.24
The health service organisation: a. Conducts processes to ensure that clinicians are credentialed, where relevant b. Monitors and improves the effectiveness of the credentialing process
Comments
NPH maintains a database of all of its registered clinicians. Healthscope maintains a Credentialling Cluster. Credentialling is managed through eCredentialling. There are established processes to regularly check the Australian Health Practitioner Regulation Agency (AHPRA) registration status of all registered clinicians engaged or employed by NPH. This occurs through electronic links between WEBPAS and the AHPRA medical register in the case of medical practitioners. The AHPRA multiple registration check process is used to check the status of other registered clinicians.

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	
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	
The NPH Principles of Clinical Care emphasises the values of the organisation and its guiding principles that include the provision of high-quality patient centred care. This is reflected in NPH position descriptions which also refer to the importance of the provision of safe, high-quality, person-centred care. Position descriptions also highlight the importance of working in a team environment. The role of clinicians in the provision of safe and high-quality care is also emphasised during onboarding, as part of mandatory and organisational training and during ongoing in-service education. Training in the use of RiskMan and in completing RiskMan incident reports is also provided. Assessors noted that up to date "Quality" boards are displayed across the site's clinical areas. The boards include a summary of quality improvement activities and trended audit data relevant to the clinical area. This reflects the focus that frontline clinicians take on monitoring and improving the care they provide.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.26	
The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate	
Comments	
The After-Hours Manager assumes responsibility for the hospital after hours. This position is supported by various protocols including On Call Roster- MET and VMO, Healthscope Telephone Triage Policy and Women's Health Unit telephone advice. The hospital has its own ICU and there is evidence of access to Intensivists if required. The hospital is also adjacent to the Nepean Public Hospital and has access to higher acuity services via a footbridge.	

ACTION 1.26	
The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.27	
The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care	
Comments	
Clinicians have ready access to a wide array of policies, protocols, guidelines, clinical pathways and decision-making tools that have been produced within the organisation. A large range of evidence-based library resources which have been sourced from credible external groups and organisations are also available. Library resources include ebooks, journals, databases such as Cochrane and Medline and point of care resources such as Up to Date and the Clinicians Health Channel. All of the resources are available to Clinicians. This is through the Governance Document Management System in the case of policies and protocols and via online library resources. The Education hub also contains the NPH education and training calendar and specific resources for graduate nurses, and midwives. Clinicians can also access several recorded lectures. A recent addition consists of a video “Innovations in Delirium Care”.	
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	
Assessors noted numerous examples of where performance and patient outcome data is collected and reviewed by clinicians in various disciplines and services.	

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
Examples include the monitoring of Hospital acquired Complication's data, Clinical Risk & Patient Safety Shared Learning Report, Peer Report and Palliative Care Outcomes Collaboration (PCOC) outcome data by the end-of-life team. NPH contributes data to Healthscope Corporate Office and receives benchmark reports from the other sites. These reports are reviewed by relevant clinical specialty teams.

Rating	Applicable HSF IDs
Met	All

ACTION 1.29
The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose
Comments
The campus appears well maintained. The Chief Engineer is responsible for the Building and Engineering Maintenance Service. Maintenance is outsourced by Healthscope Corporate Office. There is ready access to all trades. Staff of these services are involved in minor works, repair, and maintenance. There is an extensive Preventative Maintenance Program (PMP). All Job Requests are electronically entered at ward/department level and then prioritised by Engineering. Biomedical equipment is serviced by Biomedical Engineering. Testing and tagging is current. Body protection circuits are in place in all rooms where monitoring does or may possibly take place. Generators are tested fortnightly off load and then monthly on full load. A Black start is conducted every 12 months. TMV's are tested regularly and legionella tests conducted on TMV's and warm water system. Imaging Services are outsourced and have been separately NATA accredited. The Radiation Safety Plan is strictly adhered to. A robust system is in place for annual testing of lead aprons and shielding. There is a current Fire Compliance Certificate. Fire Wardens are allocated to each shift and have been appropriately trained. The Emergency Management Plan ensures readiness for any sort of emergency: internal, external, code black and purple. Codes are tested regularly, and evacuation exercise conducted routinely. Building Continuity Plans (BCPs) are tested regularly. The Health Safety Representatives are nominated from their department/work groups. The Occupational Health and Safety Committee is active and well attended. Work Health and Safety Officers assist with risk assessments following an incident. There are 34 CCTVs across the site and lighting was upgraded in the new multi-storey carpark. Duress alarms are tested regularly.

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	
Suggestion(s) for Improvement	
Send a copy of the results of legionella tests to Infection Control.	
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	
There are very few incidents of aggressive behaviour as there is no ED and the cohort of patients in a private hospital is very different to the public hospital next door. However, staff have been trained in de-escalation processes in readiness to cope with unpredictable behaviour. If required a patient can be moved to a single room to provide a calm and quiet behaviour.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.31
The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose
Comments
Signage is clear and the site is intuitive to ease of movement as it is one building. Consumers are asked if they were able to locate the unit/department they were looking for and answers are always positive.

ACTION 1.31	
The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.32	
The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so	
Comments	
The after-hours manager oversees any access after-hours. Access is determined on need. COVID has resulted in no visitors being allowed however access was granted for any end-of-life patient's family.	
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 is fortunate to have an Aboriginal Consumer Representative who guides the organisation as to how to make the environment one that Aboriginal and Torrs Strait Islanders feel welcome and comfortable. A Smoking Ceremony was held on the new builds site before any work started. There is large piece of Indigenous artwork ("Coming Together") and Aboriginal and Torres strait Islander flags in the foyer. AHPEQS Responses from Patients Identifying as Aboriginal, or Torres Strait Islander identified that Aboriginal and Torres Strait islander patients were extremely happy with the service as a whole. The Aboriginal and Torres Strait Islander Plan identifies how NPH can continue to provide a welcoming environment.	
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
Nepean Private Hospital (NPH) demonstrates the integration of clinical governance and applies quality improvement systems in their endeavours to partner with consumers. A Consumer Partnership Plan (2020 – 2023), approved by consumers, outlines the strategies to achieve consumer partnership goals and is embedded in the Clinical Governance Plan incorporating the Safety and Quality Plan. The National Sorry Day and NAIDOC week are well celebrated each year in acknowledgement of the Aboriginal and Torres Strait Islander people, but this year due to lockdown and COVID restrictions, corporate office posted notices on web sites. This will be reviewed by Healthscope and improved next year by individual hospitals. The Taste of Harmony Day celebrates cultural diversity in the workplace and is held each year. The ATSI Engagement Plan drives the vision and purpose 'to work together for better care'. The assessors were impressed with the details and resources in this document. The NPH Consumer and Volunteer Committee is the forum for discussion on partnering with consumers to improve the delivery of services and patient care with feedback from comments boxes in each ward, satisfaction surveys, informal feedback and information from representatives at the local and national consumer committee meetings. Terms of reference and standing agenda items ensure a structured approach to covering issues that covers the National Standards and Healthscope policy and procedures. The Healthscope Corporate Consumer Consultant Committee is a very active forum comprised of consumers and key personnel that meet regularly, at least 3 monthly, and engages with NPH staff providing valuable input into strategies to improve services for the community. The minutes of the Corporate Consumer Consultant Committee and the NPH Consumer and Volunteer Committee meetings were sighted and it was noted that consumers actively participate in improvement of service delivery. For example, the review and revision of menus and diets, improvements in handover, review of visiting hours, the introduction of an act of kindness and good news stories that show the empathy of nurses. Staff, VMOs, volunteers (when available) and consumer representatives undergo a comprehensive orientation which includes introduction to recognising cultural diversity.

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	
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	
Consumers play an important role in assisting NPH to integrate clinical and non-clinical systems in partnership with consumers. Participation in meetings, formal and informal comments and suggestions have been used for improvements and reported to corporate, executive and departmental committee meetings. The role of consumers is identified through position descriptions, terms of reference of the Consumer and Volunteer Committee (previously Consumer Participation Committee) and the National Consumer Advisory Council. Orientation and education are closely monitored by senior staff with feedback systems with improvements noted throughout this process. Examples of improvements are the initiation of a concierge at the front entrance, ante-natal classes by Zoom with positive feedback, an updated compendium at the bedside, reviewed and approved Consumer Engagement Plan and ATSI Engagement Plan, assisting in the accreditation process through the information presented on surveys and audit outcomes. Standard duties include completing reviews and surveys, attending committee meetings, reviewing publications and providing advice on consumer related publications, staff education and assisting with accreditation. It is acknowledged that there will be several opportunities to be engaged in the redevelopment of NPH which is about to commence. Assessors wish to acknowledge the APAS Webinar Series 2021– Adjusting for the Future held on 24 March – 30 June 2021 as a significant example of international and national partnering with consumers and congratulate the hospital and orthopaedic team for their part.	
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 Health Care Rights (2nd edition) is clearly visible throughout the hospital and each ward. The Patient Information Directory is a comprehensive booklet containing relevant information on their hospital stay, infection, falls and pressure and injury prevention, rights and responsibilities, privacy principles, how to make a complaint or comment and the REACH program to name a few topics. This directory has the Consumer Approved Publication stamp.	
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	
A consent policy and process cover consent for treatment, financial consent and use of personal information. Corporate and NPH policies and procedures incorporate consent for medical/surgical treatment and procedures and financial consent. Consent is obtained on admission for the commencement of treatment/procedures and is renewed annually. Compliance with appropriate consent is monitored through the regular documentation audits, at least annually, with good results. Individual consents are obtained for immunisation, blood and blood product treatment, use of eHealth record and Telehealth communication. Failure to obtain a valid consent and non-compliance in the consent process is included in the overall corporate Risk Register with mitigation strategies and non-compliance recorded in RiskMan.	
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	
The consent policy includes consent by a guardian/relative as a substitute decision maker if a patient is unable to make decisions for themselves and follows legal requirements and Healthscope policy and procedure. Discussions with managers and staff supports this policy. The Comprehensive Care Plan incorporates the Advance Care process for managing consent. If an Advance Care Directives is on file, an alert is placed in the patient's record. There is a section on the Patient Registration Form to document Enduring Power of Attorney, Enduring Power of Guardianship and Medical Power of Attorney. Interpreter services are available for clients with linguistic problems.	
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	
Sharing decisions and planning care is multidisciplinary and can be observed in the clinical handover, communication with other clinicians and during admission and discharge/transfer procedures in collaboration with the patient and carer/relative. Documentation in the clinical record is well recorded and managed by the multidisciplinary team. VMOs and CMOs visit patients daily and care services and treatment updated. The Patient Information Board in each patient room has enhanced the communication of patient goals and therefore staff and patient information for effective clinical handover and care delivery. Staff discuss goals of care and treatments with the patient and with a relative or carer if available. Clinical handover at the beginning of each shift and transfer passes patient information to each attending clinician and involves the patient and carer (if available). The clinical record is detailed and multidisciplinary and compliance of documentation audit results are consistently good.	
Rating	**Applicable HSF IDs**

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	
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	
There is evidence that staff participate in the education on strategies to observe consumer partnerships. Staff are trained to be competent in responding to cultural diversity as identified in the Cultural Diversity training and policy. Consumer members play an important role, according to their position descriptions and their participatory goals in providing feedback regarding patient experiences and their own experiences. The Aboriginal and Torres Strait Islander Liaison Officers from the nearest public hospital (Nepean Public) play a vital role in ensuring this cohort of patients are assisted in the admission, patient journey and discharge. Specific needs, culturally and linguistically, are identified and every effort is made to ensure these clients understand the information, instructions and treatments relevant to their care planning. The participation of an ATSI consumer member on the Consumer and Volunteer Committee is a value-added addition to cultural representation. Interpreter services are available if required.	
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	
The assessors agree that the diversity of patients is acknowledged and respected culturally and linguistically through staff interview and discussion with patients. The Consumer Partnership Plan 2020 – 2023 oversees the cultural competence of staff to ensure appropriately to multicultural needs.	

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	
All staff are trained and it is noted that the Catering Department provide exceptional refreshments and meals in accordance with patient's religious and specific diet needs and to celebrate special occasions. A Smoking Ceremony was performed by an ATSI representative to commemorate the commencement of the planned building program next to the current hospital. Patient information booklets and leaflets can be provided in different languages on request, e.g. the Australian Charter of Healthcare Rights. Feedback on documents and brochures from consumers and patients is through patient experience surveys, REACH survey and catering service survey, active consumer members and informally to staff and volunteers. Terms of reference and minutes of regular Consumer and Volunteer Committee were sighted and evidence of activities confirmed.	
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	
NPH involves consumers in the development and revision of publication utilising the ACSQHC guidelines on health literacy. Assessors viewed some of these documents such as Rights and Responsibilities, Privacy Policy booklet, Preventing Infections in IV Access Devices, Admission Information, Remembrance Day, Patient Information Directory, Cognitive Impairment, keeping a step ahead of falls, Preventing Pressure Injuries, etc., some of these have been consumer approved publications.	
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
Health information is available in the Patient Information Directory and as requested by patients and is written in easy-to-read language. Translations are provided when requested. A number of improvements in the communication between patients, carers and families have occurred over time from suggestions from the Consumer forums. Bedside handover, patient rounding, an act of kindness and the Care Board in each room. Consumer Approved Publications continue to be strong evidence of discussion and development though partnering with consumers. The Consumer Approved Publication stamp is visibly clear on documents. Notices are posted on Quality and Safety, Health, IP&C, Consumer, Education, and the 8 National Standards Boards. Relevant Healthscope Group and NPH information, specific centre quality and safety outcomes and other health literacy are posted. Examples are, understanding your grief, preparing for end of life care and a general guide to blood transfusion. Results of safety and quality audits and results from patient experience surveys may also be posted for staff, patient, carer and visitor interest.

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
Access to interpreter services is available should they be required. Results of patient satisfaction surveys indicate that patients and carers are aware of and can understand their rights and responsibilities and show good levels of satisfaction with the information provided and the service.

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	
Staff are trained in multicultural diversity and respect for different cultures and religions. Consideration is given to patients' culture, religion and personal and specific needs. Consultation with various groups such as people with disabilities, gender diversity, migrant and refugee families help to identity problems and help cater for their needs. Guidance is given through staff and consumer meetings and in the comments in patient experience surveys. Partnering with Aboriginal Liaison Officers (ALO) from the public health sector is a successful step to effective partnership with the indigenous culture and community. The ATSI Consultant on the Consumer and Volunteer Committee has added a focus on meeting the cultural and wellbeing needs of Aboriginal and Torres Strait Islander cohort of NPH patients and community.	
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	
A comprehensive orientation and training program is undertaken by consumers on committees. This is consistent with guidelines to enhance health and safety of the Australian Commission for Safety and Quality in Health Care (ACSQHC). Key Communication Strategies were developed and is ongoing. A power point presentation on health literacy has been developed and is utilised by consumers and staff. Consumer members of the Consumer Committees provide valuable input into any current or new information that is available to clients, patient record forms and other publications and new developments in service and care delivery. Evidence was sighted in the minutes of the Corporate Consumer Consultant Committee (December 2020 and April 2021.	
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	
There is sufficient information and resources on Aboriginal and Torres Strait Islander patients and consideration for their specific care. Liaising with the ATSI people, and in particular members of consumer forums has increased competency and consistency of staff to care for sick Aboriginal and Torres Islander people albeit a small cohort at this stage. It is noted that the Aboriginal and Torres Strait Islander Census 2016 population of the Penrith City indicated 3.8%of the population identified as ATSI descent. Assessors were impressed with steps taken in acknowledging and working with Aboriginal and Torres Strait Islander People. Acknowledgement Statements, ATSI flags, artwork and paintings were prominently displayed in the reception and administrative areas.	
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	
Training modules are developed by Healthscope and outline the roles and partnership strategies with hospital staff. The goals are to develop strategic directions for incorporating a comprehensive program of respecting and managing cultural diversity. Consumers on the Healthscope Consumer Consultation Committee and Consumer and Volunteer Committee, through discussion and suggestions, are able to voice their views and experiences for the training of staff. The focus is on the culture, considerations, respect and expectations of culturally diverse communities. The Healthscope policy on 'End of life care-Aboriginal and Torres Strait Islander People' is an important directive to provide the best cultural care during the End of Life Journey of Aboriginal People and Torres Strait Islander people recognizing and respecting the differences between people and cultures and is commended.	
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
The comprehensive infection prevention and control program at NPH is expertly managed by an external consultancy, HICMR, with local coordination by an IP&C Coordinator who has responsibility built into her Registered Nurse's position. A broad range of infection prevention and control policies and procedures are easily accessible in hard copies and the intranet for staff and referenced to current standards, guidelines and codes of practice. The IP&C and CSSD manuals are detailed and meets current legislation and guidelines and available electronically for each department. These were developed by HICMR and are supported with updated directives and toolkits. Consultation with key hospital staff members is acknowledged. Minutes of the Infection Prevention and Control/Pandemic Team Committee meetings were sighted and noted as being very comprehensive and productive. Terms of reference were upheld and guided the team meeting. State guidelines are met as evidenced in regular inspections and reports which contains recommendations for further actions. The audits and reviews completed regularly by the IPC Consultancy and the IP&C Coordinator is in detail and includes actions for improvement and completion or partial completion outcomes. NPH departments/wards will then respond to the compliance outcomes which are presented and discussed at the IP&C Committee. A thorough Gap Analysis of AS4187:2014 has been undertaken and an action plan developed and progressed according to timelines demonstrating compliance as noted in Advisory 18/07. All patients are risk-assessed on presentation and admission selection criteria. Existing infections govern admissions. Patients are asked to provide information on their health and infectious status on pre-admission and admission and are encouraged to comply with COVID-19 directives and guidelines. Hand hygiene initiatives are well promoted and products clearly visible with instruction posters throughout the hospital. Direct risk assessment questions relating to the COVID Pandemic and according to NSW Ministry of Health current guidelines and directions, are activated as patients, carers and visitors enter the premises. Presentation of carers/relatives are limited as part of COVID-19 restrictions. Education and training in the infection prevention and control program is carried out by HICMR and supported with on-line training modules.

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
A policy and procedure for developing and maintaining the antimicrobial stewardship program is available. The AMS program is well managed by the IC Coordinator, HICMR and assistance from an on-site pharmacist.

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
An Infection Prevention and Control Risk Management Plan 2021 is developed by HICMR and circulated to drive the IP&C systems, activities and outcomes for NPH. An action plan identifies areas for HCW responsibilities and date of completion. Infection prevention and control risks are identified and risk- rated with mitigation strategies in the clinical section of the Risk Register. Clinical events such as infections relevant to specific medical, surgical and obstetric conditions, are documented and reported to the clinical committees such as the Clinical Quality and Patient Safety Committee (CQPSC), IP&C and Medical Advisory for discussion and analysis. Infections are included in the overall Risk Register and are risk-rated with mitigation strategies. Antibiotics are prescribed and administered and this data is collected, collated and reported to the MAC as a standing agenda item. The on-site pharmacist has overall responsibility for managing and reporting on the Antimicrobial usage and has focussed on the use of prophylactic usage and high-risk antibiotics for outcome reporting to the Medical Advisory Committee. Infection Control competencies undertaken by all staff include Hand Hygiene, Aseptic technique, Invasive procedures, CSSD tasks such as cleaning, re-processing, packing/wrapping and sterilising. Competencies are managed by Nurse Unit Managers with assisted coordination by the HICMR representative and outcomes reported.

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	
Patients are actively involved in their care as observed throughout the patient's journey. Prior to admission, the patient's General Practitioner completes a health information form so that any health risks are identified and appropriate actions taken. Assessors note, following discussion with staff, that patients and their carers are actively involved in their care and that relevant information is available to them on pre-admission, admission and discharge. The Patient Information Directory is comprehensive and covers all aspects of their care and includes information on managing risks, specific information relating to their patient journey, admission, IP&C issues, care after discharge and Healthscope rights and responsibilities.	
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	
NPH presented as a safe and clean environment due to internal cleaning schedules and appropriate contracted cleaning services. Key IP&C indicators that are regularly monitored and reported are number of infections, waste management, environmental cleaning and hand hygiene. A suite of IP&C clinical indicators relevant to care delivery and services are reported within the ACHS Clinical Indicator Program with good outcomes. It is acknowledged that an external laundry service provides theatre linen meeting the current Laundry Services standards. Surveillance data is collected and reported according to schedules and the compliance achieved is compared with the previous audit. A sequential follow-up is completed and risks are identified and progressed for completion. Previous recommendations are assessed for completion including the number of times they have been reported. Personal protection equipment are readily available in all clinical areas and audits measure compliance with their use. COVID-19 guidelines are effectively followed and monitored as directives and guidelines are updated.	

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
Cleaning and waste management services are contracted and meets current standards. Waste management audits are completed by HICMR and the external service provider for waste management at the hospital. External service providers are contracted to meet Australian Standards, codes of practice and legislation, e.g. cleaning, fire prevention equipment, Legionella testing of TMVs and laundry. Legionella testing on Thermostatic Mixing Valves (TMV) is carried out as per Australian Standards at nominated periods and results have been negative as reported to the IP&C and other clinical committees.

Rating	Applicable HSF IDs
Met	All

ACTION 3.5
The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare18, and jurisdictional requirements
Comments
There is clear evidence of compliance with current infection prevention standards, guidelines and codes of practice. Audits and reviews are regularly undertaken with good results as per the Quality Plan and includes benchmarking throughout the corporate structure. Policies and procedures and gap analyses are appropriately referenced. Training and education sessions are provided in-house and on-line. Infection Prevention and control education is essentially provided by HICMR. Education provided includes the use of personal protective equipment, hand hygiene and strategies to manage the COVID-19 pandemic. Patients are also guided in the use of PPE such as masks and the use of hand hygiene products. Signs for appropriate use of products are posted throughout the wards.

ACTION 3.5	
The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare18, and jurisdictional requirements	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.6	
Clinicians assess infection risks and use transmission-based precautions based on the risk of transmission of infectious agents, and consider: a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated when clinically required during care b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs to manage infection risks d. The need to control the environment e. Precautions required when the patient is moved within the facility or to external services f. The need for additional environmental cleaning or disinfection g. Equipment requirements	
Comments	
All relevant information relating to the patient's status and care requirements is documented in clinical records and accompanies the patient throughout the continuum of care and on transfer (if applicable). Clinical records are currently mainly paper based and managed according to clinical record standards (AS 2828). Patients who have a communicable disease or a pre-existing infection on assessment may be placed in isolation according to their medical fitness and standard precautions are applied to the management of all patients. A detailed Hospital Acquired Infection (HAI) summary is collated and reported at least two monthly by HICMR. Parenteral and non-parenteral exposure incidents are recorded on RiskMan and also submitted within the ACHS clinical Indicator program.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.7	
The health service organisation has processes for communicating relevant details of a patient's infectious status whenever responsibility for care is transferred between clinicians or health service organisations	
Comments	
Patients are asked to provide information on their health and infectious status on pre-admission and admission and are encouraged to comply with COVID-19 guidelines and restrictions, hand hygiene initiatives supported with instructions and products visible throughout the hospital. Clinical handover between key areas in the patient's journey transfers relevant information from clinician to clinician and through the clinical record. This was observed by assessors at clinical handover and 'time out' procedures in the Operating Theatre Suite. The transfer of care between health facilities ensures infections status and risks are identified in clinical handover and clinical records.	
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	
Infection prevention and control surveillance and hand hygiene audits with reference to NHHI guidelines are regularly undertaken (4 monthly) and outcomes circulated and presented at meetings. Results are submitted to the MAC, CPSQC and staff meetings and posted on staff and consumer noticeboards. Compliance is above the national average and is persistently very good (refer to dashboard data for Period 3 2021), the next submission to NHHI for Period 1 is due in March 2022.	
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	
Competency-based assessments monitor staff skills and compliance, e.g. aseptic technique, hand hygiene, insertion and removal of invasive devices, ANTT peripheral cannulation. Observational audits on aseptic technique are also carried out. HICMR has scheduled training programs and modules to address competencies in aseptic technique, including competencies relevant to operating theatres. Online training modules and training and education by the IP&C Coordinator and HICMR representative addresses a range of compliances required in every clinical area. For example, surgical hand antisepsis, gowning and gloving, management of sharps, CSSD tracking and sterile stock monitoring management of waste and cleaning schedules.	
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	
Regular competency-based assessments for the insertion and removal of invasive medical devices are undertaken by clinicians and supported by the HICMR representative and IP&C Coordinator. Included in the overall Education and Training Program.	
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
New and existing equipment are risk assessed and cleaning and disinfection processes minimise environmental risks. Regular environmental audits are undertaken and cleaning schedules are developed for each department and clinical area. Safety data sheets are current and available at the point of use. Cleaning contractors provide their staff with training in the use of equipment and cleaning products and NPH staff assist in training in the use of personal protective equipment, particularly during the COVID-19 pandemic.

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
NPH has responded well to meet CSSD standards and new equipment, processes, staffing and storage facilities in their planned redevelopment. Currently, the use of existing storage space is well managed and within IP&C guidelines as evidenced in audit reports. Autoclaves, batch washers, ultrasonic machines and other endoscopic reprocessing equipment/machines meet current sterilisation standards. The ASS4187:2014 Gap Analysis and Action Plan describes strategies moving forward on the timelines given. There is a scheduled preventative maintenance program of servicing and calibration to meet these standards. Laundry services is carried out by an external service provider meeting Australian Standards, delivered and picked up regularly ensuring standards in handling, transport and storage are appropriate and meet IP&C guidelines.

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
The staff health program includes the maintenance of a record of immunisation for each nurse according to current regulations and guidelines. Monitoring of immunisation is according to jurisdictional requirements, is risk-based and reflects the Australian Immunisation Handbook. Flu vaccination is encouraged and is provided on-site with a record is maintained in each personnel file. COVID immunisation is mandatory and a record is maintained for all staff. Compliance with COVID 19 pandemic guidelines is closely monitored and changes made according to NSW Ministry of Health directives that are constantly being updated. All patients, visitors and staff are risk assessed on entering the hospital and evidence of vaccinations against COVID has to be provided at all times.

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
A visit to the CSSD demonstrated well-managed sterilising services and protocols by trained and certified Sterilising Technicians with expert directions and training opportunities provided by an experienced and qualified CSSD Manager. A traceability system is well managed and monitored by the experienced CSSD staff. Processes for reprocessing of reusable equipment and instruments are guided by a full range of policies and procedures developed by HICMR in partnership with CSSD staff. Compliance auditing of the sterilisation traceability system was observed. Assessors were impressed with plans to redevelop the CSSD and Endoscopy Unit in the adjoining block of land. The building program will be commenced soon after the assessment and clinicians, staff and consumers have had opportunities to make comment and suggestions on the plans which have been displayed in the hospital. The reprocessing of reusable equipment, instruments and devices are compliant with AS/NZS 4187:2014. A gap analysis and action plan V5 was developed in August 2021 and will be revised following the building of the new CSSD planned for completion by December 2022.

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 monitoring and auditing processing, with references to manufacturer's guidelines, are carried out according to the safety and quality schedule. Recommendations for improvements have been well documented in an action plan.

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
NPH has established policies and processes to support antimicrobial stewardship. The antimicrobial stewardship (AMS) policy and usage is reviewed as part of the Medical Advisory Committee (MAC). The program is consistent with current evidence- based guidelines. A formulary is available to guide clinicians in the restrictions and the approval process. Surgical antibiotic prophylaxis data is collected over a 6-month period for presentation at clinical committee meetings. Reports are forwarded to NAUSP and NAPS. Compliance with AS18/08 is acknowledged.

Rating	Applicable HSF IDs
Met	All

ACTION 3.16
The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy • antimicrobial use and resistance • appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing
Comments
The Antimicrobial Stewardship Program is implemented and includes the collection, use and type of antibiotics, route, date, time, patient and medical practitioner, to name a few identifiers. Outcome data is tabled at the MAC meetings and is the subject of standing agenda items. Compliance with the Therapeutic Guidelines - Antibiotics is monitored and discussed by MAC members according to statistical data presented at each meeting. The data of antimicrobial prescribing as surveillance data is regularly reviewed and reported to the MAC for further discussion. Antimicrobial resistance is also discussed. The AMS program is coordinated by the on-site pharmacist in collaboration with HICMR who implements education and auditing processes. Meeting minutes and reports are presented to the MAC for further scrutiny and to seek further improvements in line with evidence based Australian Therapeutic Guidelines.

Rating	Applicable HSF IDs
Met	All

Standard 4 - Medication Safety

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

ACTION 4.1
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management
Comments
Nepean Private Hospital (NPH) has in place sound hospital-wide systems for safety in the supply, storing, prescribing and administration of medication. Tallman lettering is used as is the clear separation and labelling of high-risk drugs. NPH also has a robust system for the reporting of medication incidents and continues to always strive to operate in a culture that encourages staff to report any medication incident or near miss. Appropriately experienced and trained staff investigate any medication incident reported and current incident data is reported to the Medication Safety/Drug and Therapeutic Committee who discuss and then ensure the data presented is referred tom the Clinical Quality and Patient Safety Committee, the Medical Advisory Committee (MAC) and Executive and used as a basis for improvement activities and education.

Rating	**Applicable HSF IDs**
Met	All

ACTION 4.2
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management
Comments
The NPH medication system operates within a framework of quality improvement and includes the ongoing monitoring of both the effectiveness and performance improvement of medication management across the whole of the hospital. Strategies to improve the NPH medication management system are introduced if required and focus on the improvement of medication management outcomes and processes that continue to ensure that any shortcomings in system are identified and addressed. These are then monitored, and the outcomes reported to the relevant committee/s. NPH has a process for medication standing orders however these are not current and Medical Officers are currently documenting all medications in the patients' medical record.

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	
Suggestion(s) for Improvement	
Review the need for and the updating of standing medication orders.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.3	
Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
NPH has a strong focus on the involvement of consumers, carers, and patients in medication management. Every effort is made by staff to ensure that there is a clear understanding of the effects of prescribed medications and their correct use in conjunction with the clinical pharmacists during the hospital satay and prior to patient discharge. Patients and/or carers are encouraged during to ask questions and importantly report any side effects or other reactions they may be experiencing. Patients can/are also provided with information in either verbal, written form, or both to inform them on any special instructions, directions and/or precautions. This information is made available to the carers and /or families who may be monitoring the administration of a patient's prescribed medication post discharge.	
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	
NPH has sound processes in place for ensuring that all relevant clinicians operate within their medicines scope of clinical practice. Any incidents that have been reported either as an incident or a near miss in either prescribing, dispensing and/or administration that may have occurred outside a clinician's scope of practice are subject to incident review, further reporting and when and if required further education. This education is planned and can be introduced either on a group or 1-1 basis with ongoing monitoring and data collection as required.	
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 assigned clinician/s take a best possible medication history on admission. This may be taken and documented with input from a carer or family member. Patients, carers, and families are encouraged to be active participants if this is considered appropriate by both the patient and the clinician. Important information is documented on allergies and adverse drug reactions. Staff are educated on the importance of obtaining a best possible medication history as this forms the basis for the initial prescribing and administration of medicines and forms part of the patient's clinical record. This documentation is well done and all legislative requirements for prescribing, dispensing and administration covered.	
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 review of prescribed medications against a patient's initial best possible medication history is ongoing and forms part of the treatment plan for all patients. Prescribing of new medications, the purpose and action are advised to the patient, are monitored closely for common side effects and interactions. The active involvement of all clinicians is paramount in accurate recording, medication reconciliation and review against both the documented treatment plan and at transitions of care. The use of the orange pharmacy sticker on the medication chart as a memory jogger for antibiotic medication review at 48 hours is a good strategy and works well. Antimicrobial compliance is high at over 95%.	
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	
NPH demonstrated the sound processes and documents in place for relevant clinicians to accurately record a patient's history of previous medicine allergies and adverse drug reactions on admission. This is supported by good clinical practice and NPH clinicians continue to demonstrate the importance for an accurate medication management plan commencing from a patient's initial admission.	
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	
The NPH medication error reporting systems are maintained by a hospital-wide approach to supporting and encouraging medication adverse drug reactions reporting by both documenting in the clinical record and the NPH RiskMan reporting system. This contributes to and is a focus to manage medication risks and uses the investigation of medication error/s and near misses to improve medication safety.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.9	
The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements	
Comments	
The NPH has policies and guidelines in place to report adverse drug reactions experienced by patients in their care journey to the Therapeutic Goods Administration (TGA) and other agencies as required by the relevant jurisdictions.	
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
Medication review/s are practiced at NPH in line with best practice guidelines. Medication reviews may be based on a patient's clinical presentation, pre-admission medication prescriptions or due to a change in medication treatment.

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	
To continue to manage a patients medication regime there is a need to consider these, the accuracy of all medication charts and that any verbal handover or discharge medication information is both accurate and supported by clear and accurate charts and documentation.	
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	
NPH has access to excellent clinical pharmacy support through an in-hospital pharmacist and remotely through a 24/7 phone arrangement in the provision of information for staff and patients on prescribed medications. Online Therapeutic Guidelines, printable patient appropriate information and literature provided by pharmaceutical companies approved for use by NPH are available. Patients bring their current medications with them for the episode of care, taking them home on discharge. It has been identified that some confusion has arisen as to what their current medication requirements are and which medications to take.	
Suggestion(s) for Improvement	
One strategy discussed during assessment for improvements in this area was that of separating and colour coding patients own medications brought into hospital, those that are current and those that have ceased. This should be trialled as a method of improve patient safety and understanding of their current /discharge medications.	
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
At discharge a patient and/or carer are given a script for their ongoing medication requirements to be filled at a community pharmacy, or if antibiotics, are given the full schedule to ensure continuation of antibiotic cover. A component of discharge documentation is the provision of a current medicines list which is given to the receiving clinician, sent to the patient's general practitioner (GP) with any reason for a change documented clearly and a copy given to the patient. One good achievement by NPH in this area relates to the Aged Care Covid 19 evacuees admitted when their home was put into lockdown. NPH staff ensured that all received a comprehensive medication review and up to date medication listing prior to their return home, a good outcome.

Rating	Applicable HSF IDs
Met	All

ACTION 4.13
The health service organisation ensures that information and decision support tools for medicines are available to clinicians
Comments
Medication prescribing decision support tools are readily available for clinicians including the Therapeutic Guidelines, MIMS online, the hospital pharmacist, 24/7 telephone pharmacy consultation, "Last days of life" prescribing recommendation, Australian Pharmaceutical Advisory Council and the Australian Commission on Safety and Quality NSW Therapeutic Advisory Group-National Quality Use of Medicines Indicators for Australian Hospitals.

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 adhere to the jurisdictional requirements for the safe and secure storage, recording and administration of medication as evidenced by assessors. The storage of temperature sensitive medicines, storage, disposal was all evidenced.

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	
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	
The guidelines around the safe storage with identified high-risk medications is well managed at NPH with clear identification and labelling, standardised processes, and guidelines in place. Any shortcomings or concerns are reported to and addressed by the Medication Safety Committee and the MAC, and any investigation/s required are undertaken by approved and appropriately trained staff.	
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	
The provision of safe Comprehensive Care is governed by National Healthscope evidence-based policies and procedures. Nepean Private Hospital (NPH) has developed local policies that were required. NPH has processes in place to manage clinical risks. The risk register demonstrates documentation of risks associated with providing Comprehensive Care and mitigation strategies that reduce the risks. Monitoring of events such as incidents, adverse events, and patient feedback are managed through the quality and risk systems, reported to the Clinical Quality and Patient Safety Committee, and included in the National Healthscope auditing and feedback system. A range of mandatory training is required for staff regarding comprehensive care, and the compliance rate for all training attendance is high.	
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	
A clinical governance and quality and safety plan has been developed at NPH with an audit schedule incorporated. Monitoring of the audits regarding comprehensive care is in place with a range of KPIs collected and reported. The audit results are reported to the Clinical Quality and Patient Safety Committee and the workforce. All outcomes from the comprehensive care standard are reported to Healthscope National for analysis and feedback. Where results are outside the target an action plan is developed.	
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	
The assessors witnessed patient involvement in their care during handover with consistent use of the patient information boards. During patient interviews with the assessors, consumers spoke about the communication and actions between patients and staff and about participation and shared decision-making in their care. NPH staff focus on identifying patient centred goals and accurately document these in the clinical record.	
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	
Healthscope and NPH policies, plans and procedures support clinicians in developing comprehensive plans and treatment for their patients. Throughout the visit, assessors noted easy and effective communication between doctors and nurses that was supported by clinical notations. The provision of safe Comprehensive Care is directed through Healthscope evidence-based policies and procedures that are reviewed regularly and as needed to ensure the best possible Comprehensive Care is maintained. The clinician responsible for overall care is noted on the patient board as is the nurse for the shift. The use of the 360 watches by physiotherapy to monitor pre- and post-surgery patient exercise is a good initiative to ensure best possible outcomes for orthopaedic surgery and for involving patients in their own 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	
Clinicians are provided with Healthscope endorsed tools that comply with Advisory AS18/14 "Screening and Assessment of Risk of Harm" and ensures comprehensive screening processes are implemented. Risk screening tools are used on admission and throughout the patient journey enabling the effective management of risk, prevention of deterioration and the development of an individualised appropriate care plan, provision of ongoing care, referral to appropriate disciplines and services through to discharge. Processes to identify risk and escalate findings for further in-depth assessments are in place and activated. Multidisciplinary meetings to discuss care of the patient are conducted. This was identified at bedside handover. Documentation audits identify gaps with strategies identified to mitigate. Position descriptions were viewed by the assessors that define the role of clinicians. NPH also conducts audits of position descriptions with 100% of those audited defining the scope of practice and responsibilities.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.6	
Clinicians work collaboratively to plan and deliver comprehensive care	
Comments	
Healthscope endorsed the Advisory AS 18/15 compliant comprehensive care plan in 2019 and this was implemented at NPH with education for staff provided. There are also several toolkits available to assist staff to work and plan to provide collaborative individualised care for the patients including the cognitive impairment toolkit and discharge planning tools.	
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	
The care plan is informed by the screening processes and developed by the multidisciplinary team in partnership with the patient and family towards meeting the patient's goals. The plan in partnership with the patient identifies and documents the support people who are to be involved in planning and implementing strategies to reflect the patient's individual needs. Plans for discharge are discussed on admission. NPH completed an audit to verify the compliance with comprehensive care plans in 2020 and achieved 100% compliance with patient having a comprehensive care plan. A patient journey was undertaken during assessment with assessors feeling confident that NPH processes are well embedded to ensure competent comprehensive safe care throughout the patient journey, as did the patient.	
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	
There is a system in place to enable patients to identify as Aboriginal and Torres Strait Islander with training regarding this being available for and undertaken by staff. Links are also available to the Aboriginal Liaison staff at the public hospital and the local Aboriginal centre, which has active women's and child and family groups.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.9	
Patients are supported to document clear advance care plans	
Comments	
Policies are available at NPH regarding Advance Care Planning. Patients are asked on admission if they have an Advance Care Plan (ACP) which if available is included in the patients notes.	
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	
Patients have a full history on admission and undergo a comprehensive screening process to identify patient risk and needs. Screening processes includes cognitive impairment, medication management, malnutrition, falls, VTE, mental health, behavioural tendencies, and skin assessment. NPH are compliant with the Health Commission advisory.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.11	
Clinicians comprehensively assess the conditions and risks identified through the screening process	
Comments	
Screening assessments occur on admission, weekly or if there is a change in a patient's condition. Documentation audits demonstrate a high level of compliance with screening, assessment and care planning processes, with confirmation of these results observed in the clinical records.	
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	
Risk screening for all patients is documented in the Comprehensive risk screening document. A comprehensive daily care plan is also completed for each patient. An alert sheet is available at the front of the clinical notes to record any alerts and allergies. Identified risks and mitigation strategies are documented in the care plan, identified on the patient journey board, discussed at bedside handover and documented in referrals for identified care needs.	
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	
The comprehensive care plan is sufficiently detailed to provide an individualised care plan that provides the complexity of the patient's health and risks of harm. Education is provided to staff regarding the comprehensive care plan and of the risks of harm. A Back to Bedside brochure is also available the provides information regarding comprehensive care for the patient where it informs them that they will be asked about their goals. The care plan identifies the patient goals and actions required to provide treatment and care to each individual patient. NPH is compliant with the Health Commission advisory. A resources folder has been developed and is available to all staff identifying community care providers and NGA support organisations to assist staff in planning ongoing care for discharge.	
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	
Healthscope and NCP policies support practices that involve patients, carers and staff to use the comprehensive care plan. The Back to Bedside brochure explains this to patients. The plan is regularly audited to monitor this. If there is a change in condition reassessment occurs and documented in the clinical record. As well as care planning and implementation, risk is a big part of this standard, and this was included in all handover processes.	
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 implemented a Last Days of Life resource folder in 2020 which details the policies relating to end of life and provides resources for staff. Escalation of care need is clearly identified by staff and processes are in place for patient/family & carer to escalate of care or seek information through the REACH process. The introduction of hourly rounding appears to have reduced the reliance on REACH to escalate care.	
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
Clinicians have ready access to specialist palliative care from Nepean Public Hospital Palliative care team if required, this includes medical, nursing, and social work services. Details of the contacts are provided in the last days of life folder.

ACTION 5.16	
The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice	
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 on admission if they have an advance care plan, and if so to bring it on admission for inclusion in the healthcare record. If not, they are given information on the process and support available to develop and document a plan. Care is planned in accordance to the patients' needs and wishes.	
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	
Staff providing end-of-life care are provided education, have access to specialist Palliative Specialists and support of the Employee Assistance Program (EAP) should this be required. NPH staff at both ward and management level also provide formal and informal support to staff providing end-of-life care.	
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	
NPH audits all end-of-life patient files to review care given and its alignment with patient and family planned goals. A follow up phone call is also made to family. An End-of-Life Care Survey for Families has been developed and implemented with two undertaken since implementation giving insufficient evidence as to its efficacy to date.	
Suggestion(s) for Improvement	
Continue review of clinical notes to identify that goals of care are provided as per the patient and family wishes at end of life and utilise findings to improve this area of care.	
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	
Healthscope and NPH have access to the NSW Clinical Excellence Last Days of Life Toolkit that is compliant with the National consensus statement: Essential elements for safe and high-quality end-of-life care. Staff have access to these resources electronically. This provides support to clinicians in the provision of care and to patients and families during this period of care.	
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	
Best practice guidelines are used to screen all patients on admission for pressure injury and manage stage one and above pressure injuries and wounds as required. Pressure Injury management is well done with systems in place to ensure all patients on admission are screened for pressure injury, findings recorded in the clinical file and appropriate strategies identified and put in place should they be needed. Equipment needed for patient care is readily available, and any incidents are reported in RiskMan.	
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	
A skin integrity inspection is conducted within eight hours of admission and daily or at each shift thereafter should this be necessary. The initial inspection is recorded on the comprehensive care plan, on the daily care plan and a skin assessment document. Critical information is passes during bedside handover and strategies to encourage patient involvement in managing their own skin care implemented. Audits of the charts indicate that the compliance with this is high. Pressure injury ion 2020 was 0.021% below the national rate with no pressure injuries recorded for 2021.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.23	
The health service organisation providing services to patients at risk of pressure injuries ensures that: a. Patients, carers and families are provided with information about preventing pressure injuries b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries	
Comments	
Patients receive written information on the prevention of pressure injuries and an explanation on how to prevent pressure injuries following discharge. All beds are equipped with pressure relieving mattresses. Pressure-relieving devices are available in inpatient areas and operating theatres with others hired from an external provides should this be necessary.	
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 Risk Assessment Tool (FRAT) is utilised to assess falls risk. Falls are professionally managed, assessed on admission with screening repeated as needed. Patients at risk of falls are highlighted on journey boards with orange label's displayed on a patient's door to alert all staff. All units displaying current incident trends in a way that is easily understood by patients and families. The establishment of post falls safety huddles is a good initiative and could be used for other incidents as well. The 2020 falls rate was 0.08 %, a reduction from 2019 with the incidence of falls is below the industry rate. No falls resulting in injury were recorded. Early rehabilitation is provided for patients post-operatively following joint replacement.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.25	
The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls	
Comments	
A number of strategies and devices are available and used to manage falls safely including, maintaining functioning walking aids and wheelchairs, adjusting chair heights, appropriate footwear, observing in a room closer to the nurses' station, calls bells in reach, always escorting to the bathroom if required and "Hourly" rounds to reduce risk of falls. The use of an orange sticker on the patient room door clearly indicates those at risk of falls.	
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	
Falls prevention information in the form of a Falls Prevention brochure and physiotherapy information is provided to patients and families. There is also information regarding falls provided on the website. Referral pathways are available for rehabilitation both hospital and home based.	
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	
Malnutrition screening occurs for all patients on admission with referral to a dietitian as required. Individual medically and culturally appropriate meals are supplied internally with a dedicated kitchen that is audited annually with all staff fully trained.	
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
Nutrition is an integral part of care planning from admission with nutrition staff supporting holistic care delivery for both clinical and cultural aspects. General nutrition and special dietary needs for patients are handled well with patient surveys providing positive feedback. The use of staggered meal deliveries ensure staff are able to assist all patients as required to open packing and assist with feeding, so all receive hot meals. Meals are freshly prepared and approved by a dietitian. Referral to dietetics and speech pathology are available as required. Patients requiring texture modified diets are provided with information and education. A great positive this year was the COVID-19 aged care evacuees that were cared for and went home with a higher BMI than when they arrived.

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
Work has been undertaken around delirium and dementia with appropriate processes to identify and manage patients with dementia and delirium well done utilising validated tools, patient support personnel, family, and aged care consultations. All patients have a Cognitive Impairment Risk (CIRAT) on admission, with the 4AT risk assessment for delirium also conducted if indicated. Patients who are identified have an alert sheet completed and individualised care plans developed. Anti-psychotics and psychotropic drugs are stored according to legislation following prescribing by Specialists should they be required. Patients requiring ongoing treatment and care are transferred to appropriate facilities.

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 NPH has recently introduced the Top Five method, which is completed with the family to identify information regarding the patient likes and dislikes, to identify triggers and possible solutions to reduce agitation. Staff are able to identify quiet places within the ward areas and strategies to reduce agitation. Families are encouraged to take part in the patients care where this is their wish. A cognitive impairment information brochure is provided to the patient and their family. Care of patients with cognitive impairment and delirium are referenced by the Delirium clinical care standard.	
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	
Screening for self-harm and suicide occurs at admission and an alert sheet is completed and an alert placed on the patient record. NPH has access to psychiatrists if required for monitoring for the patient or transfer if required.	
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	
If acute deterioration of a patient's mental state should occur, policies are in place for care support or transfer to Nepean Public Hospital.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.33	
The health service organisation has processes to identify and mitigate situations that may precipitate aggression	
Comments	
All staff have had training in Workplace Aggression and Violence Education (WAVE) and use of family experience and/or intervention aid in calming and de-escalating situations. While there have been no reported incidents all staff are aware of safety and Code Black processes.	
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 has a risk assessment on admission to identify patients who may have a mental health history or dependencies that may lead to violence and aggression. Alternate therapies are offered where indicated. An emergency code black response procedure is included in induction. Incidents are reported through the risk management system. Duress alarms are available throughout the hospital. Should a patient become aggressive or violent the staff enact the Code Black Emergency Policy.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.35	
Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of restraint b. Govern the use of restraint in accordance with legislation c. Report use of restraint to the governing body	
Comments	
Healthscope has a Restrictive Practices Policy for use of restraint where clinically indicated. All episodes of restraint are documented in RiskMan and reviewed.	
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 practiced at NPH. There are no mental health beds at NPH and therefore this should be rated as N/A.	
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 has developed systems to support timely, effective communication with a governance function provided through the Clinical Quality and Patient Safety Committee (CQPSC). The Committee provides an effective conduit between clinical workforce, and executive leadership. The Committee meets every month. The Committee has completed a very comprehensive gap analysis with progress monitored to address each of the many actions. Each action is aligned under the relevant Standard 6 action and priority rated. The Risk Register contains six items relevant to safety communication. The RiskMan system is utilised to capture incidents related to communicating for safety that following an adverse patient outcome is communicated to the Committee for review. Best practice referenced policies, procedures, and protocols to support communicating for safety are available to the workforce and accessible via HINT. There is a suite of audit tools available with audits results tabled at the CQPSC. Recent agenda and minutes include surveys, complaints management, and clinical handover. The risk register includes matters relating to communication such as consumer feedback, clinical handover, and discharge planning. Improvement initiatives have been undertaken such as a short video presentation on clinical handover, consumer review of forms, safety huddles, patient communication boards, newsletter, mapping of all handover interactions for each service. There is a culture for patient inclusion in participation in care as observed during bedside clinical handover, patient, and family conferences, and in direct discussions with patients. Patient survey results are reviewed by the CQPSC.

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	
The "Back to Bedside" Communication Leadership Guide includes several tools used to communicate with the patient and carer. During observation of bedside hand-over the assessment team saw the AIDET tool or ISOBAR being used. The many audits, key performance indicators, and quality initiatives completed or programmed to be undertaken by the CQPSC are evidence of the quality improvement culture operating at NPH. The Committee's extensive quality improvements listed on the action plan detail the monitoring and priority strategies. Reporting on the effectiveness and outcomes of clinical communication is tabled at the monthly meeting and quality improvement activity. Outcomes are communicated to the workforce via the newsletter and audit results. Results were sighted on the quality boards in the wards, units and departments, and the workforce interviewed were able to advise of quality improvements undertaken.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.3	
Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
The NPH appreciates the importance of partnering with consumers to support effective communication. The organisation has performed strongly on assessment under the Partnering with Consumers Standard. A variety of approaches to share decision-making with consumers were apparent. Examples include the bedside communication board that is audited for completeness, the bedside nursing shift handover, multidisciplinary case conferencing with patient feedback following the conclusion of the conference, and patient and family conferencing. The CQPSC has an engaged consumer partner who spoke positively about the consumer role and the support provided to contribute to safety and quality at NPH. The ability for consumers to provide more immediate feedback via a quick response code (QR code) will also enhance timely consumer feedback and response.	
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	
NPH has an overarching framework that includes numerous policies, procedures, protocols, guidelines, and flowcharts that underpin workforce communication for safety practice. Processes include patient identification, procedure matching, and clinical handover. The organisation uses ISOBAR and AIDET mnemonic as their standard clinical approaches to ensure effective communications and care. The workforce is formally trained in the use of ISOBAR & AIDET, procedure matching, clinical handover, and documentation. The information on the patient identification bands is standardised across the hospital. A quality improvement has resulted in a patient ID bracelet being placed on both and upper and lower limb. The CQPSC had recognised the deficit after investigating an incident in RiskMan and a business case was prepared and approved. A Comprehensive Care Plan Workflow Document describes the many points of care where patient ID and communication is required.	
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	
NPH procedures, protocols, guidelines, and flowcharts to guide the practice of patient identification. Key performance indicators are collected, RiskMan incidents reviewed, and many quality improvements actioned or planned. The flow of patient handover has been mapped between ward, units, and departments with any red-flagged areas reviewed, and monitoring by the CQPSC. In addition, the CQPSC in line with their Terms of Reference has the responsibility to ensure systems to maintain the identity of the patient are used to ensure that patients received the care intended for them. Reporting of incidence is occurring. RiskMan incidents are closely monitored quarterly by the CQPSC which seek further information on the investigation of each incident where the failure to use the three identifiers occurred.	
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	
The hospital reported no surgical patient identification adverse outcomes or near misses. Team Time Out accompanied by a modified World Health Organization (WHO) Surgical Safety Checklist was evident across the care continuum in the procedural areas. Trended data from time out identified 94% compliance in 2018/2019, 98% in 2019/2020 and 100% on 2020/2021. The assessors witnessed several Team Time Out and Surgical Safety Checklist processes being completed.	
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 updated, referenced Clinical Handover Policy defines the minimum information content to be communicated at each handover, for each discipline, and in each setting. Supporting documents are accessible via HINT. The document provides a set of key principles to underpin handover processes and the use of ISOBAR as the handover tool. The CQPSC monitors patient experience feedback about their involvement in care and shared decision making and RiskMan incident themes related to clinical handover, identification, and discharge summary completion rates. The “Staff Tip sheet”’ for Handover is a handy document to use ISOBAR or AIDET but primarily reminds to refer to patient.	
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
During this assessment, assessors attended several safety huddles followed by bedside patient handovers (medical and nursing). ISOBAR is the handover process methodology used and the assessor's observation confirmed practices consistent with policy. Patients were included in the handover as clinically appropriate, and the patient's identification was checked using the patient identification band and asking the patient to positively identify themselves. The handover observed consistently provided feedback that suggested entrenched practice. The introduction of the patient communication board is a quality improvement that has enhanced handover. The information on the boards has been recently audited for completeness. Main deficits were the discharge date and plan for the day. Other regular audits include: - Bedside Handover Observational - ISOBAR Transfer Form - Point of Care - Surgical Safety Checklist - Clinical Handover Compliance. 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.

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
ISOBAR is the approved communication tool to promote effective communication of critical information between clinicians. During this survey, evidence was sighted of extensive use of the tool by the multidisciplinary workforce in various care settings. Age-specific track and trigger observation charts are used across the organisation to ensure early notification and escalation of care. Daily safety huddles are used to communicate contemporary issues relevant to the clinical environment. Reporting process communicates critical information, alerts, and risks rapidly across the management structure.

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 REACH program is in place for patients and carers to escalate care. Since its inception in 2019 there have been only two (2) REACH calls both by same person and were in regard to a miscommunication. REACH posters are visible across the facility and a pamphlet in Bedside Handbook. Across the hospital assessors noted: • engagement of the patient and family in the handover and the transfer of critical information. • extensive use of bedside patient communication boards that include the information on patient risks of strategies to manage risks. • active use and refreshing of the information on the boards at times of clinical handover. • REACH escalation of care posters displayed in the inpatient wards and units and public spaces. • the workforce able to describe the deteriorating patient escalation pathway and reported no barriers to escalating care. • multidisciplinary approach to patient care. • the use of family case conferences where appliable to ensure effective communication.	
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	
NPH uses hard copies for writing of contemporaneous documentation. Documentation audits are conducted regularly with high levels of compliance. Discharge Summary performance indicators are monitored and escalated. Any changes to the patient care plan, risks, or clinical alerts are discussed during the shift-to-shift bedside handover and clinical rounds. Clinical risks and alerts are auto populated into the ISOBAR aligned nursing handover record.	
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	
NPH uses Healthscope policies to promote safe blood management for both collection and administration. This is well done with all policies, procedures, and processes in place to ensure patient safety with audit results demonstrating 90.6% compliance an improvement of 7.3% on the previous quarter. Staff undertake Blood Safe education which is ongoing and can be specific to identified areas such as operating theatres.	
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	
At NPH the performance of the blood management system is subject to ongoing monitoring with quality improvement and incident reporting principles applied. Established processes are in place to ensure no blood wastage with only two units of O negative blood kept on the premises with turnover managed by Barrett & Smith Pathology. While no blood transfusions were undertaken during the assessment period it was reported that while nursing documentation of patient vital signs was high, however documentation of the patient's condition within the clinical notes during the transfusion was low and often left until the transfusion was completed.	
Suggestion(s) for Improvement	
Review nursing documentation within the clinical notes during the transfusion process to identify and put in place processes to improve the inter transfusion documentation to ensure accuracy and patient safety.	
Rating	**Applicable HSF IDs**

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	
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	
Patients are actively involved in the provision of safe blood management wherever possible. This commences from the initial consent process, an explanation when the blood is "put up" and a further explanation of the checking procedures that occur when a patient is receiving blood. If a patient is a Jehovah's Witness, different blood products are used, and the patient discusses this with the Consultant and with clinicians guided by the Jehovah's Witness other blood policy that is in place.	
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
Patient blood management including blood conservation strategies are or may be undertaken in relation to individual choice and/or clinical situation. These decisions are usually made by the consultant specialist prior to admission. Most surgeons appear to be grouping and hold for each patient during surgery.
Suggestion(s) for Improvement
The possibility for group and hold or patients own blood collection rather than current practice prior to surgery should be explored as these reflect best practice and reduce risk and possibility of wastage.

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	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.5	
Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record	
Comments	
The blood consent form, and clinical documentation clearly stating the need for a blood or blood product transfusion becomes part of the patient's clinical record. Blood Management and Blood Product Committee is the body at NPH which has oversight of blood management, and any transfusion related issues that may have been reported with data reported to the Medical Advisory Committee (MAC) as required. The documentation in the clinical record demonstrates the clinical need for blood, the pathology results, request forms and blood transfusion documentation and patient vital signs recordings. Audits identify a 100% compliance with consent documentation.	
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	
NPH Policies and processes are based on best practice that supports clinical practice and guide clinicians' decisions and improve patient outcomes by good medical and surgical management when blood or blood products are required. NPH ensures all clinicians who prescribe and administer blood and blood products are appropriately trained in the correct techniques and procedures for the administration of blood and blood products in accordance with the National Guidelines and Healthscope policies and procedures. A whole of transfusion audit identified a 100% compliance rate with all aspects of blood transfusion.	

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	
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	
Any transfusion related incident or near miss are reported into the NPH incident management system RiskMan, with the related data reported to the Clinical Quality and Patient Safety Committee, the MAC and Executive. There have been no reported blood related incidents in the past three years.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.8	
The health service organisation participates in haemovigilance activities, in accordance with the national framework	
Comments	
NPH participates in and reports on hemovigilance activities through the Healthscope governance structure and to state and national bodies in accordance with the national framework.	
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
NPH complies with the Healthscope policy -Blood Fridge-Contents of Management and Unused Blood Products. The Blood fridge is located within the Theatre area. There is a blood register at this fridge with all staff provided with education on tracking blood products into and out of the fridge. The blood fridge temperature is monitored by Barratt & Smith Pathology according to Australian Standard 3864.2-2012. A chart recording the temperature is attached to the fridge with this changed weekly and retained by Barratt & Smith Pathology and NPH. There is one manual blood register located at the blood fridge to allow NPH to control both visibility and traceability.

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
NPH pre-admission processes ensure all those patients with a high clinical risk are screened to ascertain those risks including haematological risk. Risk assessment when completed may highlight risk/s such as medications (anticoagulants), a previous transfusion history and/or requests for a cross match as applicable prior to surgery. This assures the prompt availability of blood/products during surgery. Patients are provided with the risks and benefits of transfusion information at this time and are also provided with the opportunity and time to ask questions of the clinician. Processes are in place to manage the delivery and retrieval of blood supplied to NPH including emergency O negative blood held at NPH through contracted Barratt & Smith Pathology services.
Suggestion(s) for Improvement
Progress a project for group and hold or patient own blood rather than cross match prior to surgery as identified in 7.4 earlier in the report.

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	
NPH has implemented sound governance systems to recognise and respond to clinical deterioration. Clinician engagement in developing and monitoring the systems to support all clinical staff to recognise deterioration in physical, cognitive, and mental health deterioration has led to robust policy and procedures. A gap analysis has driven the quality improvement strategies, with a peak governance committee providing oversight of clinical deterioration, the response systems and their effectiveness. The CQPSC reports through Riskman and outcomes of any recommendations. Minutes have action plans, timelines, and an accountable officer. A Rapid Response Working Party has recently been convened to examine current practices and make improvements where required All staff interviewed during this assessment could articulate the policy and procedure intent and provide examples of how this is undertaken in practice, no matter what hour of the day. Clinical review of patients during episodes of care is inclusive of clinical handover shift to shift, medical and interdisciplinary reviews. Observation charts that are designed to flag the need to undertake a clinical review and the Medical Emergency Team (MET) response throughout NPH enables clinicians to recognise and escalate clinical deterioration. Similarly, there is the capacity to recognise mental health deterioration with the use of assessment tools to identify decline e.g., Mini Mental and reduction in cognition. The pilot is also utilising a range of assessment tools to identify deterioration in cognition. Training sessions are available for clinicians through the staff education system, nurse educator sessions and 1:1 education and support at ward level.	
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
Medical, nursing, and allied health staff have access to a range of strategies to detect, recognise and respond to clinical deterioration. The governance and monitoring of these systems are through the peak CQPSC. This supports the overarching quality and safety system through reports to the NPH Exec, incidents reported and reviewed through RiskMan and trends identified in the RiskMan. As well outcomes of the response systems to recognise and respond to clinical deterioration are reported to Morbidity and Mortality specialty reviews. However, NPH does not have a minimum mandatory criterion for mortality and morbidity review meetings across the organisation. The agenda items for these meetings are currently discipline and person specific. NPH Anaesthetists and surgeons have agreed to a standardised set of key performance indicators to be included in Morbidity and Mortality meetings. Staff when interviewed during this assessment across all specialties could provide examples of learnings that had come from these systems and improvements that had been developed to further enhance the response systems. Training and support to clinicians is prioritised and how to escalate care is included in orientation to the organisation and clinical settings. A coding system alerts responses of MET responses and Code Grey behavioural deterioration. Currently there is a quality improvement initiative regarding CCU- Deteriorating Patient which is reviewing the rapid response processes within NPH. This initiative is reviewing all policies relating to rapid responses and clinical reviews, improve management of rapid responses when they occur and review, review current chest pain management.

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
Bedside clinical handover policy enables involvement of patients in their own care, identifying risks, emerging issues, clinical review outcomes and intent for the shift. The nursing staff introduce themselves and observational audits demonstrated sound engagement between patients and the oncoming shift. During assessment the ability to interview medical staff undertaking rounds was possible. Medical teams were able to describe involvement of consumers in clinical review. There is information at the bedside of how to escalate concerns for a patient through the REACH system. Patients are asked to bring their Advanced Care Directive to hospital if they have one. Information and assistance are provided to those who do not have one but are interested in developing one.

ACTION 8.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.4	
The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient	
Comments	
Observation charts have embedded in them a flagging system to detect deterioration and there are clearly articulated guidelines of how to respond to clinical deterioration. All staff interviewed during this assessment were able to describe how this system works and how they would escalate concerns ranging from discussing concerns that may not be evident in the current observations with peers and managers, patient feedback and then how to request a clinical review through to calling a Medical Emergency Team response. Mental health documentation includes early warning signs. This approach is continually being developed and there are opportunities to work with individuals. Access to specialist clinicians to detect mental state deterioration is available and staff have training in conducting mini mental assessments, the results of which will provide triggers to escalate clinical review. The 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. Consideration of delirium, behavioural, cognitive, perception, emotional and physical function are inherent in the detection of clinical deterioration and are linked to the policies, procedures, and practices across specialties and across clinical settings. Clinical pathways also identify moments in time to monitor a patient e.g., sepsis pathway, levels of care for patients who show signs of decline in mental health in accordance with risk assessments for dementia and delirium.	
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
Any change in a patient's clinical presentation has very clear protocols for the escalation of care. Clinicians are able to consult with the senior nursing and medical staff and receive direction of the required level of observation. Progress notes include changes in presentation and the interventions provided, with clinical file audits undertaken. Handover sheets that follow the ISOBAR process, identify risks and required interventions. There are processes in place as to identify 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. Top 5 training supports staff to recognise delirium and dementia.

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 observation chart has clear parameters built into the chart that is linked to steps to consider referral for physical and mental state clinical review in a timely manner. Should a patient and/or family member raise concerns e.g., pain, mental health, physical concerns this is also factored into the clinical review requests. These parameters also trigger the need to call the Medical Emergency Team (MET). Once again, the REACH procedure can you initiated by family.

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	
Should family/carers have concerns they can make a REACH call. Posters are well displayed across the facility. There have been only two REACH calls since its inception and these were to do with a small communication problem. The consistent rounding of nursing staff and CMO's has reduced the dependency on REACH.	
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 MET is a coordinated response to a medical emergency. Any clinician is authorised to call a medical emergency. On arrival of the MET team there is a protocol to announce a quiet time to receive a handover from the clinician who called the MET, to gain a patient history and the reason a MET has been called. It also aims to identify the leading roles. There has been identification signage of lead roles trialled and this is constantly evolving with feedback and improvements. Responses to MET calls is led within ICU. There is formal review of the processes leading to the MET call, the actions taken, any learning to improve the response and interventions of the MET response. Review of policy, procedure and practice is informed from these reviews. Ongoing improvements to the MET system include education of medical and nursing workforce to recognise that should formal clinical reviews be requested more than three times for a patient, this should act as a trigger to consider requesting a MET review.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.9	
The workforce uses the recognition and response systems to escalate care	
Comments	
When interviewing clinicians and managers across the NPH all could articulate the systems in place to escalate care and call for emergency assistance. Information is provided during orientation to the hospital and clinical setting. Education sessions are available, and presentation were evident in the timetable for ongoing education.	
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	
Monitoring of staff skills and competency is undertaken on appointment and through supernumerary protocols in place in most clinical settings. Basic Life Support training is monitored at ward/unit level and through the organisation wide key performance indicators. Managers interviewed were aware of who required updated sessions and had in place strategies to support staff to attend to this training.	
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	
Staff trained in Advanced Life Support (ALS) are identified. At any given time throughout the hospital system there is staff with ALS training and expertise on the roster to respond to medical emergencies.	
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	
A Comprehensive Screening Tool is in place to identify patients exhibiting a mental health condition. The Edinburgh Post Natal Screening Tool is used in Maternity. The R25 Nursing Handover Tool provides a comprehensive assessment of the patients' condition for the next shift.	
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	
There are protocols in place for patients who need other services to resolve the cause of their acute deterioration. Escalation involves transfer interhospital to CCU or ICU. In addition, with the public tertiary hospital only metres away from NPH there is ready transfer available across the walk bridge.	
Rating	**Applicable HSF IDs**
Met	All

Recommendations from Previous Assessment

Nil