NSQHS Standards 2nd Edition Assessment Healthscope - Campbelltown Private Hospital 101567

Accreditation Status	*Accredited*
Date(s) of Assessment	*14/04/2025 - 15/04/2025 (Final)*
Site	*42 Parkside Crescent Campbelltown NSW 2560*
Scope of certification	*For the provision of anaesthetic, GIT endoscopy, medical, paediatric, rehabilitation and surgical services.*

Details and Registration of the Health Service
NSW Health Licence #PH2159 Anaesthesia, Cosmetic surgery, Gastrointestinal Endoscopy, Medical, Paediatric, Rehabilitation and Surgical
Licensed to supply drugs of addiction S8D2159
Radiation Licence #5061076 – 04/01/27

Note: The information provided in this report is based on the information provided by the Health Service Organisation at the time of the accreditation assessment. Accreditation issued by Global-Mark does not guarantee the ongoing safety or quality of an organisation or its services or programs, or that legislative requirements are being met, or will be met.

Contents

ABOUT THE COMMISSION

The Australian Commission on Safety and Quality in Health Care (Commission) leads and coordinates national improvements in healthcare safety and quality. It works in partnership with patients, carers, clinicians, the Australian, state and territory health systems, the private sector, managers and healthcare organisations to achieve a safe, high-quality and sustainable health system.
Key functions of the Commission include developing national safety and quality standards, developing clinical care standards to improve the implementation of evidence-based health care, coordinating work in specific areas to improve outcomes for patients, and providing information, publications and resources about safety and quality.
The Commission works in four priority areas:

1. Safe delivery of health care
2. Partnering with consumers
3. Partnering with healthcare professionals
4. Quality, value and outcomes.

THE AHSSQA SCHEME

Under the National Health Reform Act 2011, the Commission is responsible for the formulation of standards relating to health care safety and quality matters. This includes formulating and coordinating the Australian Health Service Safety and Quality Accreditation Scheme (the AHSSQA Scheme), which provides for the national coordination of accreditation processes.
The AHSSQA Scheme sets out the responsibilities of accrediting agencies in relation to implementation of the following safety and quality standards:

- National Safety and Quality Health Service (NSQHS) Standards including the Multi-Purpose Services Aged Care (MPS) Module
- National Safety and Quality Digital Mental Health (NSQDMH) Standards
- National Safety and Quality Primary and Community Healthcare (NSQPCH) Standards, once approved and
- Any other set of standards that may be developed by the Commission from time to time.

The National Safety and Quality Health Service (NSQHS) Standards were developed by the Commission in collaboration with the Australian Government, states and territories, the private sector, clinical experts, patients and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met.
There are eight NSQHS Standards, which cover high-prevalence adverse events, healthcare associated infections, medication safety, comprehensive care, clinical communication, the prevention and management of pressure injuries, the prevention of falls, and responding to clinical deterioration. Importantly, the NSQHS Standards have provided a nationally consistent statement about the standard of care consumers can expect from their health service organisations.

RATING SCALE DEFINITION

Whenever the NSQHS Standards (2nd ed.) are assessed, actions are to be rated using the revised rating scale outline below:

Rating	Definition of rating
MET	All requirements 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 the additional implementation is required. If there are no not met actions across the health service organisation, actions rated met with recommendations will be assessed during the next assessment cycle. Met with recommendations may not be awarded at two consecutive assessments where the recommendation is made about the same service or location and the same action. In this case an action should be rated not met.
NOT MET	Part or all of the requirements of the action have not been met.
NOT APPLICABLE	The action is not relevant in the service context being assessed. The Commission's advisory relating to not applicable actions for the health sector need to be taken into consideration when awarding a not applicable rating and assessors must confirm the action is not relevant in the service context during the assessment visit.
NOT ASSESSED	Actions that are not part of the current assessment process and therefore not reviewed.
For further information, see Fact Sheet 4: Rating scale for assessment.	

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.

Repeat Assessment

If a health service organisation has 16 or more percent of assessed actions not met or more than 8 actions from the Clinical Governance Standard not met at initial assessment and is subsequently awarded accreditation, the organisation is required to undertake a further assessment within six months of the assessment being finalised. All actions rated not met or met with recommendations from the initial assessment will be reassessed.
The aim of the reassessment is to ensure the organisation has fully embedded the necessary improvements in their safety and quality systems to maintain compliance with the NSQHS Standards. This is a one off assessment with no remediation period. All actions must be met for the organisation to retain its accreditation.
For further information, see Fact Sheet 3: Repeat assessment of health service organisations.

Safety and Quality Advice Centre and Resources

The Advice Centre provides support for health service organisations, assessors and accrediting agencies on NSQHS Standards implementation, the National Safety and Quality Primary and Community Healthcare Standards, the National General Practice Accreditation (NGPA) Scheme, the National Pathology Accreditation Scheme and the National Diagnostic Imaging Accreditation Scheme.
Telephone: 1800 304 056 | Email: AdviceCentre@safetyandquality.gov.au
Further information can be found online at the Commission's Advice Centre

ACCREDITING AGENCY

I, Kelly Gillen declare that Global-Mark Pty Ltd has the approval from the Australian Commission on Safety and Quality in Health Care to conduct assessment to the National Safety and Quality Health Service / National Safety and Quality Primary and Community Healthcare Standard(s). This approval is current until 31/12/2024.

Under this authority, Global-Mark Pty Ltd is authorised to assess health service organisations against the Australian Health Service Safety and Quality Accreditation Scheme.

Conflicts of Interest

I, Kelly Gillen declare that Global-Mark Pty Ltd has complied with Australian Commission on Safety and Quality in Health Care policy on minimising and managing conflicts of interest.

The following conflicts of interest were identified, and management of these conflicts have declared to the relevant regulator and the Australian Commission on Safety and Quality in Health Care:
NO REAL OR PERCEIVED CONFLICTS OF INTEREST IDENTIFIED
Further information can be found on the Factsheet 9: Managing conflicts of interest in accreditation

Is this the first assessment of this health service organisation by Global-Mark?	No
If yes, has the final report of the last assessment completed by the HSO been provided to Global-Mark?	NA
Matters that arose during the assessment that may have impacted on the assessment outcome	Not Applicable

Health Service Organisation and Assessment Determination

Global-Mark Pty Ltd has reviewed and verified the assessment report for	Healthscope - Campbelltown Private Hospital
The outcome for this assessment is	Accredited
Date of accrediting agency determination	17/05/2025
Date health service organisation notified	17/05/2025
Date regulator / Commission notified where accreditation not awarded	NA

ASSESSMENT DETAILS

Not Applicable Actions

All actions rated not applicable complied with Advisory 18/01: Advice on not applicable actions. Not applicable actions below:

5.19, 5.20, 5.36

Has the assessor verified actions were not applicable during the assessment	Yes
Have any actions not complying with Advisory 18/01 been approved by the Commission	Yes

Actions not complying with Advisory 18/01	Details of verification (Name and Date)
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	There has been only one patient death at the hospital in the past 2 years. Last death 17/07/2023. The hospital is unable to provide evidence of routine evaluation of end of life care. Processes are in place for the care of patients at end of life, including regular education of staff, and available resources/referral. ACSQHC approved.
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	There has been only one patient death at the hospital in the past 2 years. Last death 17/07/2023. The hospital is unable to provide evidence of routine practice about shared decision making. Processes are in place for the care of patients at end of life, including regular education of staff, and available resources/referral. ACSQHC approved.

Mandatory Reporting

The management system includes an adequate process to identify the organisation's key systems and determine their controls.	Yes
The system provides an adequate description of the organisation and its onsite processes.	Yes
The system includes an overview of the applicable regulations (including licenses and permits) and agreements with authorities, and that any licenses necessary for the relevant activities of the organisation are in place.	Yes
The management system is effective in achieving the organisation's objective.	Yes
High risk scenarios have been tested by the auditors during the review.	Yes
Safety and quality consultants have been declared at the opening meeting, and where applicable, have met the requirements of Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme Requirements for managing conflicts of interest in accreditation.	NA
The governing body's attestation statement is current and has been submitted to Global-Mark	Yes
Consumers were involved in the review in a meaningful way.	Yes
Has there been any critical incidents/accidents?	Yes sampling incidents with appropriate management RiskMan IDs #2174292 and #2181562
Has there been any inspections/audits by regulators?	Yes NSW Health Visit – Regulation and Compliance Unit, General Licensing Standards Review Summary Date of Visit: 21/03/2025- Management is currently working on a formal response to the Regulation and Compliance Unit, with the final submission due by 28/04/2025. - By-laws to reference the NSW Private Health Facilities Act 2007 - Requirements added this to the Terms of Reference of the MAC - currently in DRAFT to be presented at the next MAC. - Thermostatic mixing valves (TMV) reports to be made available - Ensure compliance to Part 14, clause 78 of the regulation - 6.1 Paediatrics Admission Policy 3/25 - now implemented

	and approved at the Quality Meeting 10/04/2025 - Inclusion of the licensee verbal and written reporting obligations if a fire occurs - Policy amended HSW Response Manual 4/25 - Retention and disposal of Health Information - clarify the retention of paediatric health records - Management reported that correct retention is currently in policy, requested greater clarity within the Corporate policy -2.21 Retention and Disposal of Health Information 5/22

Additional Assessment Details

Requirement	Assessment Outcome	Complies
Use of Certificate, Mark(s) and Advertising Material	Evidence has been sighted during the review to verify that the health service organisation uses their certificate, marks and advertising materials in accordance with certification requirements.	Yes
Patient Episode	With verbal consent, assessors had the opportunity to observe a wide range of clinical activities and patient care processes during the assessment at Campbelltown Private Hospital. These observations enabled verification of the practical implementation of the National Safety and Quality Health Service (NSQHS) Standards – Edition 2. Observed Patient Episodes of Care Included: - Theatre and Day Surgery Unit: - Nursing admission: MRN #100507 - Clinical handover (concierge nurse to anaesthetic nurse): MRN #219948 - Team "time out": MRN #277509 and #237838 - Stage 1 recovery care and handover (theatre to recovery): MRN #294656 - Medication administration: MRN #294656 - Clinical handover from PACU to DSU: MRN #296899 - Patient discharge with carer: MRN #242493 Rehabilitation Ward: - Bedside handover (night duty to morning staff): MRN #201397, #123032, #211272, #270892, #285078 Additional Clinical Observations: - Clinical bedside handover on Rehabilitation and Surgical Wards: MRN #296519, #296403, #296885 - Pre-admission assessment phone calls: MRN #240900, #296807 - Admission: MRN #296885 - S4 and S8 medication checks and administration: MRN #237515, #237838	Yes

Requirement	Assessment Outcome	Complies
	The assessment team verified that Campbelltown Private Hospital has consistently implemented the core requirements of the National Safety and Quality Health Service (NSQHS) Standards. Infection prevention and control practices were embedded in day-to-day clinical care, with appropriate use of hygiene protocols and transmission-based precautions. Medication safety and administration processes were clearly followed, including accurate documentation and checks for high-risk medications. Comprehensive care was supported by systematic risk assessments, clinical alerts, and tailored care planning and management. Clinical communication practices such as safety huddles, structured handovers, patient identification, and procedure matching were observed across various care settings and demonstrated a strong commitment to patient safety. Blood management practices were also reviewed and found to be appropriately integrated into routine clinical workflows. The hospital had effective systems in place for recognising and responding to clinical deterioration, supported by emergency equipment and clear escalation protocols. Additionally, the reprocessing of reusable medical devices in CSSD and Endoscopy met required standards. Discharge planning and patient communication were patient centred, well documented, and supported a safe and informed transition from hospital care to the next stage of treatment or recovery. Medical Record Review: A total of 13 medical records were reviewed to verify documentation supporting observed processes: MRNs: #262710, #292160, #121846, #296743, #201671, #296526, #104159, #105980, #296519, #296403, #296885, #270743 and #286748	
Consumer Interview	As part of the assessment, a consumer interview was conducted with a patient (MRN #296885), who reported consistent involvement in their care journey. The patient confirmed that they were provided with clear and adequate information and were given regular opportunities to ask questions throughout their admission. They expressed appreciation for the nursing care received and noted that their goals of care were reviewed at each shift change. The patient also reported active participation in clinical handovers, demonstrated an understanding of how to request assistance and provide feedback, and observed consistent adherence to hand hygiene practices by staff. Additionally, the patient made a positive comment regarding the quality of the meals provided during their stay. Informal feedback was also observed during the assessment, with patients offering spontaneous expressions of gratitude to staff, including remarks such as, “Thank you for looking after me so well.” These comments reflect a positive patient experience and are indicative of the commitment and professionalism of the clinical team. Further engagement with the hospital’s Consumer Consultant highlighted Campbelltown Private Hospital’s ongoing commitment to consumer partnership. The Consumer Consultant actively	Yes

Requirement	Assessment Outcome	Complies
	participates in the hospital's Consumer Engagement Plan (2024–2025) and contributes to key governance structures, including the National Rehabilitation Committee (bimonthly meetings), Quality Committee (monthly), and Infection Prevention and Control Committee (bimonthly). They reported meaningful involvement in reviewing safety and quality data presented at these forums and confirmed that their input is both encouraged and valued. This level of engagement ensures that the consumer voice remains central to hospital governance and quality improvement initiatives, reinforcing a culture of transparency, collaboration, and patient centred care.	

Attendance to Opening and Closing Meeting

Name and Designation	Opening	Closing
Nobby Alcala, General Manager	Yes	Yes
Donna Worrall,Quality Manager	Yes	Yes
Karen Anastasov,Quality Manager	Yes	Yes
Dana Rowe, Global-Mark Assessor	Yes	Yes
Shelley Bustos, Global-Mark Assessor	Yes	Yes
Bianca Woodley, Global-Mark Assessor	Yes	Yes
Sarah Robertson,ACSQHC Commission observer	Yes	No
Ann Knight - National Accreditation Manager	Yes	Yes

High Risk Scenario

At least one high risk scenario was reviewed during this assessment	Yes
Summary of high-risk scenarios	Disruptions to essential utilities Paediatric management Disruptive or aggressive patient/s, families or other member/s of the community

Shared and Contracted Services

List organisational relationships relevant to the assessment of this health service organisation. For e.g., the HSO:	CPH is a part of the Healthscope Hospital Group and receives corporate support in the form of quality management, purchasing, and human resources.

- Shares a campus, pharmacy service, biomedical, food and linen service - Is part of *other HSO* - Is affiliated with *other HSO*	
List contracted services relevant to the assessment of this health service organisation. For e.g., the HSO maintains a contract for provision of: - Sterilising - Laundry services - Food preparation - Theatre Services	Maintenance and support Services Agreement - Biomedical Equipment - SC Medical Healthscope - Equipment use and consumables agreement - Stryker dated 13/10/22 Grace Record Storage (Contract dated 09/03/2023)

Declared shared and contracted services were verified during this assessment	Yes
These agreements have been reviewed in the past three years	Yes
Consultants or Third Party participated in the assessment	NA

ASSESSMENT TEAM AND RECOMMENDATION

Assessment Team Details			
Assessor Role	**Name**	**NSQHS ID**	**Declaration of independence signed**
Lead Auditor	Dana Rowe	A1074	Yes
Auditor	Bianca Woodley	A1943	Yes
Auditor	Shelley Bustos	A1923	Yes
**Note: Assessments should have a minimum of two assessors.*			

ACCREDITATION OUTCOME RESULTS

Assessment Team Recommendation

The assessment team recommends to Global-Mark Pty Ltd, based on the information provided, that Healthscope - Campbelltown Private Hospital be Accredited. This has been confirmed by Global-Mark's Chief Executive Officer or delegate.

Executive Summary

Campbelltown Private Hospital, which opened in April 2007, provides comprehensive medical, surgical, and rehabilitation services. The facility features eight operating theatres (including robotic, minimally invasive, and

laser surgery specialties), a dedicated day surgery unit, a 34-bed specialist rehabilitation centre, an on-site gymnasium, and an eight bed High Dependency Unit (HDU). Healthscope supports the facility through the provision of corporate governance documents, accessible via the intranet, alongside local documentation. Various specialist software platforms are utilised, including RiskMan for risk, incident, and feedback management; Cgov for Visiting Medical Officer (VMO) credentialling; eLearning for education and training; and eQuarms for quality improvement actions. An extensive committee structure supports reporting and monitoring at both local and corporate levels. A new General Manager, shared with Liverpool Private Hospital, has recently been appointed to support ongoing leadership and governance.
The hospital is licensed by NSW Health under Licence #PH2159 for the provision of anaesthesia, cosmetic surgery, gastrointestinal endoscopy, medical, paediatric, rehabilitation, and surgical services.
A short-notice assessment against the National Safety and Quality Health Service Standards (NSQHSS) was undertaken. Evidence sighted during the reassessment demonstrated that the facility has undertaken extensive work to maintain and improve its processes. The health service organisation was able to demonstrate systematic progress across all assessed areas, with no findings identified. Based on the evidence presented, the assessment team believes that Campbelltown Private Hospital has the capacity to systematically meet the requirements of the NSQHSS within the defined scope of certification. The audit team extends their appreciation to the health service organisation for their openness, transparency, and hospitality during the review.

An opportunity for improvement was identified to improve traceability, support clearer documentation, strengthen accountability, and enable more effective tracking of actions through to resolution by consistently including RiskMan ID numbers in meeting minutes where incidents are discussed. This practice would enhance the visibility of incident follow-up and ensure a more structured approach to monitoring and closing the loop on reported issues.

Recommendations from Previous Assessments

Action	Gaps in implementation identified	Recommendation(s)	Rating

Summary of Recommendations from the Current Assessment

Action	Gaps in implementation identified	Recommendation(s)	Rating

DETAILED REPORT FOR STANDARDS ASSESSED

Action 1.01
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
Evidence Reviewed
The governing body of Campbell Private Hospital demonstrates clear leadership and commitment to embedding a strong culture of safety, quality improvement, and consumer partnership. This leadership is articulated through strategic plans and governance processes aligned with national frameworks. The Clinical Governance Plan 2024–2025, aligned with the National Model Clinical Governance Framework, is endorsed by the governing body and serves as a foundation for safe, high-quality care. Additionally, the Consumer Engagement Plan 2024–2025 and First Nations Engagement Plan 2024–2026 reinforce inclusive consumer partnerships in service planning and evaluation. The 02-2025 v20 Organisation Structure and CPH Committee Structure 02/25 ensure that roles and responsibilities are clearly defined across governance, management, clinicians, and the workforce. Ongoing monitoring and oversight of safety and quality performance are demonstrated through: Quality and Risk Committee (6/02/25 and 6/03/25), with a follow-up presentation scheduled for 10/04/25, where items such as audit outcomes, patient experience, incident reviews, and clinical performance are reviewed with the involvement of a Consumer Consultant Executive Meeting Minutes (13/02/25, 27/03/25) Medical Advisory Committee (MAC) Meetings (3/12/2024 and 11/03/2025) Surgical Ward Meeting Minutes (3/12/2024 and 28/03/2025) Rehabilitation Department Meeting Minutes (28/02/25 and 31/03/25) Performance and compliance are further supported by: Risk Register maintained within RiskMan Mandatory training compliance, monitored via ELMO Dashboard, currently reflecting a high completion rate of 98% A comprehensive suite of local and corporate policies and procedures

A robust Business Continuity Plan, ensuring organisational resilience

Through these integrated governance mechanisms, the governing body ensures:

A sustained culture of safety and quality

Clear strategic direction and accountability

Effective communication of clinical priorities

Robust monitoring of clinical incidents and continuous improvement

Campbell Private Hospital remains committed to high standards of governance, clinical care, and community engagement.

Rating

Met

Findings

-

Action 1.02

The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people

Evidence Reviewed

CPH ensures that the governing body oversees and supports strategies that address the specific health needs of Aboriginal and Torres Strait Islander peoples, fully aligned with the National Safety and Quality Health Service (NSQHS) Standards. The hospital's commitment is reflected in the implementation and monitoring of the First Nations Engagement Plan 2024–2026, with governance oversight provided through the Quality and Risk Committee framework. CPH fosters a culturally safe and inclusive environment, with visible acknowledgements of Aboriginal and Torres Strait Islander culture, including the display of flags, artwork, and culturally appropriate health education resources. Admission processes routinely ask patients if they identify as Aboriginal and/or Torres Strait Islander to ensure personalised, culturally responsive care from the outset, with access to an Aboriginal Liaison Officer when required. The Australian Charter of Healthcare Rights, highlighting specific rights for Aboriginal and Torres Strait Islander peoples, is prominently displayed throughout clinical areas.

Demographic data is routinely collected and reviewed, as evidenced by the Quality Meeting held on 6/03/2025, enabling CPH to tailor care to meet the needs of its diverse consumer population. Targeted actions, such as the provision of multilingual information and culturally appropriate clothing in the Day Surgery Unit, demonstrate CPH's proactive approach to addressing higher-risk groups. Through these initiatives, the governing body ensures that cultural safety, equity, and continuous improvement for Aboriginal and Torres Strait Islander peoples remain a priority within the organisation's overall safety and quality framework.

Rating
Met
Findings
-

Action 1.03
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
Evidence Reviewed
CPH has established and maintains a comprehensive clinical governance framework to drive continuous improvements in the safety and quality of care, in alignment with the National Safety and Quality Health Service (NSQHS) Standards. The Clinical Governance Plan 2024–2025 references the Australian Commission on Safety and Quality in Health Care's National Model of Clinical Governance and aligns with the One Healthscope 2025 Strategy. The Plan was formally approved by the Healthscope Board in April 2024, ensuring executive endorsement and organisation-wide accountability. The clinical governance framework is structured around eight key pillars that underpin safe, effective, and patient-centred care: Leadership and Culture; People and Partnerships; Clinical Data and Outcomes; Managing Risk; Quality Improvement; Evidence-Based Practice; Patient Experience; and Staff Capability Building. CPH also supports consumer engagement through its Consumer Engagement Plan 2024–2025, ensuring that consumers are actively involved in shaping safety and quality improvements. Clinical governance processes — including leadership oversight, use of clinical data, risk management, evidence-based practice, capability development, and patient feedback — are embedded across all service areas, systematically driving improvements and promoting a strong culture of safety, transparency, staff development, and continuous learning.
Rating
Met
Findings
-

Action 1.04
The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people

Evidence Reviewed
CPH is committed to meeting the healthcare needs of Aboriginal and Torres Strait Islander peoples through the implementation and monitoring of culturally safe, respectful, and inclusive strategies. Guided by its First Nations Engagement Plan 2024–2026, CPH ensures visible cultural acknowledgment throughout the facility, provides access to an Aboriginal Liaison Officer when required, and embeds processes to routinely ask patients if they identify as Aboriginal and/or Torres Strait Islander to ensure personalised care. The Australian Charter of Healthcare Rights, highlighting Aboriginal and Torres Strait Islander people's rights, is prominently displayed in clinical areas. These initiatives are overseen through the Quality and Risk Committee. CPH also actively collects and analyses demographic data to identify and support diverse consumer needs, with recent actions including the provision of multilingual patient information and culturally appropriate clothing to enhance respectful care delivery. Through these strategies, CPH demonstrates its commitment to improving cultural safety, equity, and quality outcomes for Aboriginal and Torres Strait Islander peoples and all consumers.
Rating
Met
Findings
-

Action 1.05
The health service organisation considers the safety and quality of health care for patients in its business decision-making
Evidence Reviewed
CPH ensures that the safety and quality of healthcare for patients remains central to all business decision-making processes. The hospital integrates its clinical governance framework across all operational levels to promote organisation-wide awareness of safety and quality data, ensuring decisions consistently prioritise patient outcomes and regulatory compliance. During the assessment, several elements demonstrated the integration of safety and quality into business practices, including compliance with NSW Private Health Licensing requirements; active participation in clinical indicator reporting and benchmarking through the Australian Council on Healthcare Standards (ACHS) and the Australasian Rehabilitation Outcomes Centre (AROC); and ongoing collection and analysis of patient satisfaction feedback via Qualtrics, a leading cloud-based experience management platform. Risk management is supported through the maintenance of a comprehensive Risk Register and incident management via the RiskMan system. A robust credentialing and scope of practice process is in place for all Visiting Medical Officers (VMOs), ensuring that only appropriately qualified clinicians provide care, with regular monitoring of nurse, allied health professional, and VMO registrations through the Australian Health Practitioner Regulation Agency (AHPRA), coordinated by the Executive Office. CPH’s clinical governance structures, regular committee reporting, and integrated quality systems ensure that safety and quality data inform clinical care, operational priorities, financial planning, and strategic decision-making, supporting a strong culture of accountability, patient-centred care, and continuous improvement across the organisation.
Rating
Met

Findings
-

Action 1.06
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
Evidence Reviewed
Clinical leaders within the health service organisation actively support clinicians to understand and perform their delegated safety and quality roles and responsibilities. All agency staff are provided with a formal orientation to the facility prior to commencing their shift to ensure familiarity with the environment, organisational policies, and specific role requirements. Position descriptions for all key workforce roles, including Registered Nurse (dated March 2022), Assistant in Nursing (dated March 2022), Physiotherapist (dated March 2022), Environmental Services Assistant (dated March 2022), and Support Services Manager (dated March 2022), are in place and clearly outline the responsibilities relating to safety and quality. The Enrolled Nurse position description (dated August 2023) also provides detailed clarification of duties related to safe and high-quality care. Personnel files (n=4) sighted confirmed that position descriptions are consistently maintained. Clinical leaders further ensure that all clinicians operate within the established clinical governance framework. The Healthscope By-Laws (dated 3 July 2024) outline formal processes for defining the scope of clinical practice, monitoring clinician performance to ensure they remain within their authorised scope, and conducting regular reviews of clinical scopes of practice. These processes support the continuous improvement of the safety and quality of healthcare delivered to patients.
Rating
Met
Findings
-

Action 1.07
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

Evidence Reviewed
CPH adopts a structured risk management approach to ensure the development, maintenance, and effective implementation of policies, procedures, and protocols. Policy governance is guided predominantly by Healthscope corporate policies, complemented by site-specific local policies where necessary to meet facility-specific operational needs. The overarching framework is provided by: Healthscope Policy 1.14 Document Control (effective 11/21), which outlines requirements for the controlled management of policies, procedures, and forms. Healthscope Policy 1.01 Policy Governance (effective 12/22), which sets out the process for the development, review, endorsement, and approval of governance documents. All current policies, procedures, and forms are maintained and accessible through the HINT intranet, providing staff with real-time access to up-to-date corporate and site-specific documentation. CPH undertakes regular reviews to ensure the currency and effectiveness of governance documents, including scheduled updates and version control processes. Monitoring of staff adherence to policies and procedures is supported through internal audits, incident reviews, clinical audits, and risk management systems (such as RiskMan). Non-adherence or gaps identified through these mechanisms are addressed through corrective action plans and monitored for completion. Compliance with legislative, regulatory, and jurisdictional requirements is a key component of the governance framework, with Healthscope policies regularly reviewed and updated to reflect current legal obligations. Local site policies are similarly reviewed in accordance with regulatory changes and operational needs.
Rating
Met
Findings
-

Action 1.08
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

Evidence Reviewed
CPH utilises an organisation-wide quality improvement system that supports the ongoing identification, monitoring, and enhancement of safety and quality performance. CPH uses RiskMan, including its EQUAMs module, to facilitate the internal audit program, system improvements, and the management of Quality Action Plans. Inputs to the quality improvement process include data from the incident management and reporting system, internal audits, patient, staff and doctor feedback, and clinical indicator reporting. Key sources informing quality improvement activities include the HACS Report, Quality KPI Reports, Quality Reports presented to the Medical Advisory Committee (MAC) and Craft Groups, ACHS Clinical Indicator data, VMO Survey results, Monthly Education Calendars, and AROC Data. The hospital systematically monitors and reports safety and quality performance through these systems to identify areas for improvement. Regular data review enables the hospital to implement targeted safety and quality strategies and to monitor the effectiveness of improvement actions. Workforce engagement is supported through regular reporting and communication channels, including Quality Boards, daily huddles, and departmental staff meetings. For example, performance data, quality improvement initiatives, and identified risks are discussed at the Surgical Ward Meetings (3/12/2024 and 28/03/2025) and Rehabilitation Department Meetings (28/02/2025 and 31/03/2025). Consumer engagement is achieved through active consumer participation in the Quality and Risk Committee. Consumer Representatives are involved in reviewing quality performance and improvement initiatives, as evidenced in Quality and Risk Minutes from 6/02/2025 and 6/03/2025, and presentations such as the one held on 10/04/2025. Additionally, CPH maintains a 2025 Alert Recall Register to track and manage alerts, recalls, and corrective actions issued by regulatory authorities and manufacturers. The Alert Recall Register ensures timely review, communication, and action regarding safety notices, contributing to the hospital's proactive management of product and system safety risks. Through these structured and integrated systems, Campbelltown Private Hospital ensures that the identification, monitoring, and improvement of safety and quality outcomes is embedded across the organisation, involving consumers and the workforce in a culture of continuous improvement.
Rating
Met
Findings
-

Action 1.09
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

Evidence Reviewed
CPH ensures that timely reports on safety and quality systems and performance are provided to the governing body, the workforce, consumers, and other relevant stakeholders. Reporting to the governing body is facilitated through a structured committee framework. While the Healthscope Board serves as the formal governing body, local governance is operationalised through the Executive Governance Committee, Quality and Risk Committee, and the Medical Advisory Committee (MAC). Regular reporting is maintained, with key meetings including the MAC Meetings (held 3/12/2024 and 11/03/2025) and Executive Governance Meetings (held 13/02/2025 and 27/03/2025), where performance against quality and safety objectives is reviewed and discussed. The workforce receives updates on quality and safety performance through multiple channels, including departmental Quality Boards, daily huddles, and regular staff meetings. Examples include Surgical Ward Meetings (3/12/2024 and 28/03/2025) and Rehabilitation Department Meetings (28/02/2025 and 31/03/2025), Quality and Risk Committee. Quality and Risk Committee (6/02/2025 and 6/03/2025) where performance data, quality improvement initiatives, and identified risks are shared and discussed. Consumer engagement is achieved through the involvement of Consumer Representatives in the Quality and Risk Committee. Quality and Risk Committee (6/02/2025 and 6/03/2025) confirm consumer participation, with presentations, such as that on 10/04/2025, further supporting ongoing consumer consultation and feedback processes. CPH also ensures that relevant clinical specialty groups are engaged through structured reporting. Specialty committee meetings such as the Rehabilitation Specialty Committee Meeting (7/11/2024) and Anaesthetic CRAFT Group Meetings (held 25/11/2024 and 5/03/2025) provide targeted opportunities to review clinical performance, safety outcomes, and improvement activities. Through this integrated reporting system, Campbelltown Private Hospital ensures that safety and quality performance is transparently communicated across all levels of the organisation and to its key stakeholders, promoting a culture of accountability, continuous improvement, and shared learning.
Rating
Met
Findings
-

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

Evidence Reviewed

CPH maintains a structured and integrated risk management system that supports the identification, assessment, management, and continuous monitoring of organisational risks.

The hospital operates under Policy 1.34 Risk Management and Integrated Risk Register (effective 12/23), which provides the framework for documenting and actively managing organisational and clinical risks. Risks are recorded and monitored through the RiskMan system, ensuring visibility, traceability, and timely action. Examples of key risks currently documented in the Integrated Risk Register include:

RiskMan ID #7933 – Medical Record Documentation

RiskMan ID #7855 – Accreditation/Certification

RiskMan ID #13823 – Patient/Visitor Aggression (staff at risk)

CPH uses clinical data, incident reports, patient feedback, and audit findings to inform ongoing risk assessments and prioritisation. Identified risks and emerging trends are discussed at regular Quality Committee meetings, with recent reviews held on 6/02/25 and 6/03/25. A Consumer Representative is actively involved in these meetings, ensuring that consumer perspectives are incorporated into risk management activities.

Action is taken to mitigate identified risks, with corrective measures and improvement strategies developed and monitored for effectiveness. For example, the Surgical Ward's top risks for the previous month—falls, clinical deterioration, and escalation of care—were prominently displayed on Quality Boards located in clinical areas, promoting staff awareness and proactive risk management.

Risks and associated actions are reviewed regularly, and outcomes are reported to the workforce through established committee structures, departmental meetings, and public Quality and Safety Boards. Consumers are also kept informed through committee representation and the visibility of risk priorities.

CPH maintains comprehensive plans for managing internal and external emergencies and disasters, ensuring preparedness and organisational resilience. These efforts are documented in the Emergency and Disaster Management Plan (currently under review) and the Pandemic Plan (updated 03/25).

Through these systematic processes, Campbelltown Private Hospital demonstrates a strong, proactive, and transparent approach to risk management, supporting safer, higher quality care and continuous organisational improvement. An opportunity for improvement was identified to improve traceability, support clearer documentation, strengthen accountability, and enable more effective tracking of actions through to resolution by consistently including RiskMan ID numbers in meeting minutes where incidents are discussed. This practice would enhance the visibility of incident follow-up and ensure a more structured approach to monitoring and closing the loop on reported issues.

Rating

Met

Findings

-

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

Evidence Reviewed

CPH maintains an organisation-wide incident management and investigation system that supports timely identification, reporting, analysis, and learning from clinical and non-clinical incidents.

The hospital utilises RiskMan as the central platform for incident reporting and management. Staff are supported and trained to recognise, report, and escalate incidents appropriately, in accordance with Policy 2.13 Incident Management (effective 10/2023) and Policy 2.02 Serious Adverse Event Review and Root Cause Analysis (effective 10/23).

Patients, carers, and families are encouraged and supported to communicate concerns and incidents through open channels and feedback mechanisms. Consumer involvement in the review of incidents is facilitated through the participation of a Consumer Representative on the Quality Meeting Committee, with attendance recorded at meetings held on 6/02/25 and 6/03/25.

Trending reports on clinical risks and incident analysis are routinely reviewed and presented to key governance committees, including the Medical Advisory Committee (MAC) and the Quality Committees. For example, incident reviews related to RiskMan IDs #2174292 and #2181562 (patient transfers) were sampled, confirming that appropriate management, investigation, and documentation were undertaken.

Serious incidents undergo formal review processes, and corrective action plans are developed, completed, and reported back to relevant governance committees, such as the MAC (meeting 3/12/25) and the Quality Committees. Quality improvement activities are actioned through the regular review of incidents and the implementation of system-wide improvements.

Feedback to staff is provided through the established committee structure and displayed on Quality and Safety Boards located throughout clinical areas, ensuring transparency and reinforcing a learning culture.

Information obtained from the analysis of incidents is used to strengthen safety and quality systems, and risks identified through incident investigations are formally incorporated into the facility's risk management system. CPH regularly reviews the effectiveness of its incident management processes through governance mechanisms, continuous monitoring, and consumer involvement, demonstrating its commitment to continuous improvement, staff engagement, and safe patient care

Rating

Met

Findings

-

Action 1.12
The health service organisation: a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework b. Monitors and acts to improve the effectiveness of open disclosure processes
Evidence Reviewed
CPH maintains a structured open disclosure program that is fully consistent with the principles outlined in the Australian Open Disclosure Framework, ensuring transparency, honesty, and respectful communication with patients and their families when incidents occur. The hospital's processes are guided by Policy 2.30 Open Disclosure (effective 10/23), which provides a clear framework for initiating open disclosure discussions following clinical incidents or adverse events. Staff are trained and supported to implement open disclosure practices promptly and appropriately, in alignment with national standards. An example demonstrating adherence to these processes is the case involving MRN #263734 (RiskMan ID #2174292), where a patient required transfer to a higher acuity facility for further management. An open disclosure discussion was initiated on the same day, with the anaesthetist documenting the conversation in the patient's clinical progress notes in accordance with policy requirements. CPH actively monitors and evaluates the effectiveness of its open disclosure processes through incident reporting via RiskMan, regular clinical audits, and governance reviews. Open disclosure cases are reviewed at relevant committee meetings, where shared learnings are discussed to drive improvements in clinical practice, staff education, and patient communication. Through these structured processes, Campbelltown Private Hospital demonstrates a strong commitment to maintaining an open and transparent culture that promotes patient safety, respects patient rights, and fosters continuous quality improvement in healthcare delivery.
Rating
Met
Findings
-

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

Evidence Reviewed

CPH has established structured processes to regularly seek and respond to feedback from patients, carers, families, and the workforce, supporting continuous improvement in the delivery of safe, high-quality care in alignment with the National Safety and Quality Health Service (NSQHS) Standards.

Patient feedback is collected through a variety of mechanisms, including formal patient surveys. Survey results sighted during the assessment were predominantly positive, reflecting a high level of patient satisfaction with care experiences and outcomes. In the most recent survey, CPH achieved a NET promoter score of 83, with a 98% satisfaction rate recorded in key performance areas. Patient feedback mechanisms are readily accessible, promoting open communication and service improvement initiatives.

Workforce feedback is also systematically collected to assess workplace culture, safety practices, and staff engagement. As part of these efforts, CPH conducted the Your Say Pulse 2024 workforce survey, achieving a 30% response rate. Post-survey action plans have been developed and implemented to address identified opportunities for improvement and to support the promotion of a positive, safe, and engaged workplace culture.

Feedback from Visiting Medical Officers (VMOs) and doctors is formally gathered through the Medical Advisory Committee (MAC), ensuring that clinical leadership feedback is incorporated into strategic planning and quality improvement initiatives.

The General Manager (GM) and Director of Nursing (DON) are accessible to both staff and doctors, and positive, collaborative working relationships were observed during the assessment, further reinforcing a strong culture of openness, responsiveness, and engagement.

Information gathered from patients, staff, and clinicians is systematically analysed and used to drive service improvements, strengthen safety and quality systems, and enhance patient care outcomes. Through these practices, Campbelltown Private Hospital demonstrates its ongoing commitment to consumer engagement, workforce involvement, and continuous quality improvement.

Rating

Met

Findings

-

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

Evidence Reviewed

CPH has a comprehensive, organisation-wide complaints management system that supports, encourages, and manages feedback from patients, carers, families, and the workforce, in alignment with the National Safety and Quality Health Service (NSQHS) Standards.

The hospital operates under the guidance of Policy 1.08 Complaints Management (effective 11/24), which provides a structured framework for the handling, investigation, and resolution of complaints. RiskMan is utilised as the central platform for logging and managing all complaints received through various channels, ensuring consistency, traceability, and transparency.

Patients, carers, and staff are actively encouraged to report complaints through clearly documented pathways, supported by Healthscope's Rights and Responsibilities and Complaints Pathways documentation. Complaints and any associated risks are formally recorded on the organisation's Risk Register (#7921 Inadequate Complaints Management), with actions tracked and monitored to address and reduce systemic risks.

Consumer involvement in the complaints review process is actively promoted. A consumer representative sits on the Quality Meeting Committee, ensuring that consumer perspectives are incorporated into complaint reviews and shared learning discussions. Since the beginning of 2024, four complaints have been reviewed through the committee framework with consumer participation.

Recent examples demonstrate CPH's commitment to transparency and continuous improvement:

HCCC Complaint #79347 MRN #117563 (lodged 29/10/2024): An appropriate investigation was conducted with family involvement. An initial response letter was sent on 08/11/2024, with resolution confirmed through a closure letter received on 10/02/2025. Updates on complaint outcomes were formally reported at the Executive Meeting on 13/02/2025.

Analysis of complaints feeds directly into CPH's safety and quality systems, informing policy updates, clinical practice improvements, and staff education initiatives. Outcomes and emerging trends are regularly discussed through the committee framework to ensure governance oversight and timely feedback to the governing body, workforce, and consumers.

CPH regularly reviews the effectiveness of its complaints management processes through structured governance mechanisms, proactive risk management, and ongoing consumer engagement, demonstrating a strong commitment to continuous improvement, transparency, and safe, patient-centred care.

Rating

Met

Findings

-

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

Evidence Reviewed

CPH actively identifies and responds to the diversity of the consumers accessing its services, in alignment with the National Safety and Quality Health Service (NSQHS) Standards.

Demographic data is routinely collected and analysed to understand the consumer profile, with the latest data presented at the Quality Meeting on 6/03/2025. Analysis indicated that 93% of patients identified English as their preferred language, with Hindi (0.92%) and Arabic (0.65%) also represented. In response to this diversity, patient information resources in Hindi and Arabic have been made available on the wards to ensure that non-English-speaking patients have access to essential healthcare information in their preferred language.

CPH also identifies higher-risk groups using its services and integrates this information into planning and care delivery. A recent quality improvement initiative within the Day Surgery Unit (DSU) involved the provision of culturally appropriate clothing (pants) for Arabic-speaking patients, recognising the importance of ensuring modesty and cultural respect during care delivery.

Rating

Met

Findings

-

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

Evidence Reviewed

CPH maintains robust healthcare record systems that ensure clinical information is accurate, accessible, secure, and auditable, fully supporting compliance with the National Safety and Quality Health Service (NSQHS) Standards.

Healthcare records are made available to clinicians at the point of care, ensuring that timely and complete information supports safe clinical decision-making. Sampling of medical records confirmed that key documentation was consistently present, including patient consent forms, demographic

information, traceability records, national medication charts, observation and response charts, discharge summaries, clinical handover documentation, operative or medical notes, assessment data, clinical pathways, and evidence of regular review and assessment.

CPH supports the workforce to maintain accurate and complete healthcare records through clear and comprehensive policies, including:

- Policy 2.21 Retention and Disposal of Health Information (effective 05/22), which aligns with state-based guidelines and regulations regarding the appropriate retention and disposal of health records.

- Policy 2.24 Release of Health Information (effective 07/22), which governs the lawful and secure release of patient information and is well understood by the Health Information Manager.

- Policy 0.21 Privacy Policy (effective 05/21), which provides a framework to ensure the protection, security, and confidentiality of patient health information in accordance with national privacy legislation.

Campbelltown Private Hospital also utilises off-site secure storage services for archived medical records under a formal agreement with Grace Record Storage (Contract dated 09/03/2023). In accordance with requirements, temperature and humidity monitoring is being implemented to ensure the environmental safety and preservation of health information.

To ensure ongoing accuracy and compliance, regular medical record documentation audits are conducted. Non-conformances identified during audits are managed through the EQAMS system. Recent audit results demonstrate strong compliance, with Level 2 Surgical achieving 90% compliance (Q2 2024) and Level 3 Surgical achieving 85% compliance (Q2 2024).

Healthcare record systems at CPH comply fully with privacy and security regulations, ensuring patient information is protected. Integration across multiple information systems is supported where necessary, enhancing the continuity of care and the availability of comprehensive clinical information.

Through these systems and practices, Campbelltown Private Hospital demonstrates its commitment to maintaining high standards in healthcare documentation, ensuring patient safety, regulatory compliance, and the protection of sensitive health information.

Rating

Met

Findings

-

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

Evidence Reviewed
CPH actively supports the use of the My Health Record system to optimise the safety and quality of healthcare for patients. Guided by Healthscope Policy 2.66 My Health Record System (effective 05/21), the hospital ensures that staff are informed and trained on the appropriate use of My Health Record. Clinical systems are designed to utilise national patient and provider identifiers and apply standard national terminologies to maintain data integrity, privacy, and interoperability. My Health Record is currently in use across the facility, enhancing clinical decision-making by providing timely and comprehensive access to patient information. Information brochures explaining My Health Record are readily available in clinical areas to support patient understanding, informed consent, and engagement. Campbelltown Private Hospital also provides access to the My Health Record system through its eApplications portal, as indicated on its official website. Through these practices, Campbelltown Private Hospital demonstrates its commitment to improving patient care, protecting patient information, and aligning with national digital health priorities.
Rating
Met
Findings
-

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
Evidence Reviewed
CPH actively supports the use of the My Health Record system to optimise the safety and quality of healthcare for patients, while ensuring compliance with legislative and regulatory requirements. Guided by Healthscope Policy 2.66 My Health Record System (effective 05/21), CPH has established processes that define appropriate workforce access to the system, ensuring that access is restricted to authorised users and managed in accordance with privacy, confidentiality, and consent obligations under national legislation. Clinical systems at CPH are designed to utilise national patient and provider identifiers and apply standard national terminologies to maintain the accuracy, integrity, and interoperability of clinical information uploaded into the system. Staff are informed and trained on appropriate usage procedures, with My Health Record incorporated into clinical workflows to enhance decision-making and support safe patient care. To maintain the accuracy and completeness of information uploaded into My Health Record, CPH participates in a National Audit Schedule, which facilitates regular reviews of data quality, system access, and upload processes. In addition, My Health Record information brochures are readily available in clinical areas to promote patient understanding, informed consent, and active participation. CPH also provides access to the My Health Record system via its eApplications portal, as indicated on its official website. Through these comprehensive strategies, Campbelltown Private Hospital demonstrates its commitment to the safe, accurate, and compliant use of digital health information to improve patient care and protect patient information.

Rating
Met
Findings
-

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
Evidence Reviewed
CPH ensures that all workforce members receive a structured and comprehensive orientation that clearly describes their roles and responsibilities related to safety and quality, consistent with the National Safety and Quality Health Service (NSQHS) Standards. Orientation is delivered through multiple methods, including the Learning Platform (eLearning) and regular onsite, face-to-face sessions held four times per year. Each new worker is provided with a position description that outlines their individual safety and quality responsibilities. Completion of the Orientation Checklist is required, and orientation compliance is tracked through formal monitoring systems. The orientation program is further supported by department-specific resources and structured materials, including: - Department-specific orientation and welcome resources, such as ward-specific welcome books (e.g., Surgical Ward, issued 10/24);Cuppa Convo Starter Checklist to support informal onboarding; Staff Orientation Handbook (2025, Version 16); Structured Hospital Orientation Program; Staff Induction Checklist (completed for staff AB, reviewed 13/03/24); Policy 4.16 Orientation – Employee (effective 06/22) Members of the Medical Advisory Committee (MAC) and members of the governing body are also provided with detailed information regarding their roles and responsibilities in safety and quality through Healthscope's Hospital By-Laws (effective 07/24). Orientation compliance rates currently stand at 98%, confirming that new staff consistently complete the structured orientation program.
Rating
Met
Findings
-

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
Evidence Reviewed
CPH effectively utilises its training systems to assess workforce competency, identify training needs, and ensure the delivery of safe, high-quality care, consistent with the National Safety and Quality Health Service (NSQHS) Standards. CPH has established formal policies, including Training Requirements for Credentialed Practitioners (effective 05/24) and Policy 4.10 Mandatory Training (effective 07/22), which outline the mandatory training framework for all staff and credentialed practitioners. Competency and training needs are systematically assessed through regular reviews and workforce feedback. Staff access mandatory and supplementary training via the eLearning platform, with interviews confirming that training is readily accessible. Mandatory training modules cover critical safety and quality areas, with current compliance rates demonstrating high levels of staff engagement: - Manual Handling: Theory 98.9%, Practical 93.8% - Infection Prevention and Control (IPC): 99.6% (inclusive of standard and transmission precautions) - Hand Hygiene: 97.9% - Fire Safety: 85% - Basic Life Support: Theory 99%, Practical 96.9% - Medication Safety: 93.1% - Blood Safety: 92.6% - Aseptic Technique: Theory 99.4%, Practical 99.4% - Diversity and Sensitivity in Healthcare: 99.3%; "Asking the Question" compliance: 99.4% - Advanced Life Support (ALS): 31 staff completed training; Paediatric Advanced Life Support (PALS): 27 staff trained, confirming all after-hours coordinators have completed training, with the next session scheduled for 5/25 - PPE Donning and Doffing Training for Cleaning Staff: 99% compliance - Ecolab Safe Chemical Handling: 91% - Clean Care Room Cleaning: 100% Overall, the staff mandatory training compliance rate stands at 95.1%, demonstrating robust participation and a strong commitment to maintaining clinical competencies and workplace safety. Training participation and compliance are monitored and reported through formal committee frameworks, including updates presented at the Quality Meeting Committee (latest review dated 6/03/25), ensuring accountability, transparency, and continuous improvement.

Rating
Met
Findings
-

Action 1.21
The health service organisation has strategies to improve the cultural safety and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients
Evidence Reviewed
Campbelltown Private Hospital is committed to fostering a culturally safe environment and enhancing the cultural competency of its workforce to better meet the needs of Aboriginal and Torres Strait Islander patients. The health service organisation has implemented a range of strategies, supported by Healthscope's organisational framework, to ensure respectful, culturally appropriate care. Training programs are a key element of this commitment. Staff are required to complete "Asking the Question: Are you of Aboriginal or Torres Strait Islander descent?" training, with a recorded compliance rate of 99.3% at the time of review. Additionally, all staff undertake "Cultural Diversity and Sensitivity in Healthcare" training, with a compliance rate of 99.4%, further reinforcing culturally respectful practices in clinical and non-clinical interactions. To support these initiatives, Campbelltown Private Hospital has in place Policy 1.58 – Appropriate Cultural Care for Aboriginal and Torres Strait Islander Patients (effective from July 2021), which outlines procedures and expectations for delivering culturally safe and responsive care. Through ongoing education, clear policy guidance, and measurable compliance monitoring, Campbelltown Private Hospital ensures that it continues to improve the cultural safety and competency of its workforce, providing care that respects and responds to the unique needs of Aboriginal and Torres Strait Islander patients.
Rating
Met
Findings
-

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

Evidence Reviewed

CPH has valid and reliable performance review processes in place that meet legislative and best practice requirements. As of March 2025, 96% of workforce members have participated in annual performance appraisals.

Performance reviews are conducted annually, with direct managers responsible for reviewing their staff. The process includes opportunities for staff to identify additional training and development needs, particularly in relation to safety and quality. This information is used to inform individual development plans and is integrated into the organisation’s broader training system.

Feedback is provided to staff at regular intervals, supporting continuous professional development. Compliance with performance review requirements is monitored through regular reporting and is tracked as a key performance indicator (KPI) for managers. Staff files reviewed during the assessment demonstrated strong adherence to annual appraisal processes.

Rating

Met

Findings

-

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

Evidence Reviewed

Campbelltown Private Hospital (CPH) upholds a rigorous credentialing framework to ensure clinicians operate within clearly defined and regularly reviewed scopes of clinical practice, aligning with the National Safety and Quality Health Service (NSQHS) Standards. Guided by Healthscope's Hospital By-Laws effective from 3 July 2024, CPH delineates each practitioner's scope based on individual qualifications, competencies, and the hospital's clinical service capacity and strategic plans.

The hospital employs the Cgov credentialing platform to manage the accreditation process efficiently. This digital system streamlines the collection, verification, and monitoring of practitioner credentials, integrating with key healthcare data systems to provide real-time oversight. All new medical practitioners and dentists undergo a comprehensive credentialing process, resulting in an initial accreditation period of one year, followed by re-credentialing every three years. This process includes a review of clinical performance, ongoing professional development, and compliance with hospital

policies. Each accredited practitioner is granted a specific scope of practice, which is clearly defined and regularly reviewed to ensure alignment with their competencies and the needs of the facility.

CPH's structured governance framework includes a Medical Advisory Committee (MAC) that oversees credentialing processes. Regular audits are conducted to assess compliance with credentialing requirements, and findings inform quality improvement initiatives. The Cgov system facilitates tracking of credentialing status and scope of practice, ensuring transparency and accessibility for relevant stakeholders.

The hospital mandates that all employed health practitioners, including nurses and allied health staff, maintain current registration with the Australian Health Practitioner Regulation Agency (AHPRA). Policy 1.54 outlines the requirements for AHPRA registration, and regular audits verify compliance. The AHPRA Registration Report is reviewed periodically to ensure all practitioners meet regulatory standards.

The credentials of the following Visiting Medical Officers (VMOs) have been verified and are actively monitored through the Cgov system: AHPRA Registration Number: MED0001627117; MED0001192405 and MED0001154742.

Rating

Met

Findings

-

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

Evidence Reviewed

Campbelltown Private Hospital is committed to ensuring that all clinicians providing care within its facilities are appropriately credentialed and operate within a defined scope of practice, in alignment with the National Safety and Quality Health Service (NSQHS) Standards.

CPH employs the Cgov credentialing platform to manage the accreditation and compliance of Visiting Medical Officers (VMOs). This digital system streamlines the credentialing process by automating workflows, integrating with key healthcare data systems, and providing real-time monitoring of practitioner credentials. All new medical practitioners and dentists undergo a comprehensive credentialing process, resulting in an initial accreditation period of one year. Following this, practitioners are re-credentialed every three years. This process includes a review of clinical performance, ongoing professional development, and compliance with the hospital's policies and procedures. Each accredited practitioner is granted a specific scope of practice, which is clearly defined and regularly reviewed to ensure alignment with their competencies and the needs of the facility. The credentials of the following VMOs have been verified and are actively monitored through the Cgov system:

AHPRA Registration Number: MED0001627117; MED0001192405 and MED0001154742.

CPH employs a structured governance framework, including a Medical Advisory Committee (MAC), to oversee credentialing processes. Regular audits are conducted to assess compliance with credentialing requirements, and findings are used to inform quality improvement initiatives. The cGov system is utilized for tracking credentialing status and scope of practice, ensuring transparency and accessibility for relevant stakeholders.

The hospital mandates that all employed health practitioners, including nurses and allied health staff, maintain current registration with the Australian Health Practitioner Regulation Agency (AHPRA). Policy 1.54 outlines the requirements for AHPRA registration, and regular audits are conducted to verify compliance. The AHPRA Registration Report is reviewed periodically to ensure all practitioners meet regulatory standards.

Campbelltown Private Hospital maintains a VMO GESA Recertification Register to track the recertification status of Visiting Medical Officers, ensuring they meet the Gastroenterological Society of Australia (GESA) standards. Working With Children Checks (WWCC) are required for all staff, with compliance monitored through regular audits.

By adhering to these processes, Campbelltown Private Hospital ensures that all clinicians are appropriately credentialed and that the credentialing process is continually monitored and improved to uphold the highest standards of patient care and safety.

Rating

Met

Findings

-

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

Evidence Reviewed

The health service organisation has established processes to ensure that all members of the workforce, including agency and locum staff, understand and perform their roles and responsibilities in relation to safety and quality.

All agency staff are provided with a formal orientation to the facility prior to commencing their shift, to ensure familiarity with the environment, organisational policies, and specific role requirements. Position descriptions for all key workforce roles, including Registered Nurse (dated March 2022), Assistant in Nursing (dated March 2022), Physiotherapist (dated March 2022), Environmental Services Assistant (dated March 2022), and Support Services Manager (dated March 2022), are in place. The Enrolled Nurse position description (dated August 2023) was also reviewed and confirms clear delineation of duties related to safety and quality of care. Personnel files (n=4) sighted all contained position descriptions that clearly detail the responsibilities relating to safety and quality.

Furthermore, the Healthscope By-Laws (dated 3 July 2024) outline formal processes for defining the scope of clinical practice for clinicians, monitoring practice to ensure it remains within the designated scope, and regularly reviewing scopes of practice. These systems ensure that all workforce members,

including temporary and agency staff, are appropriately assigned safety and quality responsibilities and operate within their authorised scope of clinical practice.
Rating
Met
Findings
-

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
Evidence Reviewed
Campbelltown Private Hospital provides appropriate supervision to ensure clinicians can safely and effectively fulfil their designated roles, including access to after-hours support where required. Supervision within the facility is provided by qualified management and senior clinical staff, ensuring consistent oversight and guidance for the workforce. An after-hours Nurse in Charge is rostered to manage clinical and operational issues that may arise outside of standard hours, offering immediate support to staff across all areas of the hospital. Additionally, there is an onsite doctor available at all times, ensuring timely access to medical expertise. Up-to-date contact details for on-call doctors are also readily accessible to staff when escalation is required. Discussions with staff during the assessment confirmed that supervision arrangements are clearly understood and effectively embedded in day-to-day operations. Campbelltown Private Hospital also supports the clinical development and supervision of its staff through structured programs such as the Preceptorship Program, Supernumerary and Student Programs, and Registered Nurse/Enrolled Nurse Graduate Programs. These programs help ensure that clinicians receive the appropriate levels of support, mentoring, and supervision required for safe and competent practice. These systems demonstrate the hospital's strong commitment to maintaining a supportive and accountable clinical environment that prioritises patient safety and professional development.
Rating
Met
Findings
-

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
Evidence Reviewed
Campbelltown Private Hospital has established robust and effective processes to ensure clinicians have ready access to best-practice guidelines, integrated care pathways, clinical pathways, and decision support tools relevant to their clinical practice. Clinicians are supported through the HINT platform, which serves as a centralised access point for clinical resources and is available at the point of care. Resources accessible via HINT include Clinical Care Standards, the Injectable Medicines Handbook, Therapeutic Guidelines, and eMIMS, which is installed on all computer desktops throughout the facility. In addition, clinicians have access to ACRON Standards, HICMR resources that provide guidance on infection prevention and control, and CHEMWATCH, which is used as the chemical register to support safe chemical management. Policy 2.75 – Advisories and Clinical Care Standards (dated 04/23) provides a framework for the adoption and application of relevant advisories, clinical care standards, and evidence-based practices across the organisation. These systems and resources demonstrate Campbelltown Private Hospital's commitment to ensuring that clinical practice is guided by the best available evidence, including nationally endorsed clinical care standards developed by the Australian Commission on Safety and Quality in Health Care, in support of safe, consistent, and high-quality care delivery.
Rating
Met
Findings
-

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

Evidence Reviewed

Campbelltown Private Hospital has established comprehensive systems to monitor, review, and manage clinical variation.

Variation in clinical practice is systematically monitored through the submission of outcome data to multiple clinical indicator datasets, including the Australian Council on Healthcare Standards (ACHS) Clinical Indicators, the Australasian Rehabilitation Outcomes Centre (AROC), Healthscope Hospital-Acquired Complications (HAC) reports, RiskMan incident reports, and patient complaints. These data sources facilitate benchmarking and enable the provision of feedback to clinicians regarding their practice patterns and associated health outcomes.

When individual variation is identified, it is addressed through structured discussions at the Medical Advisory Committee (MAC). For instance, on 12 February 2025, a meeting was convened involving five doctors, allied health staff, and the Director of Nursing to discuss observed variations in practice. A significant increase in reported Deep Vein Thrombosis (DVT) cases prompted a deep-dive analysis led by the Quality Manager. This analysis emphasised adherence to best practices, including routine VTE risk assessments and appropriate prophylactic measures. Subsequently, the Orthopaedic Craft Group convened on 13 February 2025 to reinforce these practices among its members.

Performance is regularly reviewed against external measures, and clinicians are supported to engage in clinical reviews of their practice. Information on unwarranted clinical variation is utilised to inform improvements in safety and quality systems. Risks identified from such variations are recorded in the organisation's risk management system, ensuring a proactive approach to mitigating potential adverse outcomes.

These processes demonstrate Campbelltown Private Hospital's commitment to continuous improvement in clinical care, ensuring that variations are identified, analysed, and addressed in a manner consistent with national standards and best practices.

Rating

Met

Findings

-

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

Evidence Reviewed

Campbelltown Private Hospital maximises safety and quality of care through intentional environmental design and the diligent maintenance of its buildings, equipment, and infrastructure. The facility operates a structured and well-documented system for managing maintenance and environmental safety, ensuring that both clinical and non-clinical areas support high standards of care.

Scheduled servicing and equipment checks are supported by specialist contractor involvement. For example, S/C Medical Equipment attends the site three days per week to manage, service, and assess medical equipment. Each device is tagged with a QR code that allows faults to be quickly reported and assessed. Loan equipment is arranged as needed, and a formal schedule of equipment maintenance is maintained, supported by an asset register. Full inspection reports are completed regularly, including the ERFA Report for 2024 provided on 27/03/2024, which included inspection and replacement of thermometers.

New equipment undergoes electrical safety testing before being brought into service. Campbelltown Private Hospital utilises the services of integrated facility management provider BGIS to manage both preventative and reactive maintenance. The Planned Preventative Maintenance (PPM) matrix supports ongoing infrastructure maintenance, including annual planning. Faults are triaged through a help desk system based on priority level, with technician or contractor response tracked through fault notes. A fault report dated 10/2024 confirms this process is operational and reviewed monthly.

The hospital's emergency generator undergoes a full service four times per year, including an annual load test conducted to ensure reliability. Additional infrastructure management includes the Theatre UPS battery replacement by Three Service on 24/11/2024.

Environmental safety is further supported through water quality and air management protocols. The Water Management Plan, managed by Integra, includes cooling tower oversight, with Symbio testing for Legionella carried out on 25/03/2025. Thermostatic Mixing Valves (TMVs) for the central warm water loop were inspected and passed on 30/04/2024 by Scott Martins. Backflow prevention is tested annually, with three backflow devices inspected and passed by Sydney Water on 11/11/2024.

Annual inspection of nurse call bell systems is conducted by Rouland Services, with the most recent inspection completed on 30/12/2024, including the replacement of handsets. Air conditioning systems, including HEPA filters, were inspected and passed on 14/08/2024 by a NATA-accredited contractor, with certification provided for OT1-49 air changes.

Campbelltown Private Hospital maintains compliance with fire safety regulations by ensuring that its Annual Fire Safety Statement (AFSS) is current and properly displayed. The most recent AFSS is prominently exhibited within the facility, dated 10 January 2025, in accordance with the Environmental Planning and Assessment (Development Certification and Fire Safety) Regulation 2021.

This statement confirms that all essential fire safety measures have been assessed by an accredited fire safety practitioner and are functioning to the required standards. The AFSS has been submitted to both the local council and the Commissioner of Fire and Rescue NSW, fulfilling the mandatory reporting obligations. By adhering to these requirements, Campbelltown Private Hospital demonstrates its commitment to maintaining a safe environment for patients, staff, and visitors.

These processes collectively demonstrate Campbelltown Private Hospital's commitment to providing a safe and high-quality environment for patients, staff, and visitors, aligned with accreditation standards and industry best practices.

Rating

Met

Findings

-

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
Evidence Reviewed
Campbelltown Private Hospital has established processes to identify service areas where there is a higher risk of unpredictable behaviours and to minimise potential harm to patients, carers, families, consumers, and the workforce. While instances of unpredictable behaviour are reportedly rare, a Code of Conduct is displayed in clinical areas to clearly outline the expected behaviour from patients and visitors. The hospital has a number of Work Health and Safety policies in place that support the management of occupational risks, including policies on Occupational Violence and Aggression and Incident Management, all reviewed and updated in 2023. These policies provide a framework for incident response, prevention strategies, and staff safety. Emergency Plans and internal phone directories are readily accessible to staff. Emergency flip charts were sighted in appropriate locations throughout the hospital, and staff were able to confirm when and how these would be used. In addition, restricted entry into the hospital after hours further enhances safety and limits access during periods of increased risk. To support patients who require a calm and quiet environment, the hospital offers accommodation that includes a number of single rooms, providing opportunities to reduce environmental stimulation when clinically appropriate. Common rooms are also available in areas where risk may be present, and each clinical area has access to quiet spaces for patients who may benefit from a more peaceful setting. Zero tolerance posters are displayed throughout the facility, reinforcing the hospital's commitment to safety, respect, and a culture of zero tolerance for violence or aggression.
Rating
Met
Findings
-

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
Evidence Reviewed
Campbelltown Private Hospital facilitates access to its services and facilities through the use of clear and purpose-designed signage and directional supports. Signage throughout the hospital is logical, visible, and easy to understand, helping patients and visitors navigate the facility with confidence.

The reception area is staffed at all times, providing a first point of contact for anyone requiring assistance. Staff are trained to offer guidance and are supported by a directory located at reception and within each lift, further aiding navigation throughout the hospital.

In addition, all staff wear identifiable uniforms and were observed to be approachable and willing to assist with directions when required. These measures collectively support a welcoming and accessible environment, ensuring that patients and visitors can locate services and move through the facility with ease.

Rating

Met

Findings

-

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

Evidence Reviewed

Campbelltown Private Hospital has implemented processes that support flexible visiting arrangements to meet the diverse needs of patients, particularly for those admitted overnight. Discussions with management and staff confirmed that flexibility is exercised in situations where extended visitation or overnight stays are clinically appropriate. Examples include providing social and emotional support, particularly during end-of-life care, or allowing parents or guardians to stay with paediatric patients.

These practices are supported by the documented policy 2.62 Visiting Hours Flexible Arrangements (dated 12/23), which provides clear guidance to staff and management on how to assess and manage visiting requests based on patient need and safety considerations. The policy reinforces a patient-centred approach while maintaining clinical oversight.

In addition, information regarding visiting arrangements is accessible to patients, families, and carers through the hospital’s website, ensuring transparency and consistent communication. These measures demonstrate Campbelltown Private Hospital’s commitment to compassionate care, recognising the therapeutic role that family and support persons play in a patient’s recovery and wellbeing.

Rating

Met

Findings
-

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
Evidence Reviewed
Campbelltown Private Hospital demonstrates a welcoming and inclusive environment that recognises and respects the cultural beliefs and practices of Aboriginal and Torres Strait Islander peoples. Processes are in place to routinely ask all patients if they identify as being of Aboriginal and/or Torres Strait Islander origin. This ensures that culturally appropriate and personalised care is provided from the outset of each patient's journey. Visible acknowledgements of Aboriginal and Torres Strait Islander culture are present throughout the facility, including the display of Aboriginal artwork and the Aboriginal and Torres Strait Islander flags. The hospital also provides targeted health information brochures such as "Bowel Cancer – Aboriginal and Torres Strait Islander Cancer Information" and "Make Healthy Eating Normal for Our Mob," developed by the Agency for Clinical Innovation, which are available to support culturally relevant health education. A clearly defined process is in place to access an Aboriginal Liaison Officer when required, ensuring that patients and their families receive culturally responsive support and advocacy during their care experience. Additionally, the Australian Charter of Healthcare Rights, including the specific section titled "Aboriginal and Torres Strait Islander People have the right to…", is prominently displayed throughout clinical areas. These measures reflect Campbelltown Private Hospital's ongoing commitment to cultural safety, equity in care, and respect for the values and rights of Aboriginal and Torres Strait Islander peoples.
Rating
Met
Findings
-

Action 2.01
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

Evidence Reviewed
Campbelltown Private Hospital ensures that clinicians apply the safety and quality systems outlined in the Clinical Governance Standard when partnering with consumers. These systems are embedded within the Clinical Governance Plan 2024–2025 and the Consumer Engagement Plan 2024–2025. The implementation of Healthscope Policy 1.05 – Partnering with Consumers (dated 11/24) provides the framework for engaging consumers in care delivery, planning, and evaluation. Risks associated with partnering with consumers are actively managed using the RiskMan system. Examples of recorded risks include #7958 – consent to medical treatment with noted non-compliance to policy, #7921 – inadequate complaints management, and #7960 – patient incidents involving failure to notify. These risks are regularly reviewed and managed in line with clinical governance processes, ensuring that consumer-related risks are mitigated and appropriately addressed. Training requirements for clinicians in relation to partnering with consumers are clearly identified and delivered through the eLearning platform. High compliance rates demonstrate staff engagement with these modules, with 99.3% completion of Diversity and Sensitivity in Healthcare and 99.4% completion of Asking the Question. These processes reflect the hospital's commitment to ensuring clinicians are supported to engage effectively with consumers, manage associated risks, and uphold best practice in consumer partnership.
Rating
Met
Findings
-

Action 2.02
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
Evidence Reviewed
Campbelltown Private Hospital applies the quality improvement system outlined in the Clinical Governance Standard to monitor, improve, and report on processes for partnering with consumers. The Clinical Governance Plan 2024–2025 and Consumer Engagement Plan 2024–2025 clearly define the mechanisms for monitoring consumer engagement, developing and implementing improvement strategies, and reporting outcomes to the highest levels of governance. This structured and transparent approach supports a culture of accountability, responsiveness, and continuous improvement in consumer partnership. Consumer engagement and experience are formally reported through the hospital's governance structures, as evidenced by the Quality Committee Meeting Minutes dated 6/02/25 and 6/03/25, where Patient/Consumer Experience and People and Partnerships are standing agenda items. These

meetings include regular input from the Hospital Consumer Consultant, ensuring consumer feedback is actively reviewed, discussed, and used to inform service improvements.

Staff also described clear and consistent processes for escalating feedback and identifying improvement opportunities through Quality Boards and staff meetings, fostering organisation-wide engagement in consumer-focused care.

Recent improvement initiatives include Quality Action Plan #17909, the REACH audit for inpatients, which commenced on 7/04/25 and is currently ongoing, as well as Action #17687, which led to the successful implementation of a centralised location for consumer infection prevention brochures.

These systems and quality initiatives collectively demonstrate how Campbelltown Private Hospital actively applies the principles of quality improvement to enhance consumer partnerships, evaluate performance, and drive measurable and meaningful change.

Rating

Met

Findings

-

Action 2.03

The health service organisation uses a charter of rights that is:

a. Consistent with the Australian Charter of Healthcare Rights

b. Easily accessible for patients, carers, families and consumers

Evidence Reviewed

Campbelltown Private Hospital employs a charter of rights that aligns with the Australian Charter of Healthcare Rights (ACHCR), ensuring it is readily accessible and visible to all patients, carers, families, and consumers throughout the facility. The ACHCR, including the version stating “Aboriginal and Torres Strait Islander People have the right to...”, is prominently displayed across clinical and common areas to reinforce its importance and visibility for all who access the service.

To ensure patients are informed, the Australian Charter of Healthcare Rights and the hospital’s Privacy Policy are presented and explained at the time of admission, or upon arrival. Staff are supported to confirm patients understand their rights and how these apply to their care.

Recognising the diverse community served, additional rights-based materials are displayed, including “The Rights of Every Child in Health Care” from the Association for the Wellbeing of Children in Healthcare, and a poster version of the ACHCR specifically for LGBTI communities. These resources reflect Campbelltown Private Hospital’s commitment to equity, inclusion, and culturally safe care for all patients.

Through these practices, Campbelltown Private Hospital demonstrates its strong commitment to upholding and promoting the rights of all individuals in its care, in alignment with national standards. The Healthscope Rights and Responsibilities brochure is also available.

Rating

Met

Findings
-

Action 2.04
The health service organisation ensures that its informed consent processes comply with legislation and best practice
Evidence Reviewed
Campbelltown Private Hospital (CPH) ensures that informed consent processes align with relevant legislation and reflect best practice standards. This commitment is underpinned by a documented policy—Policy 2.17: Consent to Medical/Surgical Treatment (dated April 2024)—which clearly outlines the procedures and responsibilities for obtaining valid consent. The hospital's approach is grounded in legal and ethical obligations, with routine monitoring incorporated into the National Audit Schedule to ensure consistent application across clinical areas. During the Level 2 Surgical Audit conducted in Q2 2024, CPH achieved 90% compliance with consent documentation requirements, reflecting strong adherence to both internal policy and external standards. All medical records reviewed as part of the most recent accreditation assessment contained appropriately signed consent forms, confirming consistent implementation of the consent process at the point of care. Ongoing compliance is further supported by the hospital's internal audit program, which monitors adherence and informs continuous quality improvement activities. In addition to clinical consent, the hospital obtains informed financial consent in accordance with Advisory AS 18/10, ensuring transparency, accountability, and respect for patients' rights in relation to fees and billing practices. A sample of medical records reviewed during the assessment supported verification of these processes. Records included: MRNs #262710, #292160, #121846, #296743, #201671, #296526, #104159, #105980, #296519, #296403, #296885, #270743, and #286748, all of which demonstrated compliance with consent documentation requirements.
Rating
Met
Findings
-

Action 2.05
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

Evidence Reviewed
Campbelltown Private Hospital has established processes to identify a patient's capacity to make decisions about their own care, and to determine and involve a substitute decision-maker when a patient lacks decision-making capacity. These processes are guided by Healthscope Policy 2.17 Consent to Medical/Surgical Treatment (dated 04/24), which outlines the steps clinicians must take to assess a patient's capacity and the legal and ethical requirements for involving a substitute decision-maker in such cases. Where language or communication barriers exist, clinicians are supported through the use of interpreter services, as outlined in Healthscope Policy 2.36 Interpreter Services (dated 06/22). This ensures that patients are provided with the necessary support to participate in decisions about their care wherever possible, and that any consent obtained is informed and valid. Through these structured policies and procedures, Campbelltown Private Hospital ensures that clinical staff are equipped to assess decision-making capacity appropriately and to uphold patient rights by involving substitute decision-makers when required, in line with legal and ethical standards.
Rating
Met
Findings
-

Action 2.06
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
Evidence Reviewed
Campbelltown Private Hospital has established processes to ensure clinicians actively partner with patients and, where appropriate, their substitute decision-makers to plan, communicate, set goals, and make informed decisions about both current and future care. Staff are supported with clear guidance on how to identify and document Goals of Care, helping to ensure that care is aligned with each patient's individual needs, preferences, and clinical context. Patient Care Boards are available in patient rooms and serve as a visible communication tool that facilitates ongoing dialogue between clinicians, patients, and carers. These boards help to reinforce patient-centred care and support the regular review and adjustment of care goals as required. During the assessment, clinical handovers were observed across multiple clinical areas, confirming that patients are routinely engaged in discussions about their treatment and care planning. This observed practice reflects the hospital's commitment to shared decision-making and supports the delivery of personalised, respectful, and goal-aligned healthcare.
Rating
Met

Findings
-

Action 2.07
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
Evidence Reviewed
Campbelltown Private Hospital supports its workforce to actively form partnerships with patients and carers, ensuring patients are meaningfully involved in their own care. Patient-centred care is embedded throughout the organisation and is clearly articulated in the Healthscope policy suite, including Clinical Handover – Departmental and Intra-Unit (8.18, dated 12/23), Partnering with Consumers (1.05, dated 11/24), Patient Rounding (2.63, dated 08/22), and Patients' Rights and Responsibilities (2.16, dated 11/24). Staff described the use of the structured handover tool, ISBAR, which promotes clear and inclusive communication. During the assessment, patients confirmed that clinical handover processes include them and their families, ensuring transparency and involvement in ongoing care decisions. Patients' goals of care are actively identified and communicated, with shared decision-making documented in the comprehensive care plan. Assessors observed full engagement of patients and their families during bedside handovers, where appropriate and relevant information was clearly conveyed. Safety huddles are conducted prior to bedside handover to ensure the clinical team is aligned and prepared to deliver coordinated, patient-centred care. These practices reflect Campbelltown Private Hospital's commitment to fostering meaningful partnerships with patients and carers and to delivering care that is collaborative, informed, and responsive to individual needs and preferences.
Rating
Met
Findings
-

Action 2.08
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

Evidence Reviewed
Campbelltown Private Hospital ensures communication mechanisms are tailored to reflect the diversity of its consumers and, where applicable, the broader local community. As discussed during the Quality Committee Meeting on 6/03/25, 93.7% of the hospital's patient population identify English as their preferred language. However, the organisation remains committed to inclusive communication practices for all patients, regardless of background. The Australian Charter of Healthcare Rights (ACHCR) is available in multiple languages and is prominently displayed in patient waiting areas and accessible via the hospital's website—ensuring that patients from culturally and linguistically diverse backgrounds can access essential information about their healthcare rights. To further support culturally responsive communication, staff are trained in relevant education programs. The hospital has achieved a 99.3% completion rate for "Diversity and Sensitivity in Healthcare" training and 99.4% for "Asking the Question", a program designed to enhance cultural awareness and encourage respectful inquiry about patient background and needs. Through these systems and training initiatives, Campbelltown Private Hospital demonstrates its ongoing commitment to delivering inclusive, respectful, and patient-centred care that supports the diverse needs of its consumer population.
Rating
Met
Findings
-

Action 2.09
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
Evidence Reviewed
Campbelltown Private Hospital demonstrates compliance with the requirement to involve consumers in the development and review of information provided to patients, carers, families, and consumers about health and health services. The Hospital Consumer Consultant confirmed that a formal process is in place to ensure consumer input is integrated into the creation and evaluation of patient-facing materials. The hospital is currently reviewing its patient information compendium, with a draft version awaiting finalisation from the graphics team. Consumer engagement has been evident in recent initiatives, including the review and input into the paediatric brochure, enhancements to falls prevention displays, and the expansion of health information displays throughout the facility. Additionally, the Consumer Consultant has reviewed internal resources such as the Information for Staff guide, which supports staff in facilitating patient access to hospital information systems. These efforts reflect Campbelltown Private Hospital's ongoing commitment to ensuring that information is accurate, accessible, and reflective of consumer needs and expectations.

Rating
Met
Findings
-

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
Evidence Reviewed
Campbelltown Private Hospital supports clinicians in delivering effective, patient-centred communication to ensure that patients, carers, families, and consumers are well-informed, actively involved, and supported throughout their healthcare journey. During the assessment, clinical areas were accessed and observed, confirming that staff are equipped and supported to engage in meaningful, consistent communication with patients. Interpreter services are arranged when needed, ensuring inclusivity and effective communication for patients from culturally and linguistically diverse backgrounds. A broad range of patient information is made available on the hospital's website, covering preadmission care, day surgery procedures, discharge guidance, overnight stay arrangements, nearby accommodation, maps, payment information, what to bring for admission, and information on the hospital's smoke-free policy. These resources are designed to be clear, accessible, and easy for patients and their families to navigate and understand. Patients are informed of their rights and responsibilities through access to the hospital's Privacy Policy and the Australian Charter of Healthcare Rights, both of which are communicated throughout their care journey. Discharge planning is systematically integrated into clinical workflows via the WebPAS system and aligned with the hospital's connection to My Health Record, ensuring patients receive the necessary information and documentation for safe, informed ongoing care after discharge. This includes written guidance, such as Patient Information v11/2018 for discharge pain medications, which was sighted during assessment.
Rating
Met
Findings
-

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
Evidence Reviewed
CPH actively involves consumers in governance, design, measurement, and evaluation processes to enhance healthcare delivery. A longstanding Hospital Consumer Consultant participates in the Quality Committee, as evidenced by meeting minutes from 6 February and 6 March 2025. Discussions during these meetings encompassed a broad range of topics, including Safety Share, Patient Stories, Patient Rights and Responsibilities, ACHS Clinical Reports, Quality QKI Reports, Complaints Management, Hospital Acquired Complication Reports, Internal Audit Outcomes and Schedules, AROC, Risk Register Review, Patient Incidents, Shared Learnings, Alerts and Recalls, Morbidity and Mortality Reviews, Compliments and Complaints, Education, Patient/Consumer Experience, People and Partnerships, and Accreditation. The upcoming Quality Committee meeting scheduled for 10 April 2025 continues this inclusive approach. Efforts are made to ensure that consumer representatives reflect the diversity of the patient population and the local community, aligning with the organisation's commitment to inclusive and person-centred care.
Rating
Met
Findings
-

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
Evidence Reviewed
Campbelltown Private Hospital demonstrates a strong commitment to partnering with consumers in the governance, design, measurement, and evaluation of its services. The hospital provides comprehensive orientation, ongoing support, and targeted education to ensure that consumer representatives are well-prepared and empowered to contribute meaningfully to decision-making processes that influence care delivery and organisational development. This commitment was validated through a recent phone interview with the Hospital Consumer Consultant, who confirmed the presence of appropriate support structures to enable effective participation. Consumer representatives at Campbelltown Private Hospital have completed key training requirements, including the Confidentiality Agreement (22/08/22), Healthscope Consumer Consultant Foundation Training (all modules completed 10/2022), Relationship

Centred Caring (10/2024), and Cultural Diversity and Inclusion (10/2024). These learning opportunities enhance their understanding of healthcare systems and promote effective collaboration, ensuring consumer input remains informed, respectful, and impactful.

Additionally, it was noted that Campbelltown Private Hospital is actively working to expand the number of Hospital Consumer Consultants, further strengthening consumer involvement and embedding the principles of partnership throughout the organisation.

Rating

Met

Findings

-

Action 2.13

The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs

Evidence Reviewed

Campbelltown Private Hospital is committed to working in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs in a culturally safe and respectful manner.

To support this commitment, processes are in place to routinely ask all patients if they identify as being of Aboriginal and/or Torres Strait Islander origin. This enables the provision of appropriate and personalised care from the outset of each patient's journey.

A clear process is also established to access an Aboriginal Liaison Officer when required, ensuring culturally responsive support is available to patients and their families.

In addition, the Australian Charter of Healthcare Rights "Aboriginal and Torres Strait Islander People have the right to..." is prominently displayed in clinical areas throughout the hospital. This reinforces Campbell Private Hospital's ongoing dedication to recognising and respecting the rights, values, and cultural needs of Aboriginal and Torres Strait Islander peoples.

Rating

Met

Findings

-

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

Evidence Reviewed
CPH actively partners with consumers to integrate their views and experiences into workforce training and education. The Hospital Consumer Consultant plays a central role in this process and is clearly identified on quality boards located in each clinical area, ensuring both staff and patients are informed of their presence and role. Consumer engagement is evidenced by the Patient Satisfaction Survey results for March 2025, which reported a NET score of 83 and a 98% overall satisfaction rating. Consumer perspectives are regularly shared through Patient Stories and formally documented in the Quality Meeting Committee minutes, with the Consumer Consultant present—sighted on 06/02/2025 and 06/03/2025. At the Quality Meeting Committee held on 10/04/2025, it was noted that patient stories are now integrated into the "You Said, We Did" campaign, which is reflected on the quality boards across clinical areas. This ensures that consumer feedback directly informs staff learning and service improvements. This collaborative approach is prominently displayed in clinical areas, supporting transparency and reinforcing the value of consumer input in workforce development.
Rating
Met
Findings
-

Action 3.01
The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for infection prevention and control b. Identifying and managing risks associated with infections c. Implementing policies and procedures for antimicrobial stewardship d Identifying and managing antimicrobial stewardship risks
Evidence Reviewed
Campbelltown Private Hospital demonstrates that the workforce uses the safety and quality systems from the Clinical Governance Standard when implementing policies and procedures related to infection prevention and control and antimicrobial stewardship. Assessors reviewed infection control procedures and processes which were consistent with the principles outlined in the Clinical Governance Standard. These principles underpin the hospital's approach to policy implementation, risk identification and management, and staff training. Staff were able to clearly articulate how infection prevention and control policies, including those related to antimicrobial stewardship, are operationalised in practice. They also described how associated risks are managed and how relevant training is provided. Key documents reviewed included HICMR Infection Prevention and Control Policies and Services (15.04) and the Antimicrobial Prescribing and Management Policy (18.53), supporting that appropriate governance systems are in place and effectively applied. The hospital's Risk Register – #17791 AMS – inadequate management of antimicrobial stewardship – further demonstrates that potential risks are

proactively identified, documented, and managed in alignment with the Clinical Governance Standard, reinforcing the commitment to continuous improvement in safety and quality outcomes.

Rating

Met

Findings

-

Action 3.02

The health service organisation:

a. Establishes multidisciplinary teams to identify and manage risks associated with infections using the hierarchy of controls in conjunction with infection prevention and control systems

b. Identifies requirements for, and provides the workforce with, access to training to prevent and control infections

c. Has processes to ensure that the workforce has the capacity, skills and access to equipment to implement systems to prevent and control infections

d. Establishes multidisciplinary teams, or processes, to promote effective antimicrobial stewardship

e. Identifies requirements for, and provides access to, training to support the workforce to conduct antimicrobial stewardship activities

f. Has processes to ensure that the workforce has the capacity and skills to implement antimicrobial stewardship

g. Plans for public health and pandemic risks

Evidence Reviewed

Campbelltown Private Hospital has established robust systems and governance structures that align with the requirements for infection prevention and control (IPC) and antimicrobial stewardship (AMS). The organisation utilises multidisciplinary teams to identify and manage infection-related risks, applying the hierarchy of controls in conjunction with established IPC systems. These teams operate under formal structures, including the Infection Prevention and Control (IPC) Committee, which meets bimonthly and reports through a clear governance framework—from the Management Review Committee and Quality and Risk Committee, to the Executive Governance Committee and Medical Advisory Committee (MAC).

Training and education are a key focus. IPC content is incorporated into the onboarding and orientation program for all staff, ensuring that all new personnel are equipped with foundational infection prevention knowledge from the outset. In addition, the organisation identifies ongoing training requirements and provides access to education and resources, supported by local education programs and IPC-specific position descriptions. This supports staff to maintain the capacity, skills, and access to equipment necessary to effectively implement infection prevention and antimicrobial stewardship systems. Specific training modules include Standard and Transmission-Based Precautions (IPC), with a completion rate of 99.6%, Infection Control/Hand Hygiene, with a 97.9% completion rate (hand hygiene-specific), and Antimicrobial Stewardship, which is included within IPC training and aseptic technique modules, with a 94% completion rate. These high participation rates demonstrate the organisation’s strong commitment to ensuring staff are well-prepared to manage infection risks and support safe clinical practices.

The AMS program is embedded within the governance structure, with oversight by the Medication and Pharmacy Committee, which meets monthly and reports to the IPC Committee. Risk assessments, IPC audits, and action plans—supported by the HICMR contract—ensure a proactive and multidisciplinary approach to managing both IPC and AMS risks.

Public health and pandemic preparedness are addressed through a comprehensive Pandemic Plan, which is reviewed annually and is next due in May 2025. Infection control risks are systematically reported through the committee structure, and assessors confirmed that there are defined responsibilities for infection surveillance and workforce training. Documentation reviewed included meeting minutes from the Infection Control Committee meeting held on 25/02/2025 and the Medication and Pharmacy Committee meeting held on 24/06/2024, providing evidence of ongoing oversight and review of IPC and AMS activities.

Rating

Met

Findings

-

Action 3.03

The health service organisation applies the quality improvement system from the Clinical Governance Standard when:

a. Monitoring the performance of infection prevention and control systems

b. Implementing strategies to improve infection prevention and control systems

c. Reporting to the governance body, the workforce, patients and other relevant groups on the performance of infection prevention and control systems

d. Monitoring the effectiveness of the antimicrobial stewardship program

e. Implementing strategies to improve antimicrobial stewardship outcomes

f. Reporting to the governance body, the workforce, patients and other relevant groups on antimicrobial stewardship outcomes

g. Supporting and monitoring the safe and sustainable use of infection prevention and control resources

Evidence Reviewed

Campbelltown Private Hospital applies the quality improvement system from the Clinical Governance Standard to its infection prevention and control (IPC) and antimicrobial stewardship (AMS) programs. The organisation actively monitors the performance of its IPC systems through regular audits, surveillance activities, and review of infection data, including Infection Surveillance Reports from January and February 2025. These reports are reviewed through a structured governance pathway, with evidence of reporting to the Medical Advisory Committee (MAC), as reflected in the 03/02/2025 meeting minutes.

Strategies to improve IPC systems are implemented and tracked through the Infection Prevention and Control Management Plan, action plans based on HICMR audit outcomes, and oversight by the IPC/AMS Committee. This ensures a continuous quality improvement approach that aligns with the Clinical Governance Standard.

The AMS program's effectiveness is also routinely monitored. An Antimicrobial Usage and Appropriateness Report, authored by an Infectious Diseases physician and dated 27/11/2020, was sighted during the assessment, alongside NAUSP reporting from February 2025. These reports are used to inform improvements and track the effectiveness of AMS strategies. Monthly AMS reporting through the Medication and Pharmacy Committee, with escalation to the IPC Committee, further supports integrated oversight.

There is also clear evidence of reporting performance outcomes to the governance body and workforce via established committee structures. The organisation supports the safe and sustainable use of IPC and AMS resources through ongoing staff education, regular audits, and a structured approach to monitoring equipment and supply usage, underpinned by annual reviews of the pandemic and IPC management plans.

This evidence demonstrates that Campbelltown Private Hospital meets the requirements of this action by systematically applying quality improvement principles to IPC and AMS systems.

Rating

Met

Findings

-

Action 3.04

Clinicians use organisational processes consistent with the Partnering with Consumers Standard when assessing risks and preventing and managing 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

Evidence Reviewed

Campbelltown Private Hospital demonstrates that clinicians use organisational processes consistent with the Partnering with Consumers Standard when assessing infection risks, managing infections, and implementing the antimicrobial stewardship (AMS) program. Consumers are actively involved in their care through the provision of accessible and relevant information, including clear signage promoting cough etiquette and hygiene practices.

The hospital gathers and responds to consumer feedback through hand hygiene surveys and direct input into infection prevention and control practices. Consumer consultants also participate in regular audits and contribute to discussions at the IPC Committee, ensuring consumer perspectives inform infection control strategies and education.

Patient stories and feedback are used to improve communication and engagement, highlighting the hospital's commitment to meeting patients' information needs. This also supports shared decision-making, particularly around infection prevention practices and antimicrobial use.

This approach reflects effective implementation of the Partnering with Consumers Standard in the context of IPC and AMS and confirms that the requirement is met.

Rating

Met

Findings

-

Action 3.05

The health service organisation has a surveillance strategy for infections, infection risk, and antimicrobial use and prescribing that:

a. Incorporates national and jurisdictional information in a timely manner

b. Collects data on healthcare-associated and other infections relevant to the size and scope of the organisation

c. Monitors, assesses and uses surveillance data to reduce the risks associated with infections

d. Reports surveillance data on infections to the workforce, the governing body, consumers and other relevant groups

e. Collects data on the volume and appropriateness of antimicrobial use relevant to the size and scope of the organisation

f. Monitors, assesses and uses surveillance data to support appropriate antimicrobial prescribing

g. Monitors responsiveness to risks identified through surveillance

h. Reports surveillance data on the volume and appropriateness of antimicrobial use to the workforce, the governing body, consumers and other relevant groups

Evidence Reviewed

Campbelltown Private Hospital has a comprehensive surveillance strategy for infections, infection risk, and antimicrobial use that aligns with national and jurisdictional requirements. Surveillance data are routinely collected through multiple sources including Infection Surveillance Reports, WebPAS infection alerts, RiskMan reports, and participation in the National Antimicrobial Utilisation Surveillance Program (NAUSP), ensuring relevance to the hospital’s size and scope. The data encompass healthcare-associated infections such as bloodstream infections, COVID-19, and exposure events. These are monitored

and assessed regularly to identify trends, inform practice improvements, and guide staff education. Antimicrobial prescribing is reviewed for both volume and appropriateness through NAUSP, with results used to support clinical decision-making and antimicrobial stewardship initiatives.

Findings from surveillance are reported through established governance structures including the Infection Control Committee and Medical Advisory Committee, with documented evidence in meeting minutes dated 25/02/2025 (ICC) and 03/02/2025 (MAC). Data are communicated to the workforce, executive, and consumers as appropriate, promoting transparency and engagement. Risks identified through surveillance are addressed through documented actions, policy reviews, and targeted interventions, demonstrating a responsive and proactive approach to risk management. This integrated system ensures timely use of national and local data, effective monitoring, and organisation-wide accountability for infection prevention and antimicrobial stewardship.

Rating

Met

Findings

-

Action 3.06

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 Healthcare, jurisdictional requirements, and relevant jurisdictional laws and policies, including work health and safety laws

Evidence Reviewed

Campbelltown Private Hospital has established and implemented processes for standard and transmission-based precautions that align with the current Australian Guidelines for the Prevention and Control of Infection in Healthcare, relevant jurisdictional requirements, and work health and safety laws. A review of infection control documents, including Healthscope Policy 15.03, confirmed consistency with national standards. Implementation is supported by regular audits, including transmission-based precautions, PPE usage, and environmental cleaning, along with patient screening alerts and staff competency assessments for PPE use and fit testing.

Additional controls include designated PPE stations, outbreak management kits, cleaning schedules, theatre attire guidelines, and perioperative-specific procedures, ensuring that staff are equipped to apply precautions effectively. The presence of trained fit testers, a fit testing gap analysis, and clearly defined protocols further strengthen infection control practices, confirming that the organisation meets the requirements of this Standard.

Rating

Met

Findings

-

Action 3.07

The health service organisation has:

a. Collaborative and consultative processes for the assessment and communication of infection risks to patients and the workforce

b. Infection prevention and control systems, in conjunction with the hierarchy of controls, in place to reduce transmission of infections so far as is reasonably practicable

c. Processes for the use, training, testing and fitting of personal protective equipment by the workforce

d. Processes to monitor and respond to changes in scientific and technical knowledge about infections, relevant national or jurisdictional guidance, policy and legislation

e. Processes to audit compliance with standard and transmission- based precautions

f. Processes to assess competence of the workforce in appropriate use of standard and transmission-based precautions

g. Processes to improve compliance with standard and transmission-based precautions

Evidence Reviewed

Campbelltown Private Hospital ensures that members of the workforce consistently apply standard and transmission-based precautions when required, supported by documented procedures and routine risk screening. Staff demonstrated a clear understanding of how and when to apply precautions based on patient risk factors, including communicable diseases and colonisation with organisms of concern. Risk assessments are completed at referral, admission, and throughout care, with appropriate consideration given to patient placement, isolation needs, and safe patient movement within and between facilities.

Fit testing for airborne precautions is audited annually, and any newly recruited staff are reviewed to ensure compliance with fit testing requirements. The hospital's design and environmental controls support effective infection prevention, including appropriate ventilation, surface finishes, cleaning protocols, and workflow layout. Cleaning and disinfection practices align with policy, with additional processes activated as needed. Staff assess procedural risk and use the correct equipment for routine care, confirming that infection prevention is embedded in day-to-day clinical practice and aligned with the requirements of this Standard.

Hand hygiene is actively monitored, with an audit in Q2 2024 showing a compliance rate of 89% across 204 moments. These results were presented to the Medical Advisory Committee (MAC) on 10/09/2024, demonstrating transparent reporting and governance oversight. Aseptic technique (ANTT) is also audited, with Q2 2024 results showing 100% compliance for Visiting Medical Officers (VMOs) and 91% for Scout staff, further confirming that infection prevention principles are consistently applied across the workforce.

Rating
Met
Findings
-

Action 3.08
Members of the workforce apply standard precautions and transmission-based precautions whenever required, and consider: a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated 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 and patient placement to prevent and manage infection risks d. The risks to the wellbeing of patients in isolation e. Environmental control measures to reduce risk, including but not limited to heating, ventilation and water systems; work flow design; facility design; surface finishes f. Precautions required when a patient is moved within the facility or between external services g. The need for additional environmental cleaning or disinfection processes and resources h. The type of procedure being performed i. Equipment required for routine care
Evidence Reviewed
Campbelltown Private Hospital ensures staff apply standard and transmission-based precautions based on patient risk, including at referral, admission, and throughout care. Staff demonstrated understanding of infection risk screening, the management of patients with communicable diseases or colonisation, and the precautions required during patient movement and transfers. Procedures guide decisions on patient placement, isolation, and the use of appropriate PPE and equipment, with additional precautions implemented based on the procedure being performed. The facility is designed to manage infection risks effectively, with environmental controls such as appropriate ventilation, surface finishes, and cleaning protocols. Staff follow consistent environmental cleaning practices in line with policy, including enhanced cleaning when required. The physical layout and workflow support infection prevention, and staff are trained and competent in applying precautions, confirming that the organisation meets the requirements of this Standard.
Rating
Met

Findings
-

Action 3.09
The health service organisation has processes to: a. Review data on and respond to infections in the community that may impact patients and the workforce b. Communicate details of a patient's infectious status during an episode of care, and at transitions of care c. Provide relevant information to a patient, their family and carers about their infectious status, infection risks and the nature and duration of precautions to minimise the spread of infection
Evidence Reviewed
Campbelltown Private Hospital has implemented effective processes to review and respond to community-based infections that may impact patients and staff. Communication of a patient's infectious status is embedded in care processes and consistently included at all points of handover and transfer, with compliance monitored. This was verified during the assessment through medical record reviews and direct observation of clinical handover practices across the facility. Patients, carers, families, and visitors are informed of infection risks and required precautions through clear signage at clinical area entry points and verbal communication by staff. These measures ensure transparency, safety, and engagement in infection prevention. Based on the evidence reviewed, the organisation meets the requirements of this action.
Rating
Met
Findings
-

Action 3.10
The health service organisation has a hand hygiene program that is incorporated in its overarching infection prevention and control program as part of standard precautions and: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with benchmarks and the current National Hand Hygiene Initiative

c. Provides timely reports on the results of hand hygiene compliance audits, and action in response to audits, to the workforce, the governing body, consumers and other relevant groups

d. Uses the results of audits to improve hand hygiene compliance

Evidence Reviewed

Campbelltown Private Hospital has a hand hygiene program integrated into its overarching infection prevention and control program, aligned with the National Hand Hygiene Initiative and jurisdictional requirements. The program includes regular compliance auditing, trained hand hygiene auditors (with certification sighted during the assessment), and readily available hand hygiene products throughout the facility—including dispensers, wipes, and moisturisers placed at point-of-care. Signage promoting hand hygiene is clearly displayed, and ward-level compliance data is visible to staff and consumers.

Audit results are used to monitor performance and drive improvement. Hand hygiene compliance rates were 85% in audit period 3 (2024), 89% in period 2 (2024), and 89% in audit period 1 (2025), all meeting or exceeding national benchmarks. Results are shared with the workforce and relevant committees, and any areas of non-compliance are addressed through targeted action. Audit outcomes are also visibly displayed throughout the facility to promote awareness and accountability. In addition, results are formally reported through governance structures, including the Infection Control Committee (meeting minutes dated 25/02/2025), Medical Advisory Committee (as previously noted), and the Quality and Risk Committee meetings held on 06/02/2025 and 06/03/2025. This consistent reporting and visibility support a culture of continuous improvement and reinforce the organisation’s commitment to infection prevention and control.

Rating

Met

Findings

-

Action 3.11

The health service organisation has processes for aseptic technique that:

a. Identify the procedures in which 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

Evidence Reviewed
Campbelltown Private Hospital has established comprehensive processes to support the safe application of aseptic technique, guided by the Aseptic Technique 8.38 policy and the Aseptic Technique Risk Matrix (V8, 2025), which clearly identifies the procedures where aseptic technique is required. Competence is assessed through annual audits to ensure consistent and appropriate practice across the clinical workforce. Training is provided to address any identified gaps in competency, and compliance is monitored via the MARS system, where audit outcomes are recorded and reviewed. Aseptic technique (ANTT) audit results for Q2 2024 showed 100% compliance for Visiting Medical Officers (VMOs) and 91% for Scout staff, demonstrating high adherence to aseptic technique protocols. Compliance data for the aseptic technique theory component was reported and discussed at the Infection Control Committee meeting on 25/02/2025.
Rating
Met
Findings
-

Action 3.12
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 Healthcare17
Evidence Reviewed
Campbelltown Private Hospital has established processes for the appropriate use and management of invasive medical devices that align with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare. This includes the implementation of best practice bundles and clinical standards such as the PIVC Clinical Care Standard Action Plan. A Register of Invasive Devices is maintained to support oversight, and regular audits are conducted for peripheral intravenous cannulas (PIVCs), indwelling catheters (IDCs), and other devices. Staff competency in the insertion and management of PIVCs is assessed, and ongoing training ensures adherence to evidence-based practice. Additional safeguards include the auditing and appropriate management of injectable anaesthetic and sedation agents. These measures collectively ensure that the use and maintenance of invasive medical devices are safe, monitored, and consistent with national guidelines.
Rating
Met
Findings
-

Action 3.13
The health service organisation has processes to maintain a clean, safe and hygienic environment – in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare17 and jurisdictional requirements – to: a. Respond to environmental risks, including novel infections b. Require cleaning and disinfection using products listed on the Australian Register of Therapeutic Goods, consistent with manufacturers' instructions for use and recommended frequencies c. Provide access to training on cleaning processes for routine and outbreak situations, and novel infections d. Audit the effectiveness of cleaning practice and compliance with its environmental cleaning policy e. Use the results of audits to improve environmental cleaning processes and compliance with policy
Evidence Reviewed
Campbelltown Private Hospital has implemented comprehensive processes to maintain a clean, safe, and hygienic environment in accordance with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare and jurisdictional requirements. The Infection Control Management Plan outlines structured responses to environmental risks, including emerging infections. Cleaning products used are listed on the Australian Register of Therapeutic Goods and applied in line with manufacturers' instructions. Local cleaning guidelines are in place, supported by documented training through Ecolab for both routine and outbreak cleaning, and compliance is monitored through regular audits. Training compliance is regularly monitored, with cleaning staff demonstrating high participation in scheduled education programs, ensuring continued competency in line with best practice. Recent training compliance rates include PPE Donning and Doffing – 99% (all cleaning staff), Ecolab Training (Circle of Safety & Chemicals) – 91%, and Clean Care Room Cleaning – 100%, reflecting a strong commitment to maintaining safe and effective cleaning practices. Environmental audits reviewed during the assessment included reusable equipment, sharps and waste handling, sterile stock, ice machine cleaning, and safe storage of cleaning trolleys. An IPC Environmental Cleaning Audit showed 91% compliance, and other audit results indicated 100% adherence to scheduled cleaning tasks. Legionella testing and a water management plan are in place, with documented actions for positive results. Audit outcomes are used to improve practice, and the presence of spill kits, food safety oversight, and compliance during renovations further support a proactive approach. This evidence confirms that the organisation meets the requirements of this action.
Rating
Met
Findings
-

Action 3.14
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. Clinical and non-clinical areas, and workplace amenity areas c. Maintenance, repair and upgrade of buildings, equipment, furnishings and fittings d. Handling, transporting and storing linen e. Novel infections, and risks identified as part of a public health response or pandemic planning
Evidence Reviewed
Campbelltown Private Hospital has established processes to evaluate and respond to infection risks associated with equipment, devices, and the built environment. Infection control principles are applied when introducing new equipment or products, supported by audits of reusable items and invasive devices. Infection risk management extends across clinical, non-clinical, and staff amenity areas, with routine environmental audits in place. Linen handling, transport, and storage follow documented procedures that meet infection control standards. The hospital maintains a scheduled maintenance program that is both preventative and responsive to day-to-day operational needs. Processes are in place to assess and control infection risks during maintenance and servicing of equipment, furnishings, and fittings. Infection control planning also includes responses to novel infections and public health risks, supported by a current Infection Control Management Plan and ongoing surveillance.
Rating
Met
Findings
-

Action 3.15
The health service organisation has a risk-based workforce vaccine- preventable diseases screening and immunisation policy and program that: a. Is consistent with the current edition of the Australian Immunisation Handbook19 b. Is consistent with jurisdictional requirements for vaccine- preventable diseases c. Addresses specific risks to the workforce, consumers and patients
Evidence Reviewed
Campbelltown Private Hospital has implemented a risk-based workforce vaccine-preventable diseases screening and immunisation policy and program that aligns with the current edition of the Australian Immunisation Handbook and jurisdictional requirements. A comprehensive staff immunisation database

and RL6 compliance reporting system are in place to monitor immunisation status. Influenza and COVID-19 vaccination registers are maintained, and immunisation activities are overseen by a certified Nurse Immuniser. Vaccine storage is monitored through regular temperature checks and validated using the Strive for 5 self-audit tool.

A workforce immunisation risk assessment was completed in March 2025 across all departments to identify and manage specific risks to staff, consumers, and patients. A new staff immunisation matrix supports this approach by aligning immunisation requirements with identified risk levels for various roles. The program is inclusive of Visiting Medical Officers (VMOs), ensuring consistent protection across all clinical staff. Current compliance rates are DTpA – 97%, MMR – 99%, Varicella – 100%, Hepatitis B – 89%, Influenza (2024) – 92%, COVID-19 primary course – 99%, and TB screening – 99%. These measures ensure that the immunisation program is targeted, compliant, and supports safe service delivery, confirming the organisation meets the requirements of this action.

Rating

Met

Findings

-

Action 3.16

The health service organisation has risk-based processes for preventing and managing infections in the workforce that:

a. Are consistent with the relevant state or territory work health and safety regulation and the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare17

b. Align with state and territory public health requirements for workforce screening and exclusion periods

c. Manage risks to the workforce, patients and consumers, including for novel infections

d. Promote non-attendance at work and avoiding visiting or volunteering when infection is suspected or actual

e. Monitor and manage the movement of staff between clinical areas, care settings, amenity areas and health service organisations

f. Manage and support members of the workforce who are required to isolate and quarantine following exposure to or acquisition of an infection

g. Provide for outbreak monitoring, investigation and management

h. Plan for, and manage, ongoing service provision during outbreaks and pandemics or events in which there is increased risk of transmission of infection

Evidence Reviewed

Campbelltown Private Hospital has implemented risk-based processes for preventing and managing infections in the workforce that align with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare, relevant state work health and safety regulations, and public health requirements. Workforce screening and exclusion practices are guided by staff restriction and movement protocols, quarantine guidelines, and

occupational exposure management procedures. RiskMan reporting, including Blood and Body Fluid Exposure Incident (BBFEI) data and HICMR reports, support monitoring and response to infection risks. Exposure-prone procedures are registered, and BBFEI exposure kits are readily available.

The organisation promotes non-attendance at work when infection is suspected or confirmed and has clear guidelines for managing staff required to isolate or quarantine. Contact tracing procedures are in place, and staff movement between clinical and non-clinical areas is monitored and managed. The Infection Control Management Plan incorporates outbreak monitoring and management, with structured service continuity planning for pandemics and high-risk events.

Rating

Met

Findings

-

Action 3.17

When reusable equipment 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

c. Processes to plan and manage reprocessing requirements, and additional controls for novel and emerging infections

Evidence Reviewed

Campbelltown Private Hospital has established comprehensive processes for the reprocessing of reusable equipment and devices, fully compliant with the relevant national standards. The organisation achieved full compliance with AS 4187 for sterilising services on 19/09/2023 and for flexible endoscopes in March 2023. Reprocessing practices are supported by validated sterilisation processes, routine microbiological monitoring, water testing, and adherence to manufacturers' reprocessing instructions. Performance testing of sterilisation equipment is conducted regularly to ensure ongoing safety and effectiveness.

A robust traceability system is in place through the CSSD tracking platform, allowing for clear identification of the patient, procedure, and instruments or devices used. Traceability audits—including those for flexible endoscopes and ultrasound probes—have been conducted to confirm compliance, with audit results for January and February 2025 showing 100% compliance. A sterile stock audit also supports effective oversight of inventory and reprocessed equipment. HICMR was onsite during the assessment to assess compliance with AS 5369, further validating the hospital's alignment with contemporary

standards. Additional protocols are in place to manage loan sets and plan for reprocessing needs related to novel or emerging infection risks, ensuring the hospital remains prepared and responsive.

Rating

Met

Findings

-

Action 3.18

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 is informed by current evidence- based Australian therapeutic guidelines and resources, and includes restriction rules and approval processes

d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard

e. Acts on the results of antimicrobial use and appropriateness audits to promote continuous quality improvement

Evidence Reviewed

Campbelltown Private Hospital has a comprehensive antimicrobial stewardship (AMS) program in place, supported the Antimicrobial Prescribing and Management Policy (18.53, September 2023). The program incorporates the core elements and principles of the current Antimicrobial Stewardship Clinical Care Standard and includes an AMS action plan aligned to these recommendations. Staff have access to current evidence-based resources, including the electronic Therapeutic Guidelines (eTG), antibiogram reports, and an antimicrobial restriction policy and formulary that includes defined approval processes and classification of restricted agents.

Auditing and monitoring are integral to the program, with evidence of participation in the National Antimicrobial Prescribing Survey (NAPS), NAUSP, and targeted audits such as the Surgical Antimicrobial Prophylaxis (SAP) audit for hip and knee procedures. Results from these audits, along with sepsis pathway compliance data, are reviewed and used to inform continuous quality improvement initiatives.

Rating

Met

Findings

-

Action 3.19
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 and guidance • areas of action for antimicrobial resistance • areas of action to improve appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing • the health service organisation's performance over time for use and appropriateness of use of antimicrobials
Evidence Reviewed
Campbelltown Private Hospital's antimicrobial stewardship (AMS) program includes structured processes for reviewing antimicrobial prescribing and use. Regular audits such as the National Antimicrobial Prescribing Survey (NAPS), NAUSP, Surgical Antimicrobial Prophylaxis (SAP) audits for joint procedures, and sepsis pathway audits provide robust data to support evaluation of antimicrobial use. An Infectious Diseases physician's report, sighted during the assessment, further supports clinical review and oversight of antimicrobial prescribing practices. Surveillance data, including antibiogram reports, are used to guide decision-making and ensure alignment with current Australian therapeutic guidelines and resources. The performance of the AMS program is routinely reviewed and discussed through established governance structures. Audit findings and AMS outcomes are reported to the Medication and Pharmacy Committee (24/06/2024), the Infection Control Committee (25/02/2025), and the Medical Advisory Committee (MAC) (03/02/2025). These reports address compliance with the AMS policy, antimicrobial resistance trends, prescribing appropriateness, and performance over time. The AMS action plan, Antimicrobial Prescribing and Management Policy (18.53, Sept 2023), and ID physician input guide continuous improvement. This comprehensive approach confirms that the organisation meets the requirements of this action.
Rating
Met
Findings
-

Action 4.01
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
Evidence Reviewed
Clinicians at the facility demonstrated effective use of the safety and quality systems outlined in the Clinical Governance Standard in relation to medication management. Evidence showed that clinicians are actively implementing relevant policies and procedures, including the Medication – Orders and Administration Policy 18.01 May 2021, Medication Management Plan (MMP) 18.75 Sept 2024, Medication Safety Governance including APINCHS Policy 18.89 July 2023, and Registered Nurse/Midwife -Initiated Medication Administration (Adults only) Policy 18.52 Oct 2023, to guide safe practice. Risk management processes are in place, supported by RiskMan for medication incidents, allowing for systematic identification and mitigation of associated risks. Training is undertaken on the ELMO online platform, with the Safe Medication Administration module completion rate at 87.5%. In an interview, the Pharmacist stated that he conducted medication safety in-services (04 and 06/03/2024) and an Antimicrobial Stewardship in-service (27/11/2024) and this was verified by assessor reviewing in-service attendance records. Collectively, these systems support compliance with the National Safety and Quality Health Service (NSQHS) Standards, demonstrating a structured and evidence-based approach to promoting safe medication practices across the service.
Rating
Met
Findings
-

Action 4.02
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

Evidence Reviewed
CPH applies the quality improvement system outlined in the Clinical Governance Standard to monitor, evaluate, and enhance medication management practices. The assessor reviewed evidence including the S8 Register biannual audit conducted by the Pharmacist (April 2025), with performance results indicating 99% compliance for the Level 3 Surgical Medication Chart – High Risk Medications and 80% for the Mini NIMC (Q1 2025). Ongoing improvement strategies were evident, such as the dissemination of SGLT2 Guidelines to clinical staff and continuous performance monitoring via Pharmacy Indicator and ClinPod reports. Additionally, governance structures such as the Medication/Pharmacy Committee, with documented minutes (19/02/2025), agendas (19/02/2025), and terms of reference (TOR 2025-02 V4 Ratification Date: 19/02/2025), provide a formal mechanism to oversee, review, and improve medication safety practices.
Rating
Met
Findings
-

Action 4.03
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
Evidence Reviewed
Clinicians demonstrated effective application of organisational processes from the Partnering with Consumers Standard in medication management. Compliance with the Partnering with Consumers Policy 1.05 November 2024 was evident, with clinicians actively involving patients in their own care through practices such as patient education on prescribed medications and engaging patients during clinical handovers (MRN # 296519, # 296519, # 296885, # 237515 and # 237838). Information needs were addressed through the provision of tailored educational resources, multiple Consumer Medicine Information (CMI) leaflets displayed throughout the facility, and verbal explanations, ensuring patients had a clear understanding of their medication regimens. Patients and/or carers are encouraged to ask questions and importantly report any side effects or other reactions they may be experiencing.
Rating
Met

Findings
-

Action 4.04
The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians
Evidence Reviewed
CPH has established processes to define and verify the scope of clinical practice for clinicians involved in prescribing, dispensing, and administering medicines. These processes are clearly articulated in the Medication – Orders and Administration Policy 18.01 May 2021, which outlines the credentialling, authorisation, and role delineation requirements for relevant staff. Any incidents or near misses involving prescribing, dispensing, or administration that may occur outside a clinician's scope of practice are promptly subject to incident review, reporting, and, where necessary, further education and support. These processes were verified through interviews with the Pharmacist, Career Medical Officer (CMO) and nursing staff. According to the Rehab Quality & Safety Board (March 2025)medication errors were 0.32 (target 0.30), and the Level 2 Surgical Quality & Safety Board (March 2025) reported zero medication errors.
Rating
Met
Findings
-

Action 4.05
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
Evidence Reviewed
Clinicians consistently undertake a Best Possible Medication History (BPMH), which is documented in the healthcare record either on presentation or as early as practicable during the episode of care. This practice is governed by the BPMH – Obtaining Policy 18.85 September 2024, which outlines the procedures and responsibilities for accurately collecting and recording medication histories.

Assessor observation of an admission (MRN # 296885), pre-admission assessment phone calls (MRN # 240900 and # 296807) and medical record reviews (MRN # 296519, # 296403, # 296885, # 270743 and #286748) confirmed that this process is embedded into routine clinical workflow, supporting early identification of potential medication-related risks and ensuring continuity of care.
Rating
Met
Findings
-

Action 4.06
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
Evidence Reviewed
Clinicians review patients' current medication orders against their BPMH and the documented treatment plan, reconciling any discrepancies both on presentation and at key transitions of care. This process is guided by the Medication Management Plan Policy 18.75 September 2024 and draws on information from multiple sources, including the patient, referral letters, and previous discharge summaries. Where appropriate, clinicians also seek input from carers or family members to enhance the accuracy and completeness of the medication history. Pharmacists play a central role in this process; they receive clinical handover from the CMO, access referral printouts via WebPAS, and conduct medication reviews as required.
Rating
Met
Findings
-

Action 4.07
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
Evidence Reviewed
CPH has established and consistently applied processes for documenting patients' histories of medicine allergies and adverse drug reactions (ADRs) in the healthcare record upon presentation or during the pre-admission phone call. This process is supported by the Medication – Orders and Administration

Policy 18.01 May 2021 and is operationalised through several clinical tools, including the Patient Health History HMR 4.5, the Pre-Admission Clinic Screening Checklist – Trial HMR 4.1, and the Alert Sheet HMR 000, with corresponding digital alerts added in WebPAS.

When interviewed, the Pharmacist stated that he will chart ADRs on the National Inpatient Medication Chart (NIMC), write in the Progress Notes and discuss with the Nurse Unit Manager (NUM).

Risk identification is reinforced through the use of red identification bands for patients with known allergies, and educational initiatives are in place to support staff awareness of ADRs, including in-services, education and quality boards. Additionally, patient education resources (CMIs) regarding medication interactions are made available to support informed decision-making.

Rating

Met

Findings

-

Action 4.08

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

Evidence Reviewed

The health service organisation has established robust processes for documenting ADRs experienced by patients during an episode of care, ensuring that incidents are recorded both in the healthcare record and in RiskMan. These processes are clearly detailed in the Medication – Orders and Administration 18.01 May 2021. A hospital-wide approach is implemented to support and encourage medication error and ADR reporting, ensuring staff are aware of, and engaged in, the reporting process. Year to date there have been 15 medication errors and zero ADRs reported in RiskMan.

Rating

Met

Findings

-

Action 4.09

The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements

Evidence Reviewed
CPH has established processes for reporting ADRs experienced by patients to the Therapeutic Goods Administration (TGA) in accordance with regulatory requirements. These processes are outlined in the Adverse Drug Reactions – Reporting to the TGA Policy 18.76 November 2024, which provides detailed instructions on what constitutes a reportable ADR, the information that must be included in the report, and the procedure for submitting notifications to the TGA. Staff are provided with clear guidance and education to ensure timely and accurate reporting, supporting national pharmacovigilance efforts and contributing to broader patient safety initiatives.
Rating
Met
Findings
-

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
Evidence Reviewed
The health service organisation has established processes to support safe and effective medication reviews in accordance with evidence-based practice. Pharmacists perform medication reviews upon request by the CMO, NUMs, or other clinicians, with reviews triggered by factors such as a patient's clinical presentation, pre-admission medication history, or changes in prescribed therapy. Prioritisation is informed by clinical need and the potential risk of medication-related problems, ensuring that resources are allocated where they are most impactful. The organisation also specifies requirements for the documentation of medication reviews, including details of the review findings and any actions taken, as per Medication Management Plan Policy 18.75 September 2024. Assessors verified these processes on review of patient medical records and in discussion with the Pharmacist (MRN # 123032, # 213979).
Rating
Met
Findings
-

Action 4.11
The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks
Evidence Reviewed
CPH has established processes to support clinicians in providing patients with information about their individual medication needs and associated risks. Clinicians have ready access to Pharmacists, who offer specialised guidance and assist in tailoring information to meet the specific needs of the patient population. Information on specific medications is readily available to clinicians and designed to be accessible, relevant, and easily understood by patients. These processes are further supported by the Discharge Medications Policy 18.49 April 2023, which includes clear requirements for patient education and discharge planning relating to medications. This ensures that patients are well-informed about their therapies prior to discharge, supporting continuity of care and reducing the risk of medication-related problems post-discharge.
Rating
Met
Findings
-

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
Evidence Reviewed
The health service organisation has implemented effective processes to support the generation, distribution, and communication of current medicines lists, consistent with the requirements of the NSQHS Standards. In accordance with the Medication Management Plan Policy 18.75 September 2024, clinicians document a current medicines list in partnership with patients, ensuring it is reviewed and kept up to date throughout the care journey. The Pharmacist and CMO are available to review and discuss medications with patients and carers, and updates to the National Inpatient Medication Chart (NIMC) are clearly recorded using green ink to highlight changes for healthcare professionals. This was verified by assessors in the review of medical records for patients MRN # 123032 and # 213979. At transitions of care, the current medicines list is distributed to receiving clinicians to support safe continuity of treatment and minimise the risk of medication discrepancies. Clinical handover observations in both the Rehab and Surgical wards demonstrated clear, structured communication regarding current and planned medication administration (MRN # 296519, # 296403 and # 296885). Upon discharge, patients are provided with a Medication Summary that includes their current medicines list and explanations for any changes made during admission.

Rating
Met
Findings
-

Action 4.13
The health service organisation ensures that information and decision support tools for medicines are available to clinicians
Evidence Reviewed
The health service organisation ensures that information and decision support tools related to medicines are readily available to clinicians to promote safe and effective medication management. Evidence includes the Principles of Safe Selection and Storage of Medicines Audit, the use of Tallman lettering to distinguish look-alike, sound-alike medications (confirmed through observational audit), and the application of the Traffic Light System in Antimicrobial Stewardship (AMS) initiatives. Additional support tools such as eMIMS, electronic Therapeutic Guidelines (eTG), and access to a pharmacist are readily available and known to staff.
Rating
Met
Findings
-

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
Evidence Reviewed
CPH complies with manufacturers’ directions, legislation, and jurisdictional requirements for the safe and secure storage, distribution, and disposal of medicines. The management of department imprest lists ensures appropriate stock control and traceability, while the Temperature-Sensitive Medications, Storage of Policy 18.86 November 2024 supports cold chain management and response to any temperature excursions.

Assessors verified that medicines are securely stored, with particular oversight for controlled substances, witnessing S4 and S8 shift change checks by two nurses, as per Controlled Drugs – Storage and Administration Policy 18.56 April 2023. Processes are in place for the appropriate and safe disposal of unused, unwanted, or expired medicines as per Disposal of Medications Policy 18.78 June 2023.

Rating

Met

Findings

-

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

Evidence Reviewed

The health service organisation has robust systems in place to identify and manage high-risk medicines in accordance with the NSQHS Standards. The Medication Safety Governance Policy Including APINCHS 18.89 July 2023 outlines the classification and handling of high-risk medicines, using the APINCHS acronym to guide policy and practice. Assessors verified the use of a APINCH posters, documented high-risk medications list, associated storage and register requirements, ensuring these medicines are safely managed across all stages of the medication cycle — from prescribing and dispensing to administration and monitoring.

Staff interviews, assessor observations, and supporting documentation confirm that high-risk medications are appropriately managed in line with best practice and regulatory requirements.

Rating

Met

Findings

-

Action 5.01

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

Evidence Reviewed

Clinicians at CPH use the safety and quality systems established under the Clinical Governance Standard to support the delivery of comprehensive care. A suite of current, evidence-based policies guides clinical practice across diverse care areas, including:

- Comprehensive Care Plan Policy 2.69, March 2024
- Delirium and Cognitive Impairment Prevention and Management Policy 8.94, March 2024
- Falls Prevention and Management – Patient Policy 8.04, December 2023
- Pressure Injury Prevention and Management Policy 8.05, May 2021
- Diet and Nutrition – Adult Inpatients Policy 8.27, July 2024
- Venous Thromboembolism (VTE) Prophylaxis Policy 8.06 June 2022
- Self-Harm and Suicide (Threatened, Attempted or Completed) in a Non-Mental Health Facility 2.54 December 2023
- Paediatric Admission Policy 6.1 March 2025
- Admission Criteria of HDU Patients Policy 8.11b May 2023
- Rehab Admission Criteria Policy 10.21 May 2023
- Selection and Scheduling of Day Procedure Patients Policy 14.01 July 2023

Risks associated with comprehensive care are documented and monitored through the RiskMan system, facilitating organisational awareness and continuous improvement. Clinicians undertake mandatory and role-specific training via the ELMO online platform, with an overall compliance rate of 98% reported as at 27 March 2025. These systems reflect a coordinated approach to governance, risk management, and workforce capability in delivering safe, person-centred comprehensive care.

Rating

Met

Findings

-

Action 5.02

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

Evidence Reviewed
The health service organisation applies the quality improvement system established under the Clinical Governance Standard to ensure effective monitoring and enhancement of comprehensive care delivery. The assessor reviewed Quality Committee meeting minutes dated 6 February and 6 March 2025, which demonstrated active oversight of patient safety and quality outcomes. Agenda items included detailed reviews of the Risk Register, analysis of sentinel and critical incidents, and shared learnings aimed at reducing recurrence and improving care outcomes. Assessor reviewed the following audit results for Q2 2024 Level 2 Surgical: - Medical Record Documentation 90% (annual) - Alert Sheet: 91% - Advanced Care Directives Documentation: 80% The Rehabilitation Quality and Safety Board reported in March 2025 that the falls target was set at 0.32%, with an actual result of 0.33%, and recorded zero pressure injuries, reflecting strong clinical governance and effective preventive strategies. During an interview with the Allied Health Manager (AHM), the assessor reviewed the AROC Inpatient Rehabilitation Dashboard Report for January–December 2024. The AHM noted a marked improvement in performance compared to the previous reporting period (January–December 2023) and expressed satisfaction with the positive trend. These results were subsequently discussed at the Quality Committee meeting held on 6 March 2025, demonstrating active governance oversight and commitment to continuous improvement. The evidence above confirmed incident reporting, shared learnings, and local performance monitoring are embedded across the organisation, ensuring that comprehensive care delivery is continuously evaluated, improved, and transparently reported to governing bodies.
Rating
Met
Findings
-

Action 5.03
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
Evidence Reviewed
Clinicians use organisational processes aligned with the Partnering with Consumers Standard to actively involve patients in their own care, ensure their information needs are met, and support shared decision-making. The Partnering with Consumers Policy 1.05 November 2024, provides the framework for embedding these principles across care delivery.

Patient education materials are readily available throughout the facility and include brochures on Preventing Falls, Prevention of Pressure Injuries, Advanced Care Planning, and Cognitive Impairment, enabling patients and families to make informed decisions. The organisation also demonstrates proactive consumer engagement through initiatives such as Falls Month April 2025, which included targeted posters and both patient and staff information resources. These strategies reflect a strong commitment to person-centred care and active collaboration with consumers in the planning and delivery of comprehensive care.

Assessors observed staff actively involving patients in their own care, with a clear focus on inclusion, shared decision-making, and ensuring that patients are able to comprehend and engage with the information being provided.

This approach is further supported by patient feedback obtained through the facility's satisfaction survey (March 2025), which reported that 63.6% of respondents on the Rehabilitation Ward were satisfied with their involvement in decision-making, and 60% felt cared for. In response, targeted improvement actions were implemented, including enhanced patient involvement strategies, the use of care boards, and regular patient rounding.

Rating

Met

Findings

-

Action 5.04

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

Evidence Reviewed

The health service organisation has established systems to support clinicians in the development, documentation, and communication of comprehensive care plans tailored to each patient's clinical needs, as per the Comprehensive Care Plan Policy 2.69, March 2024.

Care is delivered in settings appropriate to acuity and complexity, supported by timely referral pathways and access to a multidisciplinary team, including occupational therapists, physiotherapists, dietitians, and social workers.

The facility maintains 24/7 access to a CMO, ensuring senior clinical input is available at all times. VMOs retain overall accountability for patient care, with clear systems in place to identify the responsible clinician throughout the patient journey.

Rating

Met

Findings
-

Action 5.05
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
Evidence Reviewed
CPH has well-established processes that support multidisciplinary collaboration and clearly define the roles and responsibilities of clinicians working in teams. The Facility Organisation Structure -Reporting Lines v20 Feb 2025 outlines reporting lines across clinical and non-clinical functions, promoting coordinated service delivery and accountability. Clinicians' roles are defined through formal contracts and detailed position descriptions, ensuring clarity around scope of practice and individual responsibilities. These are reinforced through structured orientation, regular performance reviews (facility wide 70%), and access to ongoing education (ELMO) and professional development. Multidisciplinary collaboration and teamwork were observed throughout the assessment. This included at bedside handover (MRN # 296519, # 296403, and # 296885), at the Daily 1200 meeting – lead by Perioperative Services Manager, and at daily huddles.
Rating
Met
Findings
-

Action 5.06
Clinicians work collaboratively to plan and deliver comprehensive care
Evidence Reviewed
Clinicians at CPH work collaboratively to plan and deliver comprehensive care, supported by clearly defined roles, multidisciplinary input, and structured care planning processes. Collaboration is embedded in daily clinical practice through shared decision-making, routine ward-based handovers, and regular multidisciplinary team (MDT) meetings, where care goals, patient progress, and specialist input are reviewed collectively. An interview with the AHM confirmed that this collaborative approach is further supported by access to allied health professionals and the use of shared documentation systems, such as the Multidisciplinary Patient Goals Rehabilitation Form HMR 5.81, which promotes continuity and coordinated care.

During a review of patient medical record MRN #270743, the AHM outlined the use of clinical pathways, weekly case conferences, and the role of the multidisciplinary team in collaboratively managing patient care.

Rating

Met

Findings

-

Action 5.07

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

Evidence Reviewed

The health service organisation has established processes to ensure integrated and timely screening and assessment of patients, with a clear focus on identifying risks aligned to the Minimising Patient Harm criterion. Screening and assessment tools, including the Pre-Admission Clinic Screening Checklists – Trial HMR 4.1, Comprehensive Care Plan HMR 6.13E, and the Alert Sheet HMR 000 are in place to support early identification of individual needs and risks.

Staff demonstrated a strong understanding of risk assessment procedures during the assessment, with consistent application evident in clinical documentation and during observation of patient pre-admission phone calls for patients MRN # 240900 and # 296807, and during the admission of patient MRN # 296885. Medical records reviewed (MRNs #296519, #296403, #296885 #270743 and #286748) confirmed that identified risks were clearly documented and flagged for clinical attention. These systems provide a structured and responsive approach to early identification and mitigation of patient risks across the care continuum.

Rating

Met

Findings

-

Action 5.08

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

Evidence Reviewed
CPH has established processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin. This information is recorded within the WebPAS administrative system, ensuring it is consistently captured and available across both clinical and administrative records. This process supports culturally appropriate care planning and enables identification of patients who may benefit from targeted support services.
Rating
Met
Findings
-

Action 5.09
Patients are supported to document clear advance care plans
Evidence Reviewed
The health service organisation supports patients to document clear advance care plans in alignment with their values and preferences. This is guided by the Advanced Care Directives Policy 2.56, October 2023, which outlines procedures for recognising, documenting, and honouring patients' wishes regarding future care. To assist clinical decision-making, an "Is there an Advance Care Directive (ACD)?" Flow Chart was endorsed by the Quality Committee in September 2023. This tool helps ensure that ACDs are consistently identified, considered, and incorporated into the patient's care plan.
Rating
Met
Findings
-

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

Evidence Reviewed
Clinicians use a range of structured screening processes to identify clinical and contextual risks on presentation, during clinical assessments, and throughout the patient's episode of care. The Comprehensive Care Plan Policy 2.69, March 2024 and associated tools, including the Pre-Admission Clinic Screening Checklists – Trial HMR 4.1 and Comprehensive Care Plan (HMR 6.13E, and Comprehensive Risk Screening HMR 6.13G, guide clinicians in capturing information related to physical, cognitive, and psychosocial risk factors. The Delirium and Cognitive Impairment Prevention and Management Policy 8.94 March 2024, further supports targeted assessment of behavioural and cognitive issues. CPH uses the Cognitive Assessment Tool 4AT MHR 6.27 for: - patients aged >65 and >45 years for Aboriginal and Torres Strait Islander decent - known cognitive impairment or diagnosed dementia - current hip fracture - a previous diagnoses of delirium - severe medical illness (including mental illness/depression). March 2025 audit results support the effective implementation of these processes, with an 81% compliance rate in the Clinical Handover Audit and 100% in the Staff Quality and Safety Audit. These results reflect a strong focus on consistent risk identification and communication practices across the multidisciplinary team, ensuring appropriate and timely intervention for patient safety.
Rating
Met
Findings
-

Action 5.11
Clinicians comprehensively assess the conditions and risks identified through the screening process
Evidence Reviewed
Clinicians comprehensively assess the conditions and risks identified during the screening process. Standardised screening tools are used to determine the level of risk and guide appropriate clinical actions to mitigate those risks. High-risk patients are identified and admitted as per the Paediatric Admission Policy 6.1 March 2025, Admission Criteria of HDU Patients Policy 8.11b May 2023, Rehab Admission Criteria Policy 10.21 May 2023, and the Selection and Scheduling of Day Procedure Patients Policy 14.01 July 2023.

Rating
Met
Findings
-

Action 5.12
Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record
Evidence Reviewed
Clinicians document the findings of screening and clinical assessment processes, including relevant alerts, within the healthcare record. This is supported by the use of the Patient Health History HMR 4.5, alongside the Comprehensive Care Plan HMR 6.13E, and Comprehensive Risk Screening HMR 6.13G, which enables structured documentation of clinical outcomes and promotes consistency in assessment practices. Identified risks are further highlighted using the Alert Sheet HMR 000, ensuring they are clearly flagged for ongoing monitoring and management. The assessor reviewed medical records (MRNs #296519, #296403, #296885, #270743, and #286748), which confirmed accurate and timely documentation of assessment findings. Additional observations, including a patient admission (MRN #296885) and pre-admission telephone assessments (MRNs #240900 and #296807), further demonstrated consistent implementation of these processes.
Rating
Met
Findings
-

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

Evidence Reviewed
Clinicians use structured processes for shared decision-making to develop and document comprehensive, individualised care plans. Assessor observations and clinical documentation reviews confirm that these care plans address the significance and complexity of each patient's health issues and associated risks of harm. The plans clearly identify agreed goals and actions for treatment and care, specify the support people the patient wishes to involve in communication and decision-making, and initiate discharge planning at the beginning of the care episode. Where appropriate and available, the plans also include referrals to follow-up services. The care planning process is consistent with current best practice and evidence-based guidelines. This has been validated through sampling of medical records (MRN #296519, # 296403, # 296885, # 270743 and #286748), demonstrating consistent application across patient care.
Rating
Met
Findings
-

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
Evidence Reviewed
The workforce actively partners with patients, carers, and families to develop, implement, and review comprehensive care plans. This partnership is formalised through the Comprehensive Care Plan Policy 2.69, March 2024 and operationalised using the Comprehensive Care Plan HMR 6.13E, which includes prompts for documenting patient/carer identified goals and the agreed interventions to achieve them—both expressed in the patient or carer's own words. This inclusive approach ensures that care is aligned with individual values and expectations. The structure of the plan supports ongoing monitoring, reassessment, and timely updates in response to changes in diagnosis, behaviour, cognition, or clinical condition. These systems promote shared ownership of care, continuity across disciplines, and responsiveness to evolving patient needs.
Rating
Met

Findings
-

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
Evidence Reviewed
The health service organisation has established processes for identifying patients approaching the end of life that are consistent with the National Consensus Statement: Essential Elements for Safe and High-Quality End-of-Life Care. This is supported by the Last Days of Care and Management Policy 8.96, July 2022, which outlines the clinical indicators, documentation requirements, and care planning strategies for patients receiving end-of-life care. The organisation also implements the Not for Resuscitation (NFR) Policy CR 8.14, July 2022, with the use of the Medical Orders for Life-Sustaining Treatment HMR 1.1, ensuring that resuscitation preferences are clearly documented and respected in alignment with patients' wishes and clinical guidance. Assessor noted NFR discussed at huddle for MRN # 201397. Together, these processes provide a structured and respectful approach to recognising, documenting, and responding to the needs of patients nearing the end of life.
Rating
Met
Findings
-

Action 5.16
The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice
Evidence Reviewed
CPH has processes in place to ensure clinicians providing end-of-life care can access specialist palliative care advice when required. This includes established referral pathways to external specialist palliative care services, as well as access to in-house (CMO) or on-call medical leadership to support complex decision-making and symptom management. These systems ensure that patients nearing the end of life receive care that is clinically informed, respectful, and aligned with best-practice palliative care principles, even in settings without on-site specialist teams.

Rating
Met
Findings
-

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
Evidence Reviewed
CPH has clear processes in place to ensure that current ACDs can be received from patients and are accurately documented in the healthcare record. The Advanced Care Directives Policy 2.56 October 2023, provides guidance on how staff should identify, verify, and document ACD documents within clinical workflows. During a pre-admission assessment phone call for patient MRN #240900, the assessor observed the nurse confirming the presence of an ACD as part of the Patient Health History HMR 4.5 review, requesting the patient to bring a copy, and promptly entering an ACD alert into WebPAS. This interaction demonstrates that processes for recognising and recording ACDs are operational and integrated into routine practice, supporting patient autonomy and continuity of care.
Rating
Met
Findings
-

Action 5.18
The health service organisation provides access to supervision and support for the workforce providing end-of-life care

Evidence Reviewed
Although there has been only one patient death at CPH in the past two years (17/07/2023), processes are in place for the care of patients at end of life, including regular education of staff, and available resources. Staff were able to readily locate and present relevant policies and the End-of-Life Tool Kit resource folder to the assessor, demonstrating awareness of available guidance materials.
Rating
Met
Findings
-

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
Evidence Reviewed
Granted N/A by Commission
Rating
Not Applicable
Findings
-

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
Evidence Reviewed
Granted N/A by Commission

Rating
Not Applicable
Findings
-

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
Evidence Reviewed
CPH has implemented structured systems to support the prevention and management of pressure injuries, in alignment with best-practice guidelines. Policies such as the Pressure Injury Prevention and Management Policy 8.05 May 2021, outline a comprehensive approach to risk identification, assessment, and intervention planning. This policy is supported by accessible pressure injury resources and wound care inservicing provided by the Clinical Educator (April 2025), ensuring that clinical staff are equipped with current knowledge and tools to deliver safe, evidence-based care.
Rating
Met
Findings
-

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
Evidence Reviewed
Clinicians conduct comprehensive skin inspections for patients at risk of, or presenting with, pressure injuries in line with best-practice time frames and frequency. This is supported by documentation within the Comprehensive Care Plan Policy 2.69 March 2024 and associated clinical forms, including Comprehensive Care Plan HMR 6.13E, Comprehensive Care Plan - Daily HMR 6.13F, and Comprehensive Risk Screening HMR 6.13G. During the assessment, the assessor observed the skin assessment process for patient MRN #296885 and verified consistent practice through review of medical records MRN #296519, #296403, #296885, #270743, and #286748.

Further verification through review of patient medical record MRN #296697, confirmed pressure injury care planning, noted on the Alert Sheet HMR 000, and supported by photographic documentation of a skin tear.

Rating

Met

Findings

-

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

Evidence Reviewed

The health service organisation ensures that patients at risk of pressure injuries—and their carers and families—are provided with clear, accessible information to support prevention. Educational brochures on the Prevention of Pressure Injuries were observed by the assessor as being readily available throughout the facility, empowering patients and families to make informed decisions about care.

In alignment with best-practice guidelines, appropriate equipment and strategies are used to prevent and manage pressure injuries effectively. During the Rehab Ward Daily Huddle, the assessor observed active discussion of patient-specific pressure injury strategies, including the use of air mattresses and scheduled turning, which were clearly documented on Care Boards.

Rating

Met

Findings

-

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

Evidence Reviewed
The health service organisation has implemented systems that align with best-practice guidelines for falls prevention, harm minimisation, and post-fall management. These are articulated in the Falls Prevention and Management – Patient Policy 8.04 December 2023, which provides a structured approach for assessing falls risk and applying appropriate interventions. Supporting tools include the Comprehensive Care Plan HMR 6.13E, Daily Care Plan HMR 6.13F, and Comprehensive Risk Screening HMR 6.13G incorporating the Falls Risk Screening Tool, and the Falls and Balance Exercises Treatment Record MHR 5.93 to promote targeted, ongoing care. Demonstrating strong clinical governance, the Rehabilitation Quality and Safety Board reported in March 2025 that the falls target was set at 0.32%, with an actual rate of 0.33%. This reflects effective monitoring, proactive strategies, and a commitment to continuous improvement in patient safety.
Rating
Met
Findings
-

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
Evidence Reviewed
The health service organisation ensures the availability of appropriate equipment, devices and tools to support safe mobility and manage falls risk in patients. During an interview with the AHM, it was confirmed that the Allied Health team plays an active role in promoting safe mobility through patient assessments, tailored interventions, and participation in multidisciplinary falls prevention planning. Staff education is further reinforced by recent inservicing delivered by the Clinical Educator (April 2025), ensuring that clinical staff are equipped with current evidence-based knowledge. The organisation also demonstrates proactive engagement through initiatives such as Falls Month (April 2025), which featured targeted educational resources for patients and staff alike.
Rating
Met
Findings
-

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
Evidence Reviewed
Clinicians caring for patients at risk of falls provide patients, carers and families with information on reducing falls risks and implementing prevention strategies. This is supported by accessible educational resources, including brochures on Preventing Falls, Falls Prevention – Postural Hypotension, and Falls Prevention – Eyesight, as well as prominently displayed “Call Don’t Fall” posters throughout the facility. During the Rehab Ward Daily Huddle, the assessor observed active discussion of individualised falls prevention strategies, including patient education, use of sensor mats, reinforcement of the Call Don’t Fall message, and clear flagging of falls risk on Care Boards. Additionally, during bedside handover, the assessor observed consistent implementation of falls prevention strategies, including patient education, visible risk flagging on Care Boards, and the presence of informational posters in each room (MRN # 296519, # 296403 and # 296885).
Rating
Met
Findings
-

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
Evidence Reviewed
CPH has established systems for the preparation and distribution of food and fluids that are aligned with current evidence and best-practice standards. Nutritional care is guided by the Diet and Nutrition – Adult Inpatients Policy 8.27 July 2024, which ensures structured, individualised dietary planning for inpatients. A qualified dietitian is available to support the development and monitoring of nutrition care plans, contributing to safe, effective, and patient-centred nutritional management in line with NSQHS Standard 5 requirements.
Rating
Met

Findings
-

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
Evidence Reviewed
The workforce applies structured systems for the preparation and distribution of food and fluids to ensure patients' nutritional needs are met, risk is monitored, and appropriate support is provided. Nutritional care is guided by the Diet and Nutrition – Adult Inpatients Policy 8.27 July 2024, with clinical tools such as the Nutrition and Dietetics Initial Assessment Form HMR 6.16 and the Malnutrition Risk Screening Tool embedded in the Comprehensive Risk Screening Form HMR 6.13G. A dietitian is accessible to provide targeted support for patients unable to meet their nutritional requirements through food alone. The assessor verified consistent practice through observation of bedside handover (MRN # 296519, # 296403, and # 296885) and review of clinical documentation (MRN #296519, #296403, #296885, #270743 and #286748). Further, the AHM described processes for ongoing nutritional monitoring, including daily team huddles and weekly case conferencing, reinforcing multidisciplinary oversight and accountability.
Rating
Met
Findings
-

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 Standard, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation

Evidence Reviewed
The health service organisation has established systems to support the early recognition, prevention, and management of cognitive impairment and delirium. Care planning is guided by the Delirium and Cognitive Impairment Prevention and Management Policy 8.94 March 2024, supported by clinical tools including the Comprehensive Care Plan HMR 6.13E and the Cognitive Impairment Risk Screen embedded within the Comprehensive Risk Screening Form HMR 6.13G. Best-practice assessment frameworks, such as 4AT and the Rowland University Dementia Assessment Scale (RUDAS), are utilised where clinically indicated, with review of patient medical records confirming completion of the RUDAS tool for patient MRN # 296145 and Cognitive Assessment Tool 4AT MHR 6.27 for patients MRN # 296885, # 296519, # 296403, # 296697 and # 296885. During an interview, the Pharmacist confirmed that CPH also maintains processes for managing the use of antipsychotics and other psychoactive medicines in accordance with legislation and current guidelines. These systems support safe, person-centred care for patients with, or at risk of, cognitive impairment and demonstrate alignment with both the NSQHS Standards and the Delirium Clinical Care Standard.
Rating
Met
Findings
-

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
Evidence Reviewed
Clinicians caring for patients with cognitive impairment or at risk of developing delirium apply structured systems to support recognition, prevention, and management of cognitive decline. Care is guided by the Delirium and Cognitive Impairment Prevention and Management Policy 8.94 March 2024, Healthscope Cognitive Impairment Admission Screening Flow Chart, Behaviour Chart MHR 7.52, Family Carer Consult Form MHR 6.28, Specialling Care Assessment Tool MHR 6.27B, and Specialling Care Record HMR 7.53, which promote consistent early identification and responsive care planning. The assessor reviewed patient medical record MRN #296697, noting dementia flagged on the Alert Sheet HMR 000, and the use of a Medical Order for Life Sustaining Treatment HMR 1.1, and a Specialling Care Record HMR 7.53. Additional individualised strategies included implementation of the

“Sunflower Tool” for dementia care and provision of a delirium consumer fact sheet to support patient and family understanding. These measures demonstrate collaborative, patient-centred care and reflect compliance with best-practice standards for managing cognitive impairment in clinical settings.
Rating
Met
Findings
-

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
Evidence Reviewed
CPH has systems in place to support early identification and response to patients at risk of self-harm or suicide, ensuring collaborative and compassionate care involving patients, carers and families. These systems are guided by the Self-Harm and Suicide (Threatened, Attempted or Completed) in a Non-Mental Health Facility Policy 2.54 Dec 2023, which outlines procedures for recognising and responding to psychological distress in non-mental health settings. Risk identification is further supported by the Comprehensive Risk Screening Tool HMR 6.13G, which includes a Mental Health Risk Screening component, to assist staff in systematically assessing risk factors on admission and throughout the care episode. These measures promote early intervention and safe, coordinated management of patients experiencing emotional or psychological distress.
Rating
Met
Findings
-

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

Evidence Reviewed
The health service organisation ensures that appropriate follow-up arrangements are in place for individuals who have self-harmed or disclosed suicidal thoughts. These processes are supported by the Self-Harm and Suicide (Threatened, Attempted or Completed) in a Non-Mental Health Facility Policy 2.54 December 2023, which outlines clear pathways for ongoing care, escalation and referral when required. Interviews with staff confirmed that follow-up actions including referral to an appropriate facility, ensure timely clinical oversight and continuity of care.
Rating
Met
Findings
-

Action 5.33
The health service organisation has processes to identify and mitigate situations that may precipitate aggression
Evidence Reviewed
CPH has established processes to identify and mitigate situations that may lead to aggression, thereby supporting a safe environment for patients, staff and visitors. These processes are detailed in the Occupational Violence and Aggression (OVA) Management – Principles and Prevention Policy 6.15 August 2023, which outlines risk factors, early warning signs, and strategies for de-escalation and prevention. This framework enables staff to proactively recognise and manage behavioural risks, contributing to a culture of safety and prevention consistent with best-practice approaches to occupational violence in healthcare settings.
Rating
Met
Findings
-

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

Evidence Reviewed

The health service organisation has established systems to support collaboration with patients, carers and families in identifying, managing and reducing the risk of aggression and violence. These systems are guided by the Occupational Violence and Aggression (OVA) Management – Principles and Prevention Policy 6.15 August 2023 and the OVA Incident Management Policy 6.15a August 2023, which provide a structured framework for early risk identification, de-escalation strategies and safe response practices.

Staff confirmed that all incidents of aggression are reported in RiskMan and reviewed through governance structures such as the Quality Committee.

Preventative and responsive measures include high levels of supervision and duress buttons available in all clinical areas, enabling immediate staff response when required. Staff training in emergency response procedures and aggression management maintains a strong compliance rate of 98%, ensuring a coordinated, safe, and effective approach to managing occupational violence.

Rating

Met

Findings

-

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

Evidence Reviewed

Staff interviews confirmed that although restraint is rarely used, where clinically necessary to prevent harm, CPH has systems in place to minimise its use and ensure it is applied safely, legally and transparently. The Restrictive Practices – Patient Restraint Policy 8.16 Dec 2023 outlines procedures to govern restraint use in accordance with legislation and to promote alternatives wherever possible.

All restraint incidents are documented in RiskMan and reported to the governing body through established reporting channels, ensuring organisational oversight and continuous monitoring.

Rating

Met

Findings
-

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
Evidence Reviewed
N/A as per 18/01
Rating
Not Applicable
Findings
-

Action 6.01
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
Evidence Reviewed
Campbelltown Private Hospital has implemented clinical communication systems that align with the Clinical Governance Standard to support safe, effective, and coordinated care. Policies and procedures guide communication across key stages of the patient journey, including admission, handover, discharge, and high-risk scenarios. These include Admission of a Patient – Acute Medical/Surgical (2.65), Admission of a Patient – Rehabilitation (10.03), Paediatric Admission (6.1), Discharge of a Patient (2.50), Discharge Against Medical Advice (2.51), Clinical Handover – Departmental and Intra Unit (8.18), Patient Rounding (2.63), Patient Identification Bands (2.08), and Correct Patient, Correct Procedure, Correct Site (2.15). These documents outline clear communication protocols, identify training requirements, and incorporate strategies for managing associated risks.

Risks related to clinical communication are actively monitored and managed through the RiskMan incident reporting system, which supports continuous improvement. Assessors reviewed documentation and observed clinical handovers and communication practices in action, confirming consistency with organisational policy. Training needs are addressed through onboarding and ongoing education. These systems demonstrate that Campbelltown Private Hospital effectively manages clinical communication and meets the requirements of this action.

Rating

Met

Findings

-

Action 6.02

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

Evidence Reviewed

Campbelltown Private Hospital applies its quality improvement system, consistent with the Clinical Governance Standard, to monitor and improve clinical communication processes. Incidents related to communication failures are reported through the RiskMan incident management system and are also identified through patient feedback. These data sources are reviewed and analysed to monitor the effectiveness of clinical communication practices, including structured handover processes. Regular audits and feedback mechanisms are in place to assess compliance and highlight areas for improvement.

Findings from incidents and feedback inform targeted improvements in communication strategies, which are incorporated into updated policies, staff education, and procedural changes. Outcomes and effectiveness of clinical communication processes are reported through the organisation's quality and governance structures, including the Quality and Risk Committee meetings held on 06/02/2025 and 06/03/2025. This demonstrates a continuous improvement approach to clinical communication, confirming the organisation meets the requirements of this action.

Rating

Met

Findings

-

Action 6.03
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
Evidence Reviewed
Clinicians at Campbelltown Private Hospital apply organisational processes aligned with the Partnering with Consumers Standard to ensure effective communication with patients, carers, and families during high-risk situations. Structured handover processes, including the use of patient communication boards and bedside handovers, facilitate real-time involvement in care planning and decision-making. These boards are routinely updated with relevant information and patient goals. High-risk interactions—such as consent discussions and treatment planning—are conducted using clear communication methods, including ISOBAR and written information, ensuring that patients understand their options and are actively engaged. The organisation fosters shared decision-making through initiatives such as the Sit for a Bit campaign, which encourages staff to have meaningful, patient-centred conversations. Staff are also supported with training and educational resources to enhance communication skills. The March 2025 Patient Experience Survey results demonstrate the effectiveness of these strategies, with 89.1% of patients reporting feeling involved in decisions and 89.4% feeling cared for. This evidence confirms that clinicians meet patients' information needs and support active participation in care, fulfilling the requirements of this action.
Rating
Met
Findings
-

Action 6.04
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

Evidence Reviewed
Campbelltown Private Hospital has established clinical communication processes that support safe and effective communication during critical points in the patient journey, including identification and procedure matching, care transfers, and when critical information emerges or changes. The ISOBAR communication tool is consistently used across various formats—face-to-face, telephone, and written—to ensure structured communication. These processes support accurate patient identification and procedure matching, particularly during high-risk interactions such as pre-operative "time out" in the operating room. During the assessment, clinical handovers were observed across multiple settings, including bedside handover, medication administration, and multidisciplinary team interactions. These observations confirmed consistent use of ISOBAR and compliance with established handover protocols. The structured approach ensures that essential and changing information is effectively communicated between clinicians, teams, and services, including at the point of discharge, meeting the requirements of this action.
Rating
Met
Findings
-

Action 6.05
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
Evidence Reviewed
The health service organisation has defined approved patient identifiers in line with best-practice guidelines, including full name, date of birth, and medical record number. These identifiers are embedded into standard procedures and are consistently applied across the patient journey—at the points of registration, admission, medication administration, therapy, and other care interventions. Compliance with identifier use is reinforced through staff education, policy guidance, and visual cues such as patient identification posters displayed throughout the facility. The requirement to use at least three approved identifiers is operationalised in clinical workflows and was verified during the assessment through direct observation of patient episodes of care. These included: clinical handover from concierge nurse to anaesthetic nurse (MRN #219948), team time-out in theatre (MRNs #277509 and #237838), Stage 1 recovery care and handover (MRN #294656), medication administration (MRN #294656), and clinical handover from PACU to DSU (MRN #296899). Bedside handovers were observed across shifts, MRNs #201397, #123032, #211272, #270892, #285078, #296519, #296403, and #296885.

Audits and medical record reviews confirm that identification protocols are consistently followed. The organisation also provides ongoing training and support materials to ensure sustained compliance with identification standards, contributing to patient safety and effective communication during all transitions of care.

Rating

Met

Findings

-

Action 6.06

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

Evidence Reviewed

The health service organisation has defined and implemented processes to ensure correct matching of patients to their intended care, in alignment with national safety standards. This includes the consistent use of three approved patient identifiers at key clinical points—such as during procedures, medication administration, diagnostic testing, and transfer of care. These processes are integrated into policy and reinforced through theatre time-out procedures, bedside handover, and routine clinical workflows. Observations and audits confirm that staff adhere to identification protocols prior to care delivery.

Documentation requirements are clearly specified, and evidence from medical record reviews confirms that identification checks are routinely recorded during care transitions, clinical handover, and procedure matching. During the assessment, a total of 13 medical records were reviewed to verify documentation supporting these observed processes. The reviewed records included MRNs: #262710, #292160, #121846, #296743, #201671, #296526, #104159, #105980, #296519, #296403, #296885, #270743, and #286748. Staff are supported with education, posters displayed throughout the facility, and access to resources on safe handover and patient ID. The use of structured tools such as ISOBAR further ensures that matching processes are consistently communicated and documented across multidisciplinary teams and settings.

Rating

Met

Findings

-

Action 6.07
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
Evidence Reviewed
The health service organisation has defined the minimum information requirements for clinical handover in collaboration with clinicians, based on best-practice frameworks such as ISOBAR. These requirements are embedded in the Clinical Handover – Departmental and Intra-Unit Policy (8.18, Dec 2023) and supported by educational tools including the Bedside Handover Tip Sheet, Always Event Leadership Guide, and Back to Bedside videos available on HINT. Observations confirm that handovers consistently include patient identification, current condition, recent changes, planned care, and risk factors. The organisation also identifies risks relevant to its specific clinical context, such as patient deterioration, infection control, and complex discharge needs, which are communicated during handover and documented in patient records. Bedside clinical handovers involve the appropriate multidisciplinary team members, with clearly defined roles and responsibilities. These practices are reinforced through clinical handover audits, observations, and education, ensuring all relevant clinicians are engaged and that patients, carers, and families are informed and involved as appropriate.
Rating
Met
Findings
-

Action 6.08
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

Evidence Reviewed
Campbelltown Private Hospital uses structured clinical handover processes to ensure safe and effective communication and continuity of care. These are guided by the Clinical Handover – Departmental and Intra-Unit policy (8.18) and were verified during the assessment through direct observation of handovers across various clinical areas. Clinical handovers are prepared and scheduled with relevant information available, and responsibility and accountability are clearly transferred. The appropriate clinicians are present during handovers, which are conducted using the ISOBAR format. Patient involvement is actively supported through initiatives such as Sit for a Bit, bedside handover, and patient communication boards, which are routinely updated during handover to reflect current care plans and patient goals. These practices were also verified through medical record reviews, confirming documentation of shared decision-making and clinical updates. Patients, carers, and families are supported to participate in handover discussions in accordance with the patient's preferences. These processes demonstrate effective clinical communication and safe transfer of care, meeting the requirements of this action.
Rating
Met
Findings
-

Action 6.09
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
Evidence Reviewed
Clinicians and multidisciplinary teams communicate critical information, risks, and alerts in a timely manner using established clinical communication processes, including ISOBAR, written documentation, telephone communication, and face-to-face discussion. Observations and clinical audits confirm that urgent updates—such as changes in patient condition, diagnostic results, or risk status—are escalated to appropriate decision-makers promptly. Safety huddles are also used to support early communication of emerging clinical risks across the care team. Communication with patients, carers, and families is supported by structured bedside handover, the use of patient communication boards, and alignment with patient preferences regarding involvement in care. The organisation promotes patient-centred communication through staff education and visibility of Sit for a Bit and Bedside Handover campaigns, encouraging meaningful engagement. Outcomes from the March 2025 Patient Experience Survey, including 89.1% of patients feeling involved in decisions, indicate that communication about care changes is reaching both clinical teams and patients effectively.

Rating
Met
Findings
-

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
Evidence Reviewed
Campbelltown Private Hospital has established communication processes that enable patients, carers, and families to directly share critical information and concerns about care with clinicians. This is supported by the REACH initiative, with prominently displayed posters throughout the facility encouraging patients and families to speak up if they notice changes or have concerns about safety. The initiative promotes escalation pathways that are easy to understand and access, empowering patients to be active participants in their care. These communication strategies are reinforced during bedside handovers and patient rounding, where patients and families are invited to discuss their concerns, preferences, and any perceived risks. Patient communication boards are updated regularly to reflect care goals and facilitate two-way dialogue. These processes were verified during observations and medical record reviews, confirming that patients are supported and encouraged to communicate directly with the clinical team.
Rating
Met
Findings
-

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

Evidence Reviewed
The health service organisation has established processes to ensure timely and accurate documentation of clinical information in the healthcare record. This includes the recording of critical information, alerts, and identified risks, which are documented as part of routine clinical care, handover, and escalation processes. Medical record reviews confirm that these elements are consistently recorded and updated in real time as patient needs evolve. Documentation audits and observations further demonstrate that clinical teams follow established procedures to maintain up-to-date records across the patient journey. Processes are in place to document reassessment outcomes and care plan changes promptly, including updates arising from clinical handover, diagnostic results, or deterioration in patient condition. Patient goals, preferences, and care priorities are also documented and updated regularly, as observed during bedside handovers. These practices support continuity of care and ensure that all members of the care team have access to current and relevant clinical information to inform decision-making.
Rating
Met
Findings
-

Action 7.01
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
Evidence Reviewed
Clinicians at CPH are appropriately applying the safety and quality systems outlined in the Clinical Governance Standard to support effective blood management practices. Evidence reviewed confirms that policies and procedures are being implemented in alignment with the Blood Transfusion – Management of Patient, Blood and Blood Products Policy 8.64 September 2023. Risk management processes are in place, with the RiskMan Register (#7924) documenting concerns related to inadequate blood safety management, indicating active monitoring and mitigation strategies. Furthermore, training requirements are clearly identified and addressed through the inclusion of blood management modules within the ELMO online learning platform. The hospital's overall compliance rate, as per the ELMO Dashboard (27/03/2025) is 95.1%.

Rating
Met
Findings
-

Action 7.02
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
Evidence Reviewed
The health service organisation demonstrates application of the quality improvement system from the Clinical Governance Standard to support the monitoring and advancement of its blood management system. Governance oversight is evident through regular blood safety discussions embedded within the Clinical Deterioration Committee structure, with the assessor reviewing the Clinical Deterioration – Standard 7 & 8 Committee meeting minutes for 21/02/2025 and the agenda for next meeting dated 30/04/2025. Standing agenda items – including 6.4 Prescribing and use of Blood and Blood Products and 6.5 Managing the Availability of Blood and Blood Products – provide a consistent mechanism for performance monitoring and continuous improvement. Evidence of systematic auditing supports the organisation's commitment to evaluating and reporting on blood management outcomes. Audit data from Q4 2024 indicate strong compliance rates, including 97% for the Transfusion Practice Observational Audit (7.01), 90% for the Blood and Blood Products Fridge and Register Audit (7.02), and 100% for the Appropriateness and Documentation Audit (7.03). These results are reported to the governing body, reinforcing an organisational culture of accountability, quality assurance, and informed decision-making in the delivery of safe transfusion practices.
Rating
Met
Findings
-

Action 7.03
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

Evidence Reviewed

Clinicians at CPH apply the principles of the Partnering with Consumers Standard to support safe and patient-centred blood management practices. Organisational processes are in place to actively involve patients in their care, meet their information needs, and promote shared decision-making. The assessor sighted a comprehensive suite of patient education materials, including A General Guide to Blood Transfusion – Information for Patients and Families (Blood Watch), which is available in multiple languages such as Filipino, Chinese, Arabic, French, Greek, Hindi, Italian, Korean, Macedonian, Persian, Russian, Spanish, Turkish, and Vietnamese, demonstrating a commitment to accessibility and cultural inclusion.

In addition, culturally appropriate resources such as Yarning with us about Blood – Consent information for Aboriginal and Torres Strait Islander patients, further reflect the organisation's dedication to meaningful engagement and informed consent. These resources support clinicians in ensuring that patients are well-informed, culturally respected, and actively involved in decisions regarding their care, in accordance with the intent of the Partnering with Consumers Standard.

Rating

Met

Findings

-

Action 7.04

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

Evidence Reviewed

Clinicians at CPH demonstrate appropriate application of processes to manage the clinical need for, and minimise the inappropriate use of, blood and blood products. This is guided by the Blood Transfusion – Management of Patient, Blood and Blood Products Policy 8.64 September 2023, which outlines strategies for optimising patients' own red cell mass, haemoglobin, and iron stores, as well as identifying and managing patients at risk of bleeding. Education records confirm targeted training on blood conservation principles, including pre-operative optimisation strategies.

Clinical guidance on transfusion appropriateness is further reinforced through the promotion of the National Blood Authority's Single Unit Transfusion campaign, with supporting materials such as posters and correspondence from the MAC encouraging compliance with evidence-based practice. The Blood and Blood Products Appropriateness and Documentation Audit (7.03) conducted in Q4 2024 demonstrated a 100% compliance rate across departments, highlighting the effectiveness of these processes in ensuring clinically justified transfusions.

Rating
Met
Findings
-

Action 7.05
Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record
Evidence Reviewed
Clinicians consistently document clinical decisions related to blood management, transfusion history, and transfusion events within the healthcare record. This is supported by the use of standardised forms, including the Consent for Blood Transfusion/Blood Product Administration HMR 4.7B, the Blood and Blood Products Prescription and Transfusion Record HMR 10.8, and the Blood Product Register for Specific Patients, which collectively facilitate comprehensive and traceable documentation. These processes were verified by assessor review of medical patient records, for patients receiving blood or blood products (MRN # 296046, # 296697 and # 114696).
Rating
Met
Findings
-

Action 7.06
The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria
Evidence Reviewed
CPH provides clear structures and resources to support clinicians in prescribing and administering blood and blood products appropriately, in line with national guidelines and criteria. The Blood Transfusion – Management of Patient, Blood and Blood Products Policy 8.64 (Sept 2023) outlines current best-practice standards and aligns with national prescribing guidance, offering clinicians consistent direction on safe transfusion practices. The use of the Blood and Blood Products Prescription and Transfusion Record (HMR 10.8) facilitates standardised documentation and ensures that clinical decision-making is traceable and compliant. Additionally, the organisation's robust auditing program—highlighted by 100% compliance in the Blood and

Blood Products Appropriateness and Documentation Audit (7.03) for Q4 2024—demonstrates that prescribing and administration practices are both actively monitored and performing to a high standard. These mechanisms collectively reinforce safe, evidence-based transfusion care.

Rating

Met

Findings

-

Action 7.07

The health service organisation uses processes for reporting transfusion- related adverse events, in accordance with national guidelines and criteria

Evidence Reviewed

CPH has established effective processes for identifying and reporting transfusion-related adverse events in accordance with national guidelines and criteria. Incident reporting is managed through the RiskMan system, with all events reviewed by the Clinical Deterioration – Standard 7 & 8 Committee to ensure oversight and prompt corrective action where needed. The assessor sighted RiskMan ID #2161786 (06/11/2024), which documented a reaction to an albumin infusion. This was reviewed and confirmed to be appropriately managed, with adherence to relevant policy and response protocols.

Additionally, adverse events are reported to pathology services, ensuring alignment with diagnostic review processes and traceability. Collectively, these systems demonstrate a proactive and well-governed approach to adverse event management in transfusion care.

Rating

Met

Findings

-

Action 7.08

The health service organisation participates in haemovigilance activities, in accordance with the national framework

Evidence Reviewed

The health service organisation actively participates in haemovigilance activities in alignment with the national framework. These activities are routinely incorporated into the Clinical Deterioration – Standard 7 & 8 Committee meetings (21/02/2025 and agenda 30/04/2025), where data from adverse transfusion-related events are reviewed, trends are monitored, and improvement actions are discussed. This ensures continuous oversight of transfusion

safety and supports organisational learning. Additionally, adverse events are consistently reported to pathology services, contributing to local and broader haemovigilance reporting mechanisms.

Rating

Met

Findings

-

Action 7.09

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

Evidence Reviewed

The health service organisation has implemented processes that support the safe and secure handling, storage, and distribution of blood and blood products in accordance with manufacturers' instructions, relevant legislation, and jurisdictional requirements. These practices are governed by the Blood Fridge Management and Unused Blood Products Policy 8.64a Nov 2024, with operational support materials such as the Standard 7 Blood and Blood Products Resources Folder, staff education posters on the Blood Product Register, and blood group compatibility guides readily accessible to clinical staff.

Blood product traceability is maintained through consistent use of the Blood Product Register for Specific Patients, enabling the tracking of products from arrival to transfusion, discard, or transfer. The organisation's audit program provides assurance of compliance, with the Blood and Blood Products Fridge and Register Audit (7.02) from Q4 2024 showing a 90% compliance rate. Further assurance of safe storage is demonstrated by the availability of a valid calibration certificate for the blood fridge (#CGA0861, dated 10/02/2025) and the implementation of a Blood Fridge Alert Strobe Light Procedure, which supports prompt response in the event of temperature excursions.

Rating

Met

Findings

-

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

Evidence Reviewed

CPH has established robust processes to ensure the availability of blood and blood products in accordance with clinical demand, eliminate avoidable wastage, and support effective responses during shortages. Blood inventory management is guided by the Major Haemorrhage Protocol 8.62 September 2024, and Blood Fridge Management and Unused Blood Products Policy 8.64a November 2024.

Blood Wastage Reports are routinely monitored, with 0% wastage recorded on 14 April 2025—an outcome scheduled for reporting at the upcoming Clinical Deterioration – Standard 7 & 8 Committee Meeting on 30 April 2025. This result reflects the organisation's strong performance in stewardship and resource management. Collectively, these practices demonstrate a proactive and accountable approach to managing the blood supply safely and sustainably.

Rating

Met

Findings

-

Action 8.01

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

Evidence Reviewed

Campbelltown Private Hospital has implemented robust policies and procedures to guide the recognition and response to acute clinical deterioration, consistent with the Clinical Governance Standard. Staff were able to clearly describe their roles during such events, with assessors verifying this through interviews and observation. Key documentation reviewed included the Clinical Deterioration Policy (8.45), Delirium and Cognitive Impairment Prevention and Management (8.94), Anaphylaxis Management (8.88), Advanced Life Support (ALS) – Adult (8.13), and ALS – Paediatric (13.06). These documents provide a framework for managing various deterioration scenarios and support a standardised clinical response.

Risks and training needs are regularly identified and addressed through structured governance processes. Staff training records, including ALS certification, were available during the assessment. Current training compliance rates include Basic Life Support (BLS) at 99%, and Advanced Life Support (ALS) / Paediatric Advanced Life Support (PALS) training completed by 31 after-hours staff, with 27 staff specifically trained in PALS. Additionally, 25

MECAST staff have completed both ALS and PALS training. The next training session is scheduled for May 2025. Oversight is maintained by the Clinical Deterioration Committee, which reviews RiskMan data, audits, and training compliance to inform continuous improvement. These systems confirm that the organisation meets the requirements of this action.

Rating

Met

Findings

-

Action 8.02

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

Evidence Reviewed

Campbelltown Private Hospital applies the quality improvement system from the Clinical Governance Standard to monitor, evaluate, and enhance its recognition and response systems. The Clinical Deterioration Committee provides governance oversight, with meeting minutes from 21/02/2025 and the Terms of Reference reviewed as part of the assessment. The next scheduled meeting for April 2025 reflects the ongoing commitment to system review. RiskMan data and clinical indicator reports are regularly analysed to track performance, and education records—such as Rapid Response training—demonstrate a proactive approach to workforce capability.

Improvement strategies are informed by audit findings and Shared Learnings from Rapid Response events, which are discussed at committee meetings and disseminated to clinical teams. Outcomes and system effectiveness are also reported through this governance structure, supporting transparency and continuous improvement. Recent surgical audits and documentation reviews further support this approach. Documentation audits completed in Q2 2024 showed the following results: Level 2 Surgical – Overall: 90%, Alert Sheet: 91%, and ACD documentation: 80%; Level 3 Surgical – Overall: 85%, with ASA Score noted for follow-up through documentation processes. These processes demonstrate a mature and responsive quality improvement framework, confirming that the organisation meets the requirements of this action.

Rating

Met

Findings

-

Action 8.03
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
Evidence Reviewed
Clinicians at Campbelltown Private Hospital use organisational processes aligned with the Partnering with Consumers Standard to support effective communication and shared decision-making during episodes of acute deterioration. Consumer information on the Rapid Response system is made readily available throughout the facility, supporting patient and carer understanding of when and how to escalate concerns. This information empowers patients and families to be active participants in recognising and responding to changes in condition. Patient and carer feedback is routinely gathered through interviews, surveys, and consumer forums, including specific input on escalation of care processes. This feedback informs improvements and ensures that communication strategies meet patients' information needs. Clinicians encourage involvement during deterioration events, supporting timely escalation and shared decision-making.
Rating
Met
Findings
-

Action 8.04
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
Evidence Reviewed
Campbelltown Private Hospital has established processes to support clinicians in detecting acute physiological deterioration, including the requirement to document and follow individualised vital sign monitoring plans. These are guided by local escalation guidelines and supported by education on the use of

observation charts and monitoring equipment. The Sepsis Pathway further strengthens early recognition and response to deterioration. Staff are trained to ensure appropriate monitoring frequency is based on clinical condition and documented plans.

Observation chart audit results and medical record reviews conducted during the assessment confirmed consistent documentation and use of graphical observation tools to track changes over time. This enables timely detection of acute deterioration and supports proactive clinical decision-making. The 13 medical records reviewed during the assessment—MRNs: #262710, #292160, #121846, #296743, #201671, #296526, #104159, #105980, #296519, #296403, #296885, #270743, and #286748—provided clear evidence of compliance with monitoring and documentation expectations. These systems and practices demonstrate that the organisation meets the requirements of this action.

Rating

Met

Findings

-

Action 8.05

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

Evidence Reviewed

Campbelltown Private Hospital has processes in place for clinicians to recognise and respond to acute deterioration in mental state, as outlined in the Clinical Deterioration – Recognising and Responding Policy (8.45). This includes monitoring patients at risk, particularly those vulnerable to delirium, and ensuring that individualised monitoring plans incorporate known early warning signs. Clinicians assess behavioural, cognitive, perceptual, and emotional changes, and consider underlying causes such as delirium when deterioration is suspected or reported.

The required level of observation is determined based on clinical assessment and documented in the patient’s care plan. Changes in mental state are recorded and communicated effectively within the care team to support timely intervention. These practices, underpinned by policy and clinical governance oversight, confirm that the organisation meets the requirements of this action.

Rating
Met
Findings
-

Action 8.06
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
Evidence Reviewed
Campbelltown Private Hospital has established protocols that clearly define criteria for escalating care, including agreed vital sign parameters, mental state indicators, and triggers for emergency assistance. These are outlined in policies such as Clinical Emergency Response System at Campbelltown Private Hospital (8.45a), Vital Signs Observation – Adult Patient (8.45d), and R.E.A.C.H – Patient Escalation of Care (8.45b). The escalation process also includes unmanaged pain or distress and concerns raised by staff, patients, or families. Staff are trained in both clinical and consumer-led escalation pathways, and REACH information is prominently displayed to empower patients and carers to raise concerns directly. Supportive strategies include simulation-based training, mock Code Blue drills, and staff education on Rapid Response activation. System performance is monitored through Clinical Safety Reviews (CSR), Root Cause Analyses (RCA), and maintenance of call bell and alarm systems. These processes are reinforced through routine audit, review of Rapid Response incidents, and visual communication materials. Together, these measures ensure a responsive and inclusive escalation framework, confirming the organisation meets the requirements of this action.
Rating
Met
Findings
-

Action 8.07
The health service organisation has processes for patients, carers or families to directly escalate care
Evidence Reviewed
Campbelltown Private Hospital has processes in place to support direct escalation of care by patients, carers, and families, as outlined in the R.E.A.C.H – Patient Escalation of Care Policy (8.45b). REACH posters and brochures are prominently displayed, and staff are trained to support and respond to consumer-led escalation. These processes were verified during the assessment through documentation, staff interviews, and observation, confirming the organisation meets the requirements of this action.
Rating
Met
Findings
-

Action 8.08
The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance
Evidence Reviewed
Campbelltown Private Hospital provides the workforce with clear mechanisms to escalate care and call for emergency assistance, including access to patient call bells, emergency buzzers, and established Rapid Response systems. These systems are supported by staff training and regular maintenance schedules to ensure functionality. During the assessment, these mechanisms were observed to be available and operational across clinical areas, confirming that the organisation meets the requirements of this action.
Rating
Met
Findings
-

Action 8.09
The workforce uses the recognition and response systems to escalate care

Evidence Reviewed
Campbelltown Private Hospital's workforce consistently uses the established recognition and response systems to escalate care when clinical deterioration is identified. This includes following local escalation protocols, activating the Rapid Response system, and utilising tools such as observation charts and sepsis pathways. Staff demonstrated understanding of these processes during the assessment, and documentation confirmed timely escalation in line with policy, verifying that the organisation meets the requirements of this action.
Rating
Met
Findings
-

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
Evidence Reviewed
Campbelltown Private Hospital has processes in place to ensure a timely clinical response by appropriately skilled staff during episodes of acute deterioration. This is supported by scheduled Basic Life Support (BLS), Advanced Life Support (ALS), and Paediatric Advanced Life Support (PALS) training programs, with attendance registers confirming workforce participation. Current training compliance includes BLS at 99%, with 31 after-hours staff trained in ALS/PALS and 27 staff specifically trained in PALS. Additionally, 25 MECAST staff have completed both ALS and PALS training. The next training session is scheduled for May 2025, supporting ongoing capability. Post-resuscitation huddles and debriefs are conducted to support continuous learning, and Rapid Response quality data is regularly reviewed. A documented transfer-out protocol ensures appropriate escalation beyond the facility when needed. These processes collectively demonstrate a coordinated, well-prepared approach to managing acute deterioration and ensuring timely clinical response.
Rating
Met
Findings
-

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
Evidence Reviewed
Campbelltown Private Hospital has processes in place to ensure rapid access at all times to at least one clinician, either on-site or in close proximity, who is trained in advanced life support. This is supported by ALS, PALS, and BLS training schedules, with attendance records confirming staff competency. During the assessment, a bed meeting was sampled, and it was verified that appropriate staff skill mix was maintained, including rostering of ALS-trained clinicians and PALS-trained staff when paediatric patients were identified.
Rating
Met
Findings
-

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
Evidence Reviewed
Campbelltown Private Hospital has processes in place to ensure timely referral to mental health services for patients whose mental state has acutely deteriorated. All patients are screened on admission for psychosocial and delirium-related concerns, with individualised management plans developed and monitored to support patient safety. These plans include pathways for rapid referral and escalation to mental health services when required, confirming that the organisation meets the requirements of this action.
Rating
Met
Findings
-

Action 8.13
The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration

Evidence Reviewed
Campbelltown Private Hospital has established policies and procedures to support the rapid referral of patients experiencing acute physical deterioration to services that can provide definitive management. This includes the Transfer of a Patient – Inter-Hospital Policy (2.49), which outlines clear steps for timely escalation and transfer. During the assessment, staff were able to clearly describe these processes, and assessors verified understanding and implementation, confirming the organisation meets the requirements of this action.
Rating
Met
Findings
-

APPENDICES / SUPPORTING DOCUMENTS

Not applicable