NSQHS Standards Second Edition Version 2 Organisation-Wide Assessment

Final Report

Hunter Valley Private Hospital

Shortland, NSW

Organisation Code: 120308
Health Service Facility ID: 100795
Assessment Date: 22/02/2022 to 24/02/2022

Accreditation Cycle: 1

Contents

Preamble

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

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

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

A rating report is provided for each health service facility.

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

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

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

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

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

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

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

Executive Summary

Hunter Valley Private Hospital underwent a NSQHS Standards Second Edition Version 2 Organisation-Wide Assessment (NS2.1 OWA) from 22 – 24 February 2022. The NS2.1 OWA required 2 assessors for a period of 3 days. Hunter Valley Private Hospital is a Private health service. Hunter Valley Private Hospital was last assessed between 10 -12 April 2018.

Standard 1

Hunter Valley Private Hospital (HVPH) demonstrates a strong commitment to continuous improvement in the safety and quality programs referenced in the NSQHS (second edition) Standards accreditation program. The focus on safety is well demonstrated through a Clinical Governance Framework and a comprehensive Risk Register that includes the Safety and Quality Plan. The Risk Register is detailed covering clinical and business risks with a risk rating and mitigating strategies to minimise the risks.

Clinical and non-clinical policies, procedures and quality and risk management programs are easily accessible on the intranet. There is strong evidence of staff participation to achieve the highest standard of safety and care delivery following discussions with managers and staff. Staff are well trained, regularly assessed for competency and given opportunities for further education supported by the hospital and Healthscope.

HVPH is included in the One Healthscope 2025 strategy and there are a number of excellent systems, programs, policies and procedures that are developed and circulated throughout the hospital. Strong leadership, support and guidance is embedded within Healthscope.

Governance and leadership are notable through the corporate and hospital committees and regular staff meetings that are well documented. There is a noticeable culture of patient-centred care, family and community support and striving for best practice as expressed by patients and staff.

Training in the use of RiskMan and in completing RiskMan incident reports is also provided. Assessors noted that up to date Quality boards are displayed across the hospital's clinical areas. The boards include a summary of quality improvement activities and trended audit data relevant to the clinical area. This reflects the focus that frontline clinicians take on monitoring and improving the care they provide.

The hospital is well maintained and signposted with is a safe and welcoming environment and warm ambiance. The community is engaged in surveys, reviews and audits and there is recognition of Aboriginal and Torres Strait Islander people and respect for diverse cultures.

Standard 2

Policies and procedures regarding partnering with consumers are readily available and supported by orientation and training programs.

Consumer activities are documented in the minutes of corporate and local Consumer Committees. Effective partnerships exist through collaboration and monitoring of consumer activities and planned projects.

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

The relationship between staff and the consumer is clearly visible and valued, facilitating ongoing projects to better involve consumers in service provision and care delivery.

The Consumer Focus Group (HVPH) and the Healthscope Consumer Webex Team play important roles in contributing to changes to the services and care delivery of the hospital, building projects, patient and family services, information for patients and care delivery. Patients and their relatives who access services also make comments and suggestions through formal surveys and informally to the nurse providing services. They are involved in making suggestions and comments from consumers attending meetings and completing satisfaction surveys on specific services.

There is clear evidence, that training is provided to staff to expand their understanding of the culture and sensitivities of different cultures and the exchange of information has benefited patients and staff.

Consumer Consultants train staff through their experiences and knowledge base and staff are provided with education throughout their employment.

Standard 3

Infection Prevention and Control is well managed at HVPH by the teams that meet at regular IP&C Committee meetings and supported by the corporate structure and review by HICMR. Policies and evidence-based systems are used to prevent and control healthcare associated infections. All areas of HVPH are clean and hygienic, well maintained by cleaners as scheduled and verified by environmental audits conducted as part of the quality program managed by an IP&C NUM and the Quality Manager. Action plans are developed for any non-compliance areas for improvement.

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

Patients presenting with risk factors for infections are identified promptly and receive the necessary management and treatment. Hand hygiene is a focus for all staff, patients and visitors and posters and products to highlight the importance of hand hygiene is displayed throughout the hospital. A staff immunisation program is well established and maintained according to current standards.

The reprocessing of reusable equipment, instruments and devices is consistent with relevant Australian standards, and meets current best practice.

Full compliance in the reprocessing of reusable medical devices according to the AS4187: 2014 Gap Analysis and comprehensive IP&C audits and reviews is acknowledged. The CSSD is impressive in the equipment, sterilising and traceability processes.

Staff undertake a number of competency-based assessments, including hand hygiene, aseptic technique and invasive devices as per current standards.

Food services is of a high standard and commended by patients. It is pleasing to note that the regular inspection by the NSW Food Authority Department of Primary Industries (10/09/2022) demonstrates full compliance with standards and achieved an A rating.

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

The new Antimicrobial Prescribing and Management Policy is in place, and the 'traffic light' identification was evidenced in clinical areas. The facility participates in National program audits such as National Antimicrobial Utilisation Surveillance Program (NAUSP).

Standard 4

Medication safety is generally well managed with good governance which includes a comprehensive suite of policies and procedures. Slade Pharmacy provides the pharmacy services. The recent appointment of a clinical pharmacist to improve the completion of the best possible medication histories and medication reconciliation will enhance medication safety. There is safe and secure storage of medications and a strong focus on high-risk medicines.

Standard 5

Comprehensive care is done well at HVPH. Patients are the centre of comprehensive care, and they are well screened to ensure that appropriate care is provided. Very good multi-disciplinary teamwork with medical, nursing, allied health and pharmacy staff was demonstrated to Assessors. The CareBoard and Sunflower cognitive tool were well used and appreciated by patients and staff.

Standard 6

HVPH has a system in place to support effective communication with patients and carers. There are good tools which are used for clinical handover which include Isobar and a bedside handover checklist.

The workforce was observed to be working collaboratively to ensure timely and effective communication and documentation in order to provide coordinated and safe care to patients.

Standard 7

The management of blood and blood products is of a high standard at HVPH. There is a safe, prompt and effective service provided by an external Pathology company.

Policies and procedures and education and training while partnering with consumers is a focus ensuring the maintenance of the high standard. There is appropriate equipment and monitoring systems to support a safe service meeting current national guidelines.

Standard 8

The response to the deteriorating patient is supported with comprehensive policies and procedures.

A new Code Blue Committee has been established, and there has been a strengthened approach to the organisation of the emergency response team, which now has members designated at the start of each day.

Summary of Results

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

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

Sites for Assessment

Hunter Valley Private Hospital

Site	HSFID	Address	Visited
Hunter Valley Private Hospital	100795	20 Mawson St SHORTLAND NSW 2307	Yes

Standard 1 - Clinical Governance

Leaders of a health service organisation have a responsibility to the community for continuous improvement of the safety and quality of their services, and ensuring that they are person centred, safe and effective.

ACTION 1.01
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
Comments
Healthscope is one of largest provider of medical and surgical private health care in Australia. Hunter Valley Private Hospital (HVPH) in Shortland, a suburb of the city of Newcastle NSW, has provided healthcare services to the local community and satellite suburbs for more than 54 years. HVPH is comprised of 83 beds and incorporating 4 operating theatres, a procedure room, Day Surgery Unit and Allied Health Day Patient and hydrotherapy facilities. Delivering high quality care and meeting the needs of the community with the focus on ensuring safe, personal, connected and effective service delivery, a range of specialities are delivered. Leadership is evident in the corporate structure, organisational chart and committee structure. Each ward has a Nurse Unit Manager who works collaboratively with staff and the executive team providing support and partnership with quality and safety initiatives and corporate systems and programs. There is a strong community focus with a history of being built by a local community company led by a Board prior to purchasing by Healthscope in November 2015. Excellence in care and service provision embraces the NSQHS standards (second edition), legislative requirements and the Clinical Governance Framework which encompasses the Safety and Quality Plan. There is a distinct culture of safety and quality improvement through a clinical governance framework supporting comprehensive medical, surgical and rehabilitation services. Strategic objectives are set by the management team in the Strategic Business Continuity Plan which includes the growth of services, refurbishment and upgrades as continued capital investment. Committees are well structured meeting timeframes with terms of reference and standing agendas to monitor the effects of the safety and quality improvement program.

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
The roles and responsibilities of employees are defined in their position descriptions that are acknowledged and signed by each staff member and monitored through performance reviews and competency-based assessments. The newly appointed Consumer Consultant also has his role relevant to consumer participation clearly outlined in a Role Description. Meeting minutes and regular safety and quality reports are forwarded to the Corporate Office. A monthly risk report is generated and submitted to Corporate Office via RiskMan. Incident reports are detailed and includes a mechanism for an RCA to be undertaken on notifiable reportable events as per the NSW Private Health Facilities Act 2010 and Regulation 2017.

Rating	Applicable HSF IDs
Met	All

ACTION 1.02
The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people
Comments
The demographic profile of the patient population in the catchment areas indicates that the number of Aboriginal and Torres Strait Islander people are relatively low (approximately 4 %). Regardless of this, strategic directions are to incorporate a culture of diversity and acknowledge and promote Aboriginal and Torres Strait Islander People culture as a core objective in strategic directions. The Aboriginal and Torres Strait Islander Engagement Plan defines Healthscope's purpose to 'work together for better care' which is portrayed in the Healthscope original ATSI artwork, "Coming together" displayed at Head Office, at the reception area of HVPH and in publications.

Rating	Applicable HSF IDs
Met	All

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	
Comments	
The Clinical Governance Framework drives improvements in safety and quality and is comprised of clinical and non-clinical policies, procedures and quality and risk management programs that are easily accessible by staff electronically. The implementation and monitoring of strategies and programs to not only meet goals but exceed safety and quality goals and programs of Aboriginal and Torres Strait Islander people. Clinical and non-clinical data within KPIs are collected, collated and reported monthly in the MARS platform with discussion by HVPH and reported to Healthscope.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
Diverse culture training and education for staff continues to improve through orientation, mandatory education sessions and online module for administration staff called "Asking the Question". The focus on the implementation and monitoring strategies to meet safety and quality priorities for ATSI is demonstrated by the development and implementation of the Reconciliation Action Plan (RAP) which is in progress and the Aboriginal and Torres Strait Islander Engagement Plan June 2021 – June 2022.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.05	
The health service organisation considers the safety and quality of health care for patients in its business decision-making	
Comments	
There is a noticeable culture of person-centred care and striving for best practice as expressed by patients and staff on the days of assessment. Integrated into the core values of every ward is evidence that the patient and family/carer is the focus of all activities of the services. Business decision-making is a collaborative process between corporate office, state managers and executives, VMOs, staff and consumers who expressed their views and input into changes and improvements with the assessment team. Strategic and business planning is developed as a result of safety and quality outcomes and suggestions and recommendations from consumer committee meetings and patient experience surveys.	
Rating	**Applicable HSF IDs**
Met	All

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

ACTION 1.07
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
Comments
There is a risk management approach to HVPH list of policies, procedures and guidelines. Many of the policies have been developed by Healthscope so that they suit the corporate values and are appropriate for similar hospitals within the group. At the OWA it was apparent that evidence-based policies and procedures were utilised with formatting and the content of policies reflective of standardised best practice and these are easily accessible to all staff on the intranet. Adherence to policies is monitored and non-compliance issues documented and reported through RiskMan immediately and presented at committee meetings. There is evidence to support that both policies and procedures are compliant with legislation, regulation and state requirements and are reviewed at least 3 yearly.

Rating	Applicable HSF IDs
Met	All

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
Comments
The HVPH Quality Improvement Plan and Audit Schedule incorporates clinical and non-clinical audits covering all the NSQHS standards. The audit schedule ensures regular audits are undertaken in all services and some of these are benchmarked within the corporate structure. Results are available via MARS (Measurement Analysis & Reporting System). The Quality Manager assists services plan and executes quality improvement activities. These may arise from unfavourable audit results or a quality and safety initiative. All link back to the vision and clinical governance framework. Wherever possible a consumer is included in the team to ensure the actions taken are considered from the consumers perspective. Incidents reported in RiskMan often identify opportunities for improvement. The quality improvement activities are recorded in MARS. The HVPH KPI Report is sent to all governance committees and the outcomes displayed on the Quality Boards in each ward.

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	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
KPI results are reported monthly. Routinely collected process and outcome data, the monitoring of the data for trends and reporting clinical alerts including HAC (Hospital Acquired Complication) data, assists the organisation realise its performance and outcomes. The MAC and corporate Executive Committee receive a comprehensive suite of KPI reports and quality outcomes which are also available for the workforce via RiskMan. And displayed on Quality and Consumer notice boards. Minutes of departmental meetings demonstrate that these KPI's are discussed and ideas for improvements generated and actioned. Safety and quality reports are also forwarded to other agencies as part of mandatory reporting framework, e.g. private health funds, NSW Ministry of Health.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.10
The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters
Comments
The Risk Register is comprehensive and covers clinical and no-clinical risks with appropriate controls in place to mitigate risks and eliminate where possible. This register is routinely reviewed and prioritisation of the schedule was noted to occur at a corporate and local level. The risk management system includes strategies, resources and clear accountability for remedying risks. Risks are monitored by all staff with reporting through RiskMan and tabled at hospital committees. All staff and VMOs were involved in developing the Register and have had training in Risk Management. Risk is discussed at all in-house committees, e.g. MAC, Quality Activities, WH&S, IP&C, Code Blue, Emergency Planning and Management Team meetings. Emergency policies and procedures to manage internal and external emergencies are developed and circulated. Flipcharts are maintained at each telephone using AS Colour Coding. Evacuation exercises are conducted annually. Fire Training and evacuation drills are undertaken twice yearly. The risk management system includes strategies, resources and clear accountability for remedying risks. External service providers are contracted to meet Australian Standards, codes of practice and legislation, e.g. programmed maintenance schedules for biomedical and essential equipment, pest control and waste management services. Staff are trained on the Fundamentals of Risk at Orientation. The EXCOM and OPSCOM (Operational Review Committee) act as the foundation of the organisation having developed policies and procedures that define the organisation's vision, principles, objectives, practices, responsibilities, resources, and how outcomes will be measured in accordance with the risk framework. The organisation actively encourages and supports staff, consumers, and other stakeholders to report potential or actual risks. Risk audits are regularly conducted, monitored, and placed in MARS the central audit repository. Education on risk management is ongoing.

Rating	Applicable HSF IDs
Met	All

ACTION 1.11
The health service organisation has organisation-wide incident management and investigation systems, and: a. Supports the workforce to recognise and report incidents b. Supports patients, carers and families to communicate concerns or incidents c. Involves the workforce and consumers in the review of incidents d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems
Comments
There is a strong culture of reporting incidents and near misses/hazards. Incidents are also reported to the Consumer Focus Group meetings. Trends and opportunities for improvement are acted upon. Action plans are developed and closely monitored in the analysis of incidents. Each incident is managed appropriately from a clinical perspective ensuring the provision of safe, high-quality care including open disclosure if appropriate. Incident KPI's are reported to the MAC, Quality, WH&S and Corporate committees. Summation of these results are displayed on the Quality Boards located in each ward/unit. Risks identified in the analysis of incidents are added to the Risk Register with controls and accountability included.

Rating	Applicable HSF IDs
Met	All

ACTION 1.12
The health service organisation: a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework6 b. Monitors and acts to improve the effectiveness of open disclosure processes
Comments
Staff complete the Open Disclosure Learning program which is consistent with the Australian Open Disclosure Framework as part of orientation and mandatory education. It is evident from reading incidents that Open Disclosure is used as appropriate. There is a system in place for monitoring compliance with the Open Disclosure Framework. HVPH leads a culture, demonstrated through discussion with staff, marked by openness and constructive learning from mistakes.

Rating	Applicable HSF IDs
Met	All

ACTION 1.13	
The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems	
Comments	
The organisation is passionate about receiving feedback from consumers and their carers. Patient Experience Surveys are conducted routinely on all patients. Patients can complete their survey in their own time using a QR code for those who would like to respond via mobile which is recorded in Qualtrix. There is also a specific email address for feedback. It was apparent that feedback is used as a catalyst for quality improvement as observed in the daily Team Meetings.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.14	
The health service organisation has an organisation-wide complaints management system, and: a. Encourages and supports patients, carers and families, and the workforce to report complaints b. Involves the workforce and consumers in the review of complaints c. Resolves complaints in a timely way d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e. Uses information from the analysis of complaints to inform improvements in safety and quality systems f. Records the risks identified from the analysis of complaints in the risk management system g. Regularly reviews and acts to improve the effectiveness of the complaints management system	
Comments	
The DON/Quality Manager reviews complaints in accordance with Healthscope policies. The Complaint Management Framework defines roles, responsibilities and accountabilities of relevant individuals and committees. Staff attend training on what to do if they receive a complaint. Complaint data is analysed identifying trends and opportunities for improvement. The organisation acknowledges receipt of a complaint and responds immediately is possible or at least within days. Complaints are linked to HVPH open disclosure, risk management, and quality improvement systems and are reported monthly to Healthscope.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.15	
The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher risk groups into the planning and delivery of care	
Comments	
Periodic audits of the administrative data system demonstrate that the diversity of consumers of the HVPH is not wide. Regardless, small pockets of some cultural groups have been identified and these are considered in the planning and delivery of care. Cultural safety and insight training and workshops are conducted to upskill staff of specific ethnic communities. As previously reported the specific health care needs of Aboriginal and Torres Strait Islander People are addressed. There have been very little changes to the number of Aboriginal and Torres Strait Islander presentations. The health outcomes of the specific ethnic groups are closely monitored. The cultural needs of patients are addressed in terms of dietary requirements, dress codes in terms of religion and behavioural consideration.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.16	
The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used	
Comments	
Healthcare records are paper based. The Health Information Officer conducts an informing and practical session at staff orientation on health record management including confidentiality and privacy. Audits are routinely conducted by the HIO and Front Office Manager and available in MARS. Audits of unique patient identifiers demonstrate that patient identification is managed well with very few multiples/errors. Records are secured and secondary storage is both onsite and offsite with appropriate retrieval times and culling processes according to AS2828:2012. There is a rigorous system in place to obtain a medical record ensuring security and privacy. The Healthscope Privacy Policy (a Consumer Approved Publication) is available to patients in their bedside compendium.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.17	
The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that: a. Are designed to optimise the safety and quality of health care for patients b. Use national patient and provider identifiers c. Use standard national terminologies	
Comments	
The Health Information Officer (HIO) is responsible for the organisation's preparation for implementation of "My Health Record". The assessors viewed the required gap analysis and the detailed plan. The intent of Advisory AS 18/11 has been met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.18	
The health service organisation providing clinical information into the My Health Record system has processes that: a. Describe access to the system by the workforce, to comply with legislative requirements b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system	
Comments	
Processes are in place for staff to comply with legal requirements regarding access to the My Health Record system to input clinical information, and to ensure accuracy and completeness of this information when uploading into the system.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.19	
The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation	
Comments	
HVPH has established a comprehensive onboarding and orientation program for all staff members. Healthscope Corporate Orientation is followed by local hospital orientation. Much of the orientation is provided online. Department specific induction is also provided. Position descriptions refer to the importance of the provision of high quality, safe person-centred care and working in a team environment. The Agency and Locum Orientation ensures assists in providing consistent high quality, patient focused care.	

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	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.20	
The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training	
Comments	
HVPH has a strong ongoing education and training focus with oversight and support provided by the Educator and supported by Corporate with ongoing professional development encouraged and sponsored. Policy and procedures outline the mandatory and organisational training requirements for staff members and specific to their position descriptions and work area. The orientation and mandatory and organisational training requirements applicable to each clinical and non-clinical staff have been determined. Much of the training is delivered through eLearning modules, even more so since the COVID-19 pandemic commenced. The Healthscope Course Status Report provides a summary of educational courses, workshops, and other educational activities. Comprehensive electronic dashboard training reports are monitored by department heads. Assessors noted that current overall compliance with mandatory training is 87% with 2% requiring recompletion. Annual performance assessments and a range of competency-based assessments relevant to their workplace is undertaken and used for further training and improvements.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.21
The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients
Comments
Aboriginal and Torres Strait Islander Cultural Insight training "Share our Pride" is provided online as part of the Healthscope and HVPH orientation program. Cultural competency training sessions are also provided on a regular basis. There has also been an emphasis on developing role models/champions across the organisation. 90% of Healthscope staff have received cultural training through the "Working with Respect" module. The newly appointed Consumer Representative at HVPH is enthusiastic to be able to share his Indigenous background and clinical/hospital experiences.

Rating	Applicable HSF IDs
Met	All

ACTION 1.22
The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system
Comments
The performance management requirements for HVPH are described in the Clinical Governance Plan 2021 - 2025. Other documents cover specific matters such as performance management and senior medical staff performance development and process. The HVPH Performance Development Process (PDP) program has a strong emphasis on the provision of high-quality patient centred care. The PDP program is closely linked to the organisation's education and training system. Regular competency-based assessments are carried out in all departments. Employee assistance for work related issues, career and life changes is available through "Converge", a Healthscope Employee Assistance Program. There is a unique assistance program for managers through "Converge" which covers leadership, change management and addressing workplace conflict to name a few topics. Healthscope also provides assistance in furthering the employee's career and work skills.

Rating	Applicable HSF IDs
Met	All

ACTION 1.23
The health service organisation has processes to: a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan b. Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered
Comments
HVPH has well established processes supporting the credentialling and defining the scope of practice of its medical, nursing and allied health clinicians in line with the national standards. The "Credentialing and Scope of Practice" policy provides overarching guidance. This is supported by polices and protocols specific to medical and nursing staff. The policies and protocols also cover expanded scope of practice for enrolled nurses and allied health clinicians. The MAC receives medical applications for visiting rights and makes decisions on scope of practice Credentialling and scope practice for VMOs are well established and follows college guidelines and the Healthscope By-Laws. VMO applications are submitted with supporting documents, such as medical indemnity and AHPRA registration, to the General Manager for presentation at the Credentialling Committee, a sub-committee of the Medical Advisory Committee. Reports on any variations and changes to the scope of clinical practice of VMOs is also discussed at the MAC. Management of the credentialling, defining the scope of clinical practice and the appointment of senior medical staff is supported by eCredentialling and WEBPAS software. Capability framework documents such as those related to surgical and anaesthetic services assist in the alignment of clinician scope of clinical practice with HVPH service capability. The level of involvement of staff in safety and quality is outlined in their individual position descriptions. All members of the clinical team are credentialed in accordance with their individual craft groups, formal qualifications and their position descriptions. Initial accreditation is given for 12 months and then followed up after this period for a further 5 years before re-accreditation applies.

Rating	Applicable HSF IDs
Met	All

ACTION 1.24
The health service organisation: a. Conducts processes to ensure that clinicians are credentialed, where relevant b. Monitors and improves the effectiveness of the credentialing process
Comments
HVPH has a database of all of its registered clinicians which is expertly managed and kept updated by the Executive Assistant. Healthscope maintains a Credentialling register which is managed through eCredentialling.

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	
There are established processes to regularly check the Australian Health Practitioner Regulation Agency (AHPRA) registration status of all registered clinicians engaged or employed by HVPH. The AHPRA multiple registration check process is used to check the status of other registered clinicians. Theatre management staff have access to scope of practice information related to proceduralists via an excel spreadsheet. The detailed "Introduction of New Clinical Services, Procedures and other Interventions" protocol provides guidance related to the introduction of new clinical procedures and clinical technologies.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.25	
The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff	
Comments	
HVPH emphasises the values of the organisation and its guiding principles that include the provision of high-quality patient centred care. This is reflected in position descriptions which also refer to the importance of the provision of safe, high-quality, person-centred care. Position descriptions also highlight the importance of working in a team environment. The role of clinicians in the provision of safe and high-quality care is also emphasised during orientation, as part of mandatory and organisational training and during ongoing in-service education.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.26	
The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate	
Comments	
The After-Hours Manager assumes responsibility for the hospital after hours. This position is supported by various protocols including ON Call Roster- MET, CMO and VMO. The hospital is also close to the John Hunter, Calvary, Maitland District and Belmont District Hospitals.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.27	
The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care	
Comments	
Clinicians have ready access to a range of policies, protocols, guidelines, clinical pathways and decision-making tools that have been produced by Healthscope and HVPH. A large range of evidence-based library resources such as books, journals and internet accessed literature are also available. The ACSQHC resources are accessed and training and support tools are provided on the assessment processes for the hospital. Meetings and agendas are based on the NSQHS standards and reporting follows these guidelines and the Clinical Governance Framework supports this.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.28
The health service organisation has systems to: a. Monitor variation in practice against expected health outcomes b. Provide feedback to clinicians on variation in practice and health outcomes c. Review performance against external measures d. Support clinicians to take part in clinical review of their practice e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems f. Record the risks identified from unwarranted clinical variation in the risk management system
Comments
Assessors noted numerous examples of where performance and patient outcome data is collected and reviewed by clinicians in various disciplines and services. The valuable role of the DON/Quality Manager and the General Manager in promoting and reviewing performance against external measures of the safety and quality program is acknowledged. Examples include the monitoring of hospital acquired complication's data, incidents, complaints including response rate and review of content and consumer orientation and training and tools. Variances in practice are noted in the Risk Register and at MAC meetings and recommendations made to minimise them and any non-compliance issues. HVPH contributes data to Healthscope Corporate Office and receives benchmark reports from the other sites. These reports are reviewed by relevant clinical specialty teams. Inadequate VMO accreditation and clinical variances are included in the overall Risk Register.

Rating	Applicable HSF IDs
Met	All

ACTION 1.29
The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose
Comments
There is an extensive Preventative Maintenance Program covered by the Maintenance Manager employed by BGIS - Building and Engineering Maintenance Service. Staff of this service are involved in minor works, repair, and maintenance. Essential biomedical services are carried out by external contractors specialising in the specific equipment. There is ready access to all trades. All Job Requests are electronically entered at ward/department level and then prioritised by the Maintenance Manager. The Support Services Manager is responsible for housekeeping and catering. Testing and tagging is current. Body protection circuits are in place in all rooms where monitoring does or may possibly take place. TMV's are serviced regularly and legionella tests conducted on TMV's and warm water system.

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
Imaging Services are on-site with qualified and experienced radiographers providing X-rays and image intensification to theatres and wards. The service is NATA accredited and a roster covers all hours. There is a current Annual Fire Safety Certificate (August 2021). Fire Wardens are allocated to each shift and have been appropriately trained. The Emergency Management Plan ensures readiness for any sort of emergency: internal, external, code black and purple. Codes are tested regularly, and evacuation exercise conducted routinely. The Work Health and Safety Committee is active and well attended. Work Health and Safety Officers assist with risk assessments following an incident.

Rating	Applicable HSF IDs
Met	All

ACTION 1.30
The health service organisation: a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required
Comments
There are very few incidents of aggressive behaviour which could be due to the welcoming manner of staff who have been trained in de-escalation processes in readiness to cope with unpredictable behaviour. If required a patient can be moved to a single room to provide a calm and quiet behaviour.

Rating	Applicable HSF IDs
Met	All

ACTION 1.31
The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose
Comments
External and internal signage is clear and areas that are off limits clearly designated. Consumers are asked if they were able to locate the service/unit/department they were looking for and answers are always positive. The reception staff are able to show directions when requested.

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

ACTION 1.32	
The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so	
Comments	
The after-hours manager oversees any access after-hours. Access is determined on need. COVID has resulted in no visitors being allowed however access was granted for any end-of-life patients family.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.33	
The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people	
Comments	
The hospital is fortunate to have had Aboriginal Consumer Representatives who guide the organisation as to how to make the environment one that Aboriginal and Torres Strait Islanders feel welcome and comfortable. There are several Indigenous artwork and artefacts throughout patient areas and in reception and the gardens. The Aboriginal and Torres Strait Islander Engagement Plan identifies how HVPH can continue to provide a welcoming environment.	
Rating	**Applicable HSF IDs**
Met	All

Standard 2 - Partnering with Consumers

Leaders of a health service organisation develop, implement and maintain systems to partner with consumers. These partnerships relate to the planning, design, delivery, measurement and evaluation of care. The workforce uses these systems to partner with consumers.

ACTION 2.01
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
Comments
Hunter Valley Private Hospital (HVPH) demonstrates the integration of clinical governance and applies quality improvement systems in their endeavours to partner with consumers. Consumer Partnership policy and procedures guide the hospital to support patients, carers, families and consumers in the delivery of patient-centred care and service delivery. Strategies to achieve consumer partnership goals and is embedded in the Clinical Governance Plan incorporating the Safety and Quality Plan. The Consumer Partnership Plan 2020 – 2023 outline strategies for involving consumers in making comments regarding care and service delivery at HVPH. The National Sorry Day and Naidoc week are well celebrated each year in acknowledgement of the Aboriginal and Torres Strait Islander people but is limited due to COVID restrictions. The Taste of Harmony Day celebrates cultural diversity in the workplace and is held each year. The ATSI Engagement Plan drives the vision and purpose 'to work together for better care'. The assessors were impressed with the details and resources in this document. The HVPH Consumer Focus Group is the forum for discussion on partnering with consumers to improve the delivery of services and patient care with additional feedback from patient experience surveys, informal feedback and information from representatives at the national consumer committee meetings. A new Consumer Consultant who has ATSI origins has been appointed and, following discussion with him, is enthusiastic about his role and will produce new ideas and strategies. The Healthscope Corporate Consumer Consultant Committee is a very active forum comprised of consumers and key personnel that meet regularly, at least 3 monthly, and engages with HVPH staff providing valuable input into strategies to improve services for the community. The minutes of a Corporate Consumer Webex Team and the HVPH Consumer Focus Group were sighted and it was noted that consumers actively participate in improvements of service delivery. Staff and consumer representatives undergo an orientation program which includes introduction to recognising cultural diversity and an eLearning module "Share our Pride". Consumer Consultants have a detailed role description which is acknowledged and signed.

Rating	**Applicable HSF IDs**
Met	All

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
Comments
Consumers play an important role in assisting HVPH to integrate clinical and non-clinical systems in partnership with consumers. Participation in hospital committee meetings, formal and informal comments and suggestions have been used for improvements and reported to corporate, executive and departmental committee meetings. A new Consumer Consultant has recently been appointed and will be attending quarterly meetings at Healthscope. The role of consumer representatives is identified through a role description, terms of reference of the Consumer Group and the National Consumer Advisory Council that meet quarterly. Orientation and education are closely monitored by senior staff with feedback systems with improvements noted throughout this process. An Aboriginal and Torres Strait Islander Engagement Plan outlines current and planned strategies to strengthen relationships between ATSI peoples and non-indigenous people. Standard duties include completing reviews and surveys, attending committee meetings, reviewing publications and providing advice on consumer related publications, staff education and assisting with accreditation. It is acknowledged that there will be opportunities to be engaged in any planned development of the hospital.

Rating	Applicable HSF IDs
Met	All

ACTION 2.03
The health service organisation uses a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights16 b. Easily accessible for patients, carers, families and consumers
Comments
The Australian Charter of Health Care Rights (2nd edition) is clearly visible throughout the hospital and each ward. The Patient Information Directory is a comprehensive booklet containing relevant information on their hospital stay, infection, falls and pressure and injury prevention, rights and responsibilities, privacy principles, how to make a complaint or comment and the REACH program to name a few topics. Included is advice on external community services and health resources. This directory has the Consumer Approved Publication stamp.

Rating	Applicable HSF IDs
Met	All

ACTION 2.04
The health service organisation ensures that its informed consent processes comply with legislation and best practice
Comments
A consent policy and process cover consent for treatment, financial consent and use of personal information. Corporate and HVPH policies and procedures incorporate consent for medical/surgical treatment and procedures and financial consent. There is a section in the Patient Registration Form for documenting Enduring Power of Attorney for patients who are unable to give consent. Consent is obtained on admission for the commencement of treatment/procedures and is renewed annually. Compliance with appropriate consent is monitored through the regular documentation audits, at least annually, with good results. Individual consents are obtained for immunisation, blood and blood product treatment, use of eHealth record and Telehealth communication. Failure to obtain a valid consent and non-compliance in the consent process is included in the overall corporate Risk Register with mitigation strategies and non-compliance recorded in RiskMan.

Rating	Applicable HSF IDs
Met	All

ACTION 2.05
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
Comments
A consent policy and process cover consent for treatment, financial consent and use of personal information. Corporate and HVPH policies and procedures incorporate consent for medical/surgical treatment and procedures and financial consent. There is a section in the Patient Registration Form for documenting Enduring Power of Attorney for patients who are unable to give consent. Consent is obtained on admission for the commencement of treatment/procedures and is renewed annually. Compliance with appropriate consent is monitored through the regular documentation audits, at least annually, with good results. Individual consents are obtained for immunisation, blood and blood product treatment, use of eHealth record and Telehealth communication.

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	
Failure to obtain a valid consent and non-compliance in the consent process is included in the overall corporate Risk Register with mitigation strategies and non-compliance recorded in RiskMan.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.06	
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	
Comments	
Sharing decisions and planning care is multidisciplinary and can be observed in the clinical handover, communication with other clinicians and during admission and discharge/transfer procedures in collaboration with the patient and carer/relative. Documentation in the clinical record is well recorded and managed by the multidisciplinary team. VMOs and CMOs visit patients daily and care services and treatment updated. The Care Board in each patient room has enhanced the communication of patient goals and therefore staff and patient information for effective clinical handover and care delivery. Staff discuss goals of care and treatments with the patient and with a relative or carer if available. Clinical handover at the beginning of each shift and transfer passes patient information to each attending clinician and involves the patient and carer (if available). The clinical record is detailed and multidisciplinary and compliance of documentation audit results are consistently good.	
Rating	**Applicable HSF IDs**
Met	All

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
Comments
There is evidence that staff participate in the education on strategies to observe consumer partnerships. Staff are trained to be competent in responding to cultural diversity as identified in the Cultural Diversity training and policy. Consumer members play an important role, according to their position descriptions and their participatory goals in providing feedback regarding patient experiences and their own experiences. Specific needs, culturally and linguistically, are identified and every effort is made to ensure patients understand the information, instructions and treatments relevant to their care planning. The participation of an ATSI consumer representative is a value-added addition to cultural representation. Interpreter services are available if required.

Rating	Applicable HSF IDs
Met	All

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
Comments
The Assessors agree that the diversity of patients is acknowledged and respected culturally and linguistically through staff interview and discussion with patients. The cultural competence of staff to ensure appropriately to multicultural needs is monitored. It is noted that the Catering Department provide exceptional refreshments and meals in accordance with patient's religious and specific diet needs. Patient information booklets and leaflets can be provided in different languages on request, e.g. the Australian Charter of Healthcare Rights. Feedback on documents and brochures from consumers and patients is through patient experience surveys and informally by VMOs and staff.

Rating	Applicable HSF IDs
Met	All

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	
Comments	
HVPH involves consumers in the development and revision of publication utilising the ACSQHC guidelines on health literacy. Assessors viewed some of these documents such as Rights and Responsibilities, Patient Information Directory, Preventing Falls, Preventing Infections in IV Access Devices, Valuables and Medicines, Privacy Policy, to name a few. These have the consumer approved publications stamp.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.10	
The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided on discharge	
Comments	
Health information is available in the Patient Information Directory and as requested by patients and is written in easy to read language. Translations are provided when requested. Information booklets published by CEC, Healthscope, ACSQHC and the Australian Private hospital are displayed and available to patients and their relatives. A number of improvements in the communication between patients, carers and families have occurred over time from suggestions from the Consumer forums. The Consumer Approved Publication stamp is visibly clear on documents. Consumer Approved Publications continue to be strong evidence of discussion and development though partnering with consumers. Notices, patient audit outcomes and a newsletter are posted on the Quality and Safety and staff notice boards. Results of safety and quality audits and results from patient experience surveys (Qualtrix) may also be posted for staff, patient, carer and visitor interest.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.11
The health service organisation: a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community
Comments
Access to interpreter services is available should they be required. Results of patient satisfaction surveys indicate that patients and carers are aware of and can understand their rights and responsibilities and show good levels of satisfaction with the information provided and the service. Staff are orientated and subsequently trained in multicultural diversity and respect for different cultures and religions. Consideration is given to patients' culture, religion and personal and specific needs. Guidance is given through staff and consumer meetings and in the comments in patient experience surveys. Partnering with Aboriginal Liaison Officers (ALO) from the public health sector is a successful step to effective partnership with the indigenous culture and community. The ATSI Consultant on the Consumer and Volunteer Committee has added a focus on meeting the cultural and wellbeing needs of Aboriginal and Torres Strait Islander cohort of NPH patients and community.

Rating	Applicable HSF IDs
Met	All

ACTION 2.12
The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation
Comments
A comprehensive orientation and training program is undertaken by consumers on committees. This is consistent with guidelines to enhance health and safety of the Australian Commission for Safety and Quality in Health Care (ACSQHC). Consumer members of the Corporate Consumer Committee provide valuable input into any current or new information that is available to patients. For example, Complaints Management and Partnering with Consumer policies and results of quarterly KPIs, accreditation and medical record forms. Evidence was sighted in the minutes of the Corporate Consumer Webex Team (September 2021).

Rating	Applicable HSF IDs
Met	All

ACTION 2.13	
The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs	
Comments	
There is sufficient information and resources on Aboriginal and Torres Strait Islander patients and consideration for their specific care. Liaising with the ATSI people, and in particular members of consumer forums has increased competency and consistency of staff to care for sick Aboriginal and Torres Islander people albeit a small cohort at this stage. Assessors were impressed with steps taken in acknowledging and working with Aboriginal and Torres Strait Islander People. Acknowledgement Statements, ATSI flags, artwork, artifacts and paintings were prominently displayed in the reception and ward areas.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.14	
The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce	
Comments	
Training modules are developed by Healthscope and outline the roles and partnership strategies with hospital staff. The goals are to develop strategic directions for incorporating a comprehensive program of respecting and managing cultural diversity. Consumers on the Healthscope Consumer Committee and HVPH Focus Group, through discussion and suggestions, are able to voice their views and experiences for the training of staff. The focus is on the culture, considerations, respect and expectations of culturally diverse communities.	
Rating	**Applicable HSF IDs**
Met	All

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

Leaders of a health service organisation describe, implement and monitor systems to prevent, manage or control healthcare-associated infections and antimicrobial resistance, to reduce harm and achieve good health outcomes for patients. The workforce uses these systems.

ACTION 3.01	
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	
Comments	
The comprehensive infection prevention and control program at Hunter Valley Private Hospital (HVPH) is managed by the NUM who has responsibility built into her Registered Nurse's position. The development of policies and procedures are carried out by HICMR at least two yearly with local coordination by the NUM. A broad range of infection prevention and control policies and procedures are easily accessible in hard copies and the intranet for staff and referenced to current standards, guidelines and codes of practice. The IP&C and CSSD manuals are detailed and meets current legislation and guidelines and available electronically for each department. Consultation with key hospital staff members is acknowledged. State guidelines are met as evidenced in regular inspections and reports which contains recommendations for further actions. The audits and reviews are completed regularly according to the Quality Schedule by the IP&C NUM and includes actions for improvement and completion or partial completion outcomes. A policy and procedure for developing and maintaining the antimicrobial stewardship program is available. The AMS program is well managed by the IP&C NUM with assistance from an on-site pharmacist.	
Rating	**Applicable HSF IDs**
Met	All

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
Comments
An Infection Prevention Plan is developed by HICMR and circulated to drive the IP&C systems, activities and outcomes for HVPH. Infection prevention and control risks are identified and risk- rated with mitigation strategies in the clinical section of the Risk Register. Clinical events such as infections relevant to specific medical and surgical conditions, are documented and reported to the clinical committees such as the Quality, IP&C and Medical Advisory committees for discussion and analysis. Education and training in the infection prevention and control program is carried out by the IP&C NUM and the Educator and supported with online training modules. The Infection Prevention and Control Committee uses the established clinical governance structures and processes of the framework with quality indicators and outcome measures to enable reporting and benchmarking internally. The IP&C Committee meets quarterly with terms of reference and a standing agenda guiding the team meeting. The new Antimicrobial Prescribing and Management Policy is now in place, and the ‘traffic light’ identification was evidenced in clinical areas. The facility participates in National program audits such as National Antimicrobial Utilisation Surveillance Program (NAUSP). Antibiotics are prescribed and administered and this data is collected, collated and reported to the MAC as a standing agenda item. The on-site pharmacist has overall responsibility for managing and reporting on the antimicrobial usage and has focused on the use of prophylactic usage and high-risk antibiotics for outcome reporting to the Medical Advisory Committee.

Rating	Applicable HSF IDs
Met	All

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
Comments
The Clinical Governance Plan, which is also the Safety and Quality Plan for HVPH, outlines the quality improvements strategies for hospital acquired complications, pandemic planning, managing risks and staff training and education. These issues are all included in the IP&C Program which has risks identified in the Risk Register and mitigating measures to minimise the risk. The AMS program is well established and coordinated by a multidisciplinary team with outcome data reported to the Medical Advisory and National Healthscope Committees for discussion and monitoring. Infection Control competencies are undertaken by all staff include Hand Hygiene, Aseptic technique, Invasive procedures, CSSD tasks such as cleaning, re-processing, packing/wrapping and sterilising. Competencies are managed by Nurse Unit Managers and reported to the IP&C Committee.

Rating	Applicable HSF IDs
Met	All

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
Comments
All patients are risk-assessed on presentation and admission selection criteria. Existing infections govern admissions. Patients are asked to provide information on their health and infectious status on pre-admission and admission and are encouraged to comply with COVID-19 directives and guidelines. Direct risk assessment questions relating to the COVID Pandemic and according to NSW Ministry of Health current guidelines and directions, are activated as patients, carers and visitors enter the premises. Presentation of carers/relatives are limited as part of COVID-19 restrictions. Assessors note, following discussion with staff, that patients and their carers are actively involved in their care and that relevant information is available to them on pre-admission, admission, and discharge. The Patient Information Directory is comprehensive and covers all aspects of their care and includes information on managing risks, specific information relating to their patient journey, admission, IP&C issues, care after discharge and Healthscope rights and responsibilities.

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	
Patient experience surveys indicate a high level of satisfaction with information provided and communication with staff.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
There is clear evidence of compliance with current infection prevention standards, guidelines and codes of practice. Audits and reviews are regularly undertaken with good results as per the Quality Plan and includes benchmarking throughout the corporate structure. Policies and procedures and gap analyses have been developed and are appropriately referenced. Training and education sessions are provided in-house and online. Infection Prevention and control education is essentially provided by the IP&C NUM, Educators and through eLearning. Education provided includes the use of personal protective equipment, hand hygiene and strategies to manage the COVID-19 pandemic. Patients are also guided in the use of PPE such as masks and the use of hand hygiene products. Signs for appropriate use of products are posted throughout the wards. The AMS program has been approved by the MAC and closely monitored for appropriate usage with reference to therapeutic guidelines.	
Rating	**Applicable HSF IDs**
Met	All

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 Healthcare17, jurisdictional requirements, and relevant jurisdictional laws and policies, including work health and safety laws
Comments
All relevant information relating to the patient's status and care requirements is documented in clinical records and accompanies the patient throughout the continuum of care and on transfer (if applicable). Clinical records are currently mainly paper based and managed according to paper based clinical record standards (AS 2828:2012). Patients who have a communicable disease or a pre-existing infection on assessment may be placed in isolation according to their medical fitness and standard precautions are applied to the management of all patients. A Hospital Acquired Infection (HAI) summary is collated and reported at least two monthly. Parenteral and non-parenteral exposure incidents are recorded on RiskMan and also submitted within the ACHS clinical Indicator program and benchmarked with other Healthscope hospitals.

Rating	Applicable HSF IDs
Met	All

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
Comments
Patients are asked to provide information on their health and infectious status on pre-admission and admission and are encouraged to comply with COVID-19 guidelines and restrictions, hand hygiene initiatives supported with instructions and products visible throughout the hospital. Clinical handover between key areas in the patient's journey transfers relevant information from clinician to clinician and through the clinical record. This was observed by assessors at clinical handover and 'time out' procedures in the Operating Theatre Suite. The transfer of care between health facilities ensures infections status and risks are identified in clinical handover and clinical records.

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	
Rating	**Applicable HSF IDs**
Met	All

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
Comments
HVPH presented as a safe and clean environment due to internal cleaning schedules and appropriate cleaning services by trained hospital cleaners using the appropriate colour coded cleaning equipment. Key IP&C indicators that are regularly monitored and reported are number of infections, waste management, environmental cleaning and hand hygiene. A suite of IP&C clinical indicators relevant to care delivery and services are reported within the ACHS Clinical Indicator Program with good outcomes. Here is an efficient on-site laundry service providing ward, theatre, housekeeping and catering departments with services that meet current Laundry Services standards (AS4146) Surveillance data is collected and reported according to schedules and the compliance achieved is compared with the previous audit. A sequential follow-up is completed and risks are identified and progressed for completion. Personal protection equipment is readily available in all clinical areas and audits measure compliance with their use. COVID-19 guidelines are effectively followed and monitored as directives and guidelines are updated.

ACTION 3.08
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
Waste management services are contracted and meets current standards. Waste management and environmental audits are completed and reported to the IP&C and Quality Committees. Legionella testing on Thermostatic Mixing Valves (TMV) is carried out as per Australian Standards at nominated periods and results have been negative as reported to the IP&C and Quality committees.

Rating	Applicable HSF IDs
Met	All

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
Comments
HVPH as responded well to the COVID-19 Pandemic meeting all the jurisdictional guidelines and implementing the changes/amendments according to current directives. Policies and procedures are developed and circulated and there are current guidelines for infections displayed in handouts and on notice boards, including hand hygiene, social distancing and the wearing of appropriate masks at all times. Relevant information on each patient's condition is documented on their individual Careboard and discussed with them at clinical handover and medical review.

Rating	Applicable HSF IDs
Met	All

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
Comments
Infection prevention and control surveillance and hand hygiene audits with reference to NHHI guidelines are regularly undertaken (4 monthly) and outcomes circulated and presented at meetings. Results are submitted to the MAC, QC and IP&C committee meetings and posted on staff and consumer noticeboards. Compliance is above the national average and is persistently very good.

Rating	Applicable HSF IDs
Met	All

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
Comments
Competency-based assessments monitor staff skills and compliance, e.g. aseptic technique, hand hygiene, insertion and removal of invasive devices, ANTT peripheral cannulation. There is a scheduled training program, online modules and audits to address competencies in aseptic technique, including competencies relevant to operating theatres. Inadequate training is included in the Risk Register. Online training modules and training and education by the IP&C NUM and Educator addresses a range of compliances required in every clinical area.

Rating	Applicable HSF IDs
Met	All

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	
Comments	
Regular competency-based assessments for the insertion and removal of invasive medical devices are undertaken by clinicians and supported with ongoing education. This is consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare 17.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
New and existing equipment are risk assessed and cleaning and disinfection processes minimise environmental risks. Regular environmental audits are undertaken and cleaning schedules are developed for each department and clinical area. Safety data sheets are current and available at the point of use. Cleaning staff are employed by HVPH and provided with orientation and training in the use of equipment, PPE and cleaning products. All cleaners comply with COVID Cleaning Guidelines and have increased their cleaning regimes for additional precautions during the pandemic. All staff have been fitted for wearing the appropriate masks and education is ongoing.	
Rating	**Applicable HSF IDs**
Met	All

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
Comments
HVPH has responded well to meet CSSD standards and new equipment, processes, staffing and storage facilities. Assessors were impressed with the management and storage of sterilised supplies and equipment. Autoclaves, batch washers, ultrasonic machines and other endoscopic reprocessing equipment/machines meet current sterilisation standards. There is a scheduled preventative maintenance program of servicing and calibration to meet these standards. Laundry services is carried out by an on-site department that demonstrates a high level of cleanliness and laundry standards. Policies and work instructions in the collection, sorting, washing, storage and delivery to the wards were viewed and noted as meticulous and performed meeting guidelines and codes of practice. The preventative maintenance of the hospital is well managed by BGIS (a corporate maintenance company), planned and executed. The many improvements in structure and expansion of the building are acknowledged, as is the planning of further building and furnishing upgrades.

Rating	Applicable HSF IDs
Met	All

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
Comments
The staff health program includes the maintenance of a record of immunisation for each nurse according to current regulations and guidelines. Monitoring of immunisation is according to jurisdictional requirements, is risk-based and reflects the Australian Immunisation Handbook. Flu vaccination is encouraged and is provided on-site with a record maintained in each personnel file. COVID immunisation is mandatory according to NSW Health and a record is maintained for all staff.

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	
Rating	**Applicable HSF IDs**
Met	All

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
Comments
Compliance with COVID 19 pandemic guidelines is closely monitored and changes made according to NSW Ministry of Health directives that are constantly being updated. There is a COVID Pandemic Plan which is regularly updated. All patients, visitors and staff are risk assessed on entering the hospital and evidence of vaccinations against COVID has to be provided at all times. Sound evidence-based policies, corporate and local, guide staff to meet the Australian Guidelines for the Prevention and Control of Infection in Healthcare. Monitoring by NSW Ministry of Health, evaluations and audits and HICMR reviews ensure safe practices are being followed. Actions for improvements are followed as a response to any suggestions or recommendations. Infection Prevention is incorporated into the risk register as is inadequate processing of equipment, non-compliance in waste management processes and inadequate staff training in IP&C. Staff who are infectious are supported through the Employment Assistance Program (Healthscope).

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	
Rating	**Applicable HSF IDs**
Met	All

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.	
Comments	
A visit to the CSSD demonstrated well-managed sterilising services and protocols by trained and certified Sterilising Technicians with expert directions and training opportunities provided by an experienced and qualified CSSD Manager. A traceability system is well managed and monitored by the experienced CSSD staff. Processes for reprocessing of reusable equipment and instruments are guided by a full range of policies and procedures developed by HICMR in partnership with CSSD staff. Compliance auditing of the sterilisation traceability system is evident. The reprocessing of reusable equipment, instruments and devices are compliant with AS/NZS 4187:2014. A gap analysis and action plan were developed by the IP&C NUM and OT Manager and progressed according to the timeframe. Regular monitoring and auditing processes, with references to manufacturer's guidelines, are carried out according to the quality schedule.	
Rating	**Applicable HSF IDs**
Met	All

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
Comments
The organisation has an antimicrobial stewardship program that is guided by the new evidenced based 'Antimicrobial Prescribing and Management Policy'. Resources are available to staff and processes are in place to define the restriction and rules with respect to antimicrobial use, with the 'traffic light' system which describes the formulary, being on display in the wards. Results of audits are used to promote quality improvement. The organisation complies with the requirements of Advisory 18/08 and ACSQHC Fact Sheet 11 (3.15d).

Rating	Applicable HSF IDs
Met	All

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
Comments
Documentation showed that the antimicrobial stewardship program included the review of antimicrobial prescribing and use and surveillance data (e.g. from the Nationals Antimicrobial Utilisation Surveillance Program [NAUSP]) on antimicrobial resistance. The program is evaluated, and performance is monitored with reports provided to clinicians and the governing body. Clinicians interviewed were able to describe the processes in place to evaluate antimicrobial use and how surveillance data on local antimicrobial resistance is used to support appropriate prescribing. The requirements of the Advisory AS18/08 have been met.

Rating	Applicable HSF IDs
Met	All

Standard 4 - Medication Safety

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

ACTION 4.01
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
Comments
The governance of medication management is defined by Healthscope and local policies, and procedures that apply a risk-based approach to effectively minimise incidents and harm. Staff are provided with medication management training that is commensurate with their roles. Medication management is overseen by the Pharmacy Committee, which reports to the Quality Committee, which in turn reports appropriate information to the Medical Advisory Committee. Slade Pharmacy has the contract for the pharmacy services and provides staff and data analysis. The regular ward medical officers (CMOs) provide a weekday service which helps to ensure continuity for patients and staff; and excellent team collaboration was observed by Assessors.

Rating	Applicable HSF IDs
Met	All

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
Comments
The organisation monitors the effectiveness of the medication management system through incident reporting and audits such as the National Standard Medication Chart (NSMC) audit and the Medication Safety Self Assessment (MSSA). Reports are provided through the governance structure and strategies are identified to improve performance when issues are identified. These include investigating the use of smart pumps. Most medications are dispensed for the patients, which reduces the opportunity for picking errors from the imprest room. In October 2021, compliance with completion of the medication management plan (MMP) was 50%. Nursing staff received education re the correct process for completing an MMP, including the need to have more than 1 verification source. A clinical pharmacist was employed in January 2022 to concentrate on the clinical activities associated with completion of the MMP, medication reconciliation and provision of medication discharge profile for high-risk patients.

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	
Suggestion(s) for Improvement	
Although there was a predominance of generic prescribing, there be a focus on a further increase in generic prescribing.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
The organisation aims to involve patients in their care by providing appropriate information about medications and treatments and fostering shared decision making within the constraints of the person's legal status or capacity. There are brochures, for example, the Slade Pharmacy brochure on 'Managing your pain medicines at home' which provide very useful information. Patients interviewed indicated that medication management was discussed with them and that they felt involved in the process and were able to understand the information provided. Information can be tailored with respect to health literacy.	
Rating	**Applicable HSF IDs**
Met	All

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
Comments
The scope of practice with respect to medication management is defined in policy and, where appropriate, in position descriptions for clinicians.

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	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
A best practice medication history (BPMH) is undertaken as soon as practicable and documented in the clinical record. This process was further enhanced in January 2022 when a 0.5 EFT clinical pharmacist commenced at the hospital to provide the BPMH. Patients are triaged in the medical and rehabilitation wards, and a referral system is used for surgical patients.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
Interviews with clinicians together with a review of documentation and observations made by the Assessors confirmed that current medications are reviewed for accuracy and congruence with the best possible medication history on presentation and at transition points. Discrepancies are then documented. Reconciliation is carried out on discharge, and the prescriber is contacted if changes are required. A medication reconciliation flowchart was observed in the medication rooms to educate nurses about the process.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
The process for identifying and documenting medication allergies and adverse drug reactions (ADR) is well defined and monitored. Records reviewed by members of the Assessment Team confirmed their consistent use. An ADR audit in August identified that documentation compliance was greater than 90%.	
Suggestion(s) for Improvement	
Continuing education be provided to staff to improve the documentation of ADRs and ensure that allergy alert stickers are on all charts.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
Adverse drug reactions are reported through the incident management system and the organisation as a strong culture of reporting incidents and near misses. Medication related incidents are reviewed by the Pharmacy and Quality Committees.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
The organisation has established processes for reporting adverse drug reactions to the TGA where required.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.10	
The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result	
Comments	
The process for indicating the need for a medication review is evidence based and based on risk and clinical need. Responsible clinicians were able to describe this process, how it is documented and how action taken in response to the review are followed through. Clinical documentation reviewed by Assessors supported this.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.11	
The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks	
Comments	
Information for patients on specific medications is available to clinicians and appropriate to the patient population. Patients reported being able to understand information about medications that was provided to them.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.12	
The health service organisation has processes to: a. Generate a current medicines list and the reasons for any changes b. Distribute the current medicines list to receiving clinicians at transitions of care c. Provide patients on discharge with a current medicines list and the reasons for any changes	
Comments	
Staff interviews and document reviews confirmed that a list of current medications can be produced whenever a patient is discharged or transferred. A medication list is provided to patients, their GP and VMO on discharge; and if applicable, to the nursing home.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.13	
The health service organisation ensures that information and decision support tools for medicines are available to clinicians	
Comments	
Clinicians have access to information and medication management support tools via the intranet. Clinicians reported being able to readily access this information.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.14	
The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the: a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted or expired medicines	
Comments	
The organisation monitors compliance with manufacturers' directions, legislation, and jurisdictional requirements for the safe and secure storage (including cold chain management), distribution and disposal of medications. Incidents are reported through the incident management system. Tall man lettering has been introduced for high-risk medicines with similar names. Disposal of unused, unwanted and expired medicines uses the return of unwanted medicines (RUM) bin system.	

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	
Suggestion(s) for Improvement	
There be increased compliance in the operating theatre with labelling drawn up medications which are not used immediately.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.15	
The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely	
Comments	
Interviews with staff and a review of documents supported the Assessors' observation that high risk medications are clearly identified, and that there is an appropriate management system in place for the storage, dispensing and administration of those medications. The medication chart audit in September 2021 identified that improvement is required with respect to VTE prophylaxis.	
Suggestion(s) for Improvement	
That there be an emphasis on improving VTE prophylaxis.	
Rating	**Applicable HSF IDs**
Met	All

Standard 5 - Comprehensive Care

Leaders of a health service organisation set up and maintain systems and processes to support clinicians to deliver comprehensive care. They also set up and maintain systems to prevent and manage specific risks of harm to patients during the delivery of health care. The workforce uses the systems to deliver comprehensive care and manage risk.

ACTION 5.01	
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	
Comments	
Documentation demonstrates the processes that are in place for implementing policies, managing risks and identifying the training required to deliver comprehensive care. Members of the multi-disciplinary team were able to describe how the organisation's safety and quality systems are used achieve this. A review of clinical documentation confirms that processes are in place for managing risks associated with comprehensive care.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
Comprehensive care is defined and monitored with a wide range of quality improvement activities being established to improve care including the implementation of falls huddles. The organisation uses feedback, data and outcomes together with evidenced based practice to support improvements in care. An example of this is the 2020 National Stroke Foundation audit which showed a marked improvement, including having all stroke patients screened and managed appropriately for mood, and 100% of patients having documented in their medical record that they had attended stroke education.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
Processes are in place to partner with patients in their care and associated decision making as best suits the patient. Staff were able to describe to the Assessors how they actively achieve this, and patients reported that they felt actively engaged in, and informed about their care. They especially appreciated the use of the Careboards and sunflower cognition information tool which they could see from their beds. The patient information directory is comprehensive, and there are well prepared brochures which cover issues such as preventing pressure ulcers and cognitive impairment.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
Clinicians are supported by policies and procedures to establish effective comprehensive plans for patients' care and treatment. The organisation operates within their scope of service to provide care that best meets the patient's needs and has established protocols and processed for referral where needed.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
Multidisciplinary care is well established, and the role of team members is well defined across the organisation. Staff from all professional groups and disciplines interviewed by the Assessors were able to articulate how multidisciplinary care works across the organisation, and good teamwork was observed.	

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	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.06	
Clinicians work collaboratively to plan and deliver comprehensive care	
Comments	
Clinicians and patients were able to describe how they work collaboratively to plan and deliver comprehensive care. This was supported by clinical documentation and witnessed multidisciplinary meetings which confirmed this. There are meetings which include the discharge planners meeting with the allied health team, and weekly case conferences with doctors.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
Processes are in place to screen and assess patients for risks aimed at minimising preventable harm. Clinicians were able to describe the risk assessment process and evidence was sighed in clinical documentation. Regular audits are undertaken to support that timely and comprehensive risk screening and patient assessment is completed. The organisation is compliant with the requirements of Advisory AS18/14.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
The organisation demonstrates processes are in place for identifying Aboriginal and Torres Strait Islander patients and recording this information in administrative and clinical information systems. Staff were able to describe the processes in place for patients to identify as being of Aboriginal or Torres Strait Islander origin, and administrative staff ask the patient if this information is not completed on the admission form.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.09	
Patients are supported to document clear advance care plans	
Comments	
Patients are supported to document advance care plans on admission, and information is also recorded on the alert sheet.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.10	
Clinicians use relevant screening processes: a. On presentation, during clinical examination and history taking, and when required during care b. To identify cognitive, behavioural, mental and physical conditions, issues, and risks of harm c. To identify social and other circumstances that may compound these risks	
Comments	
A comprehensive and holistic assessment is conducted on admission and repeated when clinically indicated. This includes screening for a range of risks for preventable harm, including cognitive, behavioural, mental, physical risks and the social and other issues that may compound risk. Risk screening processes are subject to audit and reports are provided through the organisation's governance structure. A limited review of clinical documentation by the Assessment Team reinforced this. The organisation is compliant with the requirements of Advisory AS18/14.	

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	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.11	
Clinicians comprehensively assess the conditions and risks identified through the screening process	
Comments	
Risks are identified using standardised screening tools which identify the level of risk and appropriate actions to mitigate them.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.12	
Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record	
Comments	
Risks identified during screening and assessment are documented with appropriate action plans developed as needed to mitigate them, including alerts and responses to identified risk.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.13
Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies the support people a patient wants involved in communications and decision-making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and available f. Is consistent with best practice and evidence
Comments
Clinicians and patients were able to describe the role patients, carers and families play in their care and in determining patient centred goals and how it aims to best meet their specific needs. A review of clinical documentation by the Assessors reflected this and demonstrated that comprehensive discharge planning is initiated as early as possible in the patient's journey. Members of the assessment team witnessed interactions between staff, patients, their carers and families that demonstrated this partnership in care and decision making. Care plans reflect contemporary evidence based best practice principles. The requirements of Advisory AS18/15 have been met.

Rating	Applicable HSF IDs
Met	All

ACTION 5.14
The workforce, patients, carers and families work in partnership to: a. Use the comprehensive care plan to deliver care b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care c. Review and update the comprehensive care plan if it is not effective d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur
Comments
Patients, their carers and families were able to articulate their level of engagement in their care and expressed satisfaction that they actively participated in decision making at all points of care and transition. Goals of care are monitored, and care planning modified in response to change in goals, changing clinical status needs or risk profile.

Rating	Applicable HSF IDs
Met	All

ACTION 5.15	
The health service organisation has processes to identify patients who are at the end of life that are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care[46]	
Comments	
Processes to define those patients at end of life are in place and staff interviewed were aware of these. The organisation has aligned is processes to the National Consensus Statement: Essential elements for safe and high-quality end-of-life care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.16	
The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice	
Comments	
The organisation has access to specialist palliative care services / advice through a physician who is credentialled for palliative care. Staff interviewed were aware how to access these services.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.17	
The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record	
Comments	
A review of clinical documentation confirmed that advance care plans are documented in the patient's healthcare record. Clinicians who were interviewed could describe the process in place to ensure that patients with an advance care plan are identified, and that care is provided in accordance with these plans. The medical officer in the rehabilitation ward is championing this in conjunction with VMOs.	

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	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.18	
The health service organisation provides access to supervision and support for the workforce providing end-of-life care	
Comments	
Supervision and support for staff providing end of life care are available through the nurse unit manager and social worker; staff are provided with palliative care training and are aware of how to access support services.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.19	
The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care	
Comments	
Goals of care for patients at end of life are articulated in the clinical record and established in partnership with patients, their carers and families. The planned goals are reviewed regularly, and changes documented in the clinical record. Information from carers reported good results.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.20	
Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care[46]	
Comments	
The organisation supports shared decision making about end of like care with patients, their carers and families. This is supported by regular communication and documented in the clinical record, and the Assessors saw evidence of this in clinical documentation. Support for decision making is consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.21	
The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines	
Comments	
The organisation providing has evidence-based policies and procedures for pressure injury prevention and wound management. These are well referenced and regularly reviewed.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.22
Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency
Comments
Skin inspections are conducted in accordance with policy. All wounds are regularly reviewed and documented on the daily care plan.

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	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.23	
The health service organisation providing services to patients at risk of pressure injuries ensures that: a. Patients, carers and families are provided with information about preventing pressure injuries b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries	
Comments	
Information is available to patients, their carers / families about pressure injury prevention. This information is in a user-friendly format and staff were able to describe how they would use it. Equipment, products and devices are available to prevent and manage pressure injuries, and the Assessor witnessed these products in use.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.24	
The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: a. Falls prevention b. Minimising harm from falls c. Post-fall management	
Comments	
Evidence based policies and procedures include risk assessment, prevention, harm minimisation and post-falls management. Compliance with undertaking falls risk assessments and falls management action plans is audited. Staff were able to describe strategies to minimise harm and clinical documentation reviewed by the Assessment Team supported that this is undertaken comprehensively. Incident data related to falls is analysed and reported through the organisation's governance structure. A post-fall huddle includes the patient and the physiotherapist. The care plan is updated, a RiskMan entry is submitted, there is medical review, the family is contacted, there is physiotherapy, medical and pharmacist review, and the need for falls prevention equipment is assessed. A new committee for falls has been established.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.25	
The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls	
Comments	
Equipment, devices and strategies to prevent falls and minimise harm from falls are available to staff. Members of the Assessment Team saw evidence of the use of these in accordance with the requirements of individual patients as identified on screening.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.26	
Clinicians providing care to patients at risk of falls provide patients, carers and families with information about reducing falls risks and falls prevention strategies	
Comments	
Information is available to patients, their carers / families about falls prevention and risk management strategies. This information is in a user-friendly format.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.27	
The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice	
Comments	
Patients are assessed for nutritional needs and risk of malnutrition. Special dietary plans are established for those who require them and referrals to a dietitian are made where risks are identified. The Assessors saw evidence of screening and referral on review of records and interviews with staff confirmed their understanding of the process. Dieticians and speech therapists are involved and follow up on diets is also provided by the technical dietary assistants.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.28
The workforce uses the systems for preparation and distribution of food and fluids to: a. Meet patients' nutritional needs and requirements b. Monitor the nutritional care of patients at risk c. Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone d. Support patients who require assistance with eating and drinking
Comments
The organisation provides nutritional support to patients based on their specific needs that are identified through risk screening. Patients who are at risk of malnutrition or who require assistance with eating and / or drinking are provided with assistance. The service has access to specialist dietetic support for those patients identified as at risk or with specific needs. Food and fluid intake is monitored and reported for those patients who are at risk of not having their nutritional needs met. Information is recorded on the food chart and fluid balance chart. The onsite kitchen provides excellent flexibility if required.

Rating	Applicable HSF IDs
Met	All

ACTION 5.29
The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard47, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation
Comments
Cognition screening is undertaken on admission and as required throughout a patient's admission where clinically indicated. Evidence based policies and procedures support staff in developing appropriate management / care plans and these strategies are reviewed for effectiveness. This includes the use and monitoring of medications to ensure compliance with best-practice standards. Screening rates are audited and reported through the organisation's governance structure. The organisation is compliant with the requirements of Advisory 18/12 (1.27b) and ACSQHC Fact Sheet 11 (5.29a).

Rating	Applicable HSF IDs
Met	All

ACTION 5.30	
Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. Recognise, prevent, treat and manage cognitive impairment b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care	
Comments	
Documentation reviewed shows systems are in place to care for patients with cognitive impairment. Risk screening for cognitive impairment and delirium is undertaken, including the use of the Montreal Cognitive assessment form. Staff were able to describe how they collaborate with patients, carers and families in caring for patients with cognitive impairment. This includes using distraction: an allied health assistant is a diversional therapist; and using the sunflower cognition tool – the use of which was 92% in the medical ward in February.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.31	
The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed	
Comments	
Strategies and screening tools are in place to identify patients at risk of self-harm and / or suicide. On identification of patients who may be at risk there are documented intervention strategies that staff were able to articulate. The organisation has access to referral service where patients are identified as at risk, and they are transferred out of the facility.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.32	
The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts	
Comments	
Where patients have self-harmed or reported suicidal thoughts clinicians have access to timely follow-up and referral service. Staff were able to describe how they would access and use these services.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.33	
The health service organisation has processes to identify and mitigate situations that may precipitate aggression	
Comments	
The organisation has policies that support the identification, mitigation and management of aggression and staff are aware of how these are used. There is an eLearning module on aggression for staff.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.34	
The health service organisation has processes to support collaboration with patients, carers and families to: a. Identify patients at risk of becoming aggressive or violent b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce	
Comments	
The organisation has strategies and processes in place to identify patients at risk of becoming aggressive including de-escalation strategies. The processes to manage aggression aim to minimise harm to patients, carers, families, staff and visitors and staff were able to describe how they work with patients and others to implement these strategies effectively. Incident of aggression are reported through the organisation's governance structure.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.35	
Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of restraint b. Govern the use of restraint in accordance with legislation c. Report use of restraint to the governing body	
Comments	
Policies and processes are in place to govern and manage the use of both chemical and physical restraint and these includes alternative strategies to minimise the use of restraint. The policy is consistent with the legislation and includes to processes for reviewing and reporting the use of restraint to the governing body. Reports were viewed by the Assessors. There is no physical restraint, but nurse specials, authorised by the Director of Nursing are used. The information is then entered on RiskMan. Specialling is a 1:1 ratio and there is a specialling care record.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.36	
Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of seclusion b. Govern the use of seclusion in accordance with legislation c. Report use of seclusion to the governing body	
Comments	
Not applicable.	
Rating	**Applicable HSF IDs**
NA	All

Standard 6 - Communicating for Safety

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

ACTION 6.01	
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	
Comments	
Policies and procedures are in place to support effective clinical communication including handover. These policies identify risk management strategies and also the training requirements / expectation of all staff in support of effective clinical communication. Assessors viewed supporting documentation and staff interviewed were able to describe the processes for clinical communication. WAVE workplace aggression violence and escalation is an eLearning module for nursing staff.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
Incidents relating to failure in clinical communication are reported through RiskMan, the incident management system and identified in patient feedback. This drives improvements and changes in communication strategies and processes. The effectiveness of clinical communication, including handover, is monitored through feedback and audit. Isobar is used at bedside handover together with the bedside handover checklist. The nurse discharge summary includes information from allied health professionals, and a medication list is provided by the pharmacy. This information is provided to the patient, GP, VMO and is added to My Health Record.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
The organisation has policy that supports the engagement of patients, their carers and families in their own care and shared decision making. Patients are involved in clinical handover and the Assessors witnessed handover supporting this. Patients who were interviewed reported being engaged in their care and that they had information available to them to make informed decisions about their care. The sunflower cognition tool is used, and allied health professionals liaise with patients re their plan. When home visits have not been possible, photos and facetime have been used, and an iPad is available on the ward for family meetings.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
Policies and processes are in place to support appropriate identifiers are used, in procedure matching, transfer of care, handover, discharge and where changes in clinical care / patient risk profile are identified. Documentation viewed by the Assessors supports the use of specified identifiers in these situations. There have been no incidents with wrong procedure matching. A bedside handover checklist is used to ensure all appropriate information is shared. If critical information has to be shared with the patient's doctor, a directory of doctors is available. Staff are aware of high-risk areas such as in theatre and when administering medications.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
The organisation has policies that define the use of three approved identifiers. Staff interviewed by the assessment team were able to describe how and when these are used. Patients were also able to describe the questions asked to confirm their identity and the Assessors witnessed this when observing handover and medication administration.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
The Assessors noted the use of approved patient identifiers as noted in Action 6.5. Additionally, processes are in place for surgical / procedural time-out, and this is documented and audited. A limited review of clinical documentation supported these findings, as well as observation of operating theatre time out.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
Clinical handover documentation contains the required minimum content, relevant risk and needs of the patient, and the clinicians involved in handover. Compliance with these requirements is audited. Staff could explain their respective roles in clinical handover the processes used to support this including the minimum information communicated at clinical handover with the use of Isobar. This supported the clinical handovers witnessed by members of the Assessment Team.	

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	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
The assessment team witnessed clinical handover that was structured using the Isobar tool, and effectively engaged with patients, their carers and families in defining goals of care and decision making. The processes in place for clinical handover ensure the relevant clinicians are actively engaged in the process and members of the multidisciplinary team are encouraged to be involved as necessary. There is a nursing and allied health handover from Monday to Friday. Both patients and staff were able to articulate the process of handover and provide confirmation of patients, care and family in decision making. Clinical handover is audited regularly and incidents relating to ineffective handover are investigated with lessons learned, shared and disseminated.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
The organisation has policies and procedures to guide staff in effective communication and handover of critical information including risks and alerts. Both patients and staff were able to describe to the Assessors how this worked and how patients, their carers and families were involved when they wanted / needed to be.	

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	
Clinical handover is audited, and incidents / feedback related to communication issues are addressed appropriately. The doctor is the team leader. At the latest time out audit, compliance was 100%.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.10	
The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians	
Comments	
Documentation shows communication processes are in place for patients, carers and families to directly communicate critical information and risks about care. REACH posters are on the wall in the patient's room and explained on admission and ward orientation. Clinicians and patients / carers interviewed confirmed this and the Assessors observed information available to support and facilitate this process. There are communication boards and daily goal settings. The social worker may be involved, and there is a welfare check program. Post operation phone calls are made to patients.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.11	
The health service organisation has processes to contemporaneously document information in the healthcare record, including: a. Critical information, alerts and risks b. Reassessment processes and outcomes c. Changes to the care plan	
Comments	
Clinical documentation reviewed by the Assessors confirmed compliance with the organisation's process to ensure complete, accurate and up to date information is recorded in the healthcare record: on webPAS and the clinical record. Members of the clinical team could describe this process. Comprehensive clinical documentation audits are conducted. Changes to the care plan are documented on the care plan sheet and/or in the clinical record.	

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	
Rating	**Applicable HSF IDs**
Met	All

Standard 7 - Blood Management

Leaders of a health service organisation describe, implement and monitor systems to ensure the safe, appropriate, efficient and effective care of patients' own blood, as well as other blood and blood products. The workforce uses the blood product safety systems.

ACTION 7.01
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
Comments
HVPH has overarching governance systems in place that are consistent with national guidelines. Policies and protocols on blood management are available on the intranet and are effective given the low rate of non-compliance. Policies include the prescribing, administering and management of blood and blood products. At present there are three blood related risks on the risk register, viz. inadequate management of blood and blood products, inadequate waste management and incorrect transfusion. It is reported that there are few incidents relating to blood management due to staff education and competency-based assessments and close and regular monitoring by the Pathology service. Overall responsibility for the management of blood and blood products is allocated to the DON and Theatre Manager. Any incidents concerning the management of blood and blood products are entered into RiskMan and reported and reviewed at the relevant committee(s). Through audits and quality reviews several improvements have been made to the management of blood with assistance from the external Pathology company located within the hospital grounds.

Rating	**Applicable HSF IDs**
Met	All

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
Comments
The Pathology service provider monitors the usage of blood and blood products. Consent for blood transfusion is documented on a separate consent form. The Quality Committee and MAC monitors the outcomes of blood management and will continue to monitor completion rates. Integrated into the annual Audit Schedule is the Blood Fridge audit and the Blood Transfusion Pathway audit with positive outcomes reported.

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	
Evaluations and reviews have resulted in improvements to the efficiency of the transporting and management of blood by the Pathology service, the cold chain logbook and information provided to patients and staff.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
Consent is always obtained from patients regarding blood transfusion. There is discussion and the sharing of information prior to transfusion with the patient and the clinician. The Patient Information Directory booklet and brochures and handouts in the Blood Management Resource Folder provides very good information on blood transfusion, possible reactions, why a transfusion might be needed and other plain language information. The staff are aware of the protocols to follow if a patient refuses a blood transfusion.	
Rating	**Applicable HSF IDs**
Met	All

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
Comments
HVPH have policies and procedures in using the patient's own red cell mass, whether the patient is in need of iron infusion in order to reduce transfusions. Pre-surgery checks are done to determine any existing risks the patient might have regarding bleeding or other disorders, the amount of blood the surgeon believes will be needed for the particular surgery. Blood is registered out of the pathologist's blood fridge and registered into the blood fridge in theatre for use if needed.

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	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.05	
Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record	
Comments	
Consent for blood transfusion, blood and blood products prescription and transfusion record forms are completed and kept in the medical record.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
The eLearning Blood Safe module is provided to staff and the current Healthscope completion rate is 84% with no recompletion required. The prescription and administering of blood and blood products adheres to well defined protocols and incidents are rare. The Australian Blood Bank Authority Handbook and Healthscope policies are also available for staff information.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.07	
The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria	
Comments	
Any adverse event involving transfusion is reported into RiskMan and then reviewed by the Quality committee and MAC. To date there has been no adverse reactions, but if there is an occurrence, will be recorded in the Adverse Reaction Form held by the Pathology services. Sentinel events are reported to Healthscope and presented and discussed at the HVPH MAC.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.08	
The health service organisation participates in haemovigilance activities, in accordance with the national framework	
Comments	
The Quality Committee and MAC receive Blood Management reports that is consistent with the national framework and includes any adverse events and incidents that are documented in RiskMan. A report is forwarded to Healthscope and the National Blood Authority regularly.	
Rating	**Applicable HSF IDs**
Met	All

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
Comments
HVPH has good systems to order, track, store and distribute blood. The blood fridge in theatre is electronically alarmed and designated staff attend day or night if the alarm is activated. The pathology laboratory provides an excellent service daily and is well equipped to provide blood analysis results back to the doctors very quickly.

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	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.10	
The health service organisation has processes to: a. Manage the availability of blood and blood products to meet clinical need b. Eliminate avoidable wastage c. Respond in times of shortage	
Comments	
Blood wastage is monitored and reported by the Pathology service consistent with national guidelines and national criteria but is minimal at HVPH. If wastage is recorded, possible causes will be investigated and strategies put in place to reduce the wastage. Blood product expiry dates are checked regularly and when it is nearing expiry date the pathology service is notified of the return. Work continues with VMOs and CMOs to identify areas of improvement in blood management.	
Rating	**Applicable HSF IDs**
Met	All

Standard 8 - Recognising and Responding to Acute Deterioration

Leaders of a health service organisation set up and maintain systems for recognising and responding to acute deterioration. The workforce uses the recognition and response systems.

ACTION 8.01	
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	
Comments	
Clinical documentation reviewed by the Assessors confirmed compliance with the organisation's process to ensure complete, accurate and up to date information is recorded in the healthcare record: on webPAS and the clinical record. Members of the clinical team could describe this process. Comprehensive clinical documentation audits are conducted. Changes to the care plan are documented on the care plan sheet and/or in the clinical record.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
Systems are in place for monitoring the effectiveness of processes for identifying and managing acute deterioration. Both adult and age appropriate paediatric observation charts are used. In response to incidents related to clinical deterioration improvements have been made including establishment of the Code Blue Committee which reports to the Quality Committee and the Medical Advisory Committee. For emergency response, the clinical escalation process which commenced in September 2021 now involves response by a designated hospital team. Allocation for emergency response is carried out daily and ensures the appropriate skill mix. A sepsis pathway was also introduced in 2021. A stroke working party, has membership from nursing and allied health; and the National Stoke Foundation audit is used, in addition to staff education sessions.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
Documents reviewed show there is a process in place that supports partnering with consumers in recognising and responding to acute deterioration. This process includes involving patients, meeting their information needs and shared decision making. REACH (recognise, engage, act, call, help is on its way) information is provided in the admission poster and during patient orientation, and there are REACH posters in the patients' rooms. Interviews with staff and patients confirmed that patients are actively involved in planning and making decisions about the management of acute deterioration. The Assessors observed examples of the shared decision making which was supported by interviews with clinicians and patients. A consumer is on the Code Blue and Quality Committees and is part of the simulation program.	
Rating	**Applicable HSF IDs**
Met	All

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	
Comments	
Vital signs are monitored in according to policy using the colour coded observation chart and a review of clinical documentation supported this as did regular auditing of clinical documentation. Observations are undertaken in response to each patient's individual circumstances and the chart highlights potential clinical deterioration and the need for escalation / intervention.	
Rating	**Applicable HSF IDs**
Met	All

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
Comments
Policies and procedures support staff in identifying acute deterioration in mental state including the risk or delirium. Assessment and care planning documentation reviewed by the Assessors also supported that assessment drives the establishment of individualised and appropriate and management plans for patients with acute mental deterioration and / or delirium. Early warning signs of deterioration are documented on the comprehensive care plan and in the progress notes. Acute deterioration results in an alert on webPAS to increase the frequency of observations. Clinical documentation is audited regularly. Processes are in place to support timely communication between members of the treating team and the patient, carers and family members as detailed in Standard 6. The requirements if Advisory AS 19/01 have been met.

Rating	Applicable HSF IDs
Met	All

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
Comments
The organisation monitors performance of the identification and management of acute physiological, mental status, pain and / or distress through the appropriate observation charts, and concerns raised by staff, patients, carers and families through clinical documentation audits, incident management and clinical review. Staff and patients interviewed were aware of these processes and able to describe them to members of the Assessment Team, including the process for escalation of care where needed. Documentation reviewed identified policies and procedures are in place to support clinical staff in the management and escalation of clinical deterioration and they are current and reference best-practice. A pain specialist is available. Staff assess what can be safely looked after onsite, and transfer to another facility if this is appropriate. The requirements if Advisory AS 19/01 have been met (8.6 b, c, d, e).

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	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.07	
The health service organisation has processes for patients, carers or families to directly escalate care	
Comments	
Processes are in place for patients, carers or families to directly escalate care. Interviews with clinical staff, patients and carers confirmed this and observation of the escalation system used across the organisation further supported this process. Staff and patients were very familiar with the REACH poster and process.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.08	
The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance	
Comments	
The policy for escalation of care is clear and provides direction for staff to escalate care and respond to a clinical emergency. Staff were able to describe this process and the Assessors were provided with documentation to support the evaluation of these processes which are reported through the newly formed Code Blue Committee.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.09	
The workforce uses the recognition and response systems to escalate care	
Comments	
Staff were able to describe the systems in place to escalate care consistent with the organisations policy. Reports provided to the Assessment Team confirmed the effectiveness of these processes, and these will be reported through the Code Blue committee.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.10	
The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration	
Comments	
Education is provided to clinicians to support the timely and effective management of patients who acutely deteriorate. ALS and paediatric training are provided by an external provider.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.11	
The health service organisation has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support	
Comments	
The organisation provides access to clinicians with advanced life support skills and competency. Rosters are drawn up to enable 24 hr staffing of advanced life support skills. Staff were able to describe the process.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.12	
The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated	
Comments	
Interviews with clinicians confirmed the process for timely referral to mental health services to ensure that these referrals can meet the needs of patients whose mental state has acutely deteriorated. A psychologist can assess the patient, and if need be, the patient can be transferred out to the hospital which has psychiatric emergence care. Staff were able to articulate the referral process for these patients. The requirements if Advisory AS 19/01 have been met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.13	
The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration	
Comments	
Policies and procedures are in place for the timely referral to definitive care for patients who physically deteriorate. Staff were able to explain these processes to members of the Assessment Team, from the retrieval process to the hospitals which would be appropriate for transfer. The effectiveness of escalation of care processes are to be monitored through the new Code Blue committee.	
Rating	**Applicable HSF IDs**
Met	All

Recommendations from Previous Assessment

Nil