National Safety and Quality Health Service Standards 2.1 Short Notice Assessment

Final Report

Peninsula Private Hospital

KIPPA-RING, QLD

Organisation Code: 720861
Health Service Facility ID: 101179
ABN: 85 006 405 152
Assessment Date: 5th – 7th August 2025

Contents

Introduction

The Australian Council on Healthcare Standards
The Australian Council on Healthcare Standards (ACHS) is Australia's leading healthcare assessment and accreditation provider. ACHS is an independent, not-for-profit organisation dedicated to improving quality and inspiring excellence in health care. We accredit organisations according to either government standards, or our own established standards.

ACHS is approved to accredit the following standards

- National Safety and Quality Health Service (NSQHS) Standards including the Multi-Purpose Services Aged Care Module (MPS Module)
- National Safety and Quality Digital Mental Health (NSQDMH) Standards
- National Safety and Quality Primary and Community Healthcare (NSQPCH) Standards
- National Clinical Trials Governance Framework
- Royal Australian College of General Practitioners (RACGP) Standards for general practices (5th edition) and the RACGP Standards for point-of-care testing (5th edition)
- National Standards for Mental Health Services (NSMHS)
- Rainbow Tick Standards
- EQuIP Standards

Currently there are more than 1,600 healthcare organisations, including their associates, that undertake ACHS assessment and quality improvement programs. ACHS are proud to accredit the majority of all public and private hospitals in Australia.

With representation from governments, consumers and peak health bodies from throughout Australia, ACHS works with healthcare professionals, consumers, government and industry stakeholders to implement healthcare accreditation programs.

ACHS offers a variety of services including accreditation, education and training, data and benchmarking and consulting. We take a partnership approach to continuous improvement, tailored to the needs of individual services and health systems, using our expertise in accreditation, standards development and education.

Australian Commission on Safety and Quality in Health Care
The Australian Commission on Safety and Quality in Health Care (Commission) leads and coordinates national improvements in healthcare safety and quality. It works in partnership with patients, carers, clinicians, the Australian, state and territory health systems, the private sector, managers and healthcare organisations to achieve a safe, high-quality and sustainable health system.

Key functions of the Commission include developing national safety and quality standards, developing clinical care standards to improve the implementation of evidence-based health care, coordinating work in specific areas to improve outcomes for patients, and providing information, publications and resources about safety and quality.

The Commission works in four priority areas:

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

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

The AHSSQA Scheme sets out the responsibilities of accrediting agencies in relation to implementation of the following safety and quality standards:

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

The National Safety and Quality Health Service (NSQHS) Standards were developed by the Commission in collaboration with the Australian Government, states and territories, the private sector, clinical experts, patients, and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met.

There are eight NSQHS Standards, which cover high-prevalence adverse events, healthcare associated infections, medication safety, comprehensive care, clinical communication, the prevention and management of pressure injuries, the prevention of falls, and responding to clinical deterioration. Importantly, the NSQHS Standards have provided a nationally consistent statement about the standard of care consumers can expect from their health service organisations.

Rating scale definitions

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

Rating	Description
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. If there are no not met actions across the health service organisation, actions rated met with recommendations will be assessed during the next assessment cycle. **Met with recommendations may not be awarded at two consecutive assessments where the recommendation is made about the same service or location and the same action. In this case an action should be rated not met.** In circumstances where one or more actions are rated not met, the actions rated met with recommendations at initial assessment will be reassessed at the final assessment. If the action is not fully met at the final assessment, it can remain met with recommendations and reassessed during the next assessment cycle. If the organisation is fully compliant with the requirements of the action, the action can be rated as met.

Rating	Description
Not met	Part or all of the requirements of the action have not been met.
Not applicable	The action is not relevant in the service context being assessed. The Commission's advisory relating to not applicable actions for the health sector need to be taken into consideration when awarding a not applicable rating and assessors must confirm the action is not relevant in the service context during the assessment visit.

For further information, see Fact sheet 4: Rating scale for assessment

Repeat Assessment

If a health service organisation has 16 or more percent of assessed actions **rated not met and /or met with recommendations**, and /or more than 8 actions from the Clinical Governance Standard not met at initial assessment and is subsequently awarded accreditation, the organisation is required to undertake a further assessment within six months of the assessment being finalised. All actions rated not met or met with recommendations from the initial assessment will be reassessed. The aim of the reassessment is to ensure the organisation has fully embedded the necessary improvements in their safety and quality systems to maintain compliance with the NSQHS Standards. This is a one-off assessment with a remediation period of 60 business days. **All actions must be met when the assessment is finalised for the organisation to retain its accreditation.**
For further information, see Fact Sheet 3: Repeat assessment of health service organisations

Safety and Quality Advice Centre and Resources

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

Authority to act as an Accrediting Agency

I, Dr Karen Luxford, CEO of the Australian Council on Healthcare Standards (ACHS) declare that ACHS has the approval from the Australian Commission on Safety and Quality in Health Care to conduct assessment to the *National Safety and Quality Health Service Standards 2.1 Short Notice Assessment*. This approval is current until 31st December, 2029.

Under this authority, ACHS is authorised to assess health service organisations against the Australian Health Service Safety and Quality Accreditation Scheme.

Conflicts of Interest

I, Dr Karen Luxford, declare that ACHS has complied with Australian Commission on Safety and Quality in Health Care policy on minimising and managing conflicts of interest.

No conflicts of interest were evident as part of this assessment and no Consultants or third parties participated in this assessment.

Assessment Team

Assessor Role	Name	Declaration of independence from health service organisation signed
Lead Assessor	Heather Brown	Yes
Assessor	Judith Dixon	Yes

Assessment Determination

ACHS has reviewed and verified the assessment report for Peninsula Private Hospital. The accreditation decision was made on 16/09/2025 and Peninsula Private Hospital was notified on 16/09/2025.

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

Peninsula Private Hospital, part of the Healthscope organisation, underwent an assessment against the National Safety and Quality Health Service Standards 2.1 Short Notice Assessment from the 5th to the 7th of August 2025, requiring two assessors. The organisation was last assessed on the 4th, 5th and 6th of April 2023.

The ACSQHC PICMoRS methodology was used to conduct this assessment, with approximately 75% of assessor time spent in operational areas during the assessment.

Peninsula Private Hospital has been undergoing a major capital works program with the redevelopment of perioperative services which includes a state-of-the-art operating theatre complex and the refreshing of patient accommodation, due to open in the coming weeks. The Hospital was able to demonstrate that patient care has remained a key priority during this period of development and showed agility in working around some of the difficulties presented due to the building works without impacting adversely on patient care.

A Clinical Governance Plan is in place at both the National and local Hospital level, which describes the systems and processes in place for improving the safety and quality of services provided to patients, clinical partners, the workforce and the community and is aligned to the Strategic Plan. An effective Committee Structure is in place to monitor the performance of the Hospital and to report to the Executive Committee and to the Board on the Hospital's performance and to identify areas for improvement. A culture of safety and quality is encouraged through strong leadership and teamwork and measured through culture surveys. A good patient experience is fostered during a patient's stay and measured through patient experience surveys with consultant consumers actively involved in speaking to patients about their experience and identifying areas for improvement. Risks are identified through various means and regularly reviewed with senior managers reporting a low-risk appetite. Clinical variation is actively monitored through the Morbidity and Mortality Committee and through the reporting of clinical indicators to the ACHS.

The Consumer Partnership Plan 2024 – 2025 outlines strategies for partnering with consumers at both the National and local level to provide a strategic framework consumer engagement and partnerships at the Hospital. In discussion with Consumer Consultants who are actively engaged in the governance of the Hospital it was clear they have an important role in working with the Hospital to improve the experience of patients and their families and to guide the Hospital in further advancing the partnerships they have established within the community. Clinicians work closely with patients to share decision-making and communicate effectively considering health literacy and language barriers. Patient survey results show that patients are provided with the information they need to make decisions about their care. Consumer Consultants have developed a video to use for staff training describing the experience of being in isolation due to infection control measures. This video has a strong message to clinicians, and it would be good to see further videos developed showing different examples of the patients experience of care to clinical staff.

Infection control and antimicrobial stewardship procedures are audited to ensure that there is compliance with policy guidelines. Healthscope and Healthcare Infection Control Management Resources (HICMR) policies and procedures provide governance systems at PPH for the prevention

and control of infections and antimicrobial stewardship. There are robust national and local audit systems in place, for infection control, hand hygiene and antimicrobial stewardship to ensure there is compliance with policy guidelines.

Infection control and hand hygiene training records were reviewed, showing that further education and training of medical staff in hand hygiene is required as compliance was poor for this group. PPH is due to finish a major capital works in the operating theatre complex in September 2025, and this will ensure that the facility is able to respond to the current demands for surgical services with the integrated CSSD and theatres being vastly improved from the current lay out. The assessment team determined from the gap analysis that PPH is compliant with AS 5369:2023. Further capital work is scheduled for the few remaining patient rooms that have carpet and curtains to be updated with more appropriate finishes/materials.

Workforce screening and immunisation meets relevant requirements. The use of Blu-Tack on walls throughout the organisation is a potential source for micro-organisms to flourish, having discussed this with assessors, the team are going to review the use of Blu-Tack.

Antimicrobial stewardship (AMS) is monitored by the multidisciplinary PPH Infection Control Committee. Membership includes an infectious diseases (ID) specialist and a pharmacist from HPS Pharmacy. It was noted during SNAP that the ID specialist was not always available for this meeting. The team have reviewed the timing of the meeting and is adjusting the time to ensure that a medical officer is always available for the meeting.

HPS Pharmacy provide services to PPH. The current pharmacy is based in a small office and doesn't dispense to patients but carries pharmaceutical supplies for the hospital. The hospital may consider relocating the pharmacy to a more suitable location. Prescribing, dispensing, administering and monitoring the effects of medicines are part of everyday business. Clinicians demonstrated an understanding of the principles of medication safety and were observed engaging positively with patients and carers on multiple occasions.

Comprehensive care is governed by Healthscope policies and procedures with local governance that oversees delivery of care. Patients have comprehensive risk screening on admission and as required throughout their stay in hospital. Risk screening and incidents related to clinical risk are monitored through RiskMan and the scheduled Healthscope audits and data supported that the current rates of hospital acquired pressure injuries and falls were low. Patients and their families were observed collaborating with the multidisciplinary teams on their care and treatment options.

End-of life care is supported by palliative care physicians and meets the National Consensus Statement. PPH doesn't have a high dependency unit or a mental health unit. There are escalation processes for patients that require these services.

Patient food is prepared on site, and the quality was noted to be of a high standard, with positive comments from the patients directly and from notes they left on the meal trays. PPH is compliant with the Delirium Clinical Care Standard. Action 5.36 was confirmed as not applicable.

Governance systems and processes support effective clinical communication with policies guiding clinical practice, and safety and quality systems used to monitor and improve the effectiveness of

clinical communication and report on the hospital's performance to the Comprehensive Care and Communicating for Safety Committee. Processes are in place for the correct identification of patients using at least three patient identifiers and procedure matching was observed during a blood transfusion and in the Operating Theatre. Clinical handover uses ISOBAR as the standardised communication tool and consumers are included in clinical handover at the bedside and during ward rounds. Bedside patient boards include patient goals of care for some patients, but this is inconsistent, and goals were not updated during clinical handovers observed by the assessors. Shared decision-making is evident in conversations between clinician and patients and families.

Blood is well managed with clinical practice guided by policies and overseen by the Clinical Deterioration and Blood Management Committee. Staff have training through Blood Safe with the training required determined by a training matrix and role within the Organisation. Training rates are monitored. Patients are given information on the use of blood and blood products. Clinical incidents are reported on RiskMan and haemovigilance activities are reported to the Private Hospital Regulation Unit in the Department of Health. Blood usage is monitored, and strategies are in place to reduce this noting the single use of bags as one strategy. Blood and blood products are stored in a single blood refrigerator within the hospital with effective processes in place for the receipt, storage, collection and transport of blood and blood products. A blood and blood product refrigerator audit is conducted to verify this. Blood transfusions observed by the assessors were well managed and followed due process.

Policies and procedures are in place to provide guidance in responding to acute physical and mental deterioration. Training needs include Basic Life Support (BLS), Advanced Life Support (ALS) and Paediatric Life Support (PALS). A clinician with ALS is always on duty. Peninsula Rules and 'Are you worried' are in place for patients and carers to escalate care. There are clear processes for escalating care and referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated. Track and trigger observation charts are in place with the capacity to alter calling criteria. Escalation is via a Code Blue. Code Blues are monitored via RiskMan and the Clinical Deterioration and Blood Management Committee. The assessment team witnessed Code Blue, which was well managed.

Summary of High-Risk Scenarios Tested

A high-risk scenario was tested during with the hospital describing a critical incident with the risk of harm to patients and nearby residence as a result of the potential for an explosion of the BOC medical gas tank in the grounds of the Hospital following possible overfilling of the tank resulting in a gas leakage. Senior management described actions taken to manage the risk in line with the Emergency Management Plan. Emergency services were called and nearby residents advised of the incident with plans to evacuate patients and staff ready to activate. BOC's 24-hour emergency service was contacted and able to release pressure from the tank resulting in the situation being managed and emergency services being stood down. Investigation of the incident found that BOC was filling the gas tank late at night which contributed to the overfilling of the tank. Mitigation of the risk was undertaken with BOC required to stop late night filling of the gas tank and to notify the Hospital when they attend so that the activity could be supervised. A review of the level of ongoing risk led to the Hospital moving to another gas supplier who only delivers during the day.

Summary of Results

Peninsula Private Hospital achieved a met rating for all facilities in all actions and therefore there is no need 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

Peninsula Private Hospital

Site	HSFID	Address	Visited	Mode
Peninsula Private Hospital	101179	Cnr George & Florence St KIPPA-RING QLD 4021	Yes	On Site

Contracted Services

A sample of Contracts have been verified.

The following contracted services are used by Peninsula Private Hospital.

Provider	Description of Services	Verified During Assessment
Coregas	Medical Gases	Yes
SC Medical	Biomedical Equipment	Yes
BGIS	Generator Maintenance	Yes
Peninsula Lock & Key	Locksmith	Yes
Ecolab	Chemicals	Yes
Ensign	Laundry & Linen supplies	Yes
HPS Pharmacies	Pharmacy	Yes
Lumus Imaging	Radiology	Yes
Coregas	Gas	Yes
BGIS/ Raulands	Nurse Call	Yes
Envirofriendly	Grease Trap Maintenance	Yes
Rentokil	Pest Control	Yes
CSK Climatak	Blood Fridge	Yes
Fire Boar	Fire Detection and Suppression Equipment	Yes
BGIS/ VAE	Air Conditioning	Yes
SC Medical	Bed Maintenance	Yes
Malone Hospital Services Pty Ltd.	Bed Pan Flusher	Yes
BGIS	Building Management Systems	Yes
Cleanaway Daniels	Clinical Waste	Yes
BGIS	Door services	Yes
BGIS	Fire Walls and Penetration	Yes
BGIS	Medical Air Compressor	Yes
SNP/QML	Pathology	Yes
BGIS	Plumbing Services	Yes
Pressure Vessel Integrity	Pressure Vessel Inspections	Yes
Print Media Group	Printing	Yes
Thermoscan Inspection Service	Thermal testing switchboards	Yes
Maquet and Stryker Lights	Theatre Lights	Yes
SC Medical	Theatre Equipment	Yes
NSR Security	Security	Yes

Provider	Description of Services	Verified During Assessment
Southland/ BGIS	RO Membrane	Yes
BGIS	Electrical Safety Testing	Yes
BGIS	Electricity Works	Yes
Converge	Employee Assistance Program	Yes
Network Refrigeration	Cool room, freezer and ice machines	Yes
Baker Group	Ovens	Yes
Hobart	Dishwasher	Yes
Stoddart	Bain Marie	Yes

Peninsula Private Hospital has reviewed these agreements for the listed services in the three years preceding this assessment.

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	
A clinical governance structure at the local level enables implementation of the Clinical Governance Framework, as endorsed by the governing body, which specifies the safety and quality systems necessary to maintain and enhance patient care. Surveys are regularly conducted to assess the safety and quality culture. Committee minutes indicate that safety and quality systems are being used to monitor patient care with results communicated to the workforce and the community. Actions arising from an analysis of clinical incidents is undertaken with the organisation's progress on safety and quality performance monitored by the governing body, with a standardised agenda template used at the National and local levels to ensure consistency in information being reported. An Attestation Statement signed by the Board confirms the above.	
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
Demographic data shows that 1.2% of patients are Aboriginal or Torres Strait Islanders. The Indigenous Engagement Plan 2024 – 2026 outlines actions to be taken to address safety and quality priorities that address the specific health needs of Aboriginal and Torres Strait Islander people. These actions include providing culturally sensitive care through a welcoming environment, with staff receiving training in cultural sensitivity, access to Aboriginal Health Services external to the Hospital and the recruitment of Aboriginal and Torres Strait Islander members of the workforce. An initiative is in place to include questions in the risk screening tool around cultural

sensitivity to obtain further data to inform service delivery. Data on the First Nation patient consumer experience shows a higher net promoter score reported by this group of patients compared to other patients.

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
A Clinical Governance Plan is in place with the organisation demonstrating that it uses the framework to drive improvements in safety and quality.

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
Strategies documented in the Indigenous Engagement Plan 2024 - 2026 are monitored with evidence of progress made on each action provided to the assessors. Several strategies have been implemented including referring patients to the Aboriginal and Torres Strait Islander Hospital Liaison Service at Redcliffe Hospital to provide culturally appropriate support to Aboriginal and Torres Strait Islander patients and to support them back into the community.

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	
PPH demonstrated that issues of safety and quality are key factors in the organisation's business decision making. Senior managers confirmed this and provided examples of decisions made in relation to the purchase of equipment, consumables, new technology and major capital works demonstrating this. The Innovation, New Technology, Product and Equipment Evaluation Committee has a key role in this function. A National procurement process and guidelines include input from infection control, information technology, work health and safety and other relevant speciality areas. Risk assessments and product trials are completed prior to purchase of new equipment to ensure they meet the necessary requirements.	
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	
Staff interviews confirmed that staff operate within the clinical governance plan and understand their safety and quality responsibilities, explaining how they monitor, report, and evaluate performance.	
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	
Policies developed at the National level and for local issues are used at Peninsula Private Hospital. Policies and procedures are current, appropriately referenced, and compliant with relevant legislation, regulations, and State requirements. These documents are readily available to staff with compliance monitored through the safety and quality systems in place including incidents and audit processes.	
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	
A range of mechanisms are used to monitor the performance of the hospital and identify areas for improvement. These include safety and quality measures, audit results, benchmarking activities, clinical reviews, incidents and complaints and patient feedback. Reporting on the hospital's performance and outcomes of clinical care is through the clinical governance structure at the local level and up to the Board. The Quality Action Plan documents planned actions identified through these processes. Staff and consumers interviewed described quality improvements that they had been involved in.	
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	
Timely reports are provided to the governing body, workforce, consumers and the local community. Safety and quality data is available on the hospital's website. Safety and Quality Boards within the ward areas display safety and quality data where the information is readily accessible for patients, visitors and the workforce. A standardised agenda is used across all Healthscope Hospitals and includes quality data and reporting, the audit schedule, managing risk, evidence-based practice, external audit and a review of the quality action plan.	
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	
Risks are identified using information from a broad range of sources. The risk management system includes business continuity plans to support service delivery in the case of an emergency or disaster. The system is actively managed, evaluated and improved as needed. A risk register is maintained and reviewed regularly. Risk management is a standard agenda item in key Committees with reports provided regularly to the board, management, staff and consumers.	
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	
An incident management and investigation system is in place with staff receiving training in incident management. All incidents are investigated, with a root cause analysis conducted on all serious incidents. Data on incidents is included in the safety and quality report and monitored through the clinical governance committee structure. Themes arising from reported incidents, frequency and category of incidents are used to analyse trends and identify risks and areas for improvement.	
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 Framework b. Monitors and acts to improve the effectiveness of open disclosure processes	
Comments	
Peninsula Private Hospital has an Open Disclosure Program which is consistent with the Australian Open Disclosure Framework with training provided to key staff involved in the open disclosure process.	
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 has processes to regularly receive feedback from patients, carers and families about their outcomes and experience of care. The Net Promoter Score is a key performance indicator derived from patient feedback. This KPI is collected across all Healthscope sites and can be benchmarked to compare the hospital's performance against other similar hospitals providing an opportunity to identify areas for improvement and share learnings. Data on the results of patient experience surveys is available on the website for the community to review.	
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	
A complaints management system is in place with the Quality Manager responsible for managing complaints made by patients and their families and carers with all complaints investigated and responded to. Complaints are a standard agenda item reported through the Committee Structure with performance Indicators including the timeframes to responding and resolving complaints and complaints by classification and service. Patients, carers and families and staff are supported to report complaints. Risks identified through complaints are assessed using a risk matrix and recorded in the risk management system. Information from the analysis of complaints is used to identify areas for improvement.	
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	
Demographic data is used to identify the diversity of the consumers using the Hospital's services. Interpreters are used for non-english speaking patients as required. Groups of patients that are at higher risk of harm are identified through patient assessment and care planning and this information is used to inform service planning and delivery of care as evidenced by the rehabilitation service established within the hospital. A consumer led initiative around patients with visual impairment has led to improvements in the care of these patients.	
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	
Peninsula Private Hospital uses paper medical records which are available to clinicians at the point of care. Clinicians are supported to maintain accurate and complete healthcare records with audits completed as part of the audit program. Clinical coders will follow up where coding in the medical record is inaccurate. Medical records are stored securely, and staff have training in privacy and confidentiality. Privacy breaches are followed up through incident reporting or complaints management. Medical records older than one year are stored off site through a contracted service and available on request. Tracking of medical records is in place.	
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 Nursing Discharge Summary is uploaded into My Health Record. National patient and provider identifiers are used as are standard national terminologies. Secure messaging of patient information is in place. The requirements of AS18/11 have 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	
Access to My Health Record is controlled with a monthly audit conducted to monitor the accuracy and completeness of clinical information in My Health Record. Patients can opt out of My Health Record when completing on-line preadmission documentation.	
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	
The workforce attend orientation as part of the onboarding process at Peninsula Private Hospital with assessors attending an orientation session. Sessions on safety and quality form part of the orientation program with staff attending orientation confirming this. Training records are maintained.	
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	
A mandatory training program is in place that meet the requirements of the National Standards with training aligned to the role of the staff member, using a training matrix. Completion rates for training are monitored, and training records were reviewed. Clinical Competency Assessments are completed. Protected education time is available to the workforce to support staff in completing training.	
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	
Cultural diversity and sensitivity training is part of mandatory training and is completed as part of the onboarding process. Current compliance rate is 86.1%.	
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	
Staff performance reviews are conducted on an annual basis for all staff and include the identification of training needs. Performance review completion is audited, and current compliance rates were provided to the assessors. Staff described the performance management system and their role in the process.	
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	
Healthscope by-laws define scope of practice based on clinicians' credentials, competence, performance, professional suitability, and the organisation's clinical service capacity and plan. Senior clinicians determine this scope, which is monitored through processes like peer review. Surgeons' scope of practice is communicated via WebPAS for theatre staff. Reviews occur according to credentialling requirements or when introducing new clinical services, procedures, or technologies. The Medical Advisory Committee advises the Organisation on the suitability of the credentials and clinical scope of practice of applicants for a position in the Hospital.	
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	
Senior managers confirmed that processes are in place to ensure that all clinicians are credentialed, with a checklist used to ensure all relevant information required as part of the credentialling process is provided by the applicant and captured in eCRED. This includes the certification and recertification of clinicians undertaking colonoscopies. Annual monitoring of APHRA registration is conducted on clinical staff. The credentialling process for medical staff is undertaken every three years with provision in place for temporary credentialling when required.	
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	
Staff described their roles and responsibilities for quality and safety, which are defined in position descriptions. Orientation at on-boarding and mandatory training modules include information for staff on these roles and responsibilities.	
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	
Clinicians receive adequate supervision according to their designated roles and responsibilities and this is supported by position descriptions and the organisation structure. Access to after-hour advice is available. Clinicians described the different ways supervision was undertaken depending on the role of the person and their craft group.	
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 are given access to best practice guidelines, care pathways and decision support tools as confirmed by senior clinicians. Clinical care standards are implemented.	
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	
The Clinical Care Standards are used to monitor and act on variation in clinical practice such as monitoring the set of indicators included in the Colonoscopy Clinical Care Standard. Clinical Indicators are reported through METRIX to the ACHS. Peer review and morbidity and mortality meetings are used to monitor the quality of care provided to patients by medical staff. Advisory AS18/12 has been met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.29
The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose
Comments
The hospital's buildings, utilities, equipment, and infrastructure are well-maintained to ensure they are fit for purpose. BGIS are contracted to manage the preventative and reparative maintenance program. SC medical is contracted to manage biomedical equipment maintenance. Departments raise work orders for repairs. Maintenance activities include fire inspections, water testing, and body protection testing to ensure patient safety. All this occurs within the context of aging infrastructure and major building works at the hospital. Contracted services are managed through the National Contract Manager with day-to-day issues managed locally. The hospital is currently undergoing a major redevelopment with building works close to completion. Some storage areas currently in use were noted to be cluttered and a work-around is required while building works continue. Linen was relocated during the assessment in response to assessors' comments and it was noted that the new operating theatre complex will open within a very short time and storage provisions in this space will be used for linen. The current pharmacy is small and cluttered, and the space used to repair and maintain patient equipment is not appropriate for this function. Further development is planned to include a more suitable area to repair and maintain patient equipment. In the meantime, suggestions have been made around the pharmacy and relocating patient equipment requiring repair and maintenance to a more suitable location.

Suggestion(s) for Improvement	
• Consider relocating the pharmacy to a larger space. • Consider providing a more appropriate location for the maintenance and repair of patient equipment while waiting for further building works to be undertaken.	
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	
While there are few incidents of aggressive behaviour reported, strategies are in place to minimise the risks of harm for patients, carers, families and the workforce. Risks associated with unpredictable behaviours are considered through preadmission and admission risk assessments. Staff have OVA training and mock code black scenarios are used for training purposes. Staff have access to portable and fixed duress alarms to raise an alarm. An external security provider is contracted to provide security services to the Hospital. There is access to a calm and quiet environment if required.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.31	
The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose	
Comments	
Signage and directions are in place which are clear and fit for purpose. Consumers have been involved in reviewing signage and providing feedback to the hospital, most recently in relation to the development of the new Operating Theatre block currently underway. Information is on the website about parking and other transport options to get to the hospital. A map is also available on the hospital's website.	
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	
Visiting hours for the hospital are from 10am to 8pm, with flexibility in visiting arrangements based on the patients' need.	
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	
Creating a culturally safe environment is a goal of Peninsula Private Hospital with action being taken to identify and address gaps in current practice through the Indigenous engagement Plan 2024-2026. Aboriginal artworks are displayed within the hospital, the Aboriginal and Torres Strait Island flags are located in the reception area and T-shirts have been designed for Consumers/Volunteers to wear displaying cultural symbols and Aboriginal artwork. Cultural protocols such as an acknowledgement to country occur at the start of meetings.	
Rating	**Applicable HSF IDs**
Met	All

Standard 2 - Partnering with Consumers

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

ACTION 2.01	
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	
The organisation's Consumer Engagement Plan 2024-2025 outlines strategies that have been developed to engage with consumers as partners in care and in the governance of the organisation. The safety and quality system captures risks through incidents, complaints, patient feedback and audit processes. Risks associated with the engagement of consumer representatives are managed through established HR processes including the identification of training requirements required of consumer representatives, with consumer consultants outlining the foundation training they have completed as part of their orientation to their role.	
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	
Process are in place for monitoring partnering with consumers with data collected on the patient experience reported through the governance committee structure and reported to the community through the hospital's website. Actions to improve the patient experience are noted in the Quality Plan. Risks to consumers are identified through the safety and quality systems such as the incident reporting and complaints management systems. Consumer Consultants sit on the Consumer Consultant Forum and review safety and quality performance data in this forum in line with the standardised agenda used across all Committees. Consumer consultants interview patients about their experience of care and review this with the clinical team providing treatment.	
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 Rights b. Easily accessible for patients, carers, families and consumers	
Comments	
Patients are informed of their healthcare rights, consistent with the Australian Charter of Healthcare Rights. Posters are located throughout the hospital and included in patient information provided to patients as part of their admission. Safety and quality systems such as incidents, complaints and patient feedback are used to monitor how well patients' rights are upheld by the Hospital.	
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	
Policies guide clinical practice, outlining the requirements for obtaining informed consent including when consent should be obtained, refusal of treatment or consent, capacity of a patient to consent, emergency situations where consent is not required. An audit of informed consent finding 100% completed correctly. Audit of blood consent forms identified that patients weren't always signing the form correctly and this has since been rectified. Clinicians described how shared decision making is used in supporting the patients to make informed decisions about their care. Financial consent is obtained with patients provided information on out-of-pocket expenses with the process described to Assessors by admin staff responsible for this task. The requirements of AS18/10 have been met.	
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	
Processes are in place to identify the capacity of a patient to make decisions about their own care and identify a substitute decision maker if a patient does not have the capacity to make decisions for themselves with information on this process included in the Consent Policy.	

Regular clinical risk assessment for delirium, cognition, and mental health help provide information on a patient's cognitive function. Clinicians demonstrated a good understanding of the actions they take in this situation and how they determine who would be the substitute decision maker.	
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
Clinicians work with patients or their substitute decision makers to plan, set goals, and make care decisions. Care boards record patient goals, and while not always used consistently, those reviewed were meaningful. Clinical handover and family meetings provide opportunities to discuss current and future care. Patient experience surveys and interviews with patients by consumer consultants provide information on the patient's experience of care.
Suggestion(s) for Improvement
Improve the documentation of patient goals of care on the patient care board.

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
Staff are supported to form partnerships with patients and carers through training in ways to improve the patient experience and setting a culture around the importance of partnering with consumers. Staff described how patients are actively involved in their care and how they consider the health literacy of patients when providing care. Various ways of providing information to patients are used including the use of various media. Interpreters are used as required and translated information is available. Patient feedback is used to monitor the effectiveness of staff in establishing partnerships with patient and carers so that patients can be actively involved in their own care with patient surveys used to monitor this.

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	
Communication strategies are tailored to reflect community demographics and support diverse consumers. Interpreter services and translated materials are provided as needed. Patient information is reviewed for readability, and techniques like teach-back help confirm understanding.	
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	
Consumers help develop and review internal health information, with a Consumer Approved Publication tick added to indicate their review.	
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
Peninsula Private Hospital provides comprehensive information on their website about the clinical services available at the hospital and common conditions treated by these services. Patient information is easy to understand and readily available to patients and their families. Interpreters are available and translated material can be accessed if required. Patient surveys show that patients feel involved in their care and are kept informed about their care. There is no specific question in the patient survey regarding whether the information they receive helps them make decisions about their care. A nursing discharge summary is provided to all patients at discharge, sent to their GP and to My Health Record if consent has been given by the patient to do this.

Suggestion(s) for Improvement	
Consider including a question in the patient survey on whether the information they receive assists them in making decisions about their care.	
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	
Consumers are involved in governance, design, and evaluation of health care with a consumer consultant describing activities they've been involved in including interviewing patients about their experience of care and providing feedback to staff about any concerns raised. The Consumer Consultant Forum is held quarterly seeking input from consumers on a range of issues. Consumers had relevant past work experience in risk management and governance and quality. The consumers represent the demographic of patients who attend the hospital for care.	
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	
Consumer consultants receive comprehensive training on their role through foundation training which is undertaken when commencing in the role, and consumers described the training they received.	
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	
Healthscope has an Aboriginal Reconciliation Plan which is applied across all Healthscope hospitals, and Peninsula Private Hospital has adapted the plan to meet local needs. The hospital has access to the Aboriginal Health Liaison Service in the neighbouring Redcliffe Hospital to meet the healthcare needs of Aboriginal and Torres Strait Islander patients. The hospital is partnering with the local Aboriginal community in the design of artwork to be installed as part of the new development. The hospital has held traditional ceremonies such as a smoking ceremony and planned water ceremony as part of the Hospital's redevelopment process.	
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	
Consumers are actively involved in educating the workforce with examples of these activities including a video which has been developed for use during orientation of a patient's experience of being in isolation due to COVID. The video is a powerful way of educating staff about a patient's experience in this situation. Consumer consultants interview patients and provide feedback to staff regarding any concerns the patient may raise, with consumers describing how effective this is in ensuring the voice of the patient is heard.	
Suggestion(s) for Improvement	
It is suggested that further videos be made of patients' experience of care to build a library of resources that portray the experience of patients in different situations during their stay in Hospital that can be used to incorporate their views and experiences into training and education for the workforce.	
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	
PPH uses Healthscope policies and procedures for infection prevention and control (IPC). and antimicrobial stewardship (AMS) and these are available on HINT and in resource folders in each unit. A multidisciplinary Infection Control Committee meets bi-monthly identifies and manages risk associated with IPC and AMS. A 2025 infection control management plan is in place, with a comprehensive Healthscope schedule of audits for IPC systems and the audit results are provided to individual units. These include environmental audits, antimicrobial audits, Bare below the Elbow audits, indwelling catheter audits and invasive devices audits, central venous devices audits, linen and laundry, endoscopy tracking, sterile stock storage, aseptic technique, personal protective equipment (PPE) and AMS. AMS results are also presented to the treating physicians. Hospital Infection Control Management Resources (HICMR) provides advice and audits PPH every two years, making recommendations for improvement in relation to infection control which actively address any non-conformances. The last audit was conducted in May 2024.	
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
The Infection Control Committee is multidisciplinary and manages the risks associated with infections using the hierarchy of controls in conjunction with IPC systems. This was verified by a review of the meeting paper agenda and minutes. There is mandatory training both on line and practical in relation to infection control including aseptic technique and hand hygiene. This is monitored by the managers and education team. There is a comprehensive schedule of auditing for IPC systems, and the audit results are reviewed at this committee and provided to individual units and overseen by the National Healthscope Committee. The audits include environmental audits, antimicrobial audits, bare below the elbow audits, indwelling catheter audits and invasive devices audits, central venous devices audits, linen and laundry, endoscopy tracking, sterile stock storage and aseptic technique. There is a tiered plan for public health and pandemic risk.

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
There is a comprehensive audit schedule for IPC systems and results are provided to individual units and aggregate data is provided through the governance structure. Data was observed on the quality boards in departments. This is updated monthly and readily available to clinicians, patients and their carers. PPH provides data to the National Antimicrobial Prescribing Survey (NAPS), National Antimicrobial Utilisation Surveillance Program (NAUSP) and ACHS Infection Control Clinical Indicators. The data is monitored through the Infection Control Committee and results given to clinicians.

A hospital-wide NAPS point prevalence survey was conducted in 2024. The results showed 31/48 (64.6%) patients on antimicrobials. Compliance with guidelines was 96.9% and 100% appropriateness of antimicrobial use. The survey reviewed the indication for use and most commonly prescribed antimicrobial.	
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
Patients and staff were able to describe the actions taken to involve and inform them about IPC and AMS measures. Information is available to patients, carers and families in a format that is easily understood. An audit of 20 patients in relation to AMS was conducted in November 2024, the results, 15/20 of the patients surveyed said that they were not given any information. A suggestion is made in relation to this.
Suggestion(s) for Improvement
A suggestion is made in relation to reviewing the process of how the information is provided to patients in relation to anti-microbials and then resurvey.

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	
PPH collects and monitors data on healthcare related infections and antimicrobial use as well as broader infection control surveillance data through the Infection Control Committee locally and by Healthscope Nationally, and reports are provided to clinicians. Current data that supports the effectiveness of the organisations strategies includes hand hygiene audits, intravenous device management (Staph Aureus Bacteraemia) indwelling catheter, hospital acquired complications and surgical wound infections, blood and body fluid exposure injury (BBFEI). Benchmarking with Healthscope Nationally and externally through the ACHS Metrik (ACHS performance data program) provided the Assessors with favourable data supporting compliance. The organisation is compliant with Advisory AS21/02: Advice on implementing the 2020 AMS Clinical Care Standard.	
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 Healthcare, jurisdictional requirements, and relevant jurisdictional laws and policies, including work health and safety laws	
Comments	
The review of IPC documents indicates that processes are consistent with the Australian Guidelines of Infection in Healthcare, and transmission-based precautions are in place. Signage and other resources were consistent with the Australian Guidelines for the Prevention and Control of Infection in Healthcare. Compliance with policy across the facility was confirmed, with results reflected by the audits undertaken.	
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
Collaborative staff practice regarding communicating infectious status to both patients and the workforce are guided by policies and procedures to ensure transfer of critical information occurs at transfer of care including discharge. Handover, transfer of care and discharge processes include the requirement for documentation and communication of infectious status. Brochures, posters, Internet sites and pre-admission information are used to advise patients, carers and visitors on IPC processes in place to help reduce transmission of infections so far as is reasonably practicable. A competency-based training program is in place for the appropriate use of standard and transmission-based precautions and the testing and fitting of personal protective equipment by the workforce. This occurs at orientation as witnessed during SNAP and as required. Processes to monitor and respond to changes in scientific and technical knowledge about infections, relevant national or jurisdictional guidance, policy and legislation is overseen nationally by Healthscope and locally by the Infection Control Committee and the infectious diseases specialist. The infection prevention and control suite of audits includes monitoring compliance with standard and transmission- based precautions. Audit results reflect excellent compliance across all craft groups. It was noted that remedial action is taken in response to any non-conformance.

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
Procedures are available on standard and transmission-based precautions for patient risks which are evaluated at referral, on admission or on presentation for care, and re-evaluated during care. Staff demonstrated their understanding of risk screening procedures and the expectation of ongoing vigilance. There is a clear process for identifying and notifying relevant stakeholders of patients' risk status throughout their care journey and if they are transferred to other health facilities. Patients requiring isolation are placed in single rooms to ensure effective isolation. Appropriate resources and equipment are available to maintain compliance with infection control measures, and hand sanitiser is easily accessible. Cleaning and environmental practices are consistently aligned with current standards and requirements. The hospital uses 'Clinell clean' labels showing the date, time and name of person cleaning the equipment to inform staff the equipment has been cleaned. . The label is removed prior to use. Consumer representatives talked about being in isolation and the challenges for them. The current environment is challenging due to the major capital works of the new operating theatre complex due to be opened in September 2025. It was noted that storage of clean linen was problematic as it was near a thoroughfare with potential contamination. Staff responded and found an alternative location that complies with infection control standards. Most patient rooms have had carpets replaced with a more appropriate floor covering and there is a timeline for the remaining rooms. There are procedures to ensure the implementation of supplementary environmental cleaning and disinfection measures as necessary. Ongoing compliance with environmental hygiene standards is systematically monitored through routine audit processes. Staff reported that when the current building works are complete, there will need to be sign off prior to commissioning the new operating theatre complex by HICMR and Queensland Department of Health.

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	
All activities at PPH are designed to effectively manage infection risks. Single rooms are available for isolation, PPE is available if required, posters around the hospital indicate the precautions required and hand hygiene signage and hand gel are available. Environmental cleaning practices are consistent with policy. The housekeeping staff have systems and processes in place to ensure cross infection is minimised, and the audited routines were noted to be in place to guide workday activities. In the operating theatre the cleaning routine revolved around the activity of the unit. The theatre list allocation ensures infection risk screening is undertaken and informs patient management. Communication of a patient's infectious status is included at all handover points including transfer of care. The patient's infectious status is alerted on webPAS, the patient medical record, and on handover sheets. Patients, carers, families and visitors are alerted to precautions that are required with posters describing the required precautions at the entry of patient rooms and this is also discussed with them at bedside handover. There are pamphlets available from NHMR 'Hospital acquired infections'.	
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	
PPH has a Hand Hygiene Program that is aligned to jurisdictional requirements and the National Hand Hygiene (NHH) initiative. The organisation has three Gold Standard Hygiene Auditors and audits are undertaken in line with the National Healthscope Auditing Schedule. The audits are tabled at the PPH Infection Control Committee and as of December 2024 overall compliance was 85.1%.The audit results are used to improve compliance and the team are aware of, and looking at strategies to improve, medical officers' compliance with hand hygiene which was 44.4%. PPH is compliant with Advisories 20/02 and 23/0.	
Suggestion(s) for Improvement	
Consideration given to how compliance by medical officers can be improved.	
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	
The Healthscope Aseptic Technique policy informs the process where aseptic non-touch technique (ANTT) applies. Staff training is undertaken at orientation and throughout their employment as part of mandatory training. Gaps in competency are addressed by the clinical leads in the units. Training rates are monitored by the Infection Control Committee. The education team follow up with staff that require ANTT training theory and practical competency assessment. Audit results indicated compliance with the organisation's policies on ANTT.	
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 Healthcare	
Comments	
Training and assessment for the appropriate use and management of invasive devices are available to staff and align with the current best practice. Patients with IMDs have the line checked at each handover. Associated infection rates are reported through RiskMan and monitored through the Infection Control Committee. No line associated infections have been reported in 2025.	
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 Healthcare 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	
Cleaning procedures and schedules are in place and audits are conducted and monitored by the Infection Control Committee. Disinfection products are listed as per the Australian Register of Therapeutic Goods, and Material Safety Data sheets are located where the chemicals are stored. Cleaning processes are aligned with the Australian Guidelines for the Prevention and Control of Infection in Healthcare, and jurisdictional requirements to ensure staff can respond to environmental risks and risks from novel infections. Staff training incorporates infectious cleaning and signage, donning and doffing PPE. Generally, the facility was clean but to note there are still some patient rooms scheduled for removal of carpet and curtains to be replaced with more suitable options. It was noted that many areas use Blu-Tack to fix patient and staff information posters to the walls and windows. Blu-Tack can leave a residue and damage paintwork when it is removed from walls, making it an infection control hazard as bacteria and spores can grow in the damaged surface. A suggestion has been made regarding an audit of the use of Blu-Tack and eliminating its use. Also the environment is cluttered due to the capital works of the theatre complex due to open in September 2025. As previously highlighted in Action 3.08, a review by HICMR prior to commissioning will ensure that the environment meets all the national and jurisdictional standards.	
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	
PPH has infection control processes, policies, and procedures to respond to infection risks for equipment, devices, products, buildings, and linen that are responsive to novel infections risks and pandemic planning. All new products are reviewed and assessed for infection-related risk. As highlighted in Action 3.08, the current environment is challenging due to the major capital works of the new operating theatre complex. As previously noted, the storage of clean linen was problematic as it was near a thoroughfare with potential contamination, and an alternative location was found that complies with handling, transporting and storing of linen. Maintenance is both scheduled and responsive to failure. Also noted were the plans for refurbishing the last of the patient rooms with carpet and curtains.	
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 Handbook b. Is consistent with jurisdictional requirements for vaccine preventable diseases c. Addresses specific risks to the workforce, consumers and patients	
Comments	
PPH vaccination requirements for preventable diseases are consistent with the Australian Immunisation Handbook and Queensland guidelines. Pre-employment screening occurs for staff who are supported to complete the vaccination required. There is an annual influenza program undertaken by credentialled nurse immunisers on staff. Rates were reported at 60% during SNAP.	
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 Healthcare 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
There are policies and procedures consistent with jurisdictional regulations to prevent and manage infections in the workforce. All new staff are screened to ensure that they have the necessary immunisations required to undertake their role. The program for workforce screening and workplace exclusion is aligned with Queensland Health directions. Data is collected through RiskMan in relation to staff exposure to blood and body fluid.

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
PPH OT and CSSD is undergoing a major capital works due to open in September 2025. The assessment team viewed both the old and new complexes. All elements of reprocessing, including an HICMR audit and the AS5369:2023 gap analysis were found to be consistent with the relevant guidelines. Governance is through the PPH Infection Control Committee any non-compliance would be entered into RiskMan. A traceability process is in place that can identify the patient, the procedure, the reusable instruments used for the procedure and the operator. There are processes to plan and manage reprocessing requirements, and additional controls for novel and emerging infections. Specific training includes GENCA fundamentals for staff who undertake cleaning of the equipment. The current complex is compliant with the reprocessing of medical devices and prior to commissioning of the new complex there will be a HICMR and Queensland Department of Health sign off.

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
PPH uses the Healthscope Antimicrobial Prescribing and Management and PPH policy. Staff who prescribe and administer antibiotics have access to Antibiotic Therapeutic Guidelines, with flow charts describing their roles and responsibilities, and access to restricted antimicrobials. The traffic light system for the prescribing of antimicrobial medication restriction and approval process is in place. The team has access to a HPS Pharmacist and an Infectious Diseases (ID) specialist for advice and guidance in prescribing appropriate antimicrobials. The results from the National Antimicrobial Prescribing Survey (NAPS) and National Antimicrobial Utilisation Surveillance is monitored through the Infection Control Committee (ICC). The assessors noted that the ID physician, who is the medical lead for AMS, wasn't always available to attend the ICC meeting and the team have made a decision to change the time of the meeting to enable them to attend.

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
The AMS program includes the review of antimicrobial prescribing and use and surveillance data on antimicrobial resistance. The program is evaluated, and performance is monitored with reports provided to clinicians and the governing body. Clinicians described 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	
Healthscope and PPH policy, procedure, and consumer information, are available on the HINT intranet and the L-drive, to support standardised safe and effective medication management. A local Medication Safety Committee reports to the Clinical Governance Committee. Medication related incidents are reported in RiskMan. Incidents and trends are reviewed by the managers and the Medication Safety Committee and are used in the education of nursing staff and fed into improvement activities. Reported medication errors were said to be Moderate Medication management training requirements are outlined in the PPH training schedule and include practical (such as medication, syringe driver and patient-controlled analgesia) and theoretical (medication safety, APINCH) assessments.	
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 wide audit schedule contains a comprehensive suite of medication management audits including high risk medications and controlled drug audits, medication audits, storage of medication audits, medication chart audits and line labelling of medicines audit. Performance outcomes are reviewed by the Medication Safety Committee, and any improvement plans are loaded into the quality tool eQuaMS. Sharing learnings across Healthscope facilities has seen the introduction of coloured syringes to reduce the risk of incorrect route of administration of oral medications.	
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	
Medication management discussions are conducted with patients and carers, and education about medications is provided, together with printed information. Patients and families are given a medication list when discharged from the facility and any changes to medications during admission are conveyed to the patient and their usual pharmacist. Interactions with patients were observed which demonstrated shared decision-making about medication management. A patient survey (conducted in November 2024) in relation to antimicrobials showed generally positive results , however the response from 15/20 patients was that they did not receive any information about antibiotics. Pamphlets are available on the Medical Rehab ward 'AURA - Do I really need antibiotics'.	
Suggestion(s) for Improvement	
Consideration should be given to reviewing the given to patients and at what point in the patient journey, and re-survey patients to determine if the information is being received.	
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	
Scope of clinical practice relating to prescribing, dispensing and administering medicines is defined in policy and position descriptions, with a list of nurse-initiated medications, and processes around phone and verbal orders of medication noted.	
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 possible medication history (BPMH) is taken by medical officers, pharmacists, or nurses, as early as possible in an episode of care. Patients who have an elective admission are encouraged to complete their medication history on line pre-admission or this may be done on paper at admission. Compliance with completing the BPMH as reported through the ACHS Metric, which showed that 50% of patients have this completed within 24 hours of admission. Priority is given to the medical and rehabilitation patients and that after the medical officers have documented the medications in the paper-based chart the pharmacist will review the medications and perform the reconciliation.	
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	
Patients' medication orders are reviewed against the BPMH and documented in the patient's medical record. Unexpected variation is investigated and actioned as required. Medication reconciliation occurs at admission, at transition of care, and at discharge to home.	
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	
A history of allergies and adverse drug reactions (ADRs) is checked on admission and recorded in the following ways: • the Alert Sheet placed in the front of the paper medical record, • on the electronic WebPas patient board, • on the PBS Hospital Medication Chart, and • the patient is given a red arm band to wear to indicate allergies.	

A medication chart review demonstrated that compliance with documentation of adverse reactions during handover and medication administration was routine. ACHS Metrix data from second half of 2024 had percentage of patients whose known adverse drug reactions are documented on the current medication chart at 97%.	
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	
There have been no reported cases of adverse drug reactions (ADRs) in recent times. However, clinicians can describe what is required if one occurs. The ADR would be communicated to the appropriate clinical teams and would be recorded in the medical record. All incidents are then recorded in RiskMan and reviewed by the Medication Safety Committee and reported to the Therapeutic Goods Administration (TGA).	
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	
As noted above, there have been no recent ADRs, however the staff would report to the Therapeutics Goods Administration (TGA) in line with Healthscope policy TGA 18.76. TGA notification forms are available for clinicians and TGA 'Report it!' pamphlets are available for patients.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.10	
The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result	
Comments	
There are evidence-based processes for medication review based on a patient's clinical needs and risk to minimise medication related problems. HPS pharmacists provide advice on any medication safety concerns to ensure that patients and their support network have a clear understanding of what medication they have been prescribed. A defined process for documentation of medication reviews includes any actions taken.	
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	
Medication information is easily accessible both on HINT and in hard copy, and includes MIMS, the Australian Injectable Drugs Handbook, and Therapeutic Guidelines and patient pamphlets.	
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 confirmed that a list of current medications is produced when a patient is discharged or transferred. A medication list is provided to patients and their GP and pharmacist on discharge. Any changes to medications for patients using Webster packs is conveyed to that patient's pharmacist.	
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	
Access to a range of references, resources, and decision tools for clinicians was noted, in both electronic and hard copy format. Clinicians demonstrated their familiarity with the use of medication management support tools.	
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
PPH complies appropriately with manufacturers' directions, legislation and jurisdictional requirements for storage (including cold chain management), distribution and disposal of medications across the service. Only authorised staff can access the medication storage rooms. Unused or expired medications are managed well and there are dedicated pharmaceutical waste bins for appropriate disposal. There is limited support for pharmacy management and stock control. Healthscope Corporate and PPH medication policies provide robust guidance for the management of S4 and S8 disposal processes. It was noted that propofol use in operating theatres is entered into a drug register but is not assigned to patients and wastage is not recorded. Discussion with senior management indicated that Healthscope is reviewing the use and monitoring of propofol nationally. A suggestion is made here to support a more robust recording of this particular medication given the potential for misuse and abuse. With the opening of the new theatre complex in the next month this is an opportune time to introduce new processes.
Suggestion(s) for Improvement
• A practical and safety-enhancing measure to support management of medication stock could be the use of a coloured sticker denoting the expiry year, coupled with a clear numeric inscription for the month. This system would allow the person checking to visually identify the year immediately and then use the handwritten number to verify the precise month. The sticker should not cover critical manufacturers details such as storage instructions, batch numbers or expiry date.

• Healthscope and Peninsula Private Hospital could consider implementing a more robust process for the management of propofol, with patients' names and wastage recorded in the current drug register.

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
High risk medications are identified and there are systems to store, prescribe, dispense and administer them. Compliance with the independent double-checking process required for the administration of high-risk medications was observed. S4 medications registers are checked daily and S8 medication registers are checked each shift. Compliance with this process and the legibility in the registers was high.

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	
Healthscope and PPH policies and processes regarding managing risks and identifying the training required to deliver comprehensive care are available on the intranet (HINT). PPH has a scheduled training session for staff called Enabling EDIE (Educational Dementia Immersive Experience). This is an immersive workshop that enables participants to see the world through the eyes of a person living with dementia and to help identify support needs and develop a support plan. Staff described 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	
The organisation has a clinical governance plan outlining strategies and priorities for the delivery and monitoring of comprehensive care. Comprehensive care is defined and monitored with a range of quality improvement activities being established to improve care. PPH maintains a Safety and Quality Plan that monitors the activities through the Healthscope Electronic Quality Management System (eQuaMS). The organisation uses feedback, data and outcomes together with evidence-based practice to support improvements in care. Data on comprehensive care was on display on the quality notice boards that staff, patients and carers could observe. This included falls and pressure injury rates.	
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	
PPH has processes in place to partner with patients in their care and associated decision-making, and staff were able to describe how they achieve this. Patients reported that they felt actively engaged in, and informed about, their care, while consumer representatives gave positive feedback about consumer engagement. On admission patients' goals of care are identified and then updated daily in the medical record and the bedside communication board. Patients are also asked on admission if they have an advance care directive, which is placed in the medical record, with an alert entered in WebPAS and in the medical record. Bedside handover was witnessed, and patients were actively involved in the process and able to ask questions. The organisation has QR codes with a link to a Patient Compendium, however when accessed there were issues with the information that the patient could access. This was addressed and updated. On discharge patients can provide feedback either via email or through a paper form and the results from the surveys were mostly positive.	
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 Healthscope and local policies and procedures to establish effective comprehensive care plans (CCP) identifying patients' needs and goals of care. There are triggers in the CCP for review and referral to other services as appropriate such as allied health clinicians. There are defined scopes of service and established protocols and processes for referral and transfer when required. There are established links and pathways with other hospitals including Redcliffe Hospital and Pine Rivers for patients requiring care outside the scope of PPH. PPH has systems in place to manage sepsis, palliative care and end-of-life care. The clinician with overall accountability is identified through the admission process and is entered in the medical record, on the patient's bedside board and on WebPAS.	
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 through position descriptions. Staff from all professional groups and disciplines were able to articulate how multidisciplinary care works across the organisation and observing an MDT meeting confirmed this.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.06	
Clinicians work collaboratively to plan and deliver comprehensive care	
Comments	
Clinicians described how they work collaboratively to plan and deliver comprehensive care across the continuum of care. This was supported by observation of safety huddles, where patients at risk were discussed with the oncoming nurses, and in bedside handover at change of shift and medical rounding. A patient assessment and screening checklist assists in the decision-making for team members, with appropriate and validated screening tools used to ensure comprehensive care is delivered. The patient bedside board identifies patients at high risk, those with allergies, goals of care and shift team carer. The boards are updated at handover of care.	
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 aimed at minimising preventable harm are in place to screen and assess patients for risks on admission and as required throughout the patient journey. Clinicians described the risk assessment process and evidence was sighted in clinical documentation. Patients identified as being at risk have an alert sheet generated. The sheet is placed at the front of the bedside notes, and an alert is put into the electronic WebPAS board which is displayed at the Staff Base. If a patient is identified as	

having a risk through the screening process, a more detailed assessment of that risk is conducted and interventions are put in place to mitigate the risk. This is all documented in the medical record.

Comprehensive care audits are undertaken to support that timely and comprehensive risk screening and patient assessment is completed. The audits are presented at the local Comprehensive Care and Communicating for Safety Committee and National Healthscope Meetings. PPH is compliant with the requirements of Advisory AS18/14 Comprehensive Care Standard Screening and assessment for risk of harm.

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
Processes are in place for identifying Aboriginal and Torres Strait Islander patients at pre-admission and on admission and recording this information in administrative and clinical information systems. At the time of assessment this was recorded as less than 2%. PPH is compliant with NSQHS Standards Identifying Aboriginal and Torres Strait Islander people.

Rating	Applicable HSF IDs
Met	All

ACTION 5.09
Patients are supported to document clear advance care plans
Comments
Patients are asked at pre-admission and at admission if they have advance care plans. If they have a plan it is entered into the medical record and WebPas.

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	
PPH uses the Healthscope Comprehensive Risk Screening tool on presentation, during clinical examination and history taking, and when required during care. The screening process identifies risks associated with cognitive, behavioural, mental and physical conditions, issues and risks of harm. Social and other circumstances are identified through assessment and integrated into the care planning process. Comprehensive Care, Clinical Risk Assessment and Observation Documentation are audited by the wards in line with the Healthscope auditing schedule. The audit results are monitored by Healthscope and PPH through the Comprehensive Care and Communicating for Safety Committee. PPH is compliant with the requirements of Advisory AS18/14 Comprehensive Care Standard Screening and assessment for risk of harm.	
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 the Healthscope Comprehensive Risk Screening form and if a risk is identified standardised screening tools which identify the level of risk and appropriate actions to mitigate them are used. Examples of these tools include the Waterlow tool for pressure injury, the malnutrition risk screening tool (MST), and the 4AT for delirium and cognitive impairment.	
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 to mitigate them, including alerts and responses to identified risk. Alerts are entered into WebPASand signage is placed at the bedside. It was noted that the alert signage in the patient areas was not placed in defined locations.	
Suggestion(s) for Improvement	
In collaboration with consumers, determine the best placement of signage for alerts, with consideration for patients, carers and staff.	
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 used shared decision-making processes to develop person-centred and goal directed comprehensive care plans that meet patients' identified needs. This was confirmed by a review of medical records and bedside Comprehensive Care Plans, and observation of bedside handover involving the patient. Care is individualised depending on a patient's needs, desires and risks and who they want involved with their care. Family meetings occur with the team when required to support shared decision-making. Referrals are made through WebPAS with support provided by the allied health staff. The use of the rehabilitation gym by inpatients and outpatients was noted. Discharge planning commences at the beginning of the episode of care with evidence of the use of expected dates of discharge included in the patient records. PPH is compliant with Advisory AS18/15.	
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 including transition of care. 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	
Comments	
Processes to define patients at end-of-life are in place and staff are aware of these. This was indicated by the butterfly symbol on the door to signify to staff, patient and visitors that a person may be in their last hours and days of life and care of that patient was adjusted to meet their end-of-life needs. PPH processes are aligned to the National Consensus Statement: Essential elements for safe and high-quality end-of-life care. There are palliative care consultants available for patients at end-of-life. Families are supported to stay with the patient and there are pull-out beds and extra comfort needs for the family on the 'end-of-life trolley'.	
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	
PPH has access to palliative care physicians and advice.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.17	
The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record	
Comments	
Patients are asked if they have an advance care directive (ACD) at pre-admission and on admission, and a copy of the ACD is placed in the patient's notes. A review of clinical documentation confirmed that ACD are documented in the patient's healthcare record. Clinicians described the process for ensuring that patients with an ACD are identified, and that care is provided in accordance with these plans.	
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 is available through an external psychology service and staff know how to access these support services. Staff explained how important it is to have support from each other as well as external services as the patients at end-of-life are often well-known to the staff after multiple admissions at PPH.	
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 team have developed an end-of-life booklet and bereavement cards to send out to families whose relatives have died at PPH. The assessors had a discussion with the staff about the Palliative Care Outcomes Collaboration (PCOC), based at Wollongong University, for potential opportunities to assist with end-of-life-care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.20	
Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care	
Comments	
PPH supports shared decision-making about end-of-life care with patients, their carers and families. This is supported by regular communication and documented in the clinical record, and evidence of this was noted 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
PPH follows Healthscope evidence-based policies and procedures for pressure injury prevention and wound management, and patients at risk of pressure injuries are identified pre-admission and on admission through the screening for risk process using the Waterlow assessment tool. Patients at risk of developing pressure injuries have an alert at the bedside, in the notes and on the handover board and are discussed at the Safety Huddle and handover. Pressure relieving devices are available as required including air cell mattresses, ROHO cushions, gel heel wedges. Pressure injuries and issues with skin integrity are entered into RiskMan.

It was noted that the pressure injury rates are low. A wound specialist nurse is available for advice if pressure injuries occur. Incident data related to pressure injuries is reported into RiskMan and reviewed and monitored through the organisation's governance structure and Hospital Acquired Complications (HACs) and ACHS Metrix. ACHS Matrix data from the last half of 2024 showed 0.0% (0/8042) of patients developed a pressure injury.

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 as part of the comprehensive risk screening on admission and as required throughout the patient journey in accordance with best-practice time frames and frequency. Complete wound care assessment plans are put in place for any patient with broken skin that requires a dressing or for any pressure injury. Staff trained in wound management are available for consultation and advice.

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
The Prevention of Pressure Injury information pamphlet, developed by Healthscope with consumer consultation, is available to patients, their carers and families. This information is given out in the PPH Patient Welcome packs. Patients and their families receive ongoing education about pressure injury prevention during bedside handover. As noted earlier, the alert signage in the patient areas is not placed in defined locations. Equipment, devices and products, including, air cell mattresses, ROHO cushions and gel heel wedges are available to prevent and manage pressure injuries, and these products were observed in use.
Suggestion(s) for Improvement
As suggested in Action 5.12, the service could determine the best placement of signage for alerts, considering the needs of the patients, carers and staff.

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	
PPH has evidence-based policies and procedures, including risk assessment, prevention, harm minimisation and post-falls management and staff described the strategies used to minimise falls and harm from falls. PPH had an April Falls Day in 2025 to increase awareness of falls. Patients have a falls risk assessment on admission using the Healthscope Comprehensive Risk Screening tool, and patients at risk of falls have an alert placed in the front of their medical record, on WebPAS and an alert sign at the bedside. Patients at risk of falls or post fall are discussed at the Safety Huddle and bedside handover. Patients that have fallen have an escalation of care and have a medical review. Incident data related to falls is reported into RiskMan and reviewed and monitored through the PPH Falls Working Party, Hospital Acquired Complications (HACs) and ACHS Metrix. Metrix data from the last half of 2024 showed 0.358% (40/11167) of patients had a fall but no falls had resulted in a fracture or head injury.	
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, including sensor mats, low-low beds and walking aids. These are used 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	
Patients were observed in the ward and gym areas of the hospital having one-on-one education with nursing and physiotherapy staff about mobility and falls prevention. Healthscope falls prevention pamphlets are provided in the patient Welcome Pack and are available on the wards. 'call don't fall' posters in the patients' rooms encourage patients to call for assistance.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.27	
The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice	
Comments	
The PPH kitchen prepares food onsite and was visited during the assessment. Processes in relation to meal ordering, preparation and distribution of meals were discussed with the cooks and clinicians. Patient are assessed on admission for nutritional needs using the malnutrition risk screening tool (MST) and any food allergies are identified at this time. The patient is also assessed as to whether they can manage eating independently or require supervision or assistance to eat. Dietetic services are available three days a week onsite to accept referrals for those patients who have special dietary requirements or where risks are identified. Referrals are made through WebPAS. When dieticians are unavailable, nursing staff fulfill the role. On admission patients can select their meals through a menu, allowing for dietary allergies or special dietary needs. Patient with food allergies identified through the Comprehensive Care Plan, have an alert placed on WebPAS and the kitchens are notified. The kitchen has a rotating menu that has been developed with dietitians and has options for dietary needs. Food is available after-hours for patients who may have been fasting during the day.	
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	
Patients are assessed for nutritional needs and risk of malnutrition on admission through the Malnutrition Risk Screening Tool (MST). Special dietary plans are established for those who require them and referrals through WebPAS to a dietetics and speech pathology are made where risks are identified. Dieticians are onsite Mondays, Wednesdays and Fridays to provide specialist dietetic support and on the other days nursing staff fulfill this role. There was evidence in the patient charts that they are weighed and re-weighed if their length of stay is prolonged. Patients at risk of malnutrition or who require assistance with eating or drinking are provided with assistance and supplementary diets and fluids are available. The Comprehensive Care Plan is used in conjunction with risk assessment interventions to monitor fluid balance their input is monitored through fluid balance and whether support is required for nutrition and hydration.	
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 Standard, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation	
Comments	
Healthscope Delirium and Cognitive Impairment Prevention and Management policy and ongoing training (4AT and delirium) support staff in cognition screening and developing appropriate care plans. Cognition screening is undertaken on admission and as required throughout a patient's admission were clinically indicated. Medications are monitored to ensure compliance with best-practice standards. If an antipsychotic is given to a patient, a notification is made in RiskMan and this is monitored by the Medication Management Committee. PPH is compliant with the requirements of Advisory 22/01: Advice on implementing the updated Delirium Clinical Care Standard (released September 2021).	
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. Staff described how they collaborate with patients, carers and families to recognise, treat and manage patients with cognitive impairment. Documentation reviewed shows systems are in place to care for patients with cognitive impairment. The use of the Dementia Australia 'Sunflower' model was observed in use to help minimise anxiety or distress. PPH is compliant with the requirements of Advisory 22/01: Advice on implementing the updated Delirium Clinical Care Standard (released September 2021).	
Suggestion(s) for Improvement	
Consider working the with the consumer group regarding available distraction therapy.	
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	
A mental health and behavioural and substance withdrawal risk assessment is done on admission. Patients identified at risk of self-harm or risk of suicide are reviewed by a medical officer and if required they will be transferred to a facility that can provide the appropriate level of care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.32	
The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts	
Comments	
The organisation has process in place to refer patient that show or indicate suicidal thoughts to appropriate 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	
There are occupational violence and aggression management principles and prevention policies available on HINT, which support the identification, mitigation and management of aggression and staff are aware of them. Staff complete mandatory training in WAVE 1 Managing Conflict and Challenging Behaviour. This program provides strategies in relation to de-escalation of aggressive or violent behaviour. Staff are aware how to seek assistance from other staff and when the assistance of police may be required. Duress alarms are in place throughout the organisation and there are personal duress alarms for staff conducting home visits.	
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 Comprehensive Risk Screening Tool assists staff to identify patients with mental health, behavioural and substance withdrawal and cognitive impairment issues and who may be at risk of becoming aggressive or violent. Staff complete mandatory training in WAVE 1 Managing Conflict and Challenging Behaviour. This program provides strategies in relation to de-escalation of aggressive or violent behaviour and to safely manage aggression and minimise harm to patients, carers, families and the workforce.	
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		
Physical restraints aren't used at PPH and there is only occasional use of anti-psychotic medication. If an anti-psychotic medication is administered to a patient, it is recorded in RiskMan. The use of anti-psychotic medication would be reviewed by the treating medical officer and the Medication Safety Committee.		
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		
Approved as Not Applicable.		
Rating	**Applicable HSF IDs**	
NA	All	**NA Comment:** Non-gazetted service - does not use seclusion. **Verified During Assessment:** Yes **Complies with AS 18/01:** Yes

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 are in place to support effective clinical communication, overseen by the Communicating for Safety Committee. Risks are identified with the risk register currently including the risk of failing to identify patients correctly. It is noted that this risk is well controlled. A quality action is noted in the quality action plan around improving clinical handover in response to audit findings. Staff have training to support effective communication. The safety and quality systems provide information about the effectiveness of clinical communication and assist in identifying areas for improvement.	
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	
The effectiveness of clinical communication and associated processes is monitored through the safety and quality systems such as incident and complaint management, audit processes and patient feedback. Consumers are involved in auditing clinical handover. Strategies to improve clinical communication and associated processes include the change from using ISBAR as the standardised communication tool for clinical handover to ISOBAR. The outcomes of monitoring clinical communication process are reported through the Committee structure.	
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	
Clinicians demonstrated that they understand the process of partnering with consumers and described how communication is tailored to meet the information needs of the patient. Observation of clinical handover and ward rounds showed that patients are actively involved in the process. Patient surveys provide information on the effectiveness of communication and consumers are involved in auditing clinical handover. Interpreters are used as required to support effective communication between clinician and patient.	
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	
The use of patient identifiers was observed during clinical handover, procedure matching and time out and at the collection and administration of blood products. Handover of clinical information about a patient's care, including information on identified risks, was also observed during safety huddles and found in clinical documentation. Clinical handover of critical information is provided when a patient is transferred to another facility for care. Discharge plans are discussed in multidisciplinary meetings with discharge summaries provided to the patient and their local General Practitioner on discharge home.	
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	
Patient identifiers and the situations in which patient identification is required have been defined and the use of these identifiers was noted when staff were verifying patient identification during patient care. At least three approved identifiers are required for patient identification.	
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	
Processes are in place for correct identification and procedure matching as per policy, and this was observed in practice in the perioperative areas and during a blood transfusion on the ward.	
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 information is communicated using ISOBAR, following a recent change from ISBAR, with policy being updated to reflect this. Identified patient risks and the needs of the patient, carer and family are included in clinical handover. Audits of clinical handover are undertaken and monitored through the Comprehensive Care and Communicating for Safety Committee with audit results from 2024 noted in the Quality Action plan as being below target and further audits undertaken to check for improvement.	
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	
Clinical handover is scheduled for a set time each day with a risk huddle conducted prior to handover to review patient risks. Clinicians have the necessary information which is noted on a handover sheet and used during handover. While patient care boards were in place in patient rooms patient goals were not well documented and weren't discussed during handover. Patients and family members are involved in clinical handover as much as they wished. Policy guides the conduct of clinical handover and the situations in which it is done but in general clinical handover is conducted at change of shift, or when a patient is transferred to another ward or to another service and results in the transfer of responsibility and accountability for care.	
Suggestion(s) for Improvement	
Improve the identification and documentation of patient goals on the patient care boards and review or update them with the patient during clinical handover.	
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	
Clinical communication processes are used to effectively communicate critical information. Clinicians described a range of critical information that needs to be communicated to others including risks, alerts, cultural needs, changes in medication, post-op instructions, a deteriorating patient, not for resuscitation orders, end of life wishes and preferences, and religious issues such as blood refusal . They also explained where this information may be communicated including clinical handover, the safety huddle, multidisciplinary meetings, ward rounds and communication between clinicians such as nurse to doctor or family escalation of concern about their loved one. Critical information would always be communicated to the person who can make decisions about the patients care with escalation pathways in place.	
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	
Patients and their families are encouraged to speak up if they are worried about their clinical condition with processes in place to support them in requesting a clinical review. Medical rounds and nursing handover engage patients and family members and carers in raising their concerns with the clinical team. A family conference may be held for the family to discuss treatment or discharge options with the treating team.	
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	
Processes are in place with assessment tools, care plans used to support contemporaneous documentation about critical information, alerts, risks, reassessment processes and changes made to patient's care plans. Medical, nursing and allied health assessments and care plans documented in the medical record provide a comprehensive summary of the patient's care. Audits are conducted to review documentation in the medical record.	
Rating	**Applicable HSF IDs**
Met	All

Standard 7 - Blood Management

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

ACTION 7.01	
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	
Policies are in place to guide blood management practices, and the risks associated with blood management are identified through the safety and quality systems. The Blood Management Committee oversees blood management, reporting to the Clinical Governance Committee. Audits are regularly conducted on blood management as outlined in the audit schedule. Staff complete annual training through Bloodsafe in line with the training matrix.	
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 audit schedule includes audits that monitor different aspects of blood management, and committee reports include blood wastage and blood shortage notification. Incidents are reported in RiskMan and investigated as per policy. Ongoing monitoring provides the hospital with information to identify areas for improvement such as the issue with a pathology provider around patient identification and the Hospitals actions to address this as described by staff. Issues related to blood management may be referred to the Morbidity and Mortality meeting for review such as consent for blood. Reporting lines are through the governance structure. Haemovigilance activities are in place which are reported to the Private Health Regulation Unit which is part of the Queensland Department of Health.	
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	
The organisation uses the processes in the Partnering with Consumers Standard to involve patients in decisions regarding the provision of blood products. Information is provided to patients as part of the consent process so that they are informed about the risks and benefits before signing the consent form. Feedback mechanisms are in place regarding their experience of care. Clinicians described the importance of shared decision making describing how patients whose religious beliefs prevent them from having a blood transfusion are provided with information on other options that are available to them.	
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	
The organisation's processes and policies support the effective and efficient use of blood and blood products. Use is monitored and action has been taken to minimise wastage and the inappropriate use of blood and blood products which is reported through the Blood Committee. The clinical need for blood and blood products are assessed prior to prescribing blood or blood products.	
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	
Clinical records contain documentation of the reason for transfusion, the history of previous transfusions, and details of the transfusion procedures. This is monitored through the appropriateness and documentation audit with the last audit showing 95% compliance with requirements.	
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 policies and procedures for the prescription and administration of blood and blood products support clinicians in the management of blood. Clinicians have access to learning resources including those from Bloodsafe eLearning Australia, which they are required to complete. The audit program monitors all aspects of blood transfusion. Incidents related to the management of blood are reported through the governance structure and to the pathology provider, however the hospital reports that few incidents have occurred.	
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 transfusion-related adverse event is reported in the incident management system and investigated by the pathology providers in accordance with the national guidelines and criteria. The results of investigations are considered by the Blood Committee and reported through the governance structure.	
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 organisation participates in haemovigilance activities through the Queensland Health Department, as part of the National Haemovigilance Program.	
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	
Blood and blood products are stored, distributed and managed in compliance with legislative and regulatory requirements. Blood and blood products for the hospital are recorded in the blood register when they are received and stored in the blood refrigerator. This is monitored to ensure that the temperature meets the requirements for safe storage of blood and blood products. The use of these products can be traced from receipt to use, return or discard.	
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	
Processes are in place to manage the availability of blood and blood products, eliminate wastage, and respond to shortages. Single unit blood transfusion has been introduced to better manage blood usage. The use of blood and blood products is monitored and reported through governance reporting mechanisms.	
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	
Healthscope and PPH policies and procedures are in place for recognising and responding to acute deterioration and staff were able to describe the process and their role in such events. A Code Blue is called if a patient has deteriorated and the response team is notified by the annunciators. A Code Blue was witnessed and processes ran smoothly. Risks are monitored through the risk management system (RiskMan). The Clinical Deterioration and Blood Management Committee reviews all clinical incidents entered into RiskMan. A report of Code Blues for June 2025 showed there were 13 Code Blues, all of which were classified as minor or negligible and comprised of patients complaining of shortness of breath, chest pain or syncope. Training is conducted in orientation and then yearly, and training records showed that 80.6% of staff had completed the training requirements. Training needs for this standard include basic life support (BLS), advanced life support (ALS) and paediatric life support (PLS). All staff receive and are assessed for BLS during orientation and then yearly. Training levels shown during SNAP were 80.6%. There is dedicated education time for staff and mock codes. Compliance for training was within Healthscope's Benchmark, or close to the benchmark. Visiting medical officers are required to provide training records through a Statutory Declaration.	
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	
The effectiveness of processes for identifying and managing acute deterioration is monitored through the risk management system (RiskMan) and reviewed by clinicians at Morbidity and Mortality Meetings and the Clinical Deterioration and Blood Management Committee. TAs noted earlier, a report of Code Blues for June 2025 showed there were 13 Code Blues, all of which were classified as minor or negligible and comprised of patients complaining of shortness of breath, chest pain or syncope. Several audits are conducted, including the Observation Chart Audit, Patient/Carer Escalation of Care, Sepsis Baseline Audit Ward, Emergency Trolley Checklist and Escalation of Care. Several documents in place on the Emergency Response Trolleys were noted to be out of date. The team responded immediately and updated these.	
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	
There are processes in place that support partnering with consumers in recognising and responding to acute deterioration. PPH has a patient and carer escalation process called Peninsula Rules. This is a three-step process for patients and carers are worried about their clinical condition. Pamphlets are included in the patient welcome packs, and posters were seen on the walls and on the digital display screens. The hospital has 'Are you worried' posters which have been implemented after consumer feedback as another avenue to escalate concerns. As part of the admission process patients are asked about advance care directives, which are documented in the medical record and should identify the level of intervention they want if an acute deterioration occurs.	
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 according to policy using track and trigger Standard Adult General Observation (SAGO) and age-appropriate paediatric observation charts. These charts have a section for altered calling criteria as determined by the treating medical officer. Auditing of these charts is scheduled and results are monitored through the Clinical Deterioration and Blood Management Committee.	
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	
Clinicians screen patients on admission and throughout their hospitalisation using the Comprehensive Risk Screening Tool, and associated tools such as 4AT, to recognise acute deterioration in cognitive impairment, and mental health and behavioural and substance withdrawal risk. In collaboration with the patient and their family, early warning signs are determined to individualise care plans, and the use of the Dementia Australia Sunflower tool was noted. Patients are assessed for possible causes of deterioration (such as sepsis) and the level of observation is determined and whether the patient requires transfer to an alternate facility such as mental health or high dependency unit for more appropriate care. Observed changes are documented in the medical record or specific bed side charts such as 4AT assessment for delirium and cognitive impairment and alcohol withdrawal chart. PPH is compliant with Advisories 22/01 and 19/01.	
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	
PPH uses the track and trigger SAGO chart to escalate care and to call for emergency assistance by a Code Blue. Patients are assessed for risk on admission and as required during their stay for any mental health concerns and there is an escalation process to the treating doctor and to other facilities when the patient's condition is out of scope for PPH. Patients and carers can escalate concerns in relation to their condition or care using Peninsula Rules/Are you worried. There are clinical documentation audits, incident management and clinical reviews as required. Education on the escalation of care and SAGO charts for staff. Documentation showed that policies and procedures are in place to support clinical staff in the management and escalation of clinical deterioration. The requirements of Advisory AS 19/01: Recognising and Responding to Acute Deterioration have been met (8.6 b.c.d.e).	
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	
As previously noted, patients, carers and families can directly escalate care through the Peninsula Rule/Are you worried. This is an escalation process available 24 hours, and posters were observed in the patient rooms, as well as pamphlets in the patient Welcome Packs and the scrolling screens throughout the organisation. Clinical audits are undertaken to ascertain patient and carer knowledge of how to escalate care in addition to consumer focus groups. Clinical staff, patients and carers confirmed awareness of the 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	
There is a 24-hr system to call a Code Blue for emergency assistance to escalate care is. A Code Blue was witnessed during the assessment, and staff demonstrated that they understood their roles in this situation. Code Blues are entered into RiskMan, and all are reviewed at the Clinical Deterioration and Blood Management 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 PPH policy. Reports provided to the Clinical Deterioration and Blood Management Committee confirmed the effectiveness of these processes.	
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. This includes BLS and ALS, and paediatric resuscitation training. BLS training is provided to all staff at orientation and updated yearly. Compliance with BLS training is reported to be 80.6 %. Designated staff undertake ALS and PALS and attend refresher courses as required. Compliance with training is reported and monitored at the Clinical Deterioration and Blood Management Committee.	
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	
A Clinical Coordinator with ALS skills is always rostered on shift.	
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	
Clinicians confirmed the process for timely referral to mental health services to ensure that these referrals can meet the needs of the patients. Staff were able to articulate the referral process for these patients. The requirements of Advisory AS 19/01: Recognising and Responding to Acute Deterioration 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	
There are no intensive care, high dependency or mental health beds at PPH. All patients requiring these services and level of care are transferred to an appropriate facility. There is a local transfer and escalation of care protocol and staff were able to explain these processes clearly.	
Rating	**Applicable HSF IDs**
Met	All

Recommendations from Previous Assessment

Standard 2

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		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Met with Recommendation	All	**Recommendation NS2.1 OWA 0423.2.14** Strengthen the engagement strategy with consumers in the education and training of the workforce. **Risk Rating:** Low

Organisation Action taken	Assessor's Response
Extensive work completed on this recommendation. **Completion Due By:** End 2024 **Responsibility:** Michele Gardner **Organisation Completed:** Yes	**Recommendation Closed:** Yes This recommendation has been closed. Peninsula Private Hospital has worked with their consumer consultants to develop a video of a patient's experience of care which is played to staff during orientation. Consumer consultants work closely with patients and the workforce in obtaining and sharing patient feedback.