Report of the ACHS National Safety & Quality Health Service Standards (NSQHSS) Survey

ACHA Health

Bedford Park, SA

Organisation Code: 32 00 11

Survey Date: 05-08 September 2016

ACHS Accreditation Status: ACCREDITED

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About The Australian Council on Healthcare Standards

The Australian Council on Healthcare Standards (ACHS) is an independent, not-for-profit organisation, dedicated to improving the quality of health care in Australia through the continual review of performance, assessment and accreditation. The ACHS was established in 1974 and is the leading independent authority on the measurement and implementation of quality improvement systems for Australian health care organisations.

The ACHS mission is to 'improve the quality and safety of health care' and its vision is 'to be recognised nationally and internationally as the leading Australian organisation that independently assesses performance and promotes and improves the quality and safety of health care.'

The principles upon which all ACHS programs are developed and the characteristics displayed by an improving organisation are:

1. a customer focus
2. strong leadership
3. a culture of improving
4. evidence of outcomes
5. striving for best practice.

These principles can be applied to every aspect of service within an organisation.

What is Accreditation?

Accreditation is a formal process to assist in the delivery of safe, high quality health care based on standards and processes devised and developed by health care professionals for health care services. It is public recognition of achievement of accreditation standards by a health care organisation, demonstrated through an independent external peer assessment of that organisation's level of performance in relation to the standards.

How to Use this Survey Report

The ACHS survey report provides an overview of quality and performance and should be used to:

1. provide feedback to staff
2. identify where improvements are needed
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.

This report provides guidance for ACHS members for future quality improvement initiatives by documenting the findings from the organisations accreditation survey. This report is divided into five main sections.

1 Survey Team Summary Report
2 Action Ratings Summary Report
3 Summary of Recommendations from the Current Survey
4 Recommendations from the Previous Survey
5 Standard Ratings Summary Report

1 Survey Team Summary Report

Consists of the following:

Standard Summaries - A Standard Summary provides a critical analysis for organisations to understand how they are performing and what is needed to improve. It provides an overview of performance for that Standard and comments are made on activities that are performed well and indicating areas for improvement.

Ratings

Each action within a Standard is rated by the organisation and the survey team with one of the following ratings. The survey team also provides an overall rating for the Standard. If one core action is Not Met the overall rating for that Standard is Not Met.
The report will identify individual actions that have recommendations and/or comments.

The rating levels are:

NM – Not Met
The actions required have not been achieved

SM – Satisfactorily Met
The actions required have been achieved

MM - Met with Merit
In addition to achieving the actions required, measures of good quality and a higher level of achievement are evident. This would mean a culture of safety, evaluation and improvement is evident throughout the hospital in relation to the action or standard under review.

Action Recommendations

Recommendations are highlighted areas for improvement due to a need to improve performance under an action. Surveyors are required to make a recommendation where an action is rated as Not Met to provide guidance and to provide an organisation with the maximum opportunity to improve. Recommendations in the survey report need to be reviewed and prioritised for prompt action and will be reviewed by the survey team at the next on site survey.

Risk ratings and risk comments will be included where applicable. Risk ratings are applied to recommendations where the action rating is Not Met to show the level of risk associated with the particular action. A risk comment will be given if the risk is rated greater than low.
Risk ratings could be:

1. E: extreme 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

2 Actions Ratings Summary Report

This section summarises the ratings for each action allocated by an organisation and also by the survey team.

3 Summary of Recommendations from the Current Survey

Recommendations are highlighted areas for improvement due to a need to improve performance under a particular action.

Recommendations are structured as follows:
The action numbering relates to the Standard, Item and Action.

4 Recommendations from Previous Survey

This section details the recommendations from the previous onsite survey. The actions taken by the organisation and comments from the survey team regarding progress in relation to those recommendations are also recorded.

The action numbering relates to the month and year of survey and the action number. For example recommendation number NSQHSS0613. 1.1.1 is a recommendation from a NSQHS Standards Survey conducted in June 2013 with an action number of 1.1.1

5 Standards Ratings Summary Report

This section summarises the ratings for each Standard allocated by the survey team.

Survey Report

Survey Overview

The Adelaide Community Healthcare Alliance Incorporated health service was able to demonstrate the development and implementation of many strategic projects, which will have a positive effect on performance, service provision and patient clinical outcomes. Examples include, but are not restricted to, the introduction of information and communication technology databases, and programs, for the credentialing and scope of practice of medical officers; infection prevention and control projects in regard to cannulation and aseptic technique; and the introduction of “robotic surgery”.

The health service was able to demonstrate the active involvement of new, and existing, key staff members in ensuring patient quality, risk and safety were considered in business decision making processes and service delivery. Consumers have also been involved with the business decision making processes, with plans to further strengthen patient/potential patient involvement. New services and refurbishment were evident as a result.

The systems, processes, protocols, and programs are at various stages of evaluation, commencement and maturity. Further work does need to occur within the clinical environmental areas of two of the hospital buildings. Further work also needs to occur in relation to aligning the monitoring systems, and processes, with the results of data and information collection.

The Adelaide Community Healthcare Alliance Incorporated is complimented on the achievements to date, and encouraged to continue to strive for excellence.

STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

The governing body of the Adelaide Community Healthcare Alliance (ACHA) health service, in collaboration with Healthscope (managing associates), has developed a number of policies and procedures for the operation, and administration, of its three private hospitals in Adelaide, South Australia. This comprehensive suite of over 1700 policies and procedures clearly articulates the responsibilities of staff in the administration of patient care. The policies and procedures were researched against legislation, standards, and industry best practice. Policies and procedures from contracted sources such as Healthcare Infection Control Management Resources (HICMR) and South Australian Pathology are incorporated and integrated into the day-to-day operations of the health service. Further review of the multiple array of policies from these external organisations could take place to avoid duplication. There were also several paper-based copies of the policies and procedures, which were out-dated.

The health service through the ACHA policy (1.14 Document Control) was able to comprehensively track, and specify, existing policies and the progression through the maintenance and review systems. The health service was able to demonstrate a good understanding of various aspects of the policy review process, both through the Healthscope clinical clusters and combined ACHA working groups. Review rates scored over 99% throughout the health service. The policy system exists in an intranet environment and has been audited with its compliance in that system. These audits identify that the policies have been risk-rated, are present, understandable for staff use, and available in a timely fashion following review.

There were, however, identified weaknesses in aligning work practice with the policies and procedures at times. Work practice includes internal requirements, and it also includes the contractual relationships with external service providers, such as blood and blood product suppliers. Comments and recommendations have been made to strengthen this area.

Substantial and comprehensive reports are tabled at the executive level, as well as the Board of Management. The reports included data and information on clinical and non-clinical topics, in addition to finance. These take the form of key performance indicators, clinical indicators, results of audits, etc. The ACHA Board was able to clearly articulate its involvement in meaningful discussions and decision making as a result. Actions were also evident.

The health service was able to demonstrate many substantial projects which indicated that patient safety, and quality of care, is considered in business decision making. There are, however, several identified gaps and weaknesses based on collected data and information, which could be addressed through a more robust system of preventative strategies, and/or maintenance, rather than reactive actions.

Several examples pertaining to the environment were identified at the time of survey. For example, incident reports indicated electrocution of patients through the use of electrical equipment; complaints from patients indicated corrosion around electrical points, and poor integrity of wall and seating surfaces in bathrooms; design and flow of CSSD departments; bedrooms and communal bathrooms.

The health service was able to provide evidence that action had taken place in response to the incidents and complaints, including the addition to the risk register, however, a system of prevention through such actions as formal assessment of the building, environment, equipment, work practice, access and flows, would assist in preventing incidents, complaints and events.

The frequency of the monitoring systems, ie the annual audit process, warrants ongoing review in relation to adequate information being presented to the Board on a timely basis.

The health service has formally identified the training programs which meet their requirements, and that of the National Safety and Quality Health Service Standards (NSQHSS). Some of the hospitals were able to demonstrate a formal staff development and education program framework, and others were not.

The health service was transitioning to a new information and communication technology (ICT) software at the time of survey. The new ICT is able to link the required education and competency programs with each position, and consequently each staff member. This then provides a “dashboard” system for staff to understand what is required of

them to complete, and when; it is also able to provide reports of compliance to the health service. The health service is complimented on this progression, as it will eventually strengthen the weaknesses currently observed in data and information capture, relevant to annual mandatory training.

While it is appreciated that interruptions occur when systems are being changed, there does, nonetheless, need to be a planned strategy in place to ensure that records are able to be retrieved from prior systems on request. Some of the hospitals were able to provide relevant data and information in regard to the compliance rates of attendance to mandatory training on a timely basis. However, some were not. The inability to do so contributes to a lack of confidence in whether adequate attendance has occurred. Comments and recommendations have taken place in order to strengthen this area.

Each hospital within the health service stated that they had competency-based training relevant to the needs of the organization. Competency tools were available to record completion. One of the hospitals had a formal schedule for competency-based training, with documented evidence of compliance, eg 96% attendance at basic life support sessions, 93% attendance at aseptic technique education sessions, and 90.2% compliance rate for hand hygiene. This hospital is complimented on its achievements and good practice. Two of the hospitals, however, did not. The recording and monitoring process for compliance was also not consistent. An audit of documentation and personnel related records, at the time of survey, indicated gaps and weaknesses. The organisation needs to be able to demonstrate documented evidence of completion and compliance of competency training on a consistent, and timely, basis.

The organisation has four (4) risk registers in place – an overall core risk register ACHA corporate, along with a risk register for each hospital used and regularly monitored. Collected incidents assessed as high risk were observed as being placed on the risk register. The health service was able to demonstrate that action plans were included on the risk register to eradicate/mitigate risks to patient safety and quality.

However, an observation of collected data and information, as well as sample auditing and observation, at the time of survey, indicated missed opportunities for improvement, as well as missed opportunities to collect data and information which would further highlight risks to consumers, to the workforce, and to the health service.

Quality planning and projects do not formally incorporate a documented risk assessment; external service reports, and subsequent recommendations, do not always incorporate a formal documented risk assessment; manual auditing of incidents indicates the transfer of information to the risk register, but does not risk rate other incidents to guide the timeframe for completion. As a result, formal, documented prioritisation of required actions is not always evident, and the risk management process is not as inclusive, consistent and robust, as it should be. Comments and recommendation have been made to strengthen this area.

An organisation-wide quality management system is in place, with reports to relevant committees, personnel, and the highest level of governance. Monitoring processes include auditing and observation. A framework was evident to inform the viewer of the elements which make up Quality and Continuous Improvement.

The monitoring process is an essential element of the Quality Framework, and yet this process was not as strong as it should be. A comprehensive, formal, corporate directed, annual audit schedule is in place for the health service as a whole. Each hospital within the health service was able to demonstrate compliance with this annual audit, with consequent formally reported results of the audits. The results of these audits are tabled at relevant committees, and also at the Board of Management meetings, and Healthscope. Each hospital was also able to demonstrate that further audits had occurred in some areas where results were less than favourable. Actions taken on these occasions to improve results were comprehensive and relevant.

However, observation, and sample auditing, by the survey team at the time of survey, as well as an assessment of the results of the annually collected data and information, highlighted the need to consider the frequency, and expansion, of the monitoring process. Audits of medical records, training records, medication registers, personnel records and human resource databases, observation of work practice, and other areas requiring compliance, indicated substantial gaps across the health service. Interviews with the workforce indicated a lack of awareness, on occasion, of how to link the results of audits with determining future frequency.

The system for monitoring compliance forms a large part of the quality and governance systems; that is, documentation audits, observation of work practice against policies and procedures, and interviews. It is also an important means of providing meaningful information on other system compliance, as well as contributing to risk management. It contributes to the provision of data and information, which in turn contributes to business, and work practice, decision making.

The frequency of the monitoring process, eg auditing, and observation of work practice, needs to be aligned with the results of data and information analysis, and trends. The frequency of the monitoring process will differ for each member of the health service, according to the identified deficits, and it will differ according to a given risk assessment.

In addition to the corporate organisation-wide annual audit, each hospital needs to have a local formal audit schedule, which reflects the monitoring requirements of that particular hospital. This will in turn provide a formal guide for the workforce to follow. The audit process also needs to demonstrate accuracy and, in turn, credibility, so that the data and information can inform. For example, please refer to 1.18.2, consent forms.

Clinical practice

There is a suite of documented guidelines, and standing orders by medical officers, across the health service. They are available to all clinical staff, including nursing, midwifery and allied health. The survey team noted that many of the medical staff had their own standing orders/standardised care plans, for medical and surgical procedures. Although there were numerous orders, the staff were aware of the requirements of each specialist, with information also being available on the intranet. Clinical pathways were evident in some specialist areas such as orthopaedics, but were generally not used in other areas.

The health service was able to demonstrate that an integrated clinical record that identifies all of the patient's care was in place. Appropriate policies are readily available that address issues such as duplicate record numbers, creating a temporary record, and external requests for clinical information by other health services. Clinical records are available at the point of care, with the content audited annually.

The survey team was presented with a range of risk assessment tools which were used throughout the health service. These included falls, pressure injuries, mental health status (including dementia), infection, malnutrition, and clinical deterioration. These tools had been reviewed, and further developed, since the previous survey. The staff demonstrated a level of situational awareness with regard to the assessment processes, which had matured significantly during the past two years.

The annual audit of clinical records indicates that not all components of the clinical record are complete on all occasions. Therefore, there are identified weaknesses in relation to the accuracy of the clinical records at the point of care. Auditing of clinical records should be occurring during the currency of the records. The shift to shift handover process will assist in providing a platform for auditing clinical records. Consideration of the frequency of retrospective auditing of clinical records will also assist with the accuracy of the records.

Adult and paediatric observation charts incorporating “track and trigger” responses are used in identifying deteriorating patients. Information handover between clinical staff is communicated using the ISOBAR system. Patients at risk on admission are identified, and appropriate management processes are put in place. The health service was able to demonstrate an understanding of both the “Code Blue” and “Met Call” processes. There was evidence to indicate that these were utilised and formally analysed at the end of each month; in particular their appropriateness.

Further significant developments have occurred in the area of basic and advanced life support. Accredited education, with recognised courses, is now being made available to staff. Ashford Hospital had also been nominated as a recognised centre for basic and advanced life support courses. Additional staff education for clinical staff in the Ashford Hospital maternity service, following an incident, strongly reinforced the rationale and importance of the recognition of deteriorating vital signs in pre and post-partum patients.

The health service has further developed the PACE (Patient and Carer Emergency) process. Statistical information shows the processes have been accepted by both patients and staff. The occurrence of patient initiated help calls is monitored. Posters and TV provide readily available information to patients and carers.

Emergency call systems are regularly and formally checked to ensure they are operational, and provide timely notification. The results of the checking indicated an operational mechanical system.

Performance and skills management

A formal system for the credentialing and re-credentialing of medical and dental officers is in place. The scope of the practice is linked with the credentialing process and also the capability, and clinical service roles, of the health service. Credentialing for visiting medical officers (VMOs) for up to a maximum of five years has been in place for a period of time. Given this is linked with the performance review, it is suggested that consideration be given to formal

reviews of performance more frequently than five years.

An information and communication technology (ICT) program had recently been introduced, for e-credentialing. This new system provides the ability to capture required information in regard to medical and dental officer applications for clinical privileges; monitor the progress of information completion; store information and report on information; all on a timely basis.

Data and information inform Craft Groups, governance committees, and the executive team of not only positive clinical outcomes for patients, but also highlight areas of weakness and/or concern. The health service was able to demonstrate appropriate follow-up, and timely performance review. The formal review of medical and dental officers occurs at the time of re-credentialing. The health service is reviewing the frequency of formal performance review to ensure the frequency meets the needs of the health service.

A valid performance review process is in place for the employed clinical workforce. While some members of the health service can demonstrate a degree of reliability in the performance review process, an audit of personnel records, and databases, by the survey team, at the time of survey, indicates that this is not consistent across the health service.

There are weaknesses and/or gaps in relation to several aspects of the performance review process, such as individual professional development plans; system-wide tracking of participation in reviews; audit of clinical workforce with completed performance reviews; audit of work practice against policies and procedures. As a consequence, a review of the systems for tracking, a review of the frequency of audits, and the attainment of expected compliance across the health service need to occur. Comments and recommendations have occurred to strengthen this area.

Incident and complaints management

Policies and procedures are in place to guide the workforce on how to use the system for incidents, near misses, and complaints. The ICT software program of “Risk Management” (RiskMan) is used throughout the health service. The use of the system forms part of the orientation program. Repeat education is available to staff through the internet eLearning package. The workforce is supported in its use.

The software of RiskMan is well supported by the external service provider. It provides the ability to view the incidents, and complaints, from remote locations at any time. It generates reports for analysis, and provides the ability to communicate incidents, and complaints, immediately to the allocated levels of authority relevant to the risk rating.

The health service was able to demonstrate that incidents were regularly reviewed. There was evidence of placement on the risk register as appropriate. There was evidence of follow-up, and of reporting of collected data and information to the governance committees, including the Board of Management, and Healthscope. This process is carried out manually, rather than using the electronic system for risk rating.

A number of systems are in place to collect, analyse, and suggest improvements in response to complaints. Complaints are managed using the software of RiskMan as a database for the information. There are also “Feedback” forms, and patient satisfaction and patient centred care surveys.

The RiskMan database provides a feedback module to staff and incorporates the ongoing managerial assessment. A number of hospital quality improvement activities included issues raised during incident investigations. Feedback is provided to the workforce, volunteers, and consumers, through meetings and reports. Data and information are tabled at relevant meetings, including “cluster meetings”, to discuss and respond to findings. Patient feedback and complaints are reviewed by the Board of Management. These reports form part of the dashboard reporting system that is in place.

The health service has adopted an open disclosure policy consistent with the national open disclosure standard. Resources have been allocated for the purpose of education, and continual support of the clinical workforce. The clinical workforce has various opportunities to participate in the open disclosure training process. As part of the health service's audit program, an annual audit is undertaken with regard to the implementation of the open disclosure policy, instances of its use, and learnings from its application. The resources available through the Healthscope risk management unit provide additional support, and expert clinical judgement, for more difficult and complex incidences. One-on-one education for the workforce, with regard to specific events, is also available.

Patient rights and engagement

The Patient Charter was displayed throughout all of the ACHA health service. It is also available through the television marketing system at the patient bedside. Being able to demonstrate whether a given patient understands their rights requires strengthening.

The health service has developed specific policies with regard to advance care directives, not for resuscitation, and patient resuscitation directives. These policies are referenced against state legislative requirements, and in the case of advance care directives the organisation has adopted the newly revised South Australian advance care directive package. The health service supports and encourages the documentation of clear advance care directives. Active compilation of advance care directives by the health service only occurs in the instance of palliative care at this stage. A discussion took place in regard to the absence of “not for resuscitation” forms within the clinical records. The health service’s policy recognises that all patients are elective and therefore takes the approach that all patients will be resuscitated in the event of a medical emergency, unless otherwise documented.

Policies and procedures are in place to guide expectations in regard to informed consent. The presentation of consent forms varied across the health service. There were two dedicated consent forms that had been developed and implemented by the health service; one for the administration of blood and blood products, and one for surgical and/or procedural. These were compliant with medical records standards in their format. Several doctors were utilising their own consent forms. It was not clear if these forms complied with medical record standards in regard to the format. The policy and procedure was altered to reflect the accommodation of both, at the time of survey.

A sample audit of discharged patient records, at the time of survey, indicated that a consent form was in place for all surgical/procedural patient records audited. However, the completion of the consent form varied across the health service. Some of the hospitals demonstrated that the consent form had been fully completed, while others demonstrated only partial completion. A sample audit of inpatient clinical records also indicated varying degrees of completion of a consent form across the health service.

Interviews with staff at the time of survey indicated that some patients were reaching the operating suite prior to the completion of a consent form, with the form being completed in the reception/holding bay, prior to entry to the theatre. Consent is to be informed, and requesting the completion of a consent form just prior to entry into a theatre is not conducive to good practice. The patient may potentially feel under stress, or pressure, due to their location. Emergency situations are, of course, considered an exception. Comments and recommendations have been made to assist with closing identified gaps.

There are multiple ways of providing feedback to the health service. These can be made through formal feedback forms, correspondence, the website, the consumer representatives, and verbally. Interviews with representatives of the consumer groups indicated a system by which the representatives will often randomly seek permission to candidly talk with patients, and carers, to obtain feedback at the time of admission. Any concerns are immediately fed back to the ward at the time. The results of surveys indicated that 73% of patients felt that they had been included in the planning and execution of their care. Data and information on patient feedback is tabled at relevant meetings, including consumer, executive and ACHA Board of Management meetings, and Healthscope. The evidence provided indicated appropriate and timely follow-up.

Governance and quality improvement systems

Ratings

Action	Organisation	Surveyor
1.1.1	SM	SM
1.1.2	SM	SM
1.2.1	SM	SM
1.2.2	SM	SM
1.3.1	SM	SM
1.3.2	SM	SM
1.3.3	SM	SM
1.4.1	SM	SM
1.4.2	SM	SM
1.4.3	SM	SM
1.4.4	SM	SM
1.5.1	SM	SM
1.5.2	SM	SM
1.6.1	SM	SM
1.6.2	SM	SM

Action 1.1.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

While the policies and procedures at a local level are referenced to governing legislation, standards, and codes of practice, the development and review process does need to ensure that they are aligned with intended work practice, and work practice is compliant with policies and procedures.

Work practice includes internal requirements; and it also includes the contractual relationships with external service providers, such as blood and blood product suppliers.

This is linked with all actions, as can be seen by the included comments and recommendations throughout the report.

Surveyor's Recommendation:

1. Ensure the policies and procedures are developed and reviewed in line with intended work practice expectations.
2. Observe and/or audit work practice against policies and procedures for compliance.

Risk Level: Moderate

Risk Comments:

The policies and procedures provide the guidance and expected outcomes of the workforce. This is of particular importance where the workforce is dynamic, and contractual arrangements are in place with external service providers, including other hospitals.

Action 1.1.2 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

The health service is able to demonstrate many substantial projects which indicate that patient safety, and quality of care, is considered in business decision making. There are, however, several identified gaps and weaknesses based on collected data and information, which could be addressed through a more robust system of preventative strategies, and/or maintenance, rather than reactive actions.

Several examples pertaining to the environment were identified at the time of survey. For example, incident reports indicated electrocution of patients through the use of electrical equipment; complaints from patients indicated corrosion around electrical points, poor integrity of wall and seating surfaces in bathrooms; design and flow of CSSD departments; bedrooms and communal bathrooms.

The health service was able to provide evidence that action had taken place in response to the incidents and the complaints, including the addition to the risk register, however, a system of prevention through such actions as formal assessment of the building, environment, equipment, work practice, access, and flow, would assist in preventing incidents, complaints, and events.

This is linked with all actions.

Surveyor's Recommendation:

Implement preventative strategies based on data and information analysis.

Risk Level: Moderate

Risk Comments:

The weakness in preventative strategies contributes to a weakness in quality, risk and safety management, which in turn leads to potential events/problems.

Action 1.4.2 Developmental

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

The health service has formally identified the training programs which meet their needs, and that of the National Safety and Quality Health Service Standards (NSQHSS). Some of the hospitals were able to demonstrate a formal staff development and education program framework, and others were not.

The health service was transitioning to a new information and communication technology (ICT) software at the time of survey. The new ICT is able to link the required programs with each position, and consequently each staff member. This then provides a “dashboard” system for staff to understand what is required and when; it is also able to provide reports of compliance to the health service.

While it is appreciated that interruptions occur when systems are being changed, there does, nonetheless, need to be a planned strategy in place to ensure that records are able to be retrieved from prior systems on request. Some of the hospitals were able to provide relevant data and information in regard to compliance on a timely basis, some were not. The inability to do so contributes to a lack of confidence in whether adequate attendance has occurred.

The comments and recommendations within this action are linked with actions 1.5.1 - 1.6.2, and other related actions throughout the standards.

Surveyor's Recommendation:

Ensure that the systems and processes in place enable the health service to consistently maintain formal records on mandatory training attendance, which in turn are able to consistently demonstrate the level of compliance on a timely basis.

Risk Level: Moderate

Risk Comments:

Mandatory training has been designated where risks have been identified for patient safety. If staff have not attended the designated training, then there is a risk that required knowledge and skills are absent, or diminished, to be able to perform expected duties.

Action 1.4.4 Developmental

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

Each hospital within the health service stated that it had competency-based training relevant to the needs of the organisation. Competency tools were available to record completion. Some of the hospitals had a formal schedule for competency-based training, with documented evidence of compliance. Some did not. The recording, and monitoring process for compliance, was also not consistent and/or robust across the health service. An audit of documentation and personnel related records, at the time of survey, indicated gaps and weaknesses. The organisation needs to be able to demonstrate documented evidence of completion and compliance with competency training on a consistent and timely basis.

The comments and recommendations within this action are linked with actions 1.5.1 - 1.6.2, and other related actions throughout the standards

Surveyor's Recommendation:

1. Develop and implement a formal schedule of competency-based training across the health service.
2. Ensure required competency-based training is completed, and documented, on a timely basis and records are maintained accordingly.

Risk Level: Moderate

Risk Comments:

Competency-based training has been designated where risks have been identified for patient safety. If staff have not attended the designated training, then there is a risk that required knowledge and skills are absent, or diminished, to be able to perform expected duties.

Action 1.5.2 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

A risk register is used and regularly monitored. Collected incidents assessed as high risk were observed as being placed on the risk register. The health service was able to demonstrate that action plans were included on the risk register to minimise/mitigate risks to patient safety and quality.

However, an observation of collected data and information, as well as sample auditing and observation, at the time of survey, indicated missed opportunities for improvement, as well as missed opportunities to collect data and

information which would further highlight risks to consumers, to the workforce, and to the health service.

Quality planning and projects do not formally incorporate a documented risk assessment; external service reports, and subsequent recommendations, do not always incorporate a formal documented risk assessment; manual auditing of incidents indicates the transfer of information to the risk register, but does not risk rate other incidents to guide the timeframe for completion. As a result, formal, documented prioritisation of required actions is not always evident, and the risk management process is not as inclusive, consistent and robust, as it should be.

The comments and recommendations within this action are closely linked with the comments and recommendations made within actions 1.6.1 and 1.6.2, as well as other actions throughout the NSQHS Standards; in particular, Standards 3 and 4.

Surveyor's Recommendation:

1. Ensure the organisation-wide risk management system is inclusive, and extends beyond a risk register.
2. Ensure there is timely and appropriate action taken in relation to data and information analysis.

Risk Level: Moderate

Risk Comments:

The risk management processes underpin the ability to provide effective governance, and assist in the prevention of adverse events.

Action 1.6.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

An organisation-wide quality management system is in place, with reports to relevant committees, personnel, and the highest level of governance. Monitoring processes include processes for auditing, and observation. A comprehensive, formal, corporate directed, annual audit schedule is in place for the health service as a whole.

Each hospital within the health service was able to demonstrate compliance with this annual audit, with consequent formally reported results of the audits. Each hospital was also able to demonstrate that further audits had occurred in some areas where results were less than favourable. Actions taken on these occasions to improve results were comprehensive and relevant.

However, observation, and sample auditing, by the survey team at the time of survey, as well as an assessment of the results of the annually collected data and information, highlighted the need to consider the frequency, and expansion, of the monitoring process. Audits of medical records, training records, medication registers, personnel records and human resource databases, observation of work practice, and other areas requiring compliance, indicated substantial gaps across the health service. Interviews with the workforce indicated a lack of awareness of how to link the results of audits with determining future frequency.

The system for monitoring compliance forms a large part of the quality and governance systems. It is also an important means of providing meaningful information on other system compliance, as well as contributing to risk management. It contributes to the provision of data and information, which in turn contributes to business, and work practice, decision making.

The frequency of the monitoring process, eg auditing, and observation of work practice, needs to be aligned with the results of data and information analysis, and trends. The frequency of the monitoring process will differ for each member of the health service, according to the identified deficits, and it will differ according to a given risk assessment.

In addition to the corporate organisation-wide annual audit, each hospital needs to have a local formal audit schedule, which reflects the monitoring requirements of that particular hospital. This will in turn provide a formal guide for the work force to follow. The audit process also needs to demonstrate accuracy and, in turn, credibility, so that the data

and information can inform. For example, please refer to 1.18.2, consent forms.

The comments and recommendations within this action are as a result of findings within actions 1.5.1 - 1.6.1, as well as findings related to the other actions of the NSQHSS.

The risk rating on this occasion has been allocated a moderate risk due to changes, and planning, made at the time of survey. However, the health service is at risk of a higher rating, if formal changes are not made on a consistent, and relevant, basis going forward.

Surveyor's Recommendation:

1. Ensure the frequency of formal, documented monitoring, is relevant to collected data and information, as well as observation of work practice, and contributes to achieving expected outcomes in compliance, within appropriate timeframes.
2. Ensure that the results of audits accurately reflect findings.

Risk Level: Moderate

Risk Comments:

The quality and continuous improvement management processes underpin the ability to provide effective governance, and assist in the prevention of adverse events.

Clinical practice

Ratings

Action	Organisation	Surveyor
1.7.1	SM	SM
1.7.2	SM	SM
1.8.1	SM	SM
1.8.2	SM	SM
1.8.3	SM	SM
1.9.1	SM	SM
1.9.2	SM	SM

Action 1.9.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

The annual audit of clinical records indicates that not all components of the clinical record are complete. Therefore, there are identified weaknesses in relation to the accuracy of the clinical records at the point of care. Auditing of clinical records should be occurring during the currency of the records. The shift to shift handover process will assist in providing a platform for auditing clinical records. Consideration of the frequency of retrospective auditing of clinical records will also assist with the accuracy of the records.

The comments within this action are linked with actions 1.5.1 - 1.6.2, as well as other actions within the NSQHSS. relating to clinical records.

Surveyor's Recommendation:

Ensure the completion and accuracy of clinical records.

Risk Level: Moderate

Risk Comments:

An incomplete clinical record does not provide the necessary guidance for work practice; it raises questions as to whether all aspects of a patient's care have been identified; and it places the organisation at risk if an adverse event should occur.

Performance and skills management

Ratings

Action	Organisation	Surveyor
1.10.1	SM	SM
1.10.2	SM	SM
1.10.3	SM	SM
1.10.4	SM	SM
1.10.5	SM	SM
1.11.1	SM	SM
1.11.2	SM	SM
1.12.1	SM	SM
1.13.1	SM	SM
1.13.2	SM	SM

Action 1.11.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

A valid performance review process is in place for the clinical workforce. While some members of the health service can demonstrate a degree of reliability in the performance review process, an audit of processes, personnel records, and databases, at the time of survey, indicates that this is not consistent across the health service.

There are weaknesses and/or gaps in relation to several aspects of the performance review process, such as individual professional development plans; system-wide tracking of participation in reviews; audit of clinical workforce with completed performance reviews; audit of work practice against policies and procedures.

A review of the systems for tracking, a review of the frequency of audits, and the attainment of expected compliance across the health service need to occur.

The comments and recommendations within this action are linked with actions 1.5.1 - 1.6.2 and 1.4.1 - 1.4.4, as well as other actions within the NSQHSS; with particular mention of actions relating to patient safety.

Surveyor's Recommendation:

Ensure a valid and reliable performance review process is in place for the clinical workforce, which demonstrates consistent compliance across the health service, within specified timeframes.

Risk Level: Moderate

Risk Comments:

Appropriate, and relevant, workforce knowledge, skills, and compliance with policies and procedures, underpin the ability to achieve a quality and safe provision of service for patients, and the health service. There is a risk of exposure for the organisation should an adverse event occur.

Action 1.11.2 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

An audit of personnel records across the health service, at the time of survey, indicated weaknesses, and gaps, in regard to compliance with the process.

Please refer to the comments within action 1.11.1.

Surveyor's Recommendation:

Ensure consistent compliance with the workforce performance review process on a timely basis.

Risk Level: Moderate

Risk Comments:

Appropriate, and relevant, workforce knowledge, skills, and compliance with policies and procedures, underpin the ability to achieve a quality and safe provision of service for patients, and the health service. There is a risk of exposure for the organisation should an adverse event occur.

Incident and complaints management

Ratings

Action	Organisation	Surveyor
1.14.1	SM	SM
1.14.2	SM	SM
1.14.3	SM	SM
1.14.4	SM	SM
1.14.5	SM	SM
1.15.1	SM	SM
1.15.2	SM	SM
1.15.3	SM	SM
1.15.4	SM	SM
1.16.1	SM	SM
1.16.2	SM	SM

Patient rights and engagement

Ratings

Action	Organisation	Surveyor
1.17.1	SM	SM
1.17.2	SM	SM
1.17.3	SM	SM
1.18.1	SM	SM
1.18.2	SM	SM
1.18.3	SM	SM
1.18.4	SM	SM
1.19.1	SM	SM
1.19.2	SM	SM
1.20.1	SM	SM

Action 1.18.2 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

Policies and procedures are in place to guide expectations in regard to informed consent. The health service has a format for a consent form. The consent form completion is included on the annual organisation-wide audit schedule. The annual audit results indicated 100% compliance with consent forms.

A sample audit of discharged patient records at the time of survey indicated that the format of the consent form varied due to the use of Adelaide Community Healthcare Alliance Incorporated (ACHA) forms, and also the use of VMO consent forms. The policy and procedure was altered to reflect the accommodation of both, at the time of survey. The health service needs to ensure that the format of forms used by VMOs does meet not only the expectations of the health service, but that of governing legislation and standards.

A sample audit of discharged patient records, at the time of survey, indicated that a consent form was in place for all surgical/procedural patients; however, the completion of the consent form varied across the health service. Some of the hospitals demonstrated that the consent form had been fully completed, while others demonstrated only partial completion.

A sample audit of inpatient clinical records also indicated varying degrees of completion of a consent form across the health service.

Interviews with staff at the time of survey indicated that some patients were reaching the operating suite prior to the completion of a consent form, with the form being completed in the reception/holding bay, prior to entry. Consent is to be informed, and requesting the completion of a consent form just prior to entry into a theatre is not conducive to good practice. The patient may potentially feel under stress, or pressure, due to their location. Emergency situations are, of course, considered an exception.

The comments and recommendations within this action link with actions 1.5.1 - 1.6.2.

Surveyor's Recommendation:

1. Ensure that the consent forms used by VMOs meet the expectations of the health service, and also comply with governing legislation and standards.
2. Ensure that all consent forms are fully completed prior to the patient being transferred to the operating suite, where an emergency is not a factor.

Risk Level: Moderate

Risk Comments:

The health service needs to demonstrate that it is compliant with governing legislation and standards. The timing of the consent form completion needs to indicate that consent is fully informed, that the patient has had time to consider options, and fully agrees to the operation/procedure without pressure.

STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

ACHA is a community health care alliance and as such has a remarkable number of community members involved with the health service. There is a “Consumer Engagement Plan” in place, and a “Partnering with Consumer” Framework. Policies and procedures guide the work practices for the workforce, volunteers, and consumer groups, in relation to consumer related topics; for example, the Charter of Patient Rights, being able to provide feedback, and make a complaint.

The ACHA Board is made up of community members. There is a large cohort of dedicated volunteers who have served the health service for many years. There is also a consumer representative group for each hospital member of the alliance, as well as chaplains and pastoral carers. All members are actively involved with ascertaining the perception of the users of the health service, and are also active in feeding this information back into the formal system of review and business decision making. This includes strategic and operational planning, and decisions relating to patient safety and quality of care. An annual general meeting allows for hearty discussion by its members.

The ACHA Board, and various consumer committee meetings, contributes to the formal governance process for consumers.

The health service was able to demonstrate formal education, including an orientation process, for new ACHA Board members, volunteers, and consumer group representatives. Support for these groups of consumers was evident.

Consumer participation in the review of publications provided by the health service was evident. This included the format and presentation of annual publications on quality and safety, patient brochures, and literature. An example of changes made as a result of consumer participation was the introduction of a feedback form specifically for children, and the introduction of a “cow” feedback collection box. The health service also utilises the consumer endorsed publications of such organisations as the Australian Heart Foundation and Cancer Council.

Consumer partnership in designing care

The health service is able to demonstrate that it considers feedback, complaints, and incidents, with evidence of response and actions to correct issues raised. Consumer representatives talk about their roles within the health service at orientation sessions. Members of the community are invited to join focus groups. Interviews with the representatives of the various consumer groups indicated active participation in decision making, with positive outcomes. They all “echoed” reception of support from the management and executive teams.

Examples of changes have included refurbishment of rooms, the introduction of new surgical techniques such as robotic surgery, the review of information pre-admission to better inform the patients of their expected journey through the hospital system, the inclusion of culturally sensitive meals, and the introduction of diversional activities for children during their stay, eg “fun meal boxes”, art work, and activity boxes.

While it is acknowledged that the workforce would gain information from the data and information related to surveys, incidents, complaints, and feedback, and a consumer representative presents at the orientation of new staff, the intent behind the action of a patient/consumer training the workforce is to assist the workforce understand the journey of a patient/carer, both physically and emotionally. This is not done well at this stage, and the health service would be well served to engage patients/carers in presenting their journeys to the workforce as part of the development and education of the workforce. This approach forms a valuable learning tool for the workforce.

There is also room for improvement in regard to the buildings at two of the hospitals. It is noted that there are heritage listing restrictions on one of the buildings. The quality of some of the patient rooms is not at the standard it needs to be. This has been reflected in some of the complaints received. The doors to the entrance of the clinical areas at Ashford Private Hospital are heavy and are required to be opened manually.

Consumer partnership in service measurement and evaluation

There is a “Consumer Engagement Plan” in place, and a “Partnering with Consumers” Framework. Formal consumer groups exist for each hospital, as well as the ACHA Board. Data and information are tabled at each meeting for discussion, decisions, and follow-up. Data and information are included in annual formal reports to the community at large, on the website; and on quality boards throughout the health service.

Examples of data and information analysis, quality activities, and improvements, can be found throughout the NSQHSS report under each standard.

Consumer partnership in service planning

Ratings

Action	Organisation	Surveyor
2.1.1	SM	SM
2.1.2	SM	SM
2.2.1	SM	SM
2.2.2	SM	SM
2.3.1	SM	SM
2.4.1	SM	SM
2.4.2	SM	SM

Consumer partnership in designing care

Ratings

Action	Organisation	Surveyor
2.5.1	SM	SM
2.6.1	SM	SM
2.6.2	SM	SM

Action 2.6.2 Developmental

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

The health service is able to demonstrate that it considers feedback, complaints, and incidents, with evidence of response and actions to correct issues raised. Consumer representatives talk about their roles within the organisation at orientation sessions.

However, the intent behind the patient/consumer training the workforce is to assist the workforce understand the journey of a patient/carer, both physically and emotionally. The organisation would be well served to engage patients/carers in presenting their journeys to the workforce as part of the development and education of the workforce. This approach forms a valuable learning tool for the workforce.

Surveyor's Recommendation:

Consider other ways of engaging patients/carers to train the workforce other than feedback, complaints, and incidents.

Risk Level: Low

Consumer partnership in service measurement and evaluation

Ratings

Action	Organisation	Surveyor
2.7.1	SM	SM
2.8.1	SM	SM
2.8.2	SM	SM
2.9.1	SM	SM
2.9.2	SM	SM

STANDARD 3
PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Surveyor Summary

Governance and systems for infection prevention, control and surveillance

Formal policies and procedures are in place, many of which have been provided by the external consulting group HICMR. They are aligned with governing legislation, standards, and evidence-based best practice, and attempt to manage risks within the health service.

Infection Control Coordinators are in positions; some are new. These positions are supported through the Healthscope management arrangement, as well as HICMR, to a certain level. An infection prevention, control, and management committee convenes. Terms of reference are in place to provide parameters of roles and responsibilities.

Appropriate surveillance systems, and processes, are in place. The health service was able to demonstrate systems to identify risk pre-admission, on admission, and during admission. There were also processes in place to communicate the status of a given patient when being discharged, or transferred to another health, aged, or community service. Surveillance data demonstrates a good track record of reasonably low infection rates. Data and information inform the governance structure in relation to compliance, and any need for action/further action. This includes the medical Craft Groups and Medical Advisory Committee (MAC). Indicators are submitted to external service providers for benchmarking, eg ACHS clinical indicator program.

Quality activities were evident to improve performance. The most remarkable project being conducted at the time of survey was in relation to actively reducing the incidence of infection as a result of cannulation. Considerable work had occurred in analysing data and information in relation to infections, the source of infection, and approach to eradicating/mitigating risks. The project exemplified the execution of the quality cycle in relation to a project. That is, the issue/topic was identified; the status and level of impact on the patient was identified; a risk assessment was carried out; a consultative approach to deciding on an approach to correct the problem was arrived at; action was taken; education and effective communication occurred; actions were continually monitored; data and information were continuously collected and analysed; the results of change were examined for effectiveness; appropriate reporting is in place; the issue/topic is continually monitored to ascertain ongoing compliance. The team is commended on its efforts and achievements.

This level of excellence needs to be extended to all areas of the health service relevant to infection prevention, control, and management.

Infection prevention and control strategies

A formal hand hygiene program is in place throughout the health service. There was evidence that members of the workforce had undergone formal training associated with Hand Hygiene Australia to provide training and auditing. Monitors and mentors were also present with each service.

Posters and guides are strategically placed throughout the health service. Education on hand hygiene forms part of the orientation process for the employed workforce, volunteers, and consumers. Ongoing education occurs via on-line training. Frequent auditing occurs against the “five moments”. Immediate feedback and training occur where compliance is considered poor. The current rate of compliance for hand hygiene is 90.2%. Further work is required for VMOs.

A workforce immunisation program that complies with current national guidelines is in use. The workforce database is currently being updated to improve the capture, storage, and reporting of required information. The health service is encouraged to strengthen this area so that relevant and timely data can inform future decision making in relation to infectious diseases, and appropriate workplace placement.

Workplace safety measures are in place, including personal protective equipment (PPE). Consideration to such items as handwashing solutions and disposable glove material, takes place to mitigate risks to the workforce.

Competency-based training, and compliance with aseptic technique protocols, is evolving. Some of the hospitals are presenting compliance rates of 93%, while others are well below that figure. Further work is required in relation to

compliance rates for VMOs. This is an area which will need further strengthening over the course of the current transitional arrangements. Comments and recommendations have been made to assist with strengthening this area.

Managing patients with infections or colonisations

There are formal systems, processes, and protocols in place to ensure standard and transmission-based precautions are consistent with the current national guidelines. The surveillance systems are consistent, and capture relevant information for analysis and discussion. Weaknesses are identified and action is taken to correct work practices. This was evident in the major project on cannulation mentioned previously.

Formal screening tools are in place to detect existing infections. Planning occurs where the screening process identifies the presence of an infectious micro-organism. This includes alerts on the patient management system, and medical records; the appropriate allocation of a single room; signs to alert visitors and the non-clinical workforce; PPE and isolation practices. Recent upgrades of the “precaution” signage, across the health service, provides improved means of standardising practice. An electronic real time patient tracking system (EDEN) is used across all hospitals to communicate patient-related alerts.

The health service offers a mixture of single rooms with adjacent en-suites as well as some shared wet areas. Shared bathroom and toilet facilities are common in the two older buildings. There are no dedicated ‘isolation’ rooms (negative or positive) at either site. From a cleaning perspective, further monitoring of compliance with required cleaning regimes (eg between patient use) is encouraged for those areas that still provide shared use of bathrooms/en-suites.

There is also evidence of preventative measures undertaken in the food services area. This includes the proactive investigation and early response to a potential salmonella outbreak associated with the former stick mixer (a non-dismountable model). Work carried out by the Flinders Private Hospital food services team, involved translating the issue into awareness, and making improvements not only across all the ACHA health service, but also other local food services providers as well.

There are also processes in place to communicate the status of a given patient when being transferred between internal services, being discharged, or transferred to another health, aged, or community service.

Antimicrobial stewardship

The antimicrobial stewardship program (AMS) has continued to evolve with strong support from pharmacists, and various clinicians including the Medical Advisory Committee (MAC). A dedicated committee oversees the ACHA AMS program, with good representation from both management, and clinicians, including pharmacy, pathology and VMOs. Access to up-to-date therapeutic guidelines is easily available to clinicians via the intranet. ACHA pharmacists complete targeted reviews of antimicrobial usage, and make recommendations for further improvement. These are formally reported at the MAC, and communicated to clinicians as relevant.

Local formulary restrictions are facilitated through internal purchasing approval processes, particularly for the higher cost antimicrobials. Increased focus on restricting methods for lower cost broad spectrum antimicrobials, resistance monitoring, and increasing the number of prescribers completing the antibiotic prescribing eLearning modules, could further advance current antimicrobial stewardship efforts across ACHA.

Cleaning, disinfection and sterilisation

Policies and procedures guide work practice in regard to cleaning, disinfection and sterilisation. Compliance with standards for cleaning and reprocessing of reusable medical devices is monitored, and an action plan is in place to address the new AS4187 standard requirements as per the recently undertaken gap analysis by HICMR.

A manual traceability system (Meditrax) is used for sterilising re-usable invasive equipment. Its effectiveness is periodically verified across all sites. Planning is in place to change to an electronic instrument tracking system in the future, commencing with Ashford Hospital. There is evidence of steriliser validation, and compliance monitoring systems.

The hospital cleaning is well maintained through a range of in-house, and externally contracted, services. A number of improvements have been implemented (eg disposable bed-screen curtains, vinyl upholstery, wire shelves and baskets) to promote a hygienic environment and easy to clean surfaces. There is evidence of a recently developed environmental cleaning schedule tailored to each hospital, which lists different hospital areas/elements according to their risk profile, and required cleaning frequency. This will need to be further matched to the actual cleaning regimes

implemented by staff to ensure consistency between practices and cleaning schedule expectations.

Waste and linen are well-managed, although more focus could be placed on the segregation of clean/dirty bins, routine cleaning of the bins, and safe management of the linen chute at Flinders Private Hospital. There is evidence of compliance with legislative requirements for the cooling towers, the hydrotherapy pool, and air conditioner flows in the operating suites.

There are some areas of gaps/weaknesses which will need addressing. There are “pockets” of less than desirable attention to
• training and competencies in some of the hospitals of the health service, eg aseptic technique, positions overseeing the sterilisation of re-usable invasive instruments,
• the integrity of surfaces
• the design of the CSSD service
• available equipment for sterilising re-usable invasive equipment
• the cleaning of communal bathrooms/toilets between patients

As discussed and acknowledged by the ACHA executive team, there is a concern in relation to cleaning and sterilisation practices at the Memorial Hospital, which are at risk of being potentially compromised due to current environmental constraints. While acknowledging the ‘longer term’ redevelopment (master) plan across various sites, but also the reasonably high turnover of complex casemix currently undertaken at Memorial Hospital, a commitment has been made by ACHA to reprioritise the CSSD department renovation to ensure optimal cleaning, sterilisation and storage facilities are maintained. In that context, an upgrade of the Memorial CSSD department is in progress and aimed at being completed over the coming three to six months.

In addition to the building structure, is a concern relevant to the appropriate qualifications, and completed competencies of the workforce within this area. This contributes to a question of confidence in regard to the required knowledge and skills of the workforce, within a compromised workplace, involved with a high risk subject.

This issue has been placed on the risk register along with expected actions to mitigate the risks until the changes have been finalised. Included in the actions is a commitment to ensure that all staff working within the CSSD have appropriate formal qualifications, as well as undergoing relevant competencies within the stated timeframes.

A full discussion took place with the executive team at the time of survey, with the submission of a documented plan of action and letter of commitment. The risk rating of the following recommendation has been reduced to a moderate rating in view of the commencement of planning, and commitment to timeframes. It is essential that this commitment is fulfilled.

Communicating with patients and carers

There is evidence of a range of infection control related information provided to patients and feedback is used to improve practice. For example, it is understood that the ACHA wide ‘It’s OK to ask’ consumer engagement program originated from a relative’s feedback in relation to an infection control aspect at Ashford Hospital.

While there is some evidence of consultation and evaluation of patient infection prevention and control information, it is stronger in some of the hospitals under the health service, more than others. At this stage there is limited evaluation to determine if the information provided continues to meet the needs of the target audience, and therefore further effort is required to evaluate the infection control related information provided to consumers.

Governance and systems for infection prevention, control and surveillance

Ratings

Action	Organisation	Surveyor
3.1.1	SM	SM
3.1.2	SM	SM
3.1.3	SM	SM
3.1.4	SM	SM
3.2.1	SM	SM
3.2.2	SM	SM
3.3.1	SM	SM
3.3.2	SM	SM
3.4.1	SM	SM
3.4.2	SM	SM
3.4.3	SM	SM

Action 3.1.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

A review of the size, structure, equipment, handwashing capabilities, storage, and flows of the Central Sterilising Service (CSSD) at the Memorial Hospital, indicates that the current presentation does not sufficiently eradicate/mitigate the risks relating to potential cross-contamination; accidental use of non-sterile stock; required processing of reusable devices; and a safe work place. The review also indicates the need to effectively comply with governing legislation, standards, and codes of practice.

As a consequence, planning is in place for the redevelopment of the Central Sterilising Service. This will occur in two stages. The development of a formal plan for stage one has commenced. Building and refurbishment for stage one will commence in January 2017. Stage one will ensure that there is adequate space for the safe reception, accommodation and effective processing of re-usable devices; that relevant and appropriate equipment is purchased; that there are adequate and effective flows from the dirty area, to the clean area, to the sterile area; that the risk of accidental use of unsterile stock/equipment is eradicated; that the risk of cross contamination is eradicated; that optimal storage space for sterile and non-sterile stock will be provided; that effective compliance with governing legislation, standards and codes of practice will take place.

This issue has been placed on the risk register along with expected actions to mitigate the risks until the changes have been finalised. Included in the actions is a commitment to ensuring that all staff working within the CSSD have appropriate formal qualifications, as well as undergoing relevant competencies within the stated time-frames.

A full discussion took place with the executive team at the time of survey, with the submission of a documented plan of action and letter of commitment. The risk rating of the following recommendation has been reduced to moderate in view of the commencement of planning, and commitment to timeframes. It is essential that this commitment is fulfilled.

The comments and recommendations within this action are linked with other actions within Standard 3, in addition to actions 1.5.1 - 1.6.2.

Surveyor's Recommendation:

Ensure that the required changes to the CSSD service of the Memorial Hospital are made as specified, and within the stated timeframes.

Risk Level: Moderate

Risk Comments:

The rating has been temporarily downgraded in light of the planning and commitment, and to accommodate the time required to implement required changes. The risks have been mentioned within the comments.

Infection prevention and control strategies

Ratings

Action	Organisation	Surveyor
3.5.1	SM	SM
3.5.2	SM	SM
3.5.3	SM	SM
3.6.1	SM	SM
3.7.1	SM	SM
3.8.1	SM	SM
3.9.1	SM	SM
3.10.1	SM	SM
3.10.2	SM	SM
3.10.3	SM	SM

Action 3.5.3 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

There is evidence of improvement in the overall hand hygiene rates across the health service. However, there is still room for improvement in regard to compliance rates for medical officers.

Surveyor's Recommendation:

Further action be taken to maximise hand hygiene compliance rates for medical officers.

Risk Level: Moderate

Risk Comments:

There is a risk of cross-infection

Action 3.10.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

The effort to achieve full compliance with training in aseptic technique for the clinical workforce, including the VMOs, is acknowledged. Further work is still required for the clinical workforce across the three sites to fully meet the intent of this action.

Surveyor's Recommendation:

Fully implement the training of the clinical workforce across the three sites.

Risk Level: Moderate

Risk Comments:

Knowledge and skills assist with minimising/eradicating the risk of transmitting infections.

Managing patients with infections or colonisations

Ratings

Action	Organisation	Surveyor
3.11.1	SM	SM
3.11.2	SM	SM
3.11.3	SM	SM
3.11.4	SM	SM
3.11.5	SM	SM
3.12.1	SM	SM
3.13.1	SM	SM
3.13.2	SM	SM

Antimicrobial stewardship

Ratings

Action	Organisation	Surveyor
3.14.1	SM	SM
3.14.2	SM	SM
3.14.3	SM	SM
3.14.4	SM	SM

Cleaning, disinfection and sterilisation

Ratings

Action	Organisation	Surveyor
3.15.1	SM	SM
3.15.2	SM	SM
3.15.3	SM	SM
3.16.1	SM	SM
3.17.1	SM	SM
3.18.1	SM	SM

Action 3.15.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

There are wards within the health service where communal showers, baths, and toilets, are used. Interviews with members of the workforce indicated gaps in awareness of the need to clean and disinfect these items between patient usage. Relevant policies and procedures need to reflect this requirement. Observation of work practice needs to occur to ensure compliance.

The comments and recommendations within this action link with actions 1.5.1 - 1.5.2, 3.15.2, and 3.15.3.

Surveyor's Recommendation:

Ensure appropriate, and adequate cleaning of baths, showers, toilets, and other shared items, between patients.

Risk Level: Moderate

Risk Comments:

There is a risk of cross-infection between patients.

Action 3.15.2 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

Whilst regular monitoring of cleaning practices is undertaken, there was limited evidence to demonstrate the effectiveness of the cleaning regimes implemented for shared bathrooms/en suites.

Surveyor's Recommendation:

Further monitoring of compliance with optimal cleaning regimes (eg between patient use) is recommended for those areas that still provide shared use of bathrooms/en suites.

Risk Level: Low

Action 3.16.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

A gap analysis against the new AS4187 standard has been undertaken for each site and an action plan prepared to address any outstanding elements.

Surveyor's Recommendation:

Complete the required actions as derived from the recent AS4187 gap analysis.

Risk Level: Moderate

Risk Comments:

Substantial deficiencies were detected at the Memorial Hospital at the time of survey. A plan of action is in place. This plan needs to be completed as per the timeframe.

Action 3.18.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

The health service was able to provide evidence that relevant members of the workforce had undertaken formal training in a competency-based program to decontaminate reusable medical devices. However, there are gaps in this process. There are also gaps and weaknesses in the collection and retention of related information in either databases and/or personnel files.

The comments and recommendations of this action are linked with actions 1.5.1 - 1.6.2, actions 3.1.1, 1.4.4, and other actions within this standard.

Surveyor's Recommendation:

1. Ensure all members of the workforce, working within the areas where cleaning and decontamination of reusable medical devices and instruments take place, have successfully achieved relevant, formally recognised, competency-based qualifications.
2. Ensure that the systems and processes used to maintain required documentation is consistent and effective, and in turn is able to provide evidence of successful completion on a timely basis.

Risk Level: Moderate

Risk Comments:

The appropriate and adequate cleaning and decontamination of reusable devices and instruments contributes to the prevention of cross-infection.

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
3.19.1	SM	SM
3.19.2	SM	SM

Action 3.19.2 Developmental

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

While there is some evidence of consultation and evaluation of patient infection prevention and control information, it is stronger in some of the hospitals under the health service, more than others.

Surveyor's Recommendation:

Ensure that consultation and evaluation of patient infection prevention and control information is undertaken consistently across the health service to ensure that it meets the needs of the targeted audience.

Risk Level: Low

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

Pharmacy services are provided by Hospital Pharmacy Services (HPS), which has a national contract with Healthscope and ACHA for the provision of pharmaceuticals. The contract contains key performance indicators (KPIs) covering medication management. The surveyors noted that the KPIs did not include medication storage. HPS pharmacists meet the Director of Nursing, or General Manager, of each site on a monthly basis to discuss the contract and operational issues.

Pharmacist hours have recently been increased at the Memorial Hospital, and are due to increase at the Ashford Hospital.

The Medical Advisory Committee acts as the Drug and Therapeutics Committee, and for this purpose the pharmacist attends the relevant part of the meeting. The organisation also participates in the Healthscope Medical Safety Clinical Cluster program. Medication management issues are elevated to the ACHA Patient Care Committee, ACHA Executive Committee and the ACHA Board of Management.

The surveyors noted occurrences where medication were not stored according to legislative requirements. These issues were addressed during the survey. The surveyors recommend that the safe storage of medications becomes an additional focus of the health service's medication management audit program.

The risk register was viewed at the time of survey. Medication risks are appropriately included, and interventions updated. Medication safety alerts are discussed with staff at the Clinical Care Committees and at the Level 3 Nurse Managers' meeting.

There is a suite of organisation-wide policies covering medication management. These are current. They are available to staff through the intranet. The organisation uses the National Inpatient Medication Chart (NIMC).

The medication management system - covering storage, distribution, prescribing, dispensing and administration of medications - is covered by a range of policies, protocols and audits, both bedside and health service-wide. At Flinders Private Hospital the chemotherapy system and controls were reviewed. The chemotherapy system is supported by EviQ, which provides competency and training frameworks and tools, and standardised drug protocols. Chemotherapy prescriptions are typed, checked, and authorised by pharmacy prior to dispensing. Nursing staff have chemotherapy competencies.

Medical staff may not include medications within standing orders. Telephone orders are taken by two registered nurses and documented as single only doses. The order must be signed by the doctor within 24 hours.

The organisation has a program of training to ensure competencies of graduate nurses. An interactive on-line training package MediSafe has been trialled for a few months, and is due to be rolled out across the health service. It is credited with reducing incidents by over 30%. Annual mandatory training is in place across the organisation. Compliance rates were over 90% at each site.

Policies include the need to report and act on adverse incidents. Staff were able to detail the system for notification and reporting through RiskMan. Staff involved in an administration incident are required to complete a reflective review of their practice.

Medication incidents are trended by the Quality Unit and reported at the Medical Advisory Committee, and ACHA Patient Care Committee. Policy and practice changes are made in response to major incidents. The hospital Level 3 committees are a major communication channel back to staff. In addition, relevant Healthscope "Shared Learnings" are incorporated into policy changes.

Evaluation of the medication management system is undertaken through the risk register, incident management, and NIMC audits, and actions are taken.

There is a range of audits undertaken both at the bedside and also health service-wide. These include an annual self-

assessment of the NIMC, NIMC audits, and discharge summary audits. Results are viewed by the ACHA Patient Care Committee.

Improvement activities include the introduction of an antimicrobial strategy, led by the Medical Advisory Committee, and wall displays of safe storage rules.

Mechanisms exist for the management of Warfarin, antimicrobials and Venous Thrombosis and Embolism (VTE) prophylaxis. VTE audits across the organisation show there is work to be done in ensuring compliance with documentation but this has been recognised by hospital management and interventions are in place to improve this. It is important that this work continues to be audited on a regular basis.

Documentation of patient information

There are multiple steps across the patient journey where the staff obtain a best possible medication history. In particular, staff undertake a medication reconciliation at admission, and prior to discharge. High risk patients are seen by the pharmacist prior to discharge and a medication management plan is documented for the patient to go home. Documentation reconciliation audits show a need to improve documentation compliance and hospital managers have put further actions in place. This is an area which will require ongoing monitoring in the future. Results of audits indicated a compliance rate of 53% for reconciliation, and a compliance rate of 55% for obtaining a relevant medical history.

Medication allergies are documented on the NIMC. Their presence, or absence, must be noted on the alert sheet at the front of the record. Compliance with the documentation of the alert sheet is audited on an annual basis. Adverse drug reactions are managed by the pharmacists, and reports submitted to the TGA.

Medication management processes

MIMS is on line for the use of the staff. Its use is reviewed by the pharmacy service and updated where necessary. The surveyors noted occurrences where drugs were not stored according to legislative requirements. These issues were addressed during the survey. The surveyors recommend that safe storage of drugs becomes an additional focus of the organisation's medication audit program.

Wall posters in the pharmacy rooms display safe storage rules. Refrigerators are appropriately monitored, either electronically, or through twice daily checking. There was evidence of an appropriate disposal, and destruction, policy in place.

A sample audit of the "Dangerous Drugs of Addiction (DDA) registers across the health service, at the time of survey, indicated gaps in completion over a consistent period of time. This included amounts of medications administered. The DDA book should be completed at the time of each entry. Auditing DDA books for completion should be occurring on a shift by shift basis. There was no indication that this formed part of a formal audit schedule. Annual auditing is not frequent enough. This issue was placed on the risk register with the commencement of a plan of action. Comments and recommendations have been made to assist with the strengthening of this area.

Continuity of medication management

ISOBAR structured handover check sheets are used to attempt to capture the handover of correct medication information.

High risk patients are seen by the pharmacist prior to discharge and a medication management plan is documented for the patient to go home. Discharge summaries sent to the GP service include information on medications. A copy of the discharge summary is also given to the patients/carer.

Communicating with patients and carers

Processes are in place to communicate with patients and carers in a number of settings. Processes are in place to engage the individual patients, and their carers, about their medications through the bedside handover process, and discharge process. In a broader sense, the organisation distributes medication information through its TV channel, and brochures.

Governance and systems for medication safety

Ratings

Action	Organisation	Surveyor
4.1.1	SM	SM
4.1.2	SM	SM
4.2.1	SM	SM
4.2.2	SM	SM
4.3.1	SM	SM
4.3.2	SM	SM
4.3.3	SM	SM
4.4.1	SM	SM
4.4.2	SM	SM
4.5.1	SM	SM
4.5.2	SM	SM

Documentation of patient information

Ratings

Action	Organisation	Surveyor
4.6.1	SM	SM
4.6.2	SM	SM
4.7.1	SM	SM
4.7.2	SM	SM
4.7.3	SM	SM
4.8.1	SM	SM

Medication management processes

Ratings

Action	Organisation	Surveyor
4.9.1	SM	SM
4.9.2	SM	SM
4.9.3	SM	SM
4.10.1	SM	SM
4.10.2	SM	SM
4.10.3	SM	SM
4.10.4	SM	SM
4.10.5	SM	SM
4.10.6	SM	SM
4.11.1	SM	SM
4.11.2	SM	SM

Action 4.10.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

A sample observation of medication storage at the time of survey indicated gaps in full compliance with governing legislation. This was rectified at the time of survey.

The comments and recommendations within this action are linked with actions 1.5.1 - 1.6.2.

Surveyor's Recommendation:

1. Ensure the safe and appropriate storage of all medications in line with governing legislation.
2. Ensure appropriate and timely monitoring systems are in place to achieve compliance.

Risk Level: Moderate

Risk Comments:

There is a risk of misappropriation of medications, as well as unauthorised access.

Action 4.11.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

A sample audit of the Dangerous Drugs of Addiction (DDA) registers across the health service, at the time of survey, indicated gaps in completion over a consistent period of time. This included amounts of medications administered.

The DDA book should be completed at the time of each entry. Auditing DDA books for completion should be occurring on a shift by shift basis. There was no indication that this formed part of a formal audit schedule. Annual auditing is not frequent enough.

This issue was placed on the risk register with the commencement of a plan of action.

The comments and recommendations within this action are linked with actions 1.5.1 - 1.6.2.

Surveyor's Recommendation:

1. The DDA registers be fully completed at the time of each entry.
2. The DDA register form part of the formal audit schedule, with the frequency of auditing to occur reflective of the risk assessment, and results of audits.

Risk Level: Moderate

Risk Comments:

There is an absence of full compliance with governing legislation and regulations. There is an absence of required documented tracking for administration of high risk medications. The health service is at risk should an adverse event occur due to lack of documentation.

Continuity of medication management

Ratings

Action	Organisation	Surveyor
4.12.1	SM	SM
4.12.2	SM	SM
4.12.3	SM	SM
4.12.4	SM	SM

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
4.13.1	SM	SM
4.13.2	SM	SM
4.14.1	SM	SM
4.15.1	SM	SM
4.15.2	SM	SM

STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

The health service has policies and procedures in place to guide work practice. These are in line with the requirements of the NSQHSS. The system is monitored for compliance.

A system for reporting and investigating patient incidents relating to identification, or mismatching, is in place (via RiskMan).

Processes to transfer care

There is evidence of patient identification and treatment matching implemented throughout the patient journey, including on admission, during handover, transfer and before any care/treatment is provided. Further auditing efforts to verify compliance with patient identification across the different stages of the care continuum is encouraged to ensure consistent practices are applied across all sites.

Flinders Private Hospital is co-located with a public hospital, and has formal arrangements in place to share clinical services. Organisational policies are in place to provide guidance on the management of public patients receiving care at Flinders Private Hospital. However, they are not sufficiently clear to indicate when, and how, the two different identification bands (one with the public hospital and one with ACHA) are to be employed. A recommendation has been made to update the current patient identification policy to provide further clarity on the optimal identification of public patients receiving care at Flinders Private Hospital.

Processes to match patients and their care

A unique (ACHA tailored) ‘surgical time out’ tool has been developed and rolled out across the health service with good uptake and consistent implementation as observed during the survey. The tool combines the minimum standard requirements of patient identification and procedure matching with additional elements such as anti-coagulant therapy, antimicrobials, etc. There is evidence of regular monitoring of the ‘surgical time-out’ process and improvements made as/where necessary. A high degree of dedication and determination by the Flinders Private Hospital operating suite team, which continues to advocate for further improvement of the ‘surgical time out’ process across ACHA, is acknowledged.

A standardised system for the identification/labelling and matching of breast milk stored in the maternity and neonatal units is in place, with evidence of regular monitoring of compliance.

Feedback from patients consulted during the survey demonstrates awareness of the need for proper identification, satisfaction with its consistent application, and how they were involved in that process.

Identification of individual patients

Ratings

Action	Organisation	Surveyor
5.1.1	SM	SM
5.1.2	SM	SM
5.2.1	SM	SM
5.2.2	SM	SM
5.3.1	SM	SM

Action 5.1.2 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

Flinders Private Hospital is co-located with a public hospital, and has formal arrangements in place to share clinical services.

Organisational policies are in place to provide guidance on the management of public patients receiving care at Flinders Private Hospital. However, they are not sufficiently clear to indicate when, and how, the two different identification bands (one with the public hospital and one with ACHA) are to be employed.

The comments and recommendations within this action are linked with actions 1.1.1 and 1.5.1-1.5.2.

Surveyor's Recommendation:

1. Update the current patient identification policy to provide further clarity on the optimal identification of public patients receiving care at Flinders Private Hospital.
2. Ensure the processes are in line with the requirements of the Australian Commission on Safety and Quality in Health Care.

Risk Level: Low

Processes to transfer care

Ratings

Action	Organisation	Surveyor
5.4.1	SM	SM

Processes to match patients and their care

Ratings

Action	Organisation	Surveyor
5.5.1	SM	SM
5.5.2	SM	SM
5.5.3	SM	SM

STANDARD 6
CLINICAL HANDOVER

Surveyor Summary

Governance and leadership for effective clinical handover

Policies and procedures are in place to guide work practice. The protocols cover handover between units, inter-hospital transfers, transfers from the emergency department, patient identification, preadmission, operating suite transfers, and paediatric patients.

Bedside handover is conducted routinely between shifts. Time out protocols are in place in the operating theatres, angiography suites, and medical imaging. Medical staff participate in the “time-out” process, and the organisation is encouraged to continue to support and foster the leadership of medical staff in this area.

Clinical handover processes

All handover tools are structured around the ISOBAR principles. The emergency department at Ashford Hospital has developed a single comprehensive assessment and documentation tool which is used by the medical and nursing staff. This is based on ISOBAR principles and is going to be taken up by other Healthscope hospitals. A structured tool exists to support nurses when phoning VMOs to report changes in a patient's condition. The patient management system, WebPas, generates patient reports for shift-to shift handovers. Discharge summaries are provided to patients and also faxed to the patient’s General Practitioner.

Monitoring, and evaluating, agreed handover processes occurs. Evaluation of handover processes occurs through a variety of mechanisms. These include incident reports, observation, audits, discharge summary documentation audits, and analysis of patient surveys. Critical systems reviews are undertaken for sentinel events. Sentinel events are reported at the site Safety and Quality Committee and the ACHA Patient Care Committee. Quality improvements have included improved tools for cognitively impaired patients.

Clinical handover forms part of the orientation and ongoing education program. There is an eLearning package. Attendance at education sessions is monitored.

Patient and carer involvement in clinical handover

Patient and carers are involved in the handover of their care at several stages of their admission and care. Admission processes are structured and patients were satisfied with the level of involvement. There was a high degree of satisfaction with bedside handover and its structured consistent approach. At discharge, patients reported satisfaction with the input of the pharmacists and nurses in medication management and advice.

On a broader scale, the ACHA television channel distributes patient information. Consumer representatives are involved in the auditing process for clinical handover, and providing advice as to how best to involve consumers.

Governance and leadership for effective clinical handover

Ratings

Action	Organisation	Surveyor
6.1.1	SM	SM
6.1.2	SM	SM
6.1.3	SM	SM

Clinical handover processes

Ratings

Action	Organisation	Surveyor
6.2.1	SM	SM
6.3.1	SM	SM
6.3.2	SM	SM
6.3.3	SM	SM
6.3.4	SM	SM
6.4.1	SM	SM
6.4.2	SM	SM

Patient and carer involvement in clinical handover

Ratings

Action	Organisation	Surveyor
6.5.1	SM	SM

STANDARD 7
BLOOD AND BLOOD PRODUCTS

Surveyor Summary

Governance and systems for blood and blood product prescribing and clinical use

Specific policies and procedures are in place to guide work practice. The framework for the systems of governance relating to blood and blood product management is provided through the Clinical Governance Framework, and the Blood and Blood Products Management Framework.

The ACHA health service is part of a Healthscope Transfusion Cluster Meeting (National), which provides guidance in many areas such as policies, education and communication, haemovigilance, projects, and transfusion practice review. This is a teleconference meeting,

Feedback regarding blood administration and blood related incidents is provided to peak committees including ACHA Medical Advisory Committee, Patient Care Committee and the individual hospital's Safety and Quality Committee. It is a standing agenda item in the cluster meeting to ensure lessons learned. Clinical indicator data is submitted to the ACHS, with clinician information feedback through numerous channels. This includes, for example, Hospital Safety and Quality Plans and Departmental Meetings.

The management of blood and blood products is conducted in close collaboration with private pathology services. Each hospital within the health service has a different arrangement. The Flinders Private Hospital has an arrangement with three different providers. These associations assist with the efficient use of blood and blood products, and contribute to reducing wastage. Haemovigilant activities conducted by the health service are rudimentary, however, and are not adequately reflective. The health service would be well served to review the health service against the requirements of this action to determine gaps and weaknesses; and develop and implement, formal reflective activities accordingly.

Documenting patient information

Policies and procedures guide the requirements of documentation. Audits of clinical records at the time of survey indicated that the reasons for a blood transfusion were recorded by the VMO/HMO, along with appropriate haematological tests, eg Hb. Guidelines are in place to provide assistance with indicating suggested parameters for conducting a blood transfusion.

The process for managing adverse events is via RiskMan. Blood and blood products are included on the core risk register. There is a process in place for any serious sentinel event should it occur. To date there have been no recorded incidents.

A blood and blood product register is maintained at each hospital within the health service. Some of the hospitals have more than one provider. While the receipt and register of blood and blood products is consistent for most of the health service members, there is one provider which insists on a different avenue of documenting the details of the delivered products. The hospital concerned has altered the policy and procedure to reflect this. The survey team noted that although there were different processes, all staff were aware of the variations and appropriate signage was evident in all blood fridge areas.

Blood refrigerators are managed well across the health service, however, one of the refrigerators was seen to have skin stored within it. The health service needs to ensure that the blood refrigerators only store blood.

Education is provided across the health service, with an eLearning blood package available to staff, although non-mandatory. In areas of high risk such as Oncology, Haematology and Obstetrics, managers have compliance rates between 97-100%. A more structured approach should be considered in regard to education on blood and blood product administration.

Managing blood and blood product safety

Across ACHA there has been extensive work conducted into blood transfusion practices. All hospitals reported decreased blood usage, and an increase in iron infusion administration. Blood wastage audits were conducted prior to July 2015. Following this the audits appear to have decreased or were ad hoc. The survey team was provided

audit results during survey, however, stressed the importance of a more formal approach to demonstrate the extensive work that is currently being undertaken. Regular visits by Blood Move continue across the health service, which address areas of non-compliance.

The central storage of blood products is located off-site. It is delivered on formal requests by a VMO/HMO. The "cold-chain" requirements are adhered to by packaging and delivering the blood within a foamed container containing ice packs. The maximum turnaround time for delivery is 30 minutes. The blood is delivered to a designated blood refrigerator located at each hospital. The refrigerators are specific blood and blood product refrigerators, which have an alarm linked to a nominated area.

The policy and procedure directs two nurses to complete and sign a registry, and check the products against documentation, against the patient's identification band, and with the patient. Observations are conducted in line with "Blood Safe" guidelines.

Audits of blood products and temperatures are conducted monthly, and reported to the Patient Care Committee. The results show a consistency in compliance rates.

Communicating with patients and carers

Patient and carer resources are readily available, and include the Blood Safe Handouts and Fact Sheets. Information is also available on the TV information channel. The Blood Safe website has fact sheets available in multiple languages if required.

The health service has commenced work in improving consumer engagement by assessing patient and carer involvement in the process. An audit conducted at Ashford Hospital demonstrated that in August 2016, of the eight patients that received blood, all were satisfied with the information provided, two patients did not receive an information pamphlet, and 100% of patients had a written consent.

Informed blood consent has improved across the health service, however, an audit of clinical records at the time of survey indicated a compliance rate of 85-89%. As the consent form also forms part of the patient identification process, questions are raised in regard to whether correct processes are undertaken prior to the administration of blood or blood products.

The survey team was shown several patient surveys in relation to consumer feedback on blood products and patient-centred care with both demonstrating consumer satisfaction. However, a focus does need to occur on clinical outcomes.

Governance and systems for blood and blood product prescribing and clinical use

Ratings

Action	Organisation	Surveyor
7.1.1	SM	SM
7.1.2	SM	SM
7.1.3	SM	SM
7.2.1	SM	SM
7.2.2	SM	SM
7.3.1	SM	SM
7.3.2	SM	SM
7.3.3	SM	SM
7.4.1	SM	SM

Action 7.3.3 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

Haemovigilant activities conducted by the health service are rudimentary and not adequately reflective.

Surveyor's Recommendation:

Review the health service against the requirements of this action to determine gaps and weaknesses, and develop and implement formal reflective activities accordingly.

Risk Level: Low

Documenting patient information

Ratings

Action	Organisation	Surveyor
7.5.1	SM	SM
7.5.2	SM	SM
7.5.3	SM	SM
7.6.1	SM	SM
7.6.2	SM	SM
7.6.3	SM	SM

Managing blood and blood product safety

Ratings

Action	Organisation	Surveyor
7.7.1	SM	SM
7.7.2	SM	SM
7.8.1	SM	SM
7.8.2	SM	SM

Action 7.8.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

The approach to monitoring blood and blood product wastage is rudimentary. The health service needs to develop and implement a formal, consistent, and appropriate approach to obtaining required data and information.

Surveyor's Recommendation:

Develop and implement a formal and consistent approach to monitoring blood and blood product wastage.

Risk Level: Low

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
7.9.1	SM	SM
7.9.2	SM	SM
7.10.1	SM	SM
7.11.1	SM	SM

STANDARD 8
PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and systems for the prevention and management of pressure injuries

The health service has a suite of policies, documentation and tools that guide, and form, the framework for Preventing and Managing Pressure Injuries across the health service. Each Hospital has a program that is led by a skilled Wound Management Nurse, and trained Pressure Injury Prevention Champions. Clinical indicators and incident trends are monitored at each hospital via the Patient Care Committees. These committees report to ACHA Safety and Quality meetings and, in turn, up to the governing Cluster Committee for Pressure Injury and Prevention. The governance committees ensure that the pressure injury framework is maintained. This includes polices and guidelines that quality activities and audits continue to occur, and education on pressure injuries, and wound management, is maintained.

The reporting system RiskMan has been upgraded to incorporate a detailed reporting mechanism for pressure Injuries. The system provides comprehensive reports for the governance committees. The trend of pressure injury rates over the past three years shows an average peak in 2014 of 0.07%. This is above the key performance indicator (KPI) benchmark. There have been multiple projects implemented to improve this result, which has seen a downwards trend, and is currently sitting at an average of 0.03%. Evaluation of recent changes made to screening and prevention tools, and the increase in frequency of auditing, will assist in further reducing the number of pressure injuries, and maintaining it below the KPI benchmark.

Preventing pressure injuries

Patient screening commences on admission via the Health Assessment Questionnaire for skin integrity, and the risk of pressure injuries. This also includes nutrition screening. A malnutrition screening tool is also utilised.

The pressure injury and risk assessment tool utilises the Braden Scale for adults and the BradenQ for paediatrics/neonates. The form has recently been revised to improve compliance with skin assessments, and consequent interventions for at-risk patients. The revised form has been trialled for six weeks, with audits demonstrating improvement in the documentation of interventions, including skin assessments from 60% to 90%.

During survey, it was noted that the revised form was in use consistently across the health service. Although auditing of skin assessments is conducted, it was noted that it was combined with the interventions. A recommendation has been made to further enhance the auditing of skin assessments, which will lead to further improvement. The wound management nurses, and pressure injury prevention champions, in each of the hospitals, were able to articulate their passion, and drive, for preventing and managing pressure Injuries. It was pleasing to see and hear about the consistency of the quality activities to reduce, and/or prevent, pressure injuries, occurring across each of the hospitals.

In addition to the above assessment tools there is a variety of tools in speciality areas to further assist in preventing pressure injuries. The surgical safety checklist includes the Braden scale and skin integrity. Whilst this is in place, it was noted it was not consistently completed. It is suggested that auditing to improve compliance be initiated. The informal Perioperative Pressure Point Padding protocol at the Memorial Hospital has been informally evaluated, and there is currently a trial being undertaken to change pressure relieving mattresses in the theatre. It is suggested this informal protocol be revised, and converted to a formal ACHA policy document.

There have been purchases of additional devices, such as active alternating pressure mattresses, and repose inflatable foot protectors. A comprehensive list of equipment/devices is available on the intranet. Staff receive evidence-based education at orientation, eLearning via ELMO, and at targeted workshops, which were noted to have good attendance records.

Managing pressure injuries

Managing pressure injuries and wounds is included in the policy document - Pressure Injury - Prevention, Identification and Management. This is readily accessible on the intranet in clinical areas.

If any abnormality, or damage, is identified at the skin assessment, a Wound Assessment and Management Chart is

commenced. This chart has recently been revised, and the updated chart was noted to be in use across the health service. Skin damage and pressure injuries are reported on RiskMan. There is a referral process for the Wound Management Nurses in addition to the automatic notification of pressure/skin injuries via RiskMan. Wound Management Nurses review/evaluate Wound Management Plans to ascertain compliance with Pan Pacific Guidelines. Pan Pacific Guidelines are available for use in all clinical areas.

Discharge planning is comprehensive with direct handover of wound care/plans by the Wound Management Nurse. A repositioning policy, and tool, are in place and hourly rounding includes addressing the patient's position. The Skin Tear Project, which was conducted to provide best practice guidelines, and education to prevent and manage skin tears, was noted. This was in addition to the development of the Skin Group at Flinders Private Hospital to assist with addressing pressure occurrences, and implementing prevention strategies. While it is evident that wound management plans are evaluated by the Wound Management Nurses, it is noted there are inconsistencies between Hospitals. A recommendation has been made to review the evaluation process collaboratively as an organisation in order to further enhance the program.

Communicating with patients and carers

The revised Pressure Injury Risk Assessment and Management Tool includes evidence that patient/carer education is conducted, and the brochure on "Patients and Carers Guide to Pressure Injury Prevention" is provided, and discussed, as a mandatory component. Carers and patients are involved at bed to bed handover in regard to pressure injury prevention and wound management. Family/carer meetings/education are conducted, as required, for complex care of wounds, or pressure relieving devices, prior to discharge.

The brochure "Pressure Injury Prevention" has been developed with consumer involvement. Displays and posters relating to Pressure Injury Prevention were noted throughout the health service. This is in addition to TV channels which display ACHA Pressure Injury and Prevention information. Rates on pressure injuries are available to consumers via the "My Hospitals" public data internet.

Governance and systems for the prevention and management of pressure injuries

Ratings

Action	Organisation	Surveyor
8.1.1	SM	SM
8.1.2	SM	SM
8.2.1	SM	SM
8.2.2	SM	SM
8.2.3	SM	SM
8.2.4	SM	SM
8.3.1	SM	SM
8.4.1	SM	SM

Action 8.3.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

The following comments and recommendations are relevant to, and inclusive of, actions 8.5.2, 8.6.2, 8.7.3 and 8.8.3. They are also linked with actions 1.1.1 and 1.5.1 - 1.6.2.

There is an organisation-wide audit conducted on an annual basis. The collected data and information indicates the presence of not only pressure injuries which are present on the admission/transfer of a patient, but are also acquired during the admission process. The quality and continuous improvement program needs to not only ensure that the appropriate screening tools, planning processes and equipment are available, but they are actually used, and used on a timely basis. This can only occur through monitoring. The health service currently monitors annually, however, the sample auditing undertaken by the survey team indicated there was a lack of compliance.

The health service needs to review its monitoring processes for all the actions under Standard 8 and ensure they are reflective of each hospital's requirements, eg compliance levels, and fully meet the requirements of the NSQHSS.

Surveyor's Recommendation:

1. Review the audit monitoring process and schedule to meet the needs of each hospital site.
2. The frequency of audits/monitoring reflect the requirements of the NSQHSS, and that of the individual hospitals.

Risk Level: Low

Preventing pressure injuries

Ratings

Action	Organisation	Surveyor
8.5.1	SM	SM
8.5.2	SM	SM
8.5.3	SM	SM
8.6.1	SM	SM
8.6.2	SM	SM
8.6.3	SM	SM
8.7.1	SM	SM
8.7.2	SM	SM

8.7.3	SM	SM
8.7.4	SM	SM

Action 8.6.2 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

The survey team noted the audit of skin inspections for at risk patients is included as an intervention required to prevent or manage pressure injuries. As a result of evaluation, and audit results, changes have been made to the tool to improve compliance with skin assessments of at risk patients and documentation of interventions.

The evaluation and auditing of the new Pressure Injury Risk Assessment and Management tool must separate compliance with comprehensive skin assessments from interventions and should include more frequent targeted audits until compliance is at an acceptable level.

The comments and recommendations from this action are linked with actions 8.3.1.

Surveyor's Recommendation:

1. Evaluate and audit the new Pressure Injury Risk Assessment and Management tool for compliance with comprehensive skin assessments separate to the interventions to achieve relevant data and information for both.
2. Include more frequent targeted audits until compliance is at an acceptable level.

Risk Level: Low

Managing pressure injuries

Ratings

Action	Organisation	Surveyor
8.8.1	SM	SM
8.8.2	SM	SM
8.8.3	SM	SM
8.8.4	SM	SM

Action 8.8.3 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

There has been a recent comprehensive review of the Wound Management Plan at ACHA. The revised plan has recently been implemented at the three hospitals. Evidence of utilisation of the new plans was sighted within the medical record at the time of survey. It was noted that although wound management plans were informally audited, there was an inconsistent approach between the hospitals, with varying degrees of compliance.

Surveyor's Recommendation:

Develop an agreed tool /process for reviewing and auditing wound management plans for compliance and effectiveness.

Risk Level: Low

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
8.9.1	SM	SM
8.10.1	SM	SM

STANDARD 9
RECOGNISING AND RESPONDING TO CLINICAL DETERIORATION IN ACUTE HEALTH CARE

Surveyor Summary

Establishing recognition and response systems

Policies, procedures, and evidence-based guidelines, provide the guidance for work practice. Electronic systems, such as call bells and emergency call bells, are in place. Emergency resuscitation trolleys are located strategically throughout the organisation. Processes for calling a medical emergency are in place. A process for responding to a medical emergency is also in place. The number to ring to escalate care, and the emergency paging system, is tested on a daily basis.

Data and information are collected and tabled at the Patient Care Committee, the Medical Advisory Committee (MAC), Craft Groups, and the Board of Management (BOM).

As part of the National Consensus Statement, the health service undertook a gap analysis and established a working group that linked with the Healthscope Cluster for Standard 9. Standard 9 governance processes are present in the health service committee and governance framework, as well as the Healthscope Clinical Deteriorating Working Party, “Shared learning” report, Healthscope Governance Framework, and Risk Management Unit. The governance of Standard 9 was documented throughout the health service, through the minutes of the following committees: ACHA Medical Advisory Committee, ACHA Clinical Review Committee and Patient Care Committee, Hospital Medical Emergency Teams (MET).

Recognising clinical deterioration and escalating care

Observation charts are in line with the requirements of the NSQHSS. Charts are available for adults, children, and paediatrics. The charts provide coloured guidance for commencing a medical emergency call. This is conducted in conjunction with the clinical assessment of an individual at the time.

A medical emergency response team is available on a 24 hour basis. All are trained in advanced life support. There is a process in place for auditing clinical records, and related documentation, including observation charts. This process needs to be reviewed to ascertain whether it is effective and frequent enough.

Responding to clinical deterioration

Policies, procedures, and guidelines are in place. These are reviewed within specified timeframes, and are referenced to evidence-based resources. Emergency trolleys are located throughout the health service, with the contents reflective of the service they are located within, eg Higher Dependency Unit (HDU). The clinical workforce receives training at the time of orientation. Emergency preparedness, and response to medical emergencies, forms part of the annual mandatory training.

Basic life support (BLS) education is taught to the clinical workforce; with advanced life support (ALS) being taught to all hospital co-ordinators, and staff in high risk clinical service areas. There is a clinical workforce member trained in ALS on all shifts. The theory is taught via the information technology software. This is followed by a practical competency. The introduction of the new ICT software will improve the tracking of compliance to an individual across the health service. The system for governance needs to be further strengthened to ensure expected compliance within the required timeframe is met.

The need to activate a response is registered through RiskMan. There is a process in place to monitor incidents and events. Data and information are tabled at the Patient Care Committee for discussion and follow-up. Reports are tabled at the MAC, and BOM, meetings.

The organisation provided evidence that the following has been fully met:
• a comprehensive organisational risk assessment of BLS training needs had been undertaken; and
• a plan has been developed to ensure that the clinical workforce can initiate appropriate early intervention and respond with life-sustaining measures in the event of severe or rapid deterioration.

The organisation provided evidence that the following has been partially met:
• training in BLS is available for the clinical workforce.

Communicating with patients and carers

There is a process for informing patients and/or carers of the REACH program (Recognise, Engage, Act, Call, Help is on the way) tool. The organisation would be well served to formally evaluate the effectiveness of this program.

Policies and procedures are in place for assisting patients/families to obtain advance care directives, and end-of-life care. Policies and procedures are also in place for obtaining treatment-limiting-orders. The organisation is encouraged to assess whether the policies and procedures are effectively implemented.

Establishing recognition and response systems

Ratings

Action	Organisation	Surveyor
9.1.1	SM	SM
9.1.2	SM	SM
9.2.1	SM	SM
9.2.2	SM	SM
9.2.3	SM	SM
9.2.4	SM	SM

Recognising clinical deterioration and escalating care

Ratings

Action	Organisation	Surveyor
9.3.1	SM	SM
9.3.2	SM	SM
9.3.3	SM	SM
9.4.1	SM	SM
9.4.2	SM	SM
9.4.3	SM	SM

Responding to clinical deterioration

Ratings

Action	Organisation	Surveyor
9.5.1	SM	SM
9.5.2	SM	SM
9.6.1	SM	SM
9.6.2	SM	SM

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
9.7.1	SM	SM
9.8.1	SM	SM
9.8.2	SM	SM
9.9.1	SM	SM
9.9.2	SM	SM
9.9.3	SM	SM
9.9.4	SM	SM

STANDARD 10
PREVENTING FALLS AND HARM FROM FALLS

Surveyor Summary

Governance and systems for the prevention of falls

There is a multidisciplinary approach to falls prevention and management across Adelaide Community Healthcare Alliance Incorporated (ACHA).

A comprehensive evidence-based policy and framework is available for staff on the intranet, and were located easily by staff when requested by surveyors. There is a suite of additional policies and processes used in everyday practice to support the framework, including the policies for Grip Socks, Patient Mobility Assessment Tool, and the new Cognitive Impairment Policy. Preventing Falls and Harm from Falls Best Practice Guidelines were also available to staff via the intranet.

Falls are reported via RiskMan. Clinical indicators and incident trends are monitored at each hospital, via Patient Care Committees. These committees in turn report to the ACHA Safety and Quality meetings, and up to the governing Healthscope Cluster Committee for Falls. The governance committees ensure that the Falls Prevention Framework is maintained, including polices and guidelines; that quality activities and audits continue to occur; and that education on falls prevention and minimisation occurs.

Falls incidents and trends are communicated to staff via departmental meetings, and Shared Learnings Reports. It is noted that falls rates are predominantly below the key performance indicator (KPI) benchmark. The Memorial Hospital is complimented on the work conducted on falls prevention. There has been a focus on falls reduction with the equipment tagging system, and the “Patient Board” project. This has resulted in a reduction in falls in the last quarter from 0.40% to 0.25%.

Screening and assessing risks of falls and harm from falling

A variety of evidence-based tools, including the Falls Risk Assessment Management Tool (FRAMT) is available. The tools contribute to the risk assessment process, and aid the development of care plans accordingly to prevent falls.

Staff are educated at orientation on the Falls Prevention Framework, policies and assessment tools. In addition to orientation there has been an increase in education provided to staff, including eLearning packages, and targeted education. Education records sighted at survey demonstrated good compliance and attendance. Innovative, interactive education sessions, requiring staff to wear goggles that create visual impairment, are also conducted, which enable the staff to have a greater understanding of patient needs and challenges.

There is a need, however, to not only ensure that the appropriate screening tools, planning processes, and equipment are available, but they are actually used, and used on a timely basis. This can only occur through monitoring. There is an organisation-wide audit conducted on an annual basis. Annual monitoring is not frequent enough. The health service needs to review its monitoring processes for all the actions under Standard 10 and ensure they are reflective of each hospital’s requirements, eg compliance levels, and fully meet the requirements of the NSQHSS.

Preventing falls and harm from falling

Documented falls prevention and harm minimisation plans are used, and documented within the clinical record, using FRAMT, or other relevant care planning tools. These were observed to be in place for high risk patients across the health service at the time of the survey. The action plan developed for the patient, regarding falls prevention, is discussed at clinical handover, with standardised discharge planning, and transfer tools, in place. Patients are orientated to their environment on admission, and the hourly rounding includes strategies to minimise falls. This is inclusive of pain review, ensuring call bells and possessions are within reach, mobilisation, and personal needs such as toileting.

There is a strong multidisciplinary approach to falls prevention, and harm from falls, throughout the health service. Early assessment, and intervention by allied health, is evident. Each of the high risk areas has a falls champion who supports the program, and is key to the successful implementation of strategies/projects that assist with falls

prevention.

A number of quality activities initiated to prevent falls were evident at all three hospitals. Of note, were the tagging and “Patient Boards” projects. These identify patients at risk of falls, and the level of assistance required with mobility aids. The mobility project has several components, including an “Aim for Walks” document which has recently been merged into the hourly rounding that ensures patients are mobilised regularly and safely. This is audited weekly, and results submitted to the Director of Nursing.

Significant work has been conducted to further minimise the risk of falls, and harm from falls, for the high falls risk patient that requires additional human resources. The recent implementation of the “specialling framework”, which includes the management of patients with delirium who are at increased risk of falls, is noted. Once evaluated, and embedded, the new initiative will further enhance the achievements of this standard.

Review of falls minimisation equipment is continuous. The purchasing of equipment to support the prevention of patient falls has been ongoing, and includes hi-low beds, and an increase in the number of bed and chair alarms.

Communicating with patients and carers

The health service provides patients and carers with access to copies of various patient/carer information, and brochures, which have been created with consumer involvement. Multilingual fact sheets are also available. Education via internal TV channels provides information on falls prevention. This was updated in July 2016. A resource folder has been developed by the allied health service to ensure there is consistency with referrals, and information given to consumers.

Falls risk assessment and prevention plans are completed in partnership with patients and carers to develop strategies that may assist patients reduce the frequency and severity of falls. Medical records contain documented patient education, and falls prevention planning and management. The FRAMT contains evidence of consumer and carer involvement. The falls minimisation plan is discussed at handover where the consumers and patients participate.

The patient boards at the Memorial Hospital drive consumer involvement in their falls minimisation and prevention plans. This was observed at the time of survey when surveyors discussed the bedside boards with patients. The patients were able to clearly explain the falls risks, and what the symbols on their boards represented.

Across the various disciplines and clinical areas, it is noted there are several embedded processes in place demonstrating engagement and partnership with patients and carers in falls prevention plans including
1. Multidisciplinary meetings with families of high risk patients;
2. Education sessions for consumers/carers as inpatients and pre-admission; and.
3. Mobilisation included in hourly rounding.

All patients complete a Patient Health Questionnaire which contains a section for facilitating risk screening for falls. Pre-admission assessment for surgery also includes a falls risk assessment. The health service was able to demonstrate that falls prevention commences during the pre-admission period. Pre-surgery education is provided to orthopaedic joint replacement patients. Screening continues through the patient’s journey post discharge to the rehabilitation program.

Governance and systems for the prevention of falls

Ratings

Action	Organisation	Surveyor
10.1.1	SM	SM
10.1.2	SM	SM
10.2.1	SM	SM
10.2.2	SM	SM
10.2.3	SM	SM
10.2.4	SM	SM
10.3.1	SM	SM
10.4.1	SM	SM

Action 10.3.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

The following comments and recommendations are relevant to, and inclusive of, actions 10.5.2, 10.5.3, 10.6.2, and 10.7.2. They are also linked with 1.1.1 and 1.5.1 - 1.6.2.

The quality and continuous improvement program needs to not only ensure that the appropriate screening tools, planning processes and equipment are available, but they are actually used, and used on a timely basis. This can only occur through monitoring. There is an organisation-wide audit conducted on an annual basis. Sample auditing undertaken by the survey team indicated there was a lack of compliance.

The health service needs to review its monitoring processes for all the actions under Standard 10 and ensure they are reflective of each hospital's requirements, eg compliance levels, and fully meet the requirements of the NSQHSS.

Surveyor's Recommendation:

1. Review the audit monitoring process and schedule to meet the needs of each hospital site.
2. The frequency of audits/monitoring fully reflect the requirements of the NSQHSS, and that of the individual hospitals.

Risk Level: Low

Screening and assessing risks of falls and harm from falling

Ratings

Action	Organisation	Surveyor
10.5.1	SM	SM
10.5.2	SM	SM
10.5.3	SM	SM
10.6.1	SM	SM
10.6.2	SM	SM
10.6.3	SM	SM

Preventing falls and harm from falling

Ratings

Action	Organisation	Surveyor
10.7.1	SM	SM
10.7.2	SM	SM
10.7.3	SM	SM
10.8.1	SM	SM

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

Actions Rating Summary

Governance for Safety and Quality in Health Service Organisations

Governance and quality improvement systems

Action	Description	Organisation's self-rating	Surveyor Rating
1.1.1	An organisation-wide management system is in place for the development, implementation and regular review of policies, procedures and/or protocols	SM	SM
1.1.2	The impact on patient safety and quality of care is considered in business decision making	SM	SM
1.2.1	Regular reports on safety and quality indicators and other safety and quality performance data are monitored by the executive level of governance	SM	SM
1.2.2	Action is taken to improve the safety and quality of patient care	SM	SM
1.3.1	Workforce are aware of their delegated safety and quality roles and responsibilities	SM	SM
1.3.2	Individuals with delegated responsibilities are supported to understand and perform their roles and responsibilities, in particular to meet the requirements of these Standards	SM	SM
1.3.3	Agency or locum workforce are aware of their designated roles and responsibilities	SM	SM
1.4.1	Orientation and ongoing training programs provide the workforce with the skill and information needed to fulfil their safety and quality roles and responsibilities	SM	SM
1.4.2	Annual mandatory training programs to meet the requirements of these Standards	SM	SM
1.4.3	Locum and agency workforce have the necessary information, training and orientation to the workplace to fulfil their safety and quality roles and responsibilities	SM	SM
1.4.4	Competency-based training is provided to the clinical workforce to improve safety and quality	SM	SM
1.5.1	An organisation-wide risk register is used and regularly monitored	SM	SM
1.5.2	Actions are taken to minimise risks to patient safety and quality of care	SM	SM
1.6.1	An organisation-wide quality management system is used and regularly monitored	SM	SM
1.6.2	Actions are taken to maximise patient quality of care	SM	SM

Clinical practice

Action	Description	Organisation's self-rating	Surveyor Rating
1.7.1	Agreed and documented clinical guidelines and/or pathways are available to the clinical workforce	SM	SM
1.7.2	The use of agreed clinical guidelines by the clinical workforce is monitored	SM	SM
1.8.1	Mechanisms are in place to identify patients at increased risk of harm	SM	SM
1.8.2	Early action is taken to reduce the risks for at-risk patients	SM	SM
1.8.3	Systems exist to escalate the level of care when there is an unexpected deterioration in health status	SM	SM

1.9.1	Accurate, integrated and readily accessible patient clinical records are available to the clinical workforce at the point of care	SM	SM
1.9.2	The design of the patient clinical record allows for systematic audit of the contents against the requirements of these Standards	SM	SM

Performance and skills management

Action	Description	Organisation's self-rating	Surveyor Rating
1.10.1	A system is in place to define and regularly review the scope of practice for the clinical workforce	SM	SM
1.10.2	Mechanisms are in place to monitor that the clinical workforce are working within their agreed scope of practice	SM	SM
1.10.3	Organisational clinical service capability, planning and scope of practice is directly linked to the clinical service roles of the organisation	SM	SM
1.10.4	The system for defining the scope of practice is used whenever a new clinical service, procedure or other technology is introduced	SM	SM
1.10.5	Supervision of the clinical workforce is provided whenever it is necessary for individuals to fulfil their designated role	SM	SM
1.11.1	A valid and reliable performance review process is in place for the clinical workforce	SM	SM
1.11.2	The clinical workforce participates in regular performance reviews that support individual development and improvement	SM	SM
1.12.1	The clinical and relevant non-clinical workforce have access to ongoing safety and quality education and training for identified professional and personal development	SM	SM
1.13.1	Analyse feedback from the workforce on their understanding and use of safety and quality systems	SM	SM
1.13.2	Action is taken to increase workforce understanding and use of safety and quality systems	SM	SM

Incident and complaints management

Action	Description	Organisation's self-rating	Surveyor Rating
1.14.1	Processes are in place to support the workforce recognition and reporting of incidents and near misses	SM	SM
1.14.2	Systems are in place to analyse and report on incidents	SM	SM
1.14.3	Feedback on the analysis of reported incidents is provided to the workforce	SM	SM
1.14.4	Action is taken to reduce risks to patients identified through the incident management system	SM	SM
1.14.5	Incidents and analysis of incidents are reviewed at the highest level of governance in the organisation	SM	SM
1.15.1	Processes are in place to support the workforce to recognise and report complaints	SM	SM
1.15.2	Systems are in place to analyse and implement improvements in response to complaints	SM	SM
1.15.3	Feedback is provided to the workforce on the analysis of reported complaints	SM	SM
1.15.4	Patient feedback and complaints are reviewed at the highest level of governance in the organisation	SM	SM

1.16.1	An open disclosure program is in place and is consistent with the national open disclosure standard	SM	SM
1.16.2	The clinical workforce are trained in open disclosure processes	SM	SM

Patient rights and engagement

Action	Description	Organisation's self-rating	Surveyor Rating
1.17.1	The organisation has a charter of patient rights that is consistent with the current national charter of healthcare rights	SM	SM
1.17.2	Information on patient rights is provided and explained to patients and carers	SM	SM
1.17.3	Systems are in place to support patients who are at risk of not understanding their healthcare rights	SM	SM
1.18.1	Patients and carers are partners in the planning for their treatment	SM	SM
1.18.2	Mechanisms are in place to monitor and improve documentation of informed consent	SM	SM
1.18.3	Mechanisms are in place to align the information provided to patients with their capacity to understand	SM	SM
1.18.4	Patients and carers are supported to document clear advance care directives and/or treatment-limiting orders	SM	SM
1.19.1	Patient clinical records are available at the point of care	SM	SM
1.19.2	Systems are in place to restrict inappropriate access to and dissemination of patient clinical information	SM	SM
1.20.1	Data collected from patient feedback systems are used to measure and improve health services in the organisation	SM	SM

Partnering with Consumers

Consumer partnership in service planning

Action	Description	Organisation's self-rating	Surveyor Rating
2.1.1	Consumers and/or carers are involved in the governance of the health service organisation	SM	SM
2.1.2	Governance partnerships are reflective of the diverse range of backgrounds in the population served by the health service organisation, including those people who do not usually provide feedback	SM	SM
2.2.1	The health service organisation establishes mechanisms for engaging consumers and/or carers in the strategic and/or operational planning for the organisation	SM	SM
2.2.2	Consumers and/or carers are actively involved in decision making about safety and quality	SM	SM
2.3.1	Health service organisations provide orientation and ongoing training for consumers and/or carers to enable them to fulfil their partnership role	SM	SM
2.4.1	Consumers and/or carers provide feedback on patient information publications prepared by the health service organisation (for distribution to patients)	SM	SM
2.4.2	Action is taken to incorporate consumer and/or carers' feedback into publications prepared by the health service organisation for distribution to patients	SM	SM

Consumer partnership in designing care

Action	Description	Organisation's self-rating	Surveyor Rating
2.5.1	Consumers and/or carers participate in the design and redesign of health services	SM	SM
2.6.1	Clinical leaders, senior managers and the workforce access training on patient-centred care and the engagement of individuals in their care	SM	SM
2.6.2	Consumers and/or carers are involved in training the clinical workforce	SM	SM

Consumer partnership in service measurement and evaluation

Action	Description	Organisation's self-rating	Surveyor Rating
2.7.1	The community and consumers are provided with information that is meaningful and relevant on the organisation's safety and quality performance	SM	SM
2.8.1	Consumers and/or carers participate in the analysis of organisational safety and quality performance	SM	SM
2.8.2	Consumers and/or carers participate in the planning and implementation of quality improvements	SM	SM
2.9.1	Consumers and/or carers participate in the evaluation of patient feedback data	SM	SM
2.9.2	Consumers and/or carers participate in the implementation of quality activities relating to patient feedback data	SM	SM

Preventing and Controlling Healthcare Associated Infections

Governance and systems for infection prevention, control and surveillance

Action	Description	Organisation's self-rating	Surveyor Rating
3.1.1	A risk management approach is taken when implementing policies, procedures and/or protocols for: • standard infection control precautions • transmission-based precautions • aseptic non-touch technique • safe handling and disposal of sharps • prevention and management of occupational exposure to blood and body substances • environmental cleaning and disinfection • antimicrobial prescribing • outbreaks or unusual clusters of communicable infection • processing of reusable medical devices • single-use devices • surveillance and reporting of data where relevant • reporting of communicable and notifiable diseases • provision of risk assessment guidelines to workforce • exposure-prone procedures	SM	SM
3.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
3.1.3	The effectiveness of the infection prevention and control systems is regularly reviewed at the highest level of governance in the organisation	SM	SM

3.1.4	Action is taken to improve the effectiveness of infection prevention and control policies, procedures and/or protocols	SM	SM
3.2.1	Surveillance systems for healthcare associated infections are in place	SM	SM
3.2.2	Healthcare associated infections surveillance data are regularly monitored by the delegated workforce and/or committees	SM	SM
3.3.1	Mechanisms to regularly assess the healthcare associated infection risks are in place	SM	SM
3.3.2	Action is taken to reduce the risks of healthcare associated infection	SM	SM
3.4.1	Quality improvement activities are implemented to reduce and prevent healthcare associated infections	SM	SM
3.4.2	Compliance with changes in practice are monitored	SM	SM
3.4.3	The effectiveness of changes to practice are evaluated	SM	SM

Infection prevention and control strategies

Action	Description	Organisation's self-rating	Surveyor Rating
3.5.1	Workforce compliance with current national hand hygiene guidelines is regularly audited	SM	SM
3.5.2	Compliance rates from hand hygiene audits are regularly reported to the highest level of governance in the organisation	SM	SM
3.5.3	Action is taken to address non-compliance, or the inability to comply, with the requirements of the current national hand hygiene guidelines	SM	SM
3.6.1	A workforce immunisation program that complies with current national guidelines is in use	SM	SM
3.7.1	Infection prevention and control consultation related to occupational health and safety policies, procedures and/or protocols are implemented to address: • communicable disease status • occupational management and prophylaxis • work restrictions • personal protective equipment • assessment of risk to healthcare workers for occupational allergies • evaluation of new products and procedures	SM	SM
3.8.1	Compliance with the system for the use and management of invasive devices in monitored	SM	SM
3.9.1	Education and competency-based training in invasive devices protocols and use is provided for the workforce who perform procedures with invasive devices	SM	SM
3.10.1	The clinical workforce is trained in aseptic technique	SM	SM
3.10.2	Compliance with aseptic technique is regularly audited	SM	SM
3.10.3	Action is taken to increase compliance with the aseptic technique protocols	SM	SM

Managing patients with infections or colonisations

Action	Description	Organisation's self-rating	Surveyor Rating
3.11.1	Standard precautions and transmission-based precautions consistent with the current national guidelines are in use	SM	SM
3.11.2	Compliance with standard precautions is monitored	SM	SM

3.11.3	Action is taken to improve compliance with standard precautions	SM	SM
3.11.4	Compliance with transmission-based precautions is monitored	SM	SM
3.11.5	Action is taken to improve compliance with transmission-based precautions	SM	SM
3.12.1	A risk analysis is undertaken to consider the need for transmission-based precautions including: • accommodation based on the mode of transmission • environmental controls through air flow • transportation within and outside the facility • cleaning procedures • equipment requirements	SM	SM
3.13.1	Mechanisms are in use for checking for pre-existing healthcare associated infections or communicable disease on presentation for care	SM	SM
3.13.2	A process for communicating a patient's infectious status is in place whenever responsibility for care is transferred between service providers or facilities	SM	SM

Antimicrobial stewardship

Action	Description	Organisation's self-rating	Surveyor Rating
3.14.1	An antimicrobial stewardship program is in place	SM	SM
3.14.2	The clinical workforce prescribing antimicrobials have access to current endorsed therapeutic guidelines on antibiotic usage	SM	SM
3.14.3	Monitoring of antimicrobial usage and resistance is undertaken	SM	SM
3.14.4	Action is taken to improve the effectiveness of antimicrobial stewardship	SM	SM

Cleaning, disinfection and sterilisation

Action	Description	Organisation's self-rating	Surveyor Rating
3.15.1	Policies, procedures and/or protocols for environmental cleaning that address the principles of infection prevention and control are implemented, including: • maintenance of building facilities • cleaning resources and services • risk assessment for cleaning and disinfection based on transmission-based precautions and the infectious agent involved • waste management within the clinical environment • laundry and linen transportation, cleaning and storage • appropriate use of personal protective equipment	SM	SM
3.15.2	Policies, procedures and/or protocols for environmental cleaning are regularly reviewed	SM	SM
3.15.3	An established environmental cleaning schedule is in place and environmental cleaning audits are undertaken regularly	SM	SM
3.16.1	Compliance with relevant national or international standards and manufacturer's instructions for cleaning, disinfection and sterilisation of reusable instruments and devices is regularly monitored	SM	SM
3.17.1	A traceability system that identifies patients who have a procedure using sterile reusable medical instruments and devices is in place	SM	SM

3.18.1	Action is taken to maximise coverage of the relevant workforce trained in a competency-based program to decontaminate reusable medical devices	SM	SM

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
3.19.1	Information on the organisation's corporate and clinical infection risks and initiatives implemented to minimise patient infection risks is provided to patients and/or carers	SM	SM
3.19.2	Patient infection prevention and control information is evaluated to determine if it meets the needs of the target audience	SM	SM

Medication Safety

Governance and systems for medication safety

Action	Description	Organisation's self-rating	Surveyor Rating
4.1.1	Governance arrangements are in place to support the development, implementation and maintenance of organisation-wide medication safety systems	SM	SM
4.1.2	Policies, procedures and/or protocols are in place that are consistent with legislative requirements, national, jurisdictional and professional guidelines	SM	SM
4.2.1	The medication management system is regularly assessed	SM	SM
4.2.2	Action is taken to reduce the risks identified in the medication management system	SM	SM
4.3.1	A system is in place to verify that the clinical workforce have medication authorities appropriate to their scope of practice	SM	SM
4.3.2	The use of the medication authorisation system is regularly monitored	SM	SM
4.3.3	Action is taken to increase the effectiveness of the medication authority system	SM	SM
4.4.1	Medication incidents are regularly monitored, reported and investigated	SM	SM
4.4.2	Action is taken to reduce the risk of adverse medication incidents	SM	SM
4.5.1	The performance of the medication management system is regularly assessed	SM	SM
4.5.2	Quality improvement activities are undertaken to reduce the risk of patient harm and increase the quality and effectiveness of medicines use	SM	SM

Documentation of patient information

Action	Description	Organisation's self-rating	Surveyor Rating
4.6.1	A best possible medication history is documented for each patient	SM	SM
4.6.2	The medication history and current clinical information is available at the point of care	SM	SM
4.7.1	Known medication allergies and adverse drug reactions are documented in the patient clinical record	SM	SM
4.7.2	Action is taken to reduce the risk of adverse reactions	SM	SM

4.7.3	Adverse drug reactions are reported within the organisation and to the Therapeutic Goods Administration	SM	SM
4.8.1	Current medicines are documented and reconciled at admission and transfer of care between healthcare settings	SM	SM

Medication management processes

Action	Description	Organisation's self-rating	Surveyor Rating
4.9.1	Information and decision support tools for medicines are available to the clinical workforce at the point of care	SM	SM
4.9.2	The use of information and decision support tools is regularly reviewed	SM	SM
4.9.3	Action is taken to improve the availability and effectiveness of information and decision support tools	SM	SM
4.10.1	Risks associated with secure storage and safe distribution of medicines are regularly reviewed	SM	SM
4.10.2	Action is taken to reduce the risks associated with storage and distribution of medicines	SM	SM
4.10.3	The storage of temperature-sensitive medicines is monitored	SM	SM
4.10.4	A system that is consistent with legislative and jurisdictional requirements for the disposal of unused, unwanted or expired medications is in place	SM	SM
4.10.5	The system for disposal of unused, unwanted or expired medications is regularly monitored	SM	SM
4.10.6	Action is taken to increase compliance with the system for storage, distribution and disposal of medications	SM	SM
4.11.1	The risks for storing, prescribing, dispensing and administration of high-risk medicines are regularly reviewed	SM	SM
4.11.2	Action is taken to reduce the risks of storing, prescribing, dispensing and administering high-risk medicines	SM	SM

Continuity of medication management

Action	Description	Organisation's self-rating	Surveyor Rating
4.12.1	A system is in use that generates and distributes a current and comprehensive list of medicines and explanation of changes in medicines	SM	SM
4.12.2	A current and comprehensive list of medicines is provided to the patient and/or carer when concluding an episode of care	SM	SM
4.12.3	A current comprehensive list of medicines is provided to the receiving clinician during clinical handover	SM	SM
4.12.4	Action is taken to increase the proportion of patients and receiving clinicians that are provided with a current comprehensive list of medicines during clinical handover	SM	SM

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
4.13.1	The clinical workforce provides patients with patient specific medicine information, including medication treatment options, benefits and associated risks	SM	SM

4.13.2	Information that is designed for distribution to patients is readily available to the clinical workforce	SM	SM
4.14.1	An agreed medication management plan is documented and available in the patient's clinical record	SM	SM
4.15.1	Information on medicines is provided to patients and carers in a format that is understood and meaningful	SM	SM
4.15.2	Action is taken in response to patient feedback to improve medicines information distributed by the health service organisation to patients	SM	SM

Patient Identification and Procedure Matching

Identification of individual patients

Action	Description	Organisation's self-rating	Surveyor Rating
5.1.1	Use of an organisation-wide patient identification system is regularly monitored	SM	SM
5.1.2	Action is taken to improve compliance with the patient identification matching system	SM	SM
5.2.1	The system for reporting, investigating and analysis of patient care mismatching events is regularly monitored	SM	SM
5.2.2	Action is taken to reduce mismatching events	SM	SM
5.3.1	Inpatient bands are used that meet the national specifications for patient identification bands	SM	SM

Processes to transfer care

Action	Description	Organisation's self-rating	Surveyor Rating
5.4.1	A patient identification and matching system is implemented and regularly reviewed as part of structured clinical handover, transfer and discharge processes	SM	SM

Processes to match patients and their care

Action	Description	Organisation's self-rating	Surveyor Rating
5.5.1	A documented process to match patients and their intended treatment is in use	SM	SM
5.5.2	The process to match patients to any intended procedure, treatment or investigation is regularly monitored	SM	SM
5.5.3	Action is taken to improve the effectiveness of the process for matching patients to their intended procedure, treatment or investigation	SM	SM

Clinical Handover

Governance and leadership for effective clinical handover

Action	Description	Organisation's self-rating	Surveyor Rating
6.1.1	Clinical handover policies, procedures and/or protocols are used by the workforce and regularly monitored	SM	SM
6.1.2	Action is taken to maximise the effectiveness of clinical handover policies, procedures and/or protocols	SM	SM
6.1.3	Tools and guides are periodically reviewed	SM	SM

Clinical handover processes

Action	Description	Organisation's self-rating	Surveyor Rating
6.2.1	The workforce has access to documented structured processes for clinical handover that include: • preparing for handover, including setting the location and time while maintaining continuity of patient care • organising relevant workforce members to participate • being aware of the clinical context and patient needs • participating in effective handover resulting in transfer of responsibility and accountability for care	SM	SM
6.3.1	Regular evaluation and monitoring processes for clinical handover are in place	SM	SM
6.3.2	Local processes for clinical handover are reviewed in collaboration with clinicians, patients and carers	SM	SM
6.3.3	Action is taken to increase the effectiveness of clinical handover	SM	SM
6.3.4	The actions taken and the outcomes of local clinical handover reviews are reported to the executive level of governance	SM	SM
6.4.1	Regular reporting, investigating and monitoring of clinical handover incidents is in place	SM	SM
6.4.2	Action is taken to reduce the risk of adverse clinical handover incidents	SM	SM

Patient and carer involvement in clinical handover

Action	Description	Organisation's self-rating	Surveyor Rating
6.5.1	Mechanisms to involve a patient and, where relevant, their carer in clinical handover are in use	SM	SM

Blood and Blood Products

Governance and systems for blood and blood product prescribing and clinical use

Action	Description	Organisation's self-rating	Surveyor Rating
7.1.1	Blood and blood product policies, procedures and/or protocols are consistent with national evidence-based guidelines for pre-transfusion practices, prescribing and clinical use of blood and blood products	SM	SM
7.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
7.1.3	Action is taken to increase the safety and appropriateness of prescribing and clinically using blood and blood products	SM	SM
7.2.1	The risks associated with transfusion practices and clinical use of blood and blood products are regularly assessed	SM	SM
7.2.2	Action is taken to reduce the risks associated with transfusion practices and the clinical use of blood and blood products	SM	SM
7.3.1	Reporting on blood and blood product incidents is included in regular incident reports	SM	SM
7.3.2	Adverse blood and blood product incidents are reported to and reviewed by the highest level of governance in the health service organisation	SM	SM

7.3.3	Health service organisations participate in relevant haemovigilance activities conducted by the organisation or at state or national level	SM	SM
7.4.1	Quality improvement activities are undertaken to reduce the risks of patient harm from transfusion practices and the clinical use of blood and blood products	SM	SM

Documenting patient information

Action	Description	Organisation's self-rating	Surveyor Rating
7.5.1	A best possible history of blood product usage and relevant clinical and product information is documented in the patient clinical record	SM	SM
7.5.2	The patient clinical records of transfused patients are periodically reviewed to assess the proportion of records completed	SM	SM
7.5.3	Action is taken to increase the proportion of patient clinical records of transfused patients with a complete patient clinical record	SM	SM
7.6.1	Adverse reactions to blood or blood products are documented in the patient clinical record	SM	SM
7.6.2	Action is taken to reduce the risk of adverse events from administering blood or blood products	SM	SM
7.6.3	Adverse events are reported internally to the appropriate governance level and externally to the pathology service provider, blood service or product manufacturer whenever appropriate	SM	SM

Managing blood and blood product safety

Action	Description	Organisation's self-rating	Surveyor Rating
7.7.1	Regular review of the risks associated with receipt, storage, collection and transport of blood and blood products is undertaken	SM	SM
7.7.2	Action is taken to reduce the risk of incidents arising from the use of blood and blood product control systems	SM	SM
7.8.1	Blood and blood product wastage is regularly monitored	SM	SM
7.8.2	Action is taken to minimise wastage of blood and blood products	SM	SM

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
7.9.1	Patient information relating to blood and blood products, including risks, benefits and alternatives, is available for distribution by the clinical workforce	SM	SM
7.9.2	Plans for care that include the use of blood and blood products are developed in partnership with patients and carers	SM	SM
7.10.1	Information on blood and blood products is provided to patients and their carers in a format that is understood and meaningful	SM	SM
7.11.1	Informed consent is undertaken and documented for all transfusions of blood or blood products in accordance with the informed consent policy of the health service organisation	SM	SM

Preventing and Managing Pressure Injuries

Governance and systems for the prevention and management of pressure injuries

Action	Description	Organisation's self-rating	Surveyor Rating
8.1.1	Policies, procedures and/or protocols are in use that are consistent with best practice guidelines and incorporate screening and assessment tools	SM	SM
8.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
8.2.1	An organisation-wide system for reporting pressure injuries is in use	SM	SM
8.2.2	Administrative and clinical data are used to regularly monitor and investigate the frequency and severity of pressure injuries	SM	SM
8.2.3	Information on pressure injuries is regularly reported to the highest level of governance in the health service organisation	SM	SM
8.2.4	Action is taken to reduce the frequency and severity of pressure injuries	SM	SM
8.3.1	Quality improvement activities are undertaken to prevent pressure injuries and/or improve the management of pressure injuries	SM	SM
8.4.1	Equipment and devices are available to effectively implement prevention strategies for patients at risk and plans for the management of patients with pressure injuries	SM	SM

Preventing pressure injuries

Action	Description	Organisation's self-rating	Surveyor Rating
8.5.1	An agreed tool to screen for pressure injury risk is used by the clinical workforce to identify patients at risk of a pressure injury	SM	SM
8.5.2	The use of the screening tool is monitored to identify the proportion of at-risk patients that are screened for pressure injuries on presentation	SM	SM
8.5.3	Action is taken to maximise the proportion of patients who are screened for pressure injury on presentation	SM	SM
8.6.1	Comprehensive skin inspections are undertaken and documented in the patient clinical record for patients at risk of pressure injuries	SM	SM
8.6.2	Patient clinical records, transfer and discharge documentation are periodically audited to identify at-risk patients with documented skin assessments	SM	SM
8.6.3	Action is taken to increase the proportion of skin assessments documented on patients at risk of pressure injuries	SM	SM
8.7.1	Prevention plans for all patients at risk of a pressure injury are consistent with best practice guidelines and are documented in the patient clinical record	SM	SM
8.7.2	The effectiveness and appropriateness of pressure injury prevention plans are regularly reviewed	SM	SM
8.7.3	Patient clinical records are monitored to determine the proportion of at-risk patients that have an implemented pressure injury prevention plan	SM	SM
8.7.4	Action is taken to increase the proportion of patients at risk of pressure injuries who have an implemented prevention plan	SM	SM

Managing pressure injuries

Action	Description	Organisation's self-rating	Surveyor Rating
8.8.1	An evidence-based wound management system is in place within the health service organisation	SM	SM
8.8.2	Management plans for patients with pressure injuries are consistent with best practice and documented in the patient clinical record	SM	SM
8.8.3	Patient clinical records are monitored to determine compliance with evidence-based pressure injury management plans	SM	SM
8.8.4	Action is taken to increase compliance with evidence-based pressure injury management plans	SM	SM

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
8.9.1	Patient information on prevention and management of pressure injuries is provided to patients and carers in a format that is understood and is meaningful	SM	SM
8.10.1	Pressure injury management plans are developed in partnership with patients and carers	SM	SM

Recognising and Responding to Clinical Deterioration in Acute Health Care

Establishing recognition and response systems

Action	Description	Organisation's self-rating	Surveyor Rating
9.1.1	Governance arrangements are in place to support the development, implementation, and maintenance of organisation-wide recognition and response systems	SM	SM
9.1.2	Policies, procedures and/or protocols for the organisation are implemented in areas such as: • measurement and documentation of observations • escalation of care • establishment of a rapid response system • communication about clinical deterioration	SM	SM
9.2.1	Feedback is actively sought from the clinical workforce on the responsiveness of the recognition and response systems	SM	SM
9.2.2	Deaths or cardiac arrests for a patient without an agreed treatment-limiting order (such as not for resuscitation or do not resuscitate) are reviewed to identify the use of the recognition and response systems, and any failures in these systems	SM	SM
9.2.3	Data collected about recognition and response systems are provided to the clinical workforce as soon as practicable	SM	SM
9.2.4	Action is taken to improve the responsiveness and effectiveness of the recognition and response systems	SM	SM

Recognising clinical deterioration and escalating care

Action	Description	Organisation's self-rating	Surveyor Rating
9.3.1	When using a general observation chart, ensure that it: • is designed according to human factors principles • includes the capacity to record information about respiratory rate, oxygen saturation, heart rate, blood pressure, temperature and level of consciousness graphically over time • includes thresholds for each physiological parameter or combination of parameters that indicate abnormality • specifies the physiological abnormalities and other factors that trigger the escalation of care • includes actions required when care is escalated	SM	SM
9.3.2	Mechanisms for recording physiological observations are regularly audited to determine the proportion of patients that have complete sets of observations recorded in agreement with their monitoring plan	SM	SM
9.3.3	Action is taken to increase the proportion of patients with complete sets of recorded observations, as specified in the patient's monitoring plan	SM	SM
9.4.1	Mechanisms are in place to escalate care and call for emergency assistance	SM	SM
9.4.2	Use of escalation processes, including failure to act on triggers for seeking emergency assistance, are regularly audited	SM	SM
9.4.3	Action is taken to maximise the appropriate use of escalation processes	SM	SM

Responding to clinical deterioration

Action	Description	Organisation's self-rating	Surveyor Rating
9.5.1	Criteria for triggering a call for emergency assistance are included in the escalation policies, procedures and/or protocols	SM	SM
9.5.2	The circumstances and outcome of calls for emergency assistance are regularly reviewed	SM	SM
9.6.1	The clinical workforce is trained and proficient in basic life support	SM	SM
9.6.2	A system is in place for ensuring access at all times to at least one clinician, either on-site or in close proximity, who can practise advanced life support	SM	SM

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
9.7.1	Information is provided to patients, families and carers in a format that is understood and meaningful. The information should include: • the importance of communicating concerns and signs/symptoms of deterioration, which are relevant to the patient's condition, to the clinical workforce • local systems for responding to clinical deterioration, including how they can raise concerns about potential deterioration	SM	SM
9.8.1	A system is in place for preparing and/or receiving advance care plans in partnership with patients, families and carers	SM	SM

9.8.2	Advance care plans and other treatment-limiting orders are documented in the patient clinical record	SM	SM
9.9.1	Mechanisms are in place for a patient, family member or carer to initiate an escalation of care response	SM	SM
9.9.2	Information about the system for family escalation of care is provided to patients, families and carers	SM	SM
9.9.3	The performance and effectiveness of the system for family escalation of care is periodically reviewed	SM	SM
9.9.4	Action is taken to improve the system performance for family escalation of care	SM	SM

Preventing Falls and Harm from Falls

Governance and systems for the prevention of falls

Action	Description	Organisation's self-rating	Surveyor Rating
10.1.1	Policies, procedures and/or protocols are in use that are consistent with best practice guidelines (where available) and incorporate screening and assessment tools	SM	SM
10.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
10.2.1	Regular reporting, investigating and monitoring of falls incidents is in place	SM	SM
10.2.2	Administrative and clinical data are used to monitor and investigate regularly the frequency and severity of falls in the health service organisation	SM	SM
10.2.3	Information on falls is reported to the highest level of governance in the health service organisation	SM	SM
10.2.4	Action is taken to reduce the frequency and severity of falls in the health service organisation	SM	SM
10.3.1	Quality improvement activities are undertaken to prevent falls and minimise patient harm	SM	SM
10.4.1	Equipment and devices are available to implement prevention strategies for patients at risk of falling and management plans to reduce the harm from falls	SM	SM

Screening and assessing risks of falls and harm from falling

Action	Description	Organisation's self-rating	Surveyor Rating
10.5.1	A best practice screening tool is used by the clinical workforce to identify the risk of falls	SM	SM
10.5.2	Use of the screening tool is monitored to identify the proportion of at-risk patients that were screened for falls	SM	SM
10.5.3	Action is taken to increase the proportion of at-risk patients who are screened for falls upon presentation and during admission	SM	SM
10.6.1	A best practice assessment tool is used by the clinical workforce to assess patients at risk of falling	SM	SM
10.6.2	The use of the assessment tool is monitored to identify the proportion of at-risk patients with a completed falls assessment	SM	SM
10.6.3	Action is taken to increase the proportion of at-risk patients undergoing a comprehensive falls risk assessment	SM	SM

Preventing falls and harm from falling

Action	Description	Organisation's self-rating	Surveyor Rating
10.7.1	Use of best practice multifactorial falls prevention and harm minimisation plans is documented in the patient clinical record	SM	SM
10.7.2	The effectiveness and appropriateness of the falls prevention and harm minimisation plan are regularly monitored	SM	SM
10.7.3	Action is taken to reduce falls and minimise harm for at-risk patients	SM	SM
10.8.1	Discharge planning includes referral to appropriate services, where available	SM	SM

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
10.9.1	Patient information on falls risks and prevention strategies is provided to patients and their carers in a format that is understood and meaningful	SM	SM
10.10.1	Falls prevention plans are developed in partnership with patients and carers	SM	SM

Recommendations from Current Survey

Standard: Governance for Safety and Quality in Health Service Organisations
Item: 1.1
Action: 1.1.1 An organisation-wide management system is in place for the development, implementation and regular review of policies, procedures and/or protocols

Surveyor's Recommendation:

1. Ensure the policies and procedures are developed and reviewed in line with intended work practice expectations.
2. Observe and/or audit work practice against policies and procedures for compliance.

Standard: Governance for Safety and Quality in Health Service Organisations
Item: 1.1
Action: 1.1.2 The impact on patient safety and quality of care is considered in business decision making

Surveyor's Recommendation:

Implement preventative strategies based on data and information analysis.

Standard: Governance for Safety and Quality in Health Service Organisations
Item: 1.4
Action: 1.4.2 Annual mandatory training programs to meet the requirements of these Standards

Surveyor's Recommendation:

Ensure that the systems and processes in place enable the health service to consistently maintain formal records on mandatory training attendance, which in turn are able to consistently demonstrate the level of compliance on a timely basis.

Standard: Governance for Safety and Quality in Health Service Organisations
Item: 1.4
Action: 1.4.4 Competency-based training is provided to the clinical workforce to improve safety and quality

Surveyor's Recommendation:

1. Develop and implement a formal schedule of competency-based training across the health service.
2. Ensure required competency-based training is completed, and documented, on a timely basis and records are maintained accordingly.

Standard: Governance for Safety and Quality in Health Service Organisations
Item: 1.5
Action: 1.5.2 Actions are taken to minimise risks to patient safety and quality of care

Surveyor's Recommendation:

1. Ensure the organisation-wide risk management system is inclusive, and extends beyond a risk register.
2. Ensure there is timely and appropriate action taken in relation to data and information analysis.

Standard: Governance for Safety and Quality in Health Service Organisations
Item: 1.6
Action: 1.6.1 An organisation-wide quality management system is used and regularly monitored

Surveyor's Recommendation:

1. Ensure the frequency of formal, documented monitoring, is relevant to collected data and information, as well as observation of work practice, and contributes to achieving expected outcomes in compliance, within appropriate timeframes.
2. Ensure that the results of audits accurately reflect findings.

Standard: Governance for Safety and Quality in Health Service Organisations
Item: 1.9
Action: 1.9.1 Accurate, integrated and readily accessible patient clinical records are available to the clinical workforce at the point of care

Surveyor's Recommendation:

Ensure the completion and accuracy of clinical records.

Standard: Governance for Safety and Quality in Health Service Organisations
Item: 1.11
Action: 1.11.1 A valid and reliable performance review process is in place for the clinical workforce

Surveyor's Recommendation:

Ensure a valid and reliable performance review process is in place for the clinical workforce, which demonstrates consistent compliance across the health service, within specified timeframes.

Standard: Governance for Safety and Quality in Health Service Organisations
Item: 1.11
Action: 1.11.2 The clinical workforce participates in regular performance reviews that support individual development and improvement

Surveyor's Recommendation:

Ensure consistent compliance with the workforce performance review process on a timely basis.

Standard: Governance for Safety and Quality in Health Service Organisations
Item: 1.18
Action: 1.18.2 Mechanisms are in place to monitor and improve documentation of informed consent

Surveyor's Recommendation:

1. Ensure that the consent forms used by VMOs meet the expectations of the health service, and also comply with governing legislation and standards.
2. Ensure that all consent forms are fully completed prior to the patient being transferred to the operating suite, where an emergency is not a factor.

Standard: Partnering with Consumers
Item: 2.6
Action: 2.6.2 Consumers and/or carers are involved in training the clinical workforce

Surveyor's Recommendation:

Consider other ways of engaging patients/carers to train the workforce other than feedback, complaints, and incidents.

Standard: Preventing and Controlling Healthcare Associated Infections
Item: 3.1
Action: 3.1.1 A risk management approach is taken when implementing policies, procedures and/or protocols for:
• standard infection control precautions
• transmission-based precautions
• aseptic non-touch technique
• safe handling and disposal of sharps
• prevention and management of occupational exposure to blood and body substances
• environmental cleaning and disinfection
• antimicrobial prescribing
• outbreaks or unusual clusters of communicable infection
• processing of reusable medical devices
• single-use devices
• surveillance and reporting of data where relevant
• reporting of communicable and notifiable diseases
• provision of risk assessment guidelines to workforce
• exposure-prone procedures

Surveyor's Recommendation:

Ensure that the required changes to the CSSD service of the Memorial Hospital are made as specified, and within the stated timeframes.

Standard: Preventing and Controlling Healthcare Associated Infections
Item: 3.5
Action: 3.5.3 Action is taken to address non-compliance, or the inability to comply, with the requirements of the current national hand hygiene guidelines

Surveyor's Recommendation:

Further action be taken to maximise hand hygiene compliance rates for medical officers.

Standard: Preventing and Controlling Healthcare Associated Infections
Item: 3.10
Action: 3.10.1 The clinical workforce is trained in aseptic technique

Surveyor's Recommendation:

Fully implement the training of the clinical workforce across the three sites.

Standard: Preventing and Controlling Healthcare Associated Infections
Item: 3.15
Action: 3.15.1 Policies, procedures and/or protocols for environmental cleaning that address the principles of infection prevention and control are implemented, including:
• maintenance of building facilities
• cleaning resources and services
• risk assessment for cleaning and disinfection based on transmission-based precautions and the infectious agent involved
• waste management within the clinical environment
• laundry and linen transportation, cleaning and storage
• appropriate use of personal protective equipment

Surveyor's Recommendation:

Ensure appropriate, and adequate cleaning of baths, showers, toilets, and other shared items, between patients.

Standard: Preventing and Controlling Healthcare Associated Infections
Item: 3.15
Action: 3.15.2 Policies, procedures and/or protocols for environmental cleaning are regularly reviewed

Surveyor's Recommendation:

Further monitoring of compliance with optimal cleaning regimes (eg between patient use) is recommended for those areas that still provide shared use of bathrooms/en suites.

Standard: Preventing and Controlling Healthcare Associated Infections
Item: 3.16
Action: 3.16.1 Compliance with relevant national or international standards and manufacturer's instructions for cleaning, disinfection and sterilisation of reusable instruments and devices is regularly monitored

Surveyor's Recommendation:

Complete the required actions as derived from the recent AS4187 gap analysis.

Standard: Preventing and Controlling Healthcare Associated Infections
Item: 3.18
Action: 3.18.1 Action is taken to maximise coverage of the relevant workforce trained in a competency-based program to decontaminate reusable medical devices

Surveyor's Recommendation:

1. Ensure all members of the workforce, working within the areas where cleaning and decontamination of reusable medical devices and instruments take place, have successfully achieved relevant, formally recognised, competency-based qualifications.

2. Ensure that the systems and processes used to maintain required documentation is consistent and effective, and in turn is able to provide evidence of successful completion on a timely basis.

Standard: Preventing and Controlling Healthcare Associated Infections
Item: 3.19
Action: 3.19.2 Patient infection prevention and control information is evaluated to determine if it meets the needs of the target audience

Surveyor's Recommendation:

Ensure that consultation and evaluation of patient infection prevention and control information is undertaken consistently across the health service to ensure that it meets the needs of the targeted audience.

Standard: Medication Safety
Item: 4.10
Action: 4.10.1 Risks associated with secure storage and safe distribution of medicines are regularly reviewed

Surveyor's Recommendation:

1. Ensure the safe and appropriate storage of all medications in line with governing legislation.
2. Ensure appropriate and timely monitoring systems are in place to achieve compliance.

Standard: Medication Safety
Item: 4.11
Action: 4.11.1 The risks for storing, prescribing, dispensing and administration of high-risk medicines are regularly reviewed

Surveyor's Recommendation:

1. The DDA registers be fully completed at the time of each entry.
2. The DDA register form part of the formal audit schedule, with the frequency of auditing to occur reflective of the risk assessment, and results of audits.

Standard: Patient Identification and Procedure Matching
Item: 5.1
Action: 5.1.2 Action is taken to improve compliance with the patient identification matching system

Surveyor's Recommendation:

1. Update the current patient identification policy to provide further clarity on the optimal identification of public patients receiving care at Flinders Private Hospital.
2. Ensure the processes are in line with the requirements of the Australian Commission on Safety and Quality in Health Care.

Standard: Blood and Blood Products
Item: 7.3
Action: 7.3.3 Health service organisations participate in relevant haemovigilance activities conducted by the organisation or at state or national level

Surveyor's Recommendation:

Review the health service against the requirements of this action to determine gaps and weaknesses, and develop and implement formal reflective activities accordingly.

Standard: Blood and Blood Products
Item: 7.8
Action: 7.8.1 Blood and blood product wastage is regularly monitored

Surveyor's Recommendation:

Develop and implement a formal and consistent approach to monitoring blood and blood product wastage.

Standard: Preventing and Managing Pressure Injuries
Item: 8.3
Action: 8.3.1 Quality improvement activities are undertaken to prevent pressure injuries and/or improve the management of pressure injuries

Surveyor's Recommendation:

1. Review the audit monitoring process and schedule to meet the needs of each hospital site.
2. The frequency of audits/monitoring reflect the requirements of the NSQHSS, and that of the individual hospitals.

Standard: Preventing and Managing Pressure Injuries
Item: 8.6
Action: 8.6.2 Patient clinical records, transfer and discharge documentation are periodically audited to identify at-risk patients with documented skin assessments

Surveyor's Recommendation:

1. Evaluate and audit the new Pressure Injury Risk Assessment and Management tool for compliance with comprehensive skin assessments separate to the interventions to achieve relevant data and information for both.
2. Include more frequent targeted audits until compliance is at an acceptable level.

Standard: Preventing and Managing Pressure Injuries
Item: 8.8
Action: 8.8.3 Patient clinical records are monitored to determine compliance with evidence-based pressure injury management plans

Surveyor's Recommendation:

Develop an agreed tool /process for reviewing and auditing wound management plans for compliance and effectiveness.

Standard: Preventing Falls and Harm from Falls
Item: 10.3
Action: 10.3.1 Quality improvement activities are undertaken to prevent falls and minimise patient harm

Surveyor's Recommendation:

1. Review the audit monitoring process and schedule to meet the needs of each hospital site.
2. The frequency of audits/monitoring fully reflect the requirements of the NSQHSS, and that of the individual hospitals.

Recommendations from Previous Survey

Standard: Partnering with Consumers
Criterion: Consumer partnership in service planning
Action: 2.2.2 Consumers and/or carers are actively involved in decision making about safety and quality

Recommendation: NSQHSS Survey 0813.2.2.2

Recommendation:

Create a mechanism for consumers/carers to be actively involved in decision making about safety and quality.

Action:

Consumer consultant membership of the ACHA Executive Committee

Consumer representative membership of the 3 hospital safety and quality committees

Safety and Quality KPI –Complaints acknowledgement – 2015-16 rate sits between 87-100% (kpi >90%)

Safety and Quality KPI –Complaints response - 2015-16 rate sits between 95.2-100% (kpi >90%)

Safety and Quality KPI –Satisfaction survey response rate - 2015-16 rate sits between 50-88% (kpi>45%)

Safety and Quality KPI –Patient satisfaction overall rating - 2015-16 rate sits between 78.5-90% (kpi>80%)

Consumer forums e.g. Cardiology, Maternity, Rehabilitation

Development of Consumer Representative Handbook

Consumer consultant/representative position descriptions describe the consumer role indecision making re safety and quality

Consumer feedback on quarterly ACHA Diet Group meetings and minutes

Participation in the Healthscope Consumer Cluster

Our performance website - public disclosure of safety and quality performance information – reviewed by consumers

ACHA wide consumer forum commenced in March 2016

ACHA Executive Committee terms of reference, agenda and minutes that include consumers

Hospitals(x3) safety and quality committees Terms of Reference and Minutes - which reflect consumer involvement in decision making

Consumers review the ACHA Safety and Quality Plan and provide feedback

Consumers review the safety and quality KPI reports and plans

Consumer information / publications are reviewed by consumers – “Consumer Approved Publication” labelled

Consumer column distributed to staff

Appraisal process for consumers provides for 2-way feedback.

Completion Due By:

Responsibility: D Lloyd

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

The requirements of this recommendation had been addressed at the time of survey. As a consequence this recommendation has been closed.

Standard: Partnering with Consumers
Criterion: Consumer partnership in service planning
Action: 2.3.1 Health service organisations provide orientation and ongoing training for consumers and/or carers to enable them to fulfil their partnership role

Recommendation: NSQHSS Survey 0813.2.3.1

Recommendation:

Provide an orientation and training program to prepare consumers/carers for their partnership role with the organisation as they are introduced to the role of consumers/carers in all ACHA hospitals.

Action:

Consumers participate in hospital orientation programs

Consumer orientation package/program includes:
- Policies and procedures
- Written information, eg hand hygiene, WHS responsibilities
- Orientation checklist
- WHS
- Emergency procedures

- Position description
- Contract of service
- Confidentiality clause signed
- Duty list applicable to the consumer's negotiated level of involvement
- Tour of hospital
- Introductions to key personnel

Consumer personnel files
Consumers have access to hospital training programs applicable to their roles
Consumers are allocated a direct report at each hospital for support, or to provide further feedback
Consumers who are members of committees are inducted into the role and function of the committee, and their role within that
Orientation and training attendance recorded on the consumer's personnel file
Consumers are provided access to external support and educational services
Consumer education program

Completion Due By:

Responsibility: D Lloyd

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

The requirements of this recommendation had been addressed at the time of survey. As a consequence this recommendation has been closed.

Standard: Blood and Blood Products
Criterion: Communicating with patients and carers
Action: 7.11.1 Informed consent is undertaken and documented for all transfusions of blood or blood products in accordance with the informed consent policy of the health service organisation

Recommendation: NSQHSS Survey 0813.7.11.1

Recommendation:

1. Ensure medical officers complete all required documentation on the documents used for obtaining and documenting informed consent for transfusion of blood or blood products.
2. Implement patient surveys specifically targeted at obtaining feedback regarding the quality of the informed consent for transfusions of blood and blood products.

Action:

Ensure medical officers complete all required documentation on the documents used for obtaining and documenting informed consent for transfusion of blood or blood products

Administration of Blood and Blood Products Policy includes the requirement for consent to be taken
Standardised Blood and Blood Product Consent Forms in use
Consent for Medical Treatment Form includes provision for consent for transfusion of blood or blood products
Consumer Education Fact Sheet 'Receiving Blood Transfusion: Important Information' includes information on consent, and is available in all clinical areas and is provided to each patient requiring transfusion
ACHA TV Channel provides education to patients, carers, staff and doctors re transfusion and consent
Consent for transfusion of blood or blood products is included on the Audit Schedule

Consent audit compliance is tabled at the hospital safety and quality committees, ACHA Patient Care Committee and the ACHA Medical Advisory Committee
The ACHA Medical Advisory Committee communicates results to visiting medical officers via the Doctor's Newsletter
Consent for Blood Transfusion Audit: 88% Jan 2014, 86% July 2014 and 100% May 2016
Blood Documentation Audit: 76% Jan 2014, 86% April 2014 and 91% May 2016
Ongoing monitoring is scheduled on the Audit Schedule
Implement patient surveys specifically targeted at obtaining feedback regarding the quality of the informed consent for transfusions of blood and blood products
A patient survey developed and included on each hospital Audit Schedule
Audits are to be completed at least annually (more frequently if compliance rates are lower than expected)
The audit targets the respective responsibilities of the hospital visiting medical officer
Audit results are tabled at the hospital safety and quality committees, ACHA Patient Care Committee and the ACHA Medical Advisory Committee
Patient Knowledge of Transfusion Audit: 84% May 2014, 92% June 2016
Ongoing monitoring is scheduled on the Audit Schedule

Completion Due By:

Responsibility: D Lloyd

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

Improvement has occurred in the achievement of documented consent forms. As a consequence this action has been closed. However, this process requires further strengthening and a further recommendation has been made under action 1.18.2.

Standards Rating Summary

Organisation: ACHA Health
Orgcode: 320011

Organisation - NSQHSS V01

Core

Standard	Not Met	Met	N/A	Total
Standard 1	0	44	0	44
Standard 2	0	4	0	4
Standard 3	0	39	0	39
Standard 4	0	31	0	31
Standard 5	0	9	0	9
Standard 6	0	9	0	9
Standard 7	0	20	0	20
Standard 8	0	20	0	20
Standard 9	0	15	0	15
Standard 10	0	18	0	18
Total	**0**	**209**	**0**	**209**

Standard	SM	MM	Total
Standard 1	44	0	44
Standard 2	4	0	4
Standard 3	39	0	39
Standard 4	31	0	31
Standard 5	9	0	9
Standard 6	9	0	9
Standard 7	20	0	20
Standard 8	20	0	20
Standard 9	15	0	15
Standard 10	18	0	18
Total	**209**	**0**	**209**

Developmental

Standard	Not Met	Met	N/A	Total
Standard 1	0	9	0	9
Standard 2	0	11	0	11
Standard 3	0	2	0	2
Standard 4	0	6	0	6
Standard 5	0	0	0	0
Standard 6	0	2	0	2
Standard 7	0	3	0	3
Standard 8	0	4	0	4
Standard 9	0	8	0	8
Standard 10	0	2	0	2
Total	**0**	**47**	**0**	**47**

Standard	SM	MM	Total
Standard 1	9	0	9
Standard 2	11	0	11
Standard 3	2	0	2
Standard 4	6	0	6
Standard 5	0	0	0
Standard 6	2	0	2
Standard 7	3	0	3
Standard 8	4	0	4
Standard 9	8	0	8
Standard 10	2	0	2
Total	**47**	**0**	**47**

Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 1	0	53	0	53	Met
Standard 2	0	15	0	15	Met
Standard 3	0	41	0	41	Met
Standard 4	0	37	0	37	Met
Standard 5	0	9	0	9	Met
Standard 6	0	11	0	11	Met
Standard 7	0	23	0	23	Met
Standard 8	0	24	0	24	Met
Standard 9	0	23	0	23	Met
Standard 10	0	20	0	20	Met
Total	**0**	**256**	**0**	**256**	**Met**

Standard	SM	MM	Total	Overall
Standard 1	53	0	53	Met
Standard 2	15	0	15	Met
Standard 3	41	0	41	Met
Standard 4	37	0	37	Met
Standard 5	9	0	9	Met
Standard 6	11	0	11	Met
Standard 7	23	0	23	Met
Standard 8	24	0	24	Met
Standard 9	23	0	23	Met
Standard 10	20	0	20	Met
Total	**256**	**0**	**256**	**Met**

Standards Rating Summary

Organisation: ACHA Health
Orgcode: 320011

Surveyor - NSQHSS V01

Core

Standard	Not Met	Met	N/A	Total
Standard 1	0	44	0	44
Standard 2	0	4	0	4
Standard 3	0	39	0	39
Standard 4	0	31	0	31
Standard 5	0	9	0	9
Standard 6	0	9	0	9
Standard 7	0	20	0	20
Standard 8	0	20	0	20
Standard 9	0	15	0	15
Standard 10	0	18	0	18
Total	**0**	**209**	**0**	**209**

Standard	SM	MM	Total
Standard 1	44	0	44
Standard 2	4	0	4
Standard 3	39	0	39
Standard 4	31	0	31
Standard 5	9	0	9
Standard 6	9	0	9
Standard 7	20	0	20
Standard 8	20	0	20
Standard 9	15	0	15
Standard 10	18	0	18
Total	**209**	**0**	**209**

Developmental

Standard	Not Met	Met	N/A	Total
Standard 1	0	9	0	9
Standard 2	0	11	0	11
Standard 3	0	2	0	2
Standard 4	0	6	0	6
Standard 5	0	0	0	0
Standard 6	0	2	0	2
Standard 7	0	3	0	3
Standard 8	0	4	0	4
Standard 9	0	8	0	8
Standard 10	0	2	0	2
Total	**0**	**47**	**0**	**47**

Standard	SM	MM	Total
Standard 1	9	0	9
Standard 2	11	0	11
Standard 3	2	0	2
Standard 4	6	0	6
Standard 5	0	0	0
Standard 6	2	0	2
Standard 7	3	0	3
Standard 8	4	0	4
Standard 9	8	0	8
Standard 10	2	0	2
Total	**47**	**0**	**47**

Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 1	0	53	0	53	Met
Standard 2	0	15	0	15	Met
Standard 3	0	41	0	41	Met
Standard 4	0	37	0	37	Met
Standard 5	0	9	0	9	Met
Standard 6	0	11	0	11	Met
Standard 7	0	23	0	23	Met
Standard 8	0	24	0	24	Met
Standard 9	0	23	0	23	Met
Standard 10	0	20	0	20	Met
Total	**0**	**256**	**0**	**256**	**Met**

Standard	SM	MM	Total	Overall
Standard 1	53	0	53	Met
Standard 2	15	0	15	Met
Standard 3	41	0	41	Met
Standard 4	37	0	37	Met
Standard 5	9	0	9	Met
Standard 6	11	0	11	Met
Standard 7	23	0	23	Met
Standard 8	24	0	24	Met
Standard 9	23	0	23	Met
Standard 10	20	0	20	Met
Total	**256**	**0**	**256**	**Met**