NSQHS Standards Second Edition Version 2 Organisation-Wide Assessment

Initial Assessment Report

ACHA Health

Bedford Park, SA

Organisation Code: 320011
Health Service Organisation ID: Z1010011
ABN: 99 367 793 956
Assessment Date: 5-9 June 2023

Accreditation Cycle: 1

Contents

Preamble

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

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

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

A rating report is provided for each health service facility.

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

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

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

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

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

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

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

Executive Summary

ACHA Health underwent an NSQHS Standards Second Edition Version 2 Organisation-Wide Assessment (NS2.1 OWA) from 05/06/2023 to 09/06/2023. The NS2.1 OWA required six assessors for a period of five days. ACHA Health is a private health service. ACHA Health was last assessed between 02/09/2019 and 06/09/2019.

PICMoRS was used to conduct this assessment. Note that 64% of available time was spent in operational areas during this assessment.

The Adelaide Community Healthcare Alliance Incorporated Health (ACHA) has three hospitals providing care to patients, including Ashford Hospital, The Memorial Hospital, and Flinders Private Hospital, that deliver a very high standard of care to their patient population.

Unfortunately, recommendations from the previous assessment were not closed during this visit which has resulted in two 'Not Met' ratings (actions 1.20 and 4.02) which will require a Final Assessment in 60 working days to ensure these have been adequately actioned. All the other previous recommendations have been closed, and a number of Met with Recommendation ratings have been made, along with a few 'Suggestions for Improvement'.

The organisation must be proud of all the good news they heard from the assessment team about the high level of patient-centred care from staff from all departments within each of the three hospitals.

CLINICAL GOVERNANCE

There is a strong and positive culture of safety and quality improvement across ACHA Health. The systems that support patient safety and quality including incident reporting, risk management, and audit are well developed. Staff were aware of many performance outcome indicators and were continually looking to improve the standard of care for patients and their families. High risk scenario testing relating to these standards and risks documented on the risk register were tested and discussed with staff during the assessment visit interviews and confirmed how ACHA Health manage and mitigate risk.

Commitment to safety training and skills development was demonstrated, with attention on capability building, and access to additional courses or training available for staff in many instances. Compliance with mandatory training was high, except for VMOs and surgical assistants. This led to a Not Met for action 1.20 as it had been the subject of a recommendation at the previous assessment which had not been implemented.

Credentialing, the assignment of scope of practice, and the monitoring of practice were well established. Clinical practice is evidence informed, and outcome indicators are benchmarked and monitored closely by clinical committees, the Executive, and the Board, with actions taken to further improve safety and quality.

Self-managed insurance commenced several years ago and had led to an impressive reduction in lost time injuries. All facilities and equipment were noted to be well maintained. All hospitals within the service now have a much more inviting entry for Aboriginal and Torres Strait Islander people. ACHA have put in a lot of work with local Elders to provide this welcoming environment, adorned with artwork from local artists.

PARTNERING WITH CONSUMERS

Partnering with patients in their own care is consistent and imbedded into the safety and quality culture of the organisation. ACHA facilities use a range of feedback mechanisms to gain feedback from patients / carers which feeds back into the ongoing quality improvement strategies. The assessors observed positive and compassionate exchanges among clinicians, administrative, and support service staff throughout the assessment. It was acknowledged by the assessors that the strategies that ACHA have implemented since the last survey have served well in making connections with Aboriginal and Torres Strait Islander communities to meet their health needs.

PREVENTING AND CONTROLLING INFECTIONS

The infection control and prevention systems are appropriately risk-assessed and managed by a dedicated multidisciplinary team. There is committed leadership to promote the culture for infection control with strong liaison and rapport with all sites at ACHA. The ongoing response to COVID-19 and other transmissible infection outbreaks was evident, with good outcomes. Attention to surveillance, transmission-based precautions, hand hygiene, and other infection control techniques are implemented, and consumers are informed of the reasons.

MEDICATION SAFETY

Medication management is integrated into the ACHA systems for governance. There are cohesive systems for all aspects of the medication management pathway, and Medication Safety Committees provide evidence of a strong commitment to quality improvement. Medication risks have been identified and communicated and are delivering solutions to problems. An ongoing inconsistency with the complete documentation of the components of the National Standard Medication Chart (NSMC) requires further attention. However, overall medications are managed well across ACHA because of the accountability and professional behaviour of individuals, a strong sense of collaboration across the disciplines and the services, and an obvious focus on the needs of the patient.

COMPREHENSIVE CARE

The assessors found that systems were in place to support Comprehensive Care across all three facilities. Policies and procedures were detailed, education and training programs for comprehensive care were available and utilised, and risks relating to this standard were identified and managed appropriately. The assessors also witnessed a high standard of care at the bedside in all clinical areas visited, with excellent communication between the multidisciplinary team and the patient and carers. Shared decision making, discussing, and clarifying goals of care were observed in both verbal interchanges with the patient and at formal clinical handovers.

The use of the Patient History tool, Risk Assessment tool, Comprehensive Care Plan and Daily Care Plans were consistently observed to be completed to a high standard. The assessors witnessed real time evidence of clinical assessments being continuously reviewed by highly skilled staff. The organisation’s management of pressure injury prevention and falls prevention is excellent, and staff should be congratulated on their published outcomes. The patients’ nutritional and hydration needs were well coordinated from the kitchen to the bedside, and the recently reviewed menu appears to be addressing the issues raised by patient feedback. The patients identified with cognitive decline and those being cared for at the end of life were seen to have quality care delivered with dignity and respect.

COMMUNICATING FOR SAFETY

ACHA has systems in place for effective communication that support continuous, coordinated, and safe patient care. Assessors observed clinical communication using best practice guidelines to be professional and efficient at all facilities. Patient identifiers were used consistently by staff during transitions of care, and the care boards at the patient bedside were used as a routine opportunity to discuss shared patient care. It was evident that these processes are monitored through the ongoing audit schedule.

BLOOD MANAGEMENT

Governance of treatment with blood and blood products is overseen by the Blood and Acute Clinical Deterioration Committee which monitors compliance with best practice guidelines and management of strategies to minimise blood wastage and maximise patient's own blood supplies. There is a symbiotic relationship between the local pathology providers and the hospitals in the ACHA group. Both organisations take their responsibilities in relation to the collection, testing, preparation, transportation, and storage of blood and blood products very seriously, leading to a fast service delivery with little or no errors. If the 'wrong blood was put in the wrong tube' for example, this is very quickly picked up and action taken immediately to rectify the situation.

The supply and storage of the blood is completely dependent on the pathology company, which ensures safe transport, distribution, and storage of these products. All couriers have been provided with access to the room or rooms in the organisation where the blood fridge(s) are kept, and this is also co-located with other pathology specimens as a one-stop shop, assisting both parties and reducing the time taken to get the products. Well-trained staff then administer blood at an appropriate time and location to minimise the risks associated with blood transfusions. In the past few years, there have been a few massive blood transfusions but always following the strict protocols set down to ensure minimisation of such a precious resource.

RECOGNISING AND RESPONDING TO ACUTE DETERIORATION

The assessment team agreed that there are systems and processes in place at all three hospitals for Recognising and Responding to Acute Deterioration in relation to physiological and mental health status, and that these are appropriate for each location. Internal evidence provided showed that the organisation has a timely response by appropriately skilled clinicians with the knowledge to provide evidence-based care and procedures for rapid treatment of physical or mental deterioration. Where required, referral of patients to services that provide the most appropriate definitive care of acute deterioration was demonstrated. Patients, families, and carers are educated on their role to raise any concerns about the patient to staff to escalate care. This process of escalation is audited by the organisation. The requirements of Advisory AS19/01 referring to actions 8.05, 8.06 b, c, d and e and action 8.12 have been met.

Summary of Results

At ACHA Health's Organisation-Wide Assessment, two Actions were rated Not Met and three Actions were rated Met with Recommendation across eight Standards. The following table identifies the Actions that were rated Not Met and Met With Recommendation and lists the facilities to which the rating applies.

Summary of Recommendations Subject to the Final Assessment

Facilities (HSF IDs)	NS2.1 OWA 5/06/2023 - 9/06/2023	
	MwR	NM
Ashford Hospital-101433	1.22, 1.28, 6.08	1.20, 4.02
Flinders Private Hospital-101434	1.22, 1.28, 6.08	1.20, 4.02
The Memorial Hospital-101435	1.22, 1.28, 6.08	1.20, 4.02

Final Assessment Requirement

As there are actions rated Not Met and Met with Recommendation, there is a requirement of the Australian Commission on Safety and Quality in Health Care (ACSQHC) that the health service organisation is given a period of remediation and the Not Met and Met with Recommendation actions undergo a final assessment within 60 business days of the initial assessment.

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

Sites for Assessment

ACHA Health

Site	HSFID	Address	Visited	Mode
Ashford Hospital	101433	55 Anzac Highway ASHFORD SA 5035	Yes	On Site
Site	**HSFID**	**Address**	**Visited**	**Mode**
Flinders Private Hospital	101434	1 Flinders Drive BEDFORD PARK SA 5042	Yes	On Site
Site	**HSFID**	**Address**	**Visited**	**Mode**
The Memorial Hospital	101435	Sir Edwin Smith Ave NORTH ADELAIDE SA 5006	Yes	On Site

Contracted Services

The following contracted services are used by ACHA Health

Provider	Description of Services	Verified During Assessment
Dorma	Automatic Doors	Yes
Coloplast	Med/Surg supplies	Yes
Multigate	Med/Surg supplies	Yes
Smith and Nephew Pty Ltd	Med/Surg supplies	Yes
3M Australia Pty Ltd	Med/Surg supplies	Yes
Flinders Medical Centre	Breast Care Services	Yes
Johnson and Johnson	Med/Surg supplies	Yes
Chubb Security Services	Cash Delivery	Yes
Allianz	Claims Case Management	Yes
ABN AMRO Aust Ltd	Commercial Purchase Agreement	Yes
Schering	Contrast Media	Yes
Kimberly Clark Australia Pty Ltd	Med/Surg supplies	Yes
AGL	Electricity Supply	Yes
Tyco	Electro-surgical	Yes
Accutek	Electro-surgical	Yes
Cummins	Emergency Generator Maintenance	Yes
Engie	Emergency Lighting	Yes
Young Consulting Services	Employee Assistance Program	Yes
Hewlett Packard, Canon	Fax, copier, printer lease	Yes
Camfill Farr	Filtration/ Air Filters	Yes
Chubb Fire & Security	Fire Safety Management	Yes
ACHA / Flinders Private Hospital	Flinders Medical Centre Development Services Agreement	Yes
Baxter Healthcare	Fluids	Yes
Defries Industries Pty Ltd	Med/Surg supplies	Yes

Provider	Description of Services	Verified During Assessment
Cummins	Generator	Yes
Various	Healthfund	Yes
Smith and Nephew	Hire Equipment	Yes
Healthscope Limited	Hospital Operations Management Agreement	Yes
Flinders Medical Centre	Hydro Pool Services	Yes
Kronos	Information Technology- Rostering System	Yes
QBE	Insurance	Yes
Southern Critical Care	Intensive Care Medical Services	Yes
TMP Worldwide Pty	Internet Services	Yes
Becton Dickinson Pty Ltd	Med/Surg supplies	Yes
Finlaysons	Legal Advice Provider	Yes
OTIS	Lifts	Yes
International Linen Services	Linen Services	Yes
SSL Healthcare	Management Services	Yes
Gardner Denver	Medical Air System	Yes
Golden Grove Medical Centre P/L	Memorandum of Lease	Yes
Terumo Corporation Australia + Vascutek Division	Med/Surg supplies	Yes
Flinders Medical Centre	Neurosurgery Services	Yes
Health Care Australia	Nursing Agency	Yes
Enhance OT	Occupational Therapy	Yes
Satelco	PABX	Yes
SA Pathology / IMVS	Pathology	Yes
Clinpath	Pathology	Yes
Australian Clinical Laboratories Pathology	Pathology	Yes
ISOFT/PiMS	Patient Management System Software	Yes
ISOFT/Endoscribe	Patient Management System Software	Yes
Adelaide Perfusion	Perfusion Services	Yes
HPS	Pharmacy Supply	Yes
Glandore Podiatry Clinic	Podiatry	Yes
Hewartt Packard & Canon	Printer Lease	Yes
National Mutual Healths Ins P/L	Provider Agreement	Yes
Bensons	Radiology	Yes
Radiology SA	Radiology	Yes
Griffith Rehabilitation Hospital	Rehabilitation Services Agreement	Yes
Flinders Medical Centre	Renal Haemodialysis Services	Yes
Pink Hygiene Services	Sanitary Services	Yes
Chubb Protective Sevices Australia	Security Services	Yes
Southern Adelaide Local Health Network (SALHN)	Amendment to Project Agreement	Yes
GE Healthcare	Stenoscope and Cath Lab Maintenance	Yes
Athertons	Sterilisers	Yes

Provider	Description of Services	Verified During Assessment
ISOFT/ Endoscribe	Endoscopy Software	Yes
Performance Catering	Kitchen Equipment	Yes
Eco Lab	Catering and Domestic Chemicals	Yes
Chemtronic	Biomedical Engineering	Yes
Cook Australia Pty Ltd	Med/Surg supplies	Yes
Clifford Hallam Healthcare CH2	Med/Surg supplies	Yes
APP	Pathology	Yes
Performance Catering	Catering Equipment	Yes
Performance Catering	Tunnel Washer	Yes
Getinge	Sterilisers	Yes
HP Maintenance	Information Services Hardware	Yes
iSOFT	Information Technology	Yes
Phillips	Information Technology	Yes
Olympus	Information Technology	Yes
Australian Medical Placements	Agency Doctors	Yes
Paradise Refrigeration	Air Cond, Refrigeration	Yes
AirMaster	Air Cond, Refrigeration	Yes
Comp Air Australia	Air-Compressed	Yes
Howard Wright	Beds Electrical	Yes
Medicraft	Beds Electrical	Yes
BioMed Medtronic	Biomedical Engineering	Yes
Schneider	BMS	Yes
Bounty Parenting Group	Bounty Bags	Yes
Aqualutions	CT Water Treatment	Yes
West Torrens Council	CT Water Treatment	Yes
Air Master	Chillers	Yes
ACMA	Communications	Yes
Satelco	Communications	Yes
Gardner Denver	Compressers	Yes
Adelaide Services	Conductance Testing	Yes
Daltimore Aircoil	Cooling Towers	Yes
Clinical Laboratories Pathology	CT Water Testing	Yes
Recall	Document Storage	Yes
Campbells	Duct Cleaning	Yes
Nilsen / Edmonson Electrical	Electrical Contractor	Yes
ESafe	Electrical Testing	Yes
SAIS	Exhaust Fans (catering)	Yes
Engie	Fire Safety	Yes
Engie	Fire Doors	Yes
HICMR	Infection Control Policies and Procedures, Consultancy	Yes
Huntleigh Healthcare	Mattress Replacement	Yes
BOC / IMPS	Medical Gas	Yes

Provider	Description of Services	Verified During Assessment
Washtub Dr	Panflusher	Yes
IMS Ambulance	Patient Transport	Yes
SA Ambulance	Patient Transport	Yes
Ross Tippett - Function First Physiotherapy	Pre Employment Functional Capacity Assessment	Yes
EPA	Radiation Prot. Certs.	Yes
Arjo Huntleigh	Staminalifters	Yes
Just Steam	Sterilisers	Yes
Sterrad	Sterilisers VPRO	Yes
Veolia	Waste	Yes
Pink Hygiene Services	Waste	Yes
Clean Flow	Water Coolers	Yes
Waterforce / Aqualations	Water Treatment	Yes
RES	Beds Electrical	Yes
AirMaster	Building Services Maintenance	Yes
Alert Tech	Call Bells	Yes
TIE Networks	Communications	Yes
AGL	Boilers	Yes
ODG	Emergency Lighting	Yes
Engie	Emergency Warning Intercom System	Yes
Provation	Endoscopy Software	Yes
Barker & Barker	Medical Record Forms & Brochures	Yes
Kemp Recruitment	Nursing Agency	Yes
Mediserve Nursing Agency	Nursing Agency	Yes
Australian Business Solutions Group	Nursing Agency	Yes
Nursing Australia	Nursing Agency	Yes
Nursing One World	Nursing Agency	Yes
Your Nursing Agency	Nursing Agency	Yes
TIE Networks	PABX	Yes
Adam Pest Control	Pest Control	Yes
ESG Asia Pacific	Cleaning Supplies	Yes
Dominant (Australia) Pty Ltd	Cleaning Supplies	Yes
ECOLAB Pty Ltd	Cleaning Supplies	Yes
Adelaide Merchandising	Equipment	Yes
Crown Equipment	Forklift Maintenance	Yes
Huntleigh Healthcare	Medical Equipment	Yes
Keen Office Furniture	Office Furniture	Yes
Back Centre & Specialty Seating	Office Furniture	Yes
Bunzl Ltd	Paper goods / Cleaning	Yes
Barker & Barker	Printing	Yes
Australian Safety Specialists	Safety	Yes
CMI - HINO	Vehicle Maintenance	Yes
AAXIS Pacific	Med/Surg supplies	Yes
ABBOTT Australasia Pty Ltd	Med/Surg supplies	Yes

Provider	Description of Services	Verified During Assessment
The Royal Australasian College of Physicians	Funding and Administration Agreement	Yes
Flinders Medical Centre (FMS)	Colocation Agreement	Yes
Hudsons	Cafe Serivces	Yes
Hospital Patient Guide	Patient Hospital Guide	Yes
CAFHS Liason Nurse	Child Health	Yes
Data & Voice Communications	Information Technology	Yes
VPRO Device Technologies	Information Technology	Yes
RHIMA	Washers	Yes
RL Solutions	Infection Control Surveillance	Yes
Riskman - Risk Management System	Risk Management System	Yes
WebPAS	Patient Managerment System Software	Yes
SAS (HRS)	Patient Management System Software	Yes
Murray Pest Control	Pest Control	Yes
Verifire Protection Services	Fire Safety Management	Yes
Kennards Hire	Maintenance	Yes
Konando	Building and Renovation Services	Yes
Haines Medical	Disposable Curtains	Yes
Spectrum Fire Service	Fire Safety Management	Yes
Jeff DeSouza - Lawson Risk Management	WHS - Claims Management	Yes
Exiis Envirservices	Infection Control Surveillance	Yes
Hill-Rom	Mattress Replacement	Yes
Hindmarsh Plumming	Plumming	Yes
Uniti Wireless	Communications	Yes
Hewlett Packard, Cisco, Palo Alto, Fortinet	Information Services Networking	Yes
Rauland Australia	Information Technology - Nurse Call	Yes
Comunet (SA)	Information Technology - Network	Yes
HillRom	Beds Electrical	Yes

Standard 1 - Clinical Governance

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

ACTION 1.01
The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews reports and monitors the organisation's progress on safety and quality performance
Comments
ACHA recognises Healthscope's substantial contribution to ACHA working and operating under a contract with Healthscope Operations Pty Ltd (Hospital Operations Management Agreement (HOMA)). To quote ACHA, '*Under this model, ACHA retains ownership of all assets, operations, and staff*.' Healthscope manages the operations and is subject to direction and review by the ACHA Board. ACHA and Healthscope have integrated safety and quality and risk management systems. With this respect, the ACHA Clinical Governance Plan (CGP) is an extension of the Healthscope CGP, which is also called the ACHA Safety and Quality Plan 2021-2025. This plan describes the elements of their Safety and Quality Framework. ACHA is striving to provide a safe and high-quality hospital environment for each of its three hospitals - Ashford, Flinders Private and The Memorial - which is heavily focused on developing a strong safety culture, based on learning, and sharing learnings from health-acquired complications (HACs), complaints, adverse events, and sentinel events, and developing and implementing actions to prevent reoccurrence and therefore, reduce the potential for harm recurring. The assessors conducted a review of the documentation that was available to them to ensure this information was 'consistent with the requirements of the ACSQHC Checklist for Assessors – Reviewing information accessed and actioned by the Governing Body'. Board minutes were made available and met these requirements. In addition, observation and interviews with key personnel, including the Board Chair and an additional Board member, the Chair of the Medical Advisory Committee, Executive staff from all three sites, and key clinicians (Intensivists, Anaesthetists, Proceduralists, and Nursing and Allied Health staff from many departments across the three hospital sites), demonstrated and strongly reinforced that a culture of safety and quality improvement had been established. The leadership team set the organisation's strategic direction and ensured that was very clearly communicated to all staff within the entire organisation. The ACHA Committee Structure has been revised with feedback from the last assessment to include a committee for Blood and Acute Deterioration (to assist with reporting of some of the National Standards), reporting to the Safety and Quality Committee. It was obvious from the minutes of these committee that the organisation takes a risk management approach underpins all aspects of clinical safety and quality. The 2022-23 CGP has the following eight pillars; Leadership and Culture, People and Partnerships, Clinical Data and Outcome, Managing Risk, Quality Improvement, Evidence Based Practice Building Staff Capability, and of course, the Patient Experience.

ACTION 1.01	
The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews reports and monitors the organisation's progress on safety and quality performance	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.02	
The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people	
Comments	
ACHA has taken on this action very seriously since the last accreditation assessment. Despite the relatively low representation of Aboriginal and Torres Strait Islander patients, the organisation is attempting to get a much more accurate knowledge of the true representation by having all staff, at entry points to the organisation, ask all patients in a respectful way (follow training using a video made in Victoria by Aboriginal Elders at one of the local Community Health Centres) about whether or not they identify as being of Aboriginal and / or Torres Strait Islander descent. An amazing 96% of staff have undertaken this mandatory training to date, and observation by the assessment team confirmed this occurs, even when they are not aware they are being observed. Having evidence of how many and which patients are from these backgrounds will allow the organisation to focus their attention to improve the clinical outcomes for these patients, utilising the knowledge and skills provided to staff to better build a respectful rapport with these patients. ACHA worked with at least one local Aboriginal Elder, as well as recruiting local Aboriginal artists, to paint commissioned artwork throughout the three hospitals. These are large pieces of artwork are immediately obvious on entry to the organisation. The 'welcome signs' are written in the native Aboriginal language. Pictorial displays, especially those leading to the Heart Centre at Ashford Hospital, tell the story of sick and unwell Aboriginal people coming to the hospital and leaving with a much better heart at the end. All attempts are being made to identify and provide more specific and targeted supports and services for these patients. The organisation meets the requirements of Advisory AS18/04.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.03	
The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality	
Comments	
Staff in key clinical governance leadership roles were able to articulate the organisation's Clinical Governance Framework. Senior Managers and Senior Clinicians were also able to explain to the assessment team how the Framework was utilised. They also described the changes that had been made because of the monitoring and reporting of its effectiveness relating to the 'culture of safety' within the ACHA hospitals. Staff on the floor were also very committed to providing a safe environment for their patients, and all who were asked said that they felt 'safe' about speaking up for safety, should they witness something that possibly could go wrong.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.04	
The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people	
Comments	
Interviews with staff and managers, supported by observation and documentary evidence, confirmed that ACHA has strategies in place to monitor the effectiveness of quality and safety initiatives aimed at improving health outcomes for Aboriginal and Torres Strait Islander people. The development of closer relationships with the local Aboriginal Elders has provided evidence of taking very seriously advice provided, despite the Health Service Aboriginal population being between 0.44% and 0.84% of the local population (average across all campuses of 0.65%). The organisation provided sufficient evidence of strong attempts to provide a service that meets the needs of both Aboriginal and Torres Strait Islander people. The organisation meets the requirements of Advisory AS18/04.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.05	
The health service organisation considers the safety and quality of health care for patients in its business decision-making	
Comments	
Interviews with senior managers and the Board, along with a review of minutes of relevant committee meetings, confirmed that issues of safety and quality are key factors in the organisation's business decision-making. Examples included the purchase of equipment to aid with the transfer and movement of bariatric patients, the relationships with local pathology providers to minimise risks associated with blood transfusions, and the installation of life-saving infrastructure in the Ashford Cardiac suite, which confirm that action is taken to reduce harm to staff and patients.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.06	
Clinical leaders support clinicians to: a. Understand and perform their delegated safety and quality roles and responsibilities b. Operate within the clinical governance framework to improve the safety and quality of health care for patients	
Comments	
The ACHA Clinical Governance Program sets out the vision and strategy to always support safe and high care delivery and clearly articulates staff roles and responsibilities across the eight domains of safer care as identified in Action 1.01. During discussions with clinical leaders within the three hospitals, it was obvious that they were all committed to providing a very high level of care, and that they took their clinical safety and quality responsibilities very seriously. They reported their role in monitoring the outcomes of care and steps they may or had taken to investigate lower than expected results and act to improve them along with their care team. Interviews with the Chair of the Medical Advisory Committee (MAC) and another senior member on the team reinforced that clinical leaders work within the governance framework, closely monitoring and acting of any areas of concern that arise.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.07	
The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements	
Comments	
Documents reviewed during the assessment visit, as well as interviews with Executive team members and other senior managers at ACHA Health, could demonstrate how policy documents, procedures, and protocols are managed to ensure they are current, comprehensive, effective, appropriately referenced, and comply with legislative and State requirements. This is supported by Healthscope. There were approximately 700 documents readily available to support staff, and they were easily and readily accessible. Most are reviewed every three years but a risk management approach was taken when defining the scheduled revision. Compliance is monitored through incident reporting, and trends influence the review and revision of specific documents.	
Suggestion(s) for Improvement	
Ensure policies are reviewed by their due date, as a few were identified as past their review date during the assessment visit.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.08	
The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems	
Comments	
ACHA Health was able to demonstrate it uses an organisation-wide quality improvement system. Governance documents outlining the safety and quality committee reporting structure, terms of reference and committee minutes, as well as discussions with staff and consumers during the assessment visit, confirmed this. Staff advised they received information on quality and safety performance and that ACHA Health actively supported this. The Safety and Quality Boards in all wards and departments were visible for staff, patients, and consumers. These displayed many indicators of performance and outcome data relevant to the area. Outcome data and information are used to continually drive improvement. This was evident in the actions arising from quality and safety reports in committee minutes, as well as comments on the ward and department boards identifying areas for attention and improvement locally.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.09	
The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: a. The governing body b. The workforce c. Consumers and the local community d. Other relevant health service organisations	
Comments	
ACHA Health ensures timely reports on safety and quality systems and performance to the Board, the executive, senior managers, the workforce, and consumers. In recent times, the ACHA Clinical Review Committee (CRC) had increased its frequency of reporting to the ACHA Medical Advisory Committee (MAC) and ACHA Board. Staff, including the Chair of the MAC, confirmed during interview how ACHA Health manages and reports on their safety and quality system. Reporting is through clinical committees and is undertaken through a range of appropriate reports demonstrated during the assessment visit. The Board Chair and medical representative on the Board, interviewed during the assessment visit, were able to provide confirmation of the reports they received relating to safety and quality. Staff, patients and consumers had performance indicators relevant to their areas displayed on their local Safety and Quality Boards.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.10	
The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters	
Comments	
The Board, Executive and senior staff, as well as the ACHA Risk/Quality Manager, explained during the assessment visit how risks are identified, managed, and reported. Information from a broad reporting base informs management and the Board to define and document risks. The ACHA Health risk register had 12 broad headings, including clinical, facility infrastructure, and financial risks, with over one hundred individual risks identified under the 12 headings. All risks had a nominated responsible manager, controls, and review dates. Regular monthly reports are provided to the ACHA Executive Committee and relevant Safety and Quality Committees. The ACHA Executive Committee's terms of reference clearly outlined the responsibility for monitoring risks and escalation of non-compliance. The individual hospitals have their own local risk registers with nominated responsible managers and review dates. The assessors saw evidence that the risk reporting system is actively managed. The MARS auditing system was implemented in 2022 and now enables live reporting of audit results for improved evaluating and management of the risk system.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.11
The health service organisation has organisation-wide incident management and investigation systems, and: a. Supports the workforce to recognise and report incidents b. Supports patients, carers and families to communicate concerns or incidents c. Involves the workforce and consumers in the review of incidents d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems
Comments
ACHA Health staff report incidents and near misses into the RiskMan incident reporting system. Documents reviewed, committee minutes, and interviews with staff confirmed an active and open culture of incident reporting. The quality managers provide analysis and trending reports of incidents to the relevant clinical committees overseeing safety and quality for ACHA Health. Trend analysis of incidents drives quality improvement activities. Identification of risks is documented and recorded on the risk register. Incident investigations are conducted and any areas for improvement are identified, with action plans to be reviewed by the relevant clinical committee.

Rating	Applicable HSF IDs
Met	All

ACTION 1.12
The health service organisation: a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework b. Monitors and acts to improve the effectiveness of open disclosure processes
Comments
ACHA Health has an Open Disclosure Policy and associated program that is consistent with the Australian Open Disclosure Framework. ACHA Health monitors how, why, when, and who is involved in open disclosure discussions. The assessors viewed these records that demonstrated 70 episodes of open disclosure were undertaken in the previous 12 months. 45 of these were by the VMOs. Examples of incidents requiring open disclosure were provided during the assessment visit. Staff were able to describe this policy and their role in initiating and participating in it.

Rating	Applicable HSF IDs
Met	All

ACTION 1.13
The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems
Comments
ACHA Health has a variety of mechanisms to gather feedback from patients, consumers, families, and staff about the quality of care provided at its three hospitals and associated departments. Feedback is actively sorted, analysed, and reported through the relevant safety and quality committees, as well as locally on the Safety and Quality Boards in all wards and departments. This was demonstrated in committee minutes reviewed during the assessment visit, as well as during interviews with staff, patients, and consumers. Staff and management provided examples of improvements undertaken because of feedback. One example was the 'Quiet Ward' or 'Shhh' posters in the ward areas reminding staff and visitors of the importance of a quiet, restful environment for patients.

Rating	Applicable HSF IDs
Met	All

ACTION 1.14
The health service organisation has an organisation-wide complaints management system, and: a. Encourages and supports patients, carers and families, and the workforce to report complaints b. Involves the workforce and consumers in the review of complaints c. Resolves complaints in a timely way d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e. Uses information from the analysis of complaints to inform improvements in safety and quality systems f. Records the risks identified from the analysis of complaints in the risk management system g. Regularly reviews and acts to improve the effectiveness of the complaints management system
Comments
ACHA Health has a complaints management policy and associated processes which were reviewed by the assessors during the assessment visit. This supports patients, families, and consumers to raise concerns and report complaints. It was evident that staff and management were involved in the review of complaints and all complaints were addressed in a timely manner. Analysis of complaints is undertaken and feedback reported to the relevant clinical committee, Executive, and the Board. It was reported there had been 200 complaints across ACHA Health in the previous 12 months, and timely action had been taken in addressing all of them. Actions are taken on individual complaints to inform improvements when indicated.

Rating	Applicable HSF IDs
Met	All

ACTION 1.15	
The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher risk groups into the planning and delivery of care	
Comments	
During the assessment visit, it was evident from discussions with the Executive team, as well as department managers, that ACHA Health is attentive to the demographics and characteristics of its patient population and has processes in place to identify and manage patients at higher risk because of their characteristics. This information and knowledge is also used in service planning and facility design. A good example of this is the development of the day procedure area for children at Memorial Hospital.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.16
The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used
Comments
At ACHA Health, the medical record remains paper-based and is available to clinicians at the point of care. Records can be retrieved out of hours and made available, particularly for Ashford Hospital, where the Emergency Department is open until late evening. Clinicians were able to describe how they use the medical record, and many records were reviewed by the assessment team in the wards, other clinical areas, and in the medical record departments. The record was arranged in such a way to support accurate, comprehensive, and timely documentation. The nursing and allied health assessments and progress notes were of high quality. The procedure area reports had improved in recent times with the implementation of Clinical Documentation Specialists to provide education and support on coding related documentation. An audit of 60 records for documentation compliance across the three hospitals had been undertaken in October 2022. The audit results were generally good across all hospitals, but medical discharge letters / summaries varied from 18-50% completed. The nursing discharge was 100% completed for this audit. Results of the audits are reported to the Comprehensive Care Committee and the Medical Advisory Committee. An action plan for a quality improvement activity to ensure all discharge letters completed in VMO rooms are copied and sent to the medical records departments for inclusion in the paper record was developed. Any reports or results provided electronically are referenced and printed to complete the paper record documentation. Medical records are securely maintained and comply with privacy legislation.

ACTION 1.16	
The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.17	
The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that: a. Are designed to optimise the safety and quality of health care for patients b. Use national patient and provider identifiers c. Use standard national terminologies	
Comments	
The MyHealth Record (MyHR) system was implemented during 2015/6 at all Healthscope sites, including ACHA Health. Event summaries (admission notifications) and Nursing Discharge Summaries are uploaded to MyHR with the patients consent. This is a highly automated process. Front office registration staff have had education on gaining consent for the upload of the information existing in WebPAS into MyHR. Education was provided in 2018 and again in 2021. For 2022, the MyHR uptake for this information was 25,982 at Ashford Hospital, 23,751 at Flinders Private Hospital, and 15,148 at Memorial Hospital. Just over 11% of patients had not consented to the information going into MyHR. ACHA continues to upload over 8,000 event / discharge summaries a month, with the patient's consent. ACHA Health adheres to standards that are externally tested to ensure the system that interacts with MyHR complies with standards set in place by NEHTA. The requirements of Advisory 18/11 have been met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.18	
The health service organisation providing clinical information into the My Health Record system has processes that: a. Describe access to the system by the workforce, to comply with legislative requirements b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system	
Comments	
ACHA has actively progressed the event Summaries and Nursing Discharge Summaries being uploaded to patient MyHR with patient consent. There is an ACHA policy that describes the authorised access. ACHA IT personnel have access for the purpose of monitoring the quality of the download of the event and discharge summaries that are uploaded into MyHR. The upload into MyHR is a highly automated process. The requirements of Advisory 18/11 have been met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.19	
The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation	
Comments	
The assessment team reviewed documentation detailing the orientation program provided to members of the Board and staff. There had been no new Board appointments since the previous assessment, but education on the quality and safety roles for Board members had been undertaken. Staff were able to describe the orientation program and the inclusion of safety and quality responsibilities covered. All new staff attended the orientation program. Position descriptions and performance reviews also covered these expectations and responsibilities.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.20
The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training
Comments
ACHA has policies and procedures to support orientation and training of their workforce. Position descriptions detail skills and competencies required of positions, as well as clarifying the importance of safety and quality responsibilities. A schedule of education activities, the orientation program, and other education and training programs were described and viewed by assessors during the assessment visit. Mandatory training compliance was monitored, and rates were provided on department and ward Quality and Safety Boards. They were noted to have high compliance rates. The new Proposed Matrix for Mandatory training was provided to assessors during the assessment visit. This has been developed to clarify mandatory training requirements for all staff. The eLearning modules were aligned to the NSQHS standards. The role-specific training had also been detailed and outlined in the same document, also aligned to the NSQHS standards. Overall, there were over 90 eLearning topics covered in the document. At the previous assessment, a recommendation was made to implement a mandatory training framework for VMOs that supported mutual recognition for training undertaken by medical staff at other health services, and also to develop specific training for VMOs whose sole hospital appointment was at ACHA Health. An action plan had been developed in 2019 to address this recommendation, and this was reviewed by the assessment team during the previous assessment. Actions included checking APHRA registration, and VMO and surgical assistant participation in observational audits for hand hygiene and aseptic technique. There was also to be a risk assessment for VMOs required to undertake BLS and aseptic technique training. Salaried medical officers were to undergo mandatory training with reports on compliance monitored through the General Manager and the ACHA Patient Care Committee. It was noted all MET / Code Blue teams responding to clinical deterioration are employed staff. Another action was to implement a process to capture details of the VMOs undertaking training at other health services. At the time of this assessment visit, it was noted VMOs and surgical assistants were not employed staff, and when the action plan had been reviewed by ACHA Health, there had been an assumption VMOs and surgical assistants were not included as staff in this action, and actions relating to them had not been undertaken. During the current assessment visit, it was clarified with the Australian Commission on Quality and Safety that VMOs and surgical assistants were included as workforce in Action 1.20. The assessors noted 75% of the VMOs had a public hospital appointment where it was likely mandatory training was being undertaken. The salaried medical officers were undertaking mandatory training, however, the SMO numbers and compliance with ALS and aseptic technique report had to be completed manually to be provided to the assessors to check for the SMOs working at the time of the assessment. For this, 37 SMOs compliance with ALS was 80%, and aseptic technique was 72%. Observational audit results for medical staff were also provided.

ACTION 1.20		
The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training		
An updated action plan was developed during the assessment visit in which credentialed VMOs and surgical assistants were included in the mandatory training requirements. Of the 1,500 VMOs, 508 were assessed to be in high-risk clinical areas, and 72% of these had public hospital appointments.		
Rating	**Applicable HSF IDs**	**Recommendation(s) / Risk Rating & Comment**
NM	All	**Comment:** The recommendation made for this action at the previous assessment had not been undertaken as it related to VMOs and surgical assistants who had not been categorised as workforce for ACHA Health, in accordance with the Commissions Fact Sheet – Key Actions for Health Service Organisations – Training Requirements for credentialed practitioners (2019). An updated action plan to address this action was developed during the assessment visit. The risk has been assessed as moderate as salaried medical officers attend all MET /Code Blue calls. **Recommendation:** Finalise the updated action plan to address the mandatory training of VMOs and surgical assistants, and ensure that work is undertaken to implement it, with particular attention on the following four areas as the priority: 1. Develop a process to capture the mandatory training undertaken by VMOs and surgical assistants at public hospitals and document this and periodically update it. 2. Risk rate the training requirements of VMOs and surgical assistants who do not have public hospital appointments or have not undertaken the required mandatory training. 3. Ensure the training requirements of the 25% of VMOs and surgical assistants who do not have public hospital appointments are completed according to the training prescribed following the risk assessment of their training requirements. 4. Ensure all salaried medical officers undertake mandatory training and compliance is monitored. **Risk Rating:** Moderate

ACTION 1.21	
The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients	
Comments	
An Aboriginal and Torres Strait Islander Cultural Awareness program (Cultural Awareness and Sensitivity Training) is part of mandatory training for staff. The program has been reviewed by Healthscope Aboriginal advisors, and advice has been sought from local Aboriginal Elder to implement more localised 'on country' training. The program and training records were reviewed by assessors, and current attendance rates are currently being monitored to meet KPI of 92%. The requirements for AS18/04 have been met.	
Suggestion(s) for Improvement	
ACHA to continue to monitor the compliance to the Cultural Awareness and Sensitivity Training program.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.22
The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system
Comments
At ACHA, staff performance reviews are conducted annually for all staff. In recent times, a new performance program had been implemented by Healthscope for the executive and senior management staff. This was discussed favourably by the staff interviewed during the assessment visit who had undertaken this process. Other staff had performance reviews undertaken with their managers by the existing in-house performance review process. The rates of compliance were reported on the department and ward Quality and Safety Boards. Rates were generally high. Education and training plans were discussed during the performance review and opportunities were identified and followed up by ACHA Health to enhance education and training opportunities for individual staff and organisationally, when appropriate. Staff interviewed during the assessment visit were able to describe the performance review process. The VMOs and surgical assistants were not involved in this performance review process described above, but had reports completed at the time of appointment and reappointment. These reports were completed by peer consultant medical staff. All VMOs and surgical assistants must also sign they had read and agree to the Medical Services Regulations which outline many aspects of performance review. The Medical Advisory Committee Chair confirmed the importance of performance review being part of the credentialing and appointment process of VMOs and surgical assistants. Two peer medical staff must provide a written report, including the professional, technical skills, educational activities, peer review and quality activities. These reports are included in the CGov database and must be completed for the applicant to progress the appointment.

Rating	Applicable HSF IDs	Recommendation(s) / Risk Rating & Comment
MWR	All	**Comment:** During the assessment visit, examples of the reports completed for VMOs and surgical assistants were viewed by assessors. While many met the items covering performance review, not all aspects were always completed. The Medical Advisory Committee does not review the individual referee reports when processing the applications but confirm that they have been completed. **Recommendation:** ACHA Health to implement processes to ensure all referee reports for VMOs and surgical assistants are checked for appropriate performance review information by the general managers of each hospital prior to submission to the Medical Advisory Committee for appointment endorsement. **Risk Rating:** Moderate

ACTION 1.23	
The health service organisation has processes to: a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan b. Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered	
Comments	
ACHA Health utilises CGov to support the documentation and processing of VMO and surgical assistant appointments. Policies and procedures guide the process. Credentialling is initially for one year, and then recredentialing occurs every five years. The process is overseen by the General Managers at each hospital and the ACHA Health CEO. The Medical Advisory Committee endorses the credentialling and appointments. Defining the scope of practice is reviewed and handled competently and renewed at each reappointment, or if the practitioner changes scope of practice in between due to new technologies or reducing their scope. Schedule 4 of the Medical Services Regulations provides a comprehensive list of scope of practice options by craft group. The requirements of Advisory 18/12 have been met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.24	
The health service organisation: a. Conducts processes to ensure that clinicians are credentialed, where relevant b. Monitors and improves the effectiveness of the credentialing process	
Comments	
Credentialling is overseen by the General Managers at each hospital and the ACHA CEO. The Medical Advisory Committee reviews and endorses the credentialing and scope of practice. All professions subject to professional registration requirements are monitored and checked on the AHPRA database by the relevant professional head. The credentialing processes are monitored and reviewed to ensure they remain appropriate and robust. Re-credentialing is undertaken one year after the first appointment for VMOs and surgical assistants, and then five yearly unless there is a change in between. The requirements of Advisory 18/12 have been met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.25	
The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff	
Comments	
ACHA Health staff, interviewed in the wards and departments during the assessment visit, were able to describe their role in safety and quality of care for patients. This included contracted services staff. The orientation program, as well as local orientation for wards and departments, included information and support for staff to understand and perform these roles. Quality and Safety Boards in ward and departments reinforced these responsibilities displaying many outcome indicators of the patient care in that area.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.26	
The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate	
Comments	
Clinicians at ACHA Health are provided with appropriate supervision for their level of role and responsibility. This is supported by the organisational structure, with General Managers and members of the Executive team available and able to intervene, if clinically required. After-hours access to medical staff is provided by salaried medical officers who are available at all three hospitals, 24 hours a day. VMOs are always available after hours to provide advice or to return to review their patients, if required. This requirement is clearly set out in the Medical Services Regulations and is a condition of their appointment.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.27	
The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care	
Comments	
ACHA Health provides clinicians with a range of decision support tools, best practice guidelines, care pathways, and clinical care standards to support their clinical practice. Performance reviews provide an opportunity for clinical staff to request additional evidence-based documents. For example, it was noted ACHA Health had imported well-established clinical guidelines from Monash Children's Hospital for their paediatric care as their decision support tools. Staff did comment on the benefits of access to library services that were no longer available for undertaking literature reviews. This may be possible to review and reinstate. ACHA Health is compliant with Advisory 18/12(b) and ACSQHC Fact Sheet 11.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.28
The health service organisation has systems to: a. Monitor variation in practice against expected health outcomes b. Provide feedback to clinicians on variation in practice and health outcomes c. Review performance against external measures d. Support clinicians to take part in clinical review of their practice e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems f. Record the risks identified from unwarranted clinical variation in the risk management system
Comments
Clinical variation is monitored and reviewed by individual clinicians, clinical committees, and governance committees at ACHA Health. Clinical data reports from registries, HAC reports, as well as comparative indicator reports from ACHS and Healthscope, are used to inform individual and aggregate performance. Clinicians are involved in clinical reviews, and these are used to inform changes where required. The Medical Advisory Committee and other committee minutes and agendas provided evidence of the type of clinical indicators and reports being reviewed by the clinical groups, and evidence of actions being undertaken to minimise clinical variation, when warranted, to address these. The Colonoscopy Clinical Standard requires recording and reviewing performance indicators. These indicators relate to: 1. Proportion of patients scheduled for colonoscopy whose bowel preparation was adequate. 2. Proportion of patients undergoing colonoscopy who have their entire colon examined. 3. Proportion of patients who had a colonoscopy that detected one or more adenoma(s). 4. Proportion of patients who had a colonoscopy that detected one or more sessile serrated adenoma(s) or sessile serrated polyp(s). The Medical Advisory Committee recently discussed and endorsed these indicators being collected and reviewed at ACHA Health at the organisational level. This is required to meet Advisory 18/12 (1.28a).

Rating	Applicable HSF IDs	Recommendation(s) / Risk Rating & Comment
MWR	All	**Comment:** The Colonoscopy Clinical Care standard requires the collection and monitoring of four performance indicators to meet the Advisory 18/12 (1.28a). **Recommendation:** ACHA Health to monitor and review the performance indicators relating to the Colonoscopy Clinical Care Standard in line with Advisory 18/12. **Risk Rating:** Moderate

ACTION 1.29	
The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose	
Comments	
A review of documentation relating to maintenance, as well as staff interviews and observations by the assessment team, substantiated that preventative and restorative maintenance is undertaken to ensure the maintenance of buildings, plant, equipment, utilities, devices, and other infrastructure. It was confirmed that they are fit for purpose. Safety and improvements in the environment are considered in any service planning and capital works. Staff were able to describe and demonstrate how to log a job for a maintenance issue, and the team reported responses were timely.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.30	
The health service organisation: a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required	
Comments	
ACHA Health is attentive to risk screening patients who may have unpredictable behaviours due to their clinical or cognitive conditions. Strategies were demonstrated during the assessment visit on attention to patient placement and utilizing bedrooms with natural light or close to the nurse's station in wards to minimise risk of harm from unpredictable behaviours. An improvement project had been undertaken to impress the importance of a quiet environment for patients following feedback from patients and their families. Posters at ward entry points remind visitors and staff of the importance of a quiet, calm environment for patients care delivery.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.31	
The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose	
Comments	
ACHA Health hospitals are all different in design and age, but all had appropriate directional signage which was as clear as possible given the nature of the design of the buildings. Assessors were generally able to find their way to wards and departments in the unfamiliar environment.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.32	
The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so	
Comments	
Visiting hours were specified in different clinical locations, but interviews with patients and staff reported flexible arrangements were possible depending on the patient and carer or family circumstances. Patients interviewed did not raise any issues about visiting arrangements and confirmed the flexible approach.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.33	
The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people	
Comments	
ACHA demonstrated a welcoming environment and showed an understanding of the cultural beliefs and practices of the Aboriginal and Torres Strait Islander people. Paintings by local Indigenous artists were displayed on walls, symbols of welcome greeted people to the health service, and murals led Aboriginal patients to the 'Heart Centre' along the locally identified journey informed by local Elders.	
Rating	**Applicable HSF IDs**
Met	All

Standard 2 - Partnering with Consumers

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

ACTION 2.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for partnering with consumers b. Managing risks associated with partnering with consumers c. Identifying training requirements for partnering with consumers	
Comments	
Interviews with staff and patients, together with a review of policies and procedures supporting partnering with consumers, show that the principles of safety and quality are applied when these documents are developed. Consumers are engaged in policy development, implementation, and training. They assist the organisation in identifying risks associated with partnering with consumers and inform risk mitigation. Training is provided to staff at orientation on partnering with consumers, and consumer representatives report they are involved in this training.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring processes for partnering with consumers b. Implementing strategies to improve processes for partnering with consumers c. Reporting on partnering with consumers	
Comments	
A review of documentation and interviews with staff and consumers confirmed that the organisation aims to improve partnerships with consumers at all levels. The assessors observed how these strategies are monitored and how the organisation reports on partnering with consumers. ACHA have continued to be committed in this area and imbedded a number of strategies to achieve positive outcomes for partnering with consumers.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.03	
The health service organisation uses a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights b. Easily accessible for patients, carers, families and consumers	
Comments	
A review of ACHA hospitals demonstrated that the Charter of Rights, consistent with the Australian Charter of Healthcare Rights, is readily available throughout, and that action is taken to ensure that it can be easily accessed and understood.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.04	
The health service organisation ensures that its informed consent processes comply with legislation and best practice	
Comments	
Interviews with staff indicated that they understood their responsibilities with respect to informed consent. The consent policy and processes comply with legislation and reference best practice. Compliance with informed financial consent is audited, and compliance is reported as 100% as of June 2022. The requirements of Advisory 18/10 have been met with respect to informed financial consent.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.05	
The health service organisation has processes to identify: a. The capacity of a patient to make decisions about their own care b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves	
Comments	
A review of documentation shows there are processes in place to establish a patient's capacity to make decisions regarding their own care, plus the process to be followed if a substitute decision-maker is required. Staff were able to articulate this process and access the relevant policy.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.06	
The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care	
Comments	
Interviews with patients and clinicians confirmed that staff work with patients, or a substitute decision-maker, in shared decision-making about their care planning and goals of care. The bedside care boards are a strategy for both staff and patients to engage in these conversations.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.07	
The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care	
Comments	
Staff and patients were able to describe to the assessors how patients are actively involved in their care. Satisfaction surveys undertaken by the organisation also support that patients are satisfied with the level of engagement in their care.	
Suggestion(s) for Improvement	
It will be important to continue to audit and monitor feedback from patients / carers and act on feedback.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.08	
The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community	
Comments	
A review of documentation and interviews with staff and consumers confirmed that the organisation is committed to improve partnerships with consumers at all levels. The assessors observed how these strategies are monitored and how the organisation reports on partnering with consumers. The diversity of the local community has informed communication and information that is available that reflects this diversity. Patient satisfaction with communication and information provided to them is included in satisfaction surveys and is reported positively. This was also corroborated by patient interviews. ACHA has imbedded a number of strategies to achieve positive outcomes for addressing the needs of diverse communities.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.09	
Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review	
Comments	
Documentation reviewed by the assessment team, and interviews with consumer representatives, confirmed that any internally developed information has been reviewed by consumers to ensure that it is understandable and meets their needs. All brochures / pamphlets that have been reviewed by consumer representatives are clearly identified. Consumer representatives reported that they felt valued and could demonstrate where their feedback was acted upon.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.10	
The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided on discharge	
Comments	
Clinicians were able to articulate how they effectively partner with patients in their care whilst accessing services provided by the organisation, and how they work with patients to support their ongoing care needs. Patient satisfaction with the information provided to them is reported as high, as is their satisfaction with discharge planning. Patients who were interviewed by assessors also confirmed that they felt information was provided to them in a manner and format they could understand.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.11	
The health service organisation: a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community	
Comments	
Interviews with members of the Consumer Representative Committees confirmed their active role in the governance and evaluation of health care across this organisation. This is supported by the role consumers play on a range of key committees and groups across the ACHA hospitals. In seeking feedback on service delivery, the organisation engages various mechanisms that encourage input from a diverse range of consumers and from the broader community as required.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.12	
The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation	
Comments	
Documentation and interviews with consumer representatives confirmed that they felt supported in their roles. This includes orientation for consumer representatives and ongoing education where needed. Consumer representatives reported being satisfied with the level of support provided to them, and also stated that the organisation was responsive to their information needs in interpreting data / reports/ documents etc.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.13	
The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs	
Comments	
The organisation has pursued a range of activities to better partner with local Aboriginal and Torres Strait Islander communities, and to better understand and meet their specific and unique healthcare needs. Staff interviews and a review of documents confirmed that the organisation actively engages with local Aboriginal and Torres Strait Islander Elders and seeks their input into service planning and care.	
Suggestion(s) for Improvement	
ACHA to continue to seek input and liaise with local Aboriginal and Torres Strait Islander communities.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.14	
The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce	
Comments	
Consumer representatives and managers were able to explain how the organisation works with consumers to incorporate their views and experiences into training and education for the workforce. Staff interviewed were also able to provide examples of this training. Training records and programs were reviewed by the assessment team to support this occurring.	
Rating	**Applicable HSF IDs**
Met	All

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

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

ACTION 3.01	
The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for infection prevention and control b. Identifying and managing risks associated with infections c. Implementing policies and procedures for antimicrobial stewardship d. Identifying and managing antimicrobial stewardship risks	
Comments	
There are ACHA policies, procedures, and guidelines to guide, monitor, and improve infection prevention and control. HICMR provides and supports detailed guidance on infection prevention and control practices, including risk-based precautions. Staff were able to describe how they relate to managing infection control. As a result, the Hospital Acquired Infection rate is very low. Infection prevention and management risks are entered into RiskMan and included on the risk register. Antimicrobial Stewardship (AMS) governance has strong leadership and numerous references, tools, and educational resources.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.02
The health service organisation: a. Establishes multidisciplinary teams to identify and manage risks associated with infections using the hierarchy of controls in conjunction with infection prevention and control systems b. Identifies requirements for, and provides the workforce with, access to training to prevent and control infections c. Has processes to ensure that the workforce has the capacity, skills and access to equipment to implement systems to prevent and control infections d. Establishes multidisciplinary teams, or processes, to promote effective antimicrobial stewardship e. Identifies requirements for, and provides access to, training to support the workforce to conduct antimicrobial stewardship activities f. Has processes to ensure that the workforce has the capacity and skills to implement antimicrobial stewardship g. Plans for public health and pandemic risks
Comments
The ACHA Infection Control Committee has the overarching governance across all sites. This Committee is supported by an Infection Control Nurse at each site, ward Champions, and access to an Infectious Diseases Physician. Terms of reference clearly describe their responsibilities of monitoring and improving infection prevention and the effectiveness of the surveillance system and workforce training. There is an ACHA Infection Prevention and Control Management Plan 2022 – 25. The Antimicrobial Stewardship program (AMS) complies with policy, and all infection risks are reported for ongoing monitoring and implementation of improvements. Training and education on Preventing and Controlling Infections (PCI) is an ongoing requirement for clinicians. Mandated PCI Practice is assessed regularly, and those specific to PCI, including hand hygiene and aseptic technique, show results above the benchmark. The organisation is compliant with Advisory AS22/02.

Rating	Applicable HSF IDs
Met	All

ACTION 3.03
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of infection prevention and control systems b. Implementing strategies to improve infection prevention and control systems c. Reporting to the governance body, the workforce, patients and other relevant groups on the performance of infection prevention and control systems d. Monitoring the effectiveness of the antimicrobial stewardship program e. Implementing strategies to improve antimicrobial stewardship outcomes f. Reporting to the governance body, the workforce, patients and other relevant groups on antimicrobial stewardship outcomes g. Supporting and monitoring the safe and sustainable use of infection prevention and control resources
Comments
There is a comprehensive auditing schedule for PCI and AMS systems, and audit results are provided to individual units and departments. In addition, aggregate data is provided through the governance structure. Infection control and AMS are discussed at the Infection Control Committee and MAC, and strategies are documented to improve performance where gaps are identified. ACHA has implemented numerous strategies to improve infection control, including, Champions to promote best practice, infection control programs, communication, and the infection control leads.

Rating	Applicable HSF IDs
Met	All

ACTION 3.04
Clinicians use organisational processes consistent with the Partnering with Consumers Standard when assessing risks and preventing and managing infections, and implementing the antimicrobial stewardship program to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Comments
There are numerous and appropriate brochures available for patient information. Some brochures are specific to the identified potential risk and clinicians explain to the patient what the brochure is about and confirm that they understand. Patients interviewed by members of the assessment team were able to describe the actions taken to involve and inform them about infection prevention and control and AMS measures. Feedback is sought regularly on infection-related information.

Rating	Applicable HSF IDs
Met	All

ACTION 3.05
The health service organisation has a surveillance strategy for infections, infection risk, and antimicrobial use and prescribing that: a. Incorporates national and jurisdictional information in a timely manner b. Collects data on healthcare-associated and other infections relevant to the size and scope of the organisation c. Monitors, assesses and uses surveillance data to reduce the risks associated with infections d. Reports surveillance data on infections to the workforce, the governing body, consumers and other relevant groups e. Collects data on the volume and appropriateness of antimicrobial use relevant to the size and scope of the organisation f. Monitors, assesses and uses surveillance data to support appropriate antimicrobial prescribing g. Monitors responsiveness to risks identified through surveillance h. Reports surveillance data on the volume and appropriateness of antimicrobial use to the workforce, the governing body, consumers and other relevant groups
Comments
Healthcare infection surveillance is voluntary for SA Health. However, ACHA conducts regular surveillance on Surgical Site Infections (SSI), SABSIs, C Difficile, Multi-Resistant Organisms (MRO), intravascular devices, and notifiable outbreaks. These are monitored and reported to the ACHA Infection Control Committee and for ownership back to the Ward. Audits showed few SSIs were reported. ACHS uses clinical and other data to support risk assessments, and reviews and acts on assessments to improve infection prevention and control effectiveness. IPC performance is discussed by the Executive routinely with feedback to the workforce, and assessors recognised the amount of work to address any results requiring action and feedback.

Rating	Applicable HSF IDs
Met	All

ACTION 3.06
The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare, jurisdictional requirements, and relevant jurisdictional laws and policies, including work health and safety laws
Comments
Infection control documents, including policies, procedures, medical history forms, signages, and other PCI resources demonstrated that the ACHA processes are fully consistent and compliant with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare. Post pandemic, staff are fully aware of, and familiar with, both standard and transmission-based precautions, and these remain in place to be utilised as and when required. The assessment team observed very high levels of both hand hygiene and standard precautions at all times whilst observing staff in clinical areas.

Rating	Applicable HSF IDs
Met	All

ACTION 3.07
The health service organisation has: a. Collaborative and consultative processes for the assessment and communication of infection risks to patients and the workforce b. Infection prevention and control systems, in conjunction with the hierarchy of controls, in place to reduce transmission of infections so far as is reasonably practicable c. Processes for the use, training, testing and fitting of personal protective equipment by the workforce d. Processes to monitor and respond to changes in scientific and technical knowledge about infections, relevant national or jurisdictional guidance, policy and legislation e. Processes to audit compliance with standard and transmission-based precautions f. Processes to assess competence of the workforce in appropriate use of standard and transmission-based precautions g. Processes to improve compliance with standard and transmission-based precautions
Comments
Infection risks are communicated to staff, patients, family, and carers in an effort to minimise the transmission of infection both within and external to the organisation. There were multiple points throughout each hospital encouraging and offering people the ability to use both hand hygiene products and surgical masks (although not mandated at this point in SA). The pandemic has instilled a greater staff and public awareness of infection prevention and control systems such as the use of PPE (masks, gloves and gowns) and standard and transmission-based precautions which have been implemented as required. Monitoring of these PCI measures has been implemented to ensure compliance. In addition, competency-based assessments are regularly conducted to minimise the risk of transmission of infection in any of the three hospitals. ACHA has clearly demonstrated that it has worked within the relevant national and / or jurisdictional legislation, policy, and guidance to enable rapid action is being taken to address emerging threats and novel infections.

Rating	Applicable HSF IDs
Met	All

ACTION 3.08
Members of the workforce apply standard precautions and transmission-based precautions whenever required, and consider: a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated during care b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs and patient placement to prevent and manage infection risks d. The risks to the wellbeing of patients in isolation e. Environmental control measures to reduce risk, including but not limited to heating, ventilation and water systems; workflow design; facility design; surface finishes f. Precautions required when a patient is moved within the facility or between external services g. The need for additional environmental cleaning or disinfection processes and resources h. The type of procedure being performed i. Equipment required for routine care
Comments
Staff interviewed during the assessment could identify those procedures that were available in relation to implementing standard and transmission-based precautions and all staff, including non-clinical staff, have been provided with education appropriate to their role. Staff were able to confirm their use and understanding of these measures and risk screening procedures. Each of the three hospitals are designed to effectively manage infection risks with the aid of single rooms and in some cases, negative pressure rooms, environmental control management such as restricted access/visiting, and strict cleaning practices which were consistent with PCI policies and procedures.

Rating	Applicable HSF IDs
Met	All

ACTION 3.09	
The health service organisation has processes to: a. Review data on and respond to infections in the community that may impact patients and the workforce b. Communicate details of a patient's infectious status during an episode of care, and at transitions of care c. Provide relevant information to a patient, their family and carers about their infectious status, infection risks and the nature and duration of precautions to minimise the spread of infection	
Comments	
All patients admitted to any of the three hospitals that make up ACHA undergo an extensive screening process, mostly designed around the individualised needs of each and every individual as part of the construction of an individual Comprehensive Care Plan. The communication of a patient's infectious status is included as part of this assessment process, and this information is then conveyed to all staff who will be responsible for the ongoing care of that patient at any transfer of care or handover points along the patient journey. Compliance with the transfer of this vital information is monitored both as part of the clinical handover and discharge processes, but also by the PCI processes. During the patient's stay, carers, families, and visitors are alerted to precautions that may be required if the patient has a Multi-Resistant Organism (MRO) or infectious condition.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.10	
The health service organisation has a hand hygiene program that is incorporated in its overarching infection prevention and control program as part of standard precautions and: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with benchmarks and the current National Hand Hygiene Initiative c. Provides timely reports on the results of hand hygiene compliance audits, and action in response to audits, to the workforce, the governing body, consumers and other relevant groups d. Uses the results of audits to improve hand hygiene compliance	
Comments	
The Hand Hygiene program is consistent with the current National Hand Hygiene Initiative (HHI) as well as jurisdictional requirements. The organisation has access to Gold Standard Hand Hygiene auditors, the majority of whom are infection control nurses / consultants. Regular monitoring of compliance via observational audits to each of 'the five moments for hand hygiene' are undertaken and provided to staff and through the governance structure, which involves the Infection Control Committee. Current compliance rates vary between hospitals and individual wards / departments /units; however, all rates are proudly displayed on the quality boards in each area, with the majority sitting around 90-93%. In addition, the organisation is fully compliant with the requirements of Advisory AS22/02 in relation to hand hygiene.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.11	
The health service organisation has processes for aseptic technique that: a. Identify the procedures in which aseptic technique applies b. Assess the competence of the workforce in performing aseptic technique c. Provide training to address gaps in competency d. Monitor compliance with the organisation's policies on aseptic technique	
Comments	
Regular monitoring of compliance with aseptic technique is conducted via observational audits during surgical and interventional procedures. Processes for aseptic technique are in place in the form of procedures and training, both at the undergraduate and post-graduate levels. Staff competency / compliance is monitored, and unfortunately, the results observed within the organisation showed less than optimal compliance with the requirements of aseptic technique. The organisation is compliant with the requirements of Advisory AS22/02 in relation to aseptic technique.	
Suggestion(s) for Improvement	
To improve the education / training and competency of theatre and interventional proceduralists in aseptic technique based on the last observational audit which recorded a VMO aseptic procedure compliance rate of around 80-82%, and scrub and scout nurse compliance rates of around 90-92%.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.12	
The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare	
Comments	
Training and assessment for the management of invasive devices has been made available to staff, and this training aligns with the current legislation. As per Action 3.11 (aseptic technique), observational audits demonstrated less than ideal results, with some rates of aseptic technique as low as 80% in the operating theatre / procedure room. So far, no correlation has been identified between post-operative / procedural infection rates that are monitored and reported, although no reports such as this were observed. A suggestion for improvement has been provided to ensure there is no correlation between low aseptic compliance rates and post-surgical infections.	
Suggestion(s) for Improvement	
Identify any post-procedure / operative infections that may have occurred in the locations audited during this reporting period to see if there is any correlation / opportunity for improvement.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.13
The health service organisation has processes to maintain a clean, safe and hygienic environment – in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare and jurisdictional requirements – to: a. Respond to environmental risks, including novel infections b. Require cleaning and disinfection using products listed on the Australian Register of Therapeutic Goods, consistent with manufacturers' instructions for use and recommended frequencies c. Provide access to training on cleaning processes for routine and outbreak situations, and novel infections d. Audit the effectiveness of cleaning practice and compliance with its environmental cleaning policy e. Use the results of audits to improve environmental cleaning processes and compliance with policy
Comments
Cleaning procedures and schedules follow the SA Health Cleaning Standards, with regular auditing and reports made available through the governance structure. Cleaning standard audits are consistently at or above benchmark targets. ACHA conducted a review of the environmental cleaning products in use and made changes, as necessary. The assessment team visited the sites within ACHA and observed some had ageing infrastructure, but were clean and well-maintained. The Environmental & Equipment Cleaning audits demonstrate high compliance across all sites. The workforce has completed training on cleaning processes for routine cleaning, outbreak situations, and novel infections.

Rating	Applicable HSF IDs
Met	All

ACTION 3.14
The health service organisation has processes to evaluate and respond to infection risks for: a. New and existing equipment, devices and products used in the organisation b. Clinical and non-clinical areas, and workplace amenity areas c. Maintenance, repair and upgrade of buildings, equipment, furnishings and fittings d. Handling, transporting and storing linen e. Novel infections, and risks identified as part of a public health response or pandemic planning
Comments
New and existing equipment undergo rigorous testing for trialling, training, and ongoing infection control safety. The infection risks are considered and include water quality testing and contract management. The management of linen at each site is handled well, with designated areas for clean and soiled linen. The assessors were informed the linen truck is cleaned between the transport of dirty linen and loading of clean linen. The attention to segregating, storing, and disposal of all waste meets standards.

Rating	Applicable HSF IDs
Met	All

ACTION 3.15
The health service organisation has a risk-based workforce vaccine preventable diseases screening and immunisation policy and program that: a. Is consistent with the current edition of the Australian Immunisation Handbook b. Is consistent with jurisdictional requirements for vaccine preventable diseases c. Addresses specific risks to the workforce, consumers and patients
Comments
There is a workforce immunisation program in place that is attempting to comply with the jurisdictional policy and national guidelines to avoid vaccine-preventable diseases. The immunisation status of all staff is now captured during the recruitment process to ensure 100% compliance with the national guidelines, meaning that employment with the organisation cannot commence until the vaccination status has been fully verified. As there is a gap between staff working in the organisation for years and the newest recruits, the organisation is busy testing all staff to identify their immunisation status based on their serology results, and an extra effort is being undertaken to catch up any 'under-vaccinated staff' to improve their immunisation status. There is an annual influenza vaccination program and COVID-19 vaccination program in place. The results of the general immunisation program are sub-optimal and require some additional time and effort to correct. Current results arising from the ACHS Infection Control Clinical indicators for H2 2022, are as follows: • Hepatitis B immunisation: Ashford 56%, Flinders 78%, and The Memorial 67%. • Influenza immunisation: Ashford 6%, Flinders 4%, and The Memorial 16%. • MMR immunisation: Ashford 46%, Flinders 84%, and The Memorial 62%. • Pertussis immunisation: Ashford 8%, Flinders 82%, and The Memorial 20%. • Varicella immunisation: Ashford 34%, Flinders 70%, and The Memorial 46%. In relation to immunisation for COVID-19 and Influenza, the rates are as follow for the three ACHA hospitals contained in a different report which related to FIT testing of P2/N95 masks: • COVID-19: Ashford 63.6%, Flinders 64.7%, and The Memorial 83.3%. • Influenza: Ashford 49.1%, Flinders 51.4%, and The Memorial 67.8%. These results, while much better, still reflect an opportunity for improvement in staff safety.
Suggestion(s) for Improvement
Continue to identify any ‘under-immunised’ staff in line with the National Immunisation Guidelines for Health Care Workers (HCW) and progress their immunisation status to maximise the chances of avoiding vaccine-preventable diseases in the workplace, particularly in relation to COVID-19 and influenza.

Rating	Applicable HSF IDs
Met	All

ACTION 3.16	
The health service organisation has risk-based processes for preventing and managing infections in the workforce that: a. Are consistent with the relevant state or territory work health and safety regulation and the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare b. Align with state and territory public health requirements for workforce screening and exclusion periods c. Manage risks to the workforce, patients and consumers, including for novel infections d. Promote non-attendance at work and avoiding visiting or volunteering when infection is suspected or actual e. Monitor and manage the movement of staff between clinical areas, care settings, amenity areas and health service organisations f. Manage and support members of the workforce who are required to isolate and quarantine following exposure to or acquisition of an infection g. Provide for outbreak monitoring, investigation and management h. Plan for, and manage, ongoing service provision during outbreaks and pandemics or events in which there is increased risk of transmission of infection	
Comments	
ACHA has a risk-based approach and processes for preventing and managing infections in the workplace. There are policies and procedures consistent with jurisdictional regulations to prevent and manage these infections for employees at risk, and there is guidance for employees with blood and body fluid exposure. There is an annual influenza vaccination program. Records of workplace allocation include both appointed and locum staff. The program for workforce screening and workplace exclusion is aligned with SA Health directions. A tiered approach to outbreak and pandemic planning and management is in place.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.17
When reusable equipment and devices are used, the health service organisation has: a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying • the patient • the procedure • the reusable equipment, instruments and devices that were used for the procedure c. Processes to plan and manage reprocessing requirements, and additional controls for novel and emerging infections.
Comments
ACHA has processes for quality management of reprocessing reusable equipment, instruments, and devices that are consistent with national and international standards and manufacturers guidelines. Assessors discussed the current work underway to upgrade the CSSD Department at Flinders Private Hospital and the scope of reprocessing and storage upgrades at Ashford and Flinders Private Hospitals. The works are due for completion by the end of 2023 and ACHA will then comply with and fully meet the requirements of the Australian Commission on Safety and Quality in Health Care (ACSQHC) Advisory AS18/07 (published 15 November 2022) regarding compliance with AS4187. Interviews with management and staff involved in reprocessing reusable medical devices confirmed that relevant national standards are followed. The segregation of clean and dirty activities has unidirectional flow practices to reduce the risk of cross-contamination. Reprocessed sterile stock is stored, as per recommendations, in compliant shelving. An electronic traceability process facilitates routine monitoring and recall when required. Staff who reprocess reusable medical devices have completed the education and annual competencies as per training provisions. Water quality is tested, monitored, and concerns resolved. Storage of sterile stock in wards was appropriate.

Rating	Applicable HSF IDs
Met	All

ACTION 3.18
The health service organisation has an antimicrobial stewardship program that: a. Includes an antimicrobial stewardship policy b. Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing c. Has an antimicrobial formulary that is informed by current evidence based Australian therapeutic guidelines and resources, and includes restriction rules and approval processes d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard e. Acts on the results of antimicrobial use and appropriateness audits to promote continuous quality improvement
Comments
ACHA has established an antimicrobial stewardship (AMS) program that is guided by evidence-based policy. Resources are available to staff, and processes are in place to define the restriction and rules with respect to antimicrobial use. ACHA, in liaison with HPS pharmacies, reviews the surgical prophylaxis procedures and guidelines to promote AMS within its hospitals, and complies with the requirements of Advisories 18/08 and 21/02 and the ACSQHC Fact Sheet 11(3.15d).

Rating	Applicable HSF IDs
Met	All

ACTION 3.19
The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy and guidance • areas of action for antimicrobial resistance • areas of action to improve appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing • the health service organisation's performance over time for use and appropriateness of use of antimicrobials
Comments
ACHA's AMS Program reviews antimicrobial prescribing and use throughout all three hospitals in conjunction with any surveillance data on antimicrobial resistance to guide appropriate prescribing. The performance of the AMS program, including opportunities for improvement, is undertaken to improve the appropriateness of prescribing and use in line with the AMS Clinical Care Standard. Outcome reports are provided back to clinicians, the Medical Advisory Committee (MAC), and the Board in relation to compliance with AMS policy and compliance with AMS principles and policy, in line with the Australian TGA. Compliance with these is discussed with each clinician, and with Craft Groups, to improve compliance, which was evident over time.

Rating	Applicable HSF IDs
Met	All

Standard 4 - Medication Safety

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

ACTION 4.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management	
Comments	
ACHA has policies and procedures to provide governance for medication management. ACHA has implemented a Medication Safety Committee at each site for the strategic leadership of medication management, and this Committee reports the Safety and Quality Committee, and through the reporting structure, to Executive and the Board. The pharmacy department supports the delivery of a medication safety system that is effective and of high quality. This includes the supply of goods, evidence-based advice, and on-the-ground support with the delivery of safe medication management practices. Medication incidents are entered into RiskMan, the Incident Monitoring System, and the medication audit results are reviewed to identify potential for errors or risk of harm. Clinicians at ward level were able to identify their risks, and the nurse unit managers implement reviews, analysis, and education where necessary. Completed medication safety training for staff is undertaken, and managers reported good compliance.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.02		
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management		
Comments		
ACHA undertakes a series of medication safety audits in accordance with the annual audit schedule to monitor the effectiveness and performance of medication management. As with the recommendation from the last assessment, the complete documentation of the components of the National Standard Medication Chart (NSMC) demonstrated inconsistency when the annual audits were conducted. The overall ACHA compliance for the 2021 and 2022 audits showed 39%, and a spot audit conducted during assessment for 2023 was 68%. The results had been tabled at the Medication Safety Committee and MAC with action plans developed. However, the small improvement in the 2023 spot audit of the NSMC documentation shows the results remain below the ACHA compliance targets. The assessors have rated this action Not Met in line with the Rating Fact Sheet. Quality improvement initiatives included the monitoring of adverse drug reactions and the documentation on the Surgical Safety and & Fire Risk Checklist if anticoagulants are ordered or N/A.		
Rating	**Applicable HSF IDs**	**Recommendation(s) / Risk Rating & Comment**
NM	All	**Comment:** As with the recommendation from the last assessment, the complete documentation of the components of the National Standard Medication Chart (NSMC) demonstrated inconsistency when the annual audits were conducted. The overall ACHA compliance for the 2021 and 2022 audits showed 39%, and a spot audit conducted during assessment for 2023 was 68%. The results had been tabled at the Medication Safety Committee and MAC with action plans developed. However, the small improvement in the 2023 spot audit of the NSMC documentation shows the results remain below the ACHA compliance targets. **Recommendation:** 1. Provide education to clinicians who conduct the NSMC audits. 2. As per policy, increase the frequency of the NSMC audits until a sustained improvement and compliance is achieved. 3. Develop clear action plans, with responsible person and timelines, to address the specific elements of concern and achieve compliance with organisational and Healthscope targets. **Risk Rating:** High

ACTION 4.03	
Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
There is a range of information regarding medicines available for consumers. The assessors spoke with patients and discussed medication management along with other aspects of their care. The patients felt included in their care and were provided with adequate information, including about any medicines and side-effects. The pharmacist and nurses provide education to patients as required, including counselling on discharge medications.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.04	
The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians	
Comments	
Clinicians prescribe, dispense, and administer medication in line with their scope of practice, and their qualifications are verified annually. The Medication Policy describes the process and the responsibilities for each clinician. There is a list for approved nurse-initiated medicines.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.05	
Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care	
Comments	
The Medication Reconciliation Policy incorporates the process to obtain and document the actual medicines the patient is taking before presentation to hospital. Patients booked for elective admission have the Best Possible Medication History (BPMH) completed and recorded in the pre-admission documentation. The VMOs are alerted to any concerns. The VMO and / or anaesthetist discuss preoperative medications with the patients.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.06	
Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care	
Comments	
The patient's current medicines orders, using the four steps of reconciliation, are reviewed against the BPMH by the nurses, VMO and / or anaesthetist and pharmacist who reconcile these with the patient's own medicines. Sources for reconciling the medicines includes the patient, family, GP referral, or the patient's local pharmacy. Each site has a clinical pharmacist available at each hospital to review the BPMH and medication orders to assist with reconciliation. The pharmacist completes the risk rating criteria for patients who may require a pharmacy review.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.07	
The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation	
Comments	
Processes are in place to record information on allergies and adverse drug reactions provided by the patient at admission and are recorded in the medical record, with alert sticker added.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.08	
The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system	
Comments	
Should a patient experience an Adverse Drug Reaction during a current episode of care, it is documented in the medical record, on the ADR Summary sheet, and an alert sticker is initiated. The incident is entered into RiskMan and the incident reviewed. The patient is informed of the allergy and given information about what happened and what to report in future admissions.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.09	
The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements	
Comments	
There is a process for reporting an Adverse Drug Reaction (ADR) to the Therapeutic Drugs Administration (TGA). There is an online portal for reporting, and the manufacturer is notified, if necessary. ACHA advised there are few reported ADRs, and these would be discussed at the Medication Management Meeting.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.10	
The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result	
Comments	
The Medication Management Plan provides an ongoing plan for actual and potential medicines, patient medication goals, and strategies to address issues. Reviews are completed for patients more likely to experience medication-related problems; and for these patients, medication reviews are regularly prioritised and conducted. Changes to medications as a result of medication review are documented in the clinical record, communicated to the patient's external healthcare provider at discharge, and included in the discharge summary provided to patients.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.11	
The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks	
Comments	
Pharmacists, medical and nursing staff can access a large range of patient medication information and resources via the intranet. Information for specialised areas, such as chemotherapy, is available at point of care. Patients confirmed the information assists with informed choices and decisions about treatment. The Discharge Pain Medication for Patients leaflet includes the pain scale, type of medication, and a timetable to document when medication taken.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.12	
The health service organisation has processes to: a. Generate a current medicines list and the reasons for any changes b. Distribute the current medicines list to receiving clinicians at transitions of care c. Provide patients on discharge with a current medicines list and the reasons for any changes	
Comments	
The systems for generating a current discharge list of medications, and any changes to the patient at discharge, commences with the Medication Discharge Checklist which is completed by the nurses. HPS pharmacists prepare and supply discharge medicines with the discharge medication list and, where appropriate, education to patients. The admitting VMO provides a discharge summary to the patient's general practitioner.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.13	
The health service organisation ensures that information and decision support tools for medicines are available to clinicians	
Comments	
Decision support tools are available electronically for clinicians. Other information is available in MIMS and the Australian Medicines Handbook. There is information on the Thromboprophylaxis and Antimicrobial programs.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.14	
The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the: a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted or expired medicines	
Comments	
Medication rooms, pharmacies, medication cupboards, and storage areas were secure across the organisation. S4 and S8 drugs are stored in safes located within the medication rooms. Each operating theatre has its own medication safe. The correct completion of the separate S8 and S4 Registers is routinely monitored, and audits show good compliance. All medication fridges have the temperature monitored, and there is a process if alarms activate. Immediate action by ACHA has removed the risk in storage of potassium ampoules.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.15	
The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely	
Comments	
A structured framework for the monitoring and review of high-risk medicines has been developed in conjunction with HPS, with reporting to the Medication Safety Committees, and education provided to clinicians. High-risk medicines are managed through an integrated system of policy, guidelines, forms, audits, education, and tools. The acronym APINCHS is used to identify high-risk medicines. High-risk medicines are identified by clinicians, as is the need to take extra care in their safe procurement, storage, handling, prescribing, dispensing, and administration. HYDRO-morphine is managed well with prominent warnings, use of tall man letters, delivery, and education to patients. Restricted S4 and S8 drugs are stored in safes located within the medication rooms, and each operating theatre has its own medication safe. The correct completion of the separate S8 and S4D Registers is routinely monitored, and audits show good compliance.	
Rating	**Applicable HSF IDs**
Met	All

Standard 5 - Comprehensive Care

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

ACTION 5.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for comprehensive care b. Managing risks associated with comprehensive care c. Identifying training requirements to deliver comprehensive care	
Comments	
Documentation reviewed from ACHA facilities demonstrates the processes that are in place for implementing policies and procedures, managing risks, and identifying the required training for staff to be competent in the delivery of comprehensive care. Members of the multidisciplinary team were able to describe how the organisations safety and quality systems are used to achieve high quality coordinated care. The clinical documentation reviewed supported the appropriate management of risks related to comprehensive care. There was excellent uptake for the relevant training programs, and these were available online and in person for staff to access.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care	
Comments	
Comprehensive care is defined and monitored with a wide range of clinical and documentation audits. Quality improvement activities were evident to achieve ongoing improvement in care, such as the “call before you fall” awareness program, the Day Procedure Unit’s information video, and the menu review and modifications project. The organisation uses feedback from staff and patient's data, and evidence-based practice to support this action.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.03	
Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
The assessors witnessed strong evidence that there were processes in place to engage patients and families in their care and decision-making across the clinical journey. Staff were able to easily describe the processes used to achieve this, and on speaking to many patients, they expressed that they were actively engaged and informed about their care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.04	
The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify, at all times, the clinician with overall accountability for a patient's care	
Comments	
Clinicians are supported by their policies and procedures to establish effective comprehensive care plans for their patients. The organisation operates within its scope of practice, and the clinicians are clear about the protocols for referrals to other health professionals or to different care settings when required. The assessors determined that the clinician accountable for a patient's care was clear and easily identified 100% of the time.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.05	
The health service organisation has processes to: a. Support multidisciplinary collaboration and teamwork b. Define the roles and responsibilities of each clinician working in a team	
Comments	
Multidisciplinary care was well established at all three hospitals, and the role of each member was well defined by the staff interviewed. In addition, this was supported by the job descriptions of clinicians found online. The assessors had the opportunity to be part of multidisciplinary case conferences and team handovers on many occasions.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.06	
Clinicians work collaboratively to plan and deliver comprehensive care	
Comments	
Clinicians and patients were able to describe how the multidisciplinary team worked together to deliver effective comprehensive care. This was supported by clinical documentation, and witnessed in the clinical environment, with a healthy culture evident among staff members.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.07	
The health service organisation has processes relevant to the patients using the service and the services provided: a. For integrated and timely screening and assessment b. That identify the risks of harm in the 'Minimising patient harm' criterion	
Comments	
Processes were in place to screen and assess all patients for relevant risks of harm. Clinicians were able to easily describe the risk assessment process, and this was also witnessed in the clinical documentation. Regular audits are undertaken by the organisation. This data is provided to the clinical leaders to ensure a high level of timely comprehensive risk screening of the patients is maintained. The organisation is compliant with the requirements of Advisory AS/18/14.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.08	
The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems	
Comments	
The organisation has demonstrated that there are processes in place to identify Aboriginal and Torres Strait Islander peoples as they enter the care environment. This information is recorded in the administrative and clinical systems, and is available for all staff to access. There is an elearning training package for administration staff called "Asking the Question." Training uptake is high with, for example, Flinders Private Hospital achieving 97% of eligible staff trained.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.09	
Patients are supported to document clear advance care plans	
Comments	
Information and resources are available for staff to support and assist patients to document advanced care plans. While there were not a large number found within the patient care records reviewed, staff knew how to access the State-wide resource called “Advanced Care Directive, your wishes for future care.”	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.10	
Clinicians use relevant screening processes: a. On presentation, during clinical examination and history taking, and when required during care b. To identify cognitive, behavioural, mental and physical conditions, issues, and risks of harm c. To identify social and other circumstances that may compound these risks	
Comments	
A comprehensive and holistic assessment is conducted on admission, during clinical examination, and repeated when clinically indicated. This includes using the Braden tool to screen for a range of risks of preventable harm, including using the 4AT to screen for cognitive and behavioural risks, as well as risk assessments for mental health, and the social and other issues that may compound risk. Risk screening processes are subject to regular documentation audits, and reports are provided through the organisation’s governance structure. A review of clinical documentation by the assessment team validated the high compliance with the completion of timely risk assessments on admission and throughout the episode of care. The organisation is compliant with the requirements of Advisory AS18/14 as it relates to actions 5.07 and 5.10.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.11
Clinicians comprehensively assess the conditions and risks identified through the screening process
Comments
ACHA has an organisational approach to venous thromboembolism (VTE) risk assessment. The pre-admission and admission assessments are completed by the nurses and documented appropriately in the medical record. The VMO and anaesthetist discuss VTE with the patient pre-surgery, however, the documentation of the risk assessment needs improvement. Assessors observed for elective surgery patients the VTE risk assessment is completed and has been added to the Surgical Safety and Fire Risk Checklist, and cannot proceed without confirmation. However, the documentation on the National Standard Medication Chart (refer Action 4.02) and the Anaesthetic Record requires attention. This has been discussed at MAC, and a memo was sent to all medical staff. Risks for Hospital Acquired Complications (HACs) - nutrition, cognition, delirium, mental health and social issues - are identified using standardised screening tools, on admission and during episodes of care, which identify the level of risk, and appropriate actions are put into place to mitigate them.
Suggestion(s) for Improvement
The Comprehensive Care VTE audit and the NSMC documentation audit require correlation for completion and documentation of the risk assessment by all medical staff.

Rating	Applicable HSF IDs
Met	All

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

Rating	Applicable HSF IDs
Met	All

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

ACTION 5.14	
The workforce, patients, carers and families work in partnership to: a. Use the comprehensive care plan to deliver care b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care c. Review and update the comprehensive care plan if it is not effective d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur	
Comments	
Patients, as well as their carers and families, were able to articulate the level of engagement in patient care and expressed satisfaction that they actively participated in decision making at all points of care and transitions of care. Goals of care are monitored, and care planning modified, in response to a change in goals, changing clinical status needs, or change in risk profile. It was noted that each patient had their own Patient Journey Board near their bed. Staff are to be congratulated for their commitment to using and updating these boards on each shift.	
Rating	**Applicable HSF IDs**
Met	All

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

ACTION 5.16	
The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice	
Comments	
The organisation has access to Specialist Palliative Care services. Staff interviewed were aware of how to access these services.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.17	
The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record	
Comments	
A review of clinical documentation confirmed that advance care plans are documented in the patient's healthcare record on admission. Clinicians who were interviewed could describe the process in place to ensure that patients with an advance care plan are identified, and that care is provided in accordance with these plans.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.18	
The health service organisation provides access to supervision and support for the workforce providing end-of-life care	
Comments	
Supervision and support for staff providing end-of-life care is available, and staff are aware of how to access support services.	
Rating	**Applicable HSF IDs**
Met	All

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

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

ACTION 5.21	
The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines	
Comments	
The organisation provided staff with evidence-based policies / procedures for Pressure Injury Prevention (PIP) and Wound Management. To support the content of these documents, the organisation employed skilled specialist clinicians and best practice training for clinical staff to become PIP champions. Hospital-acquired pressure injury rates were reported to be below benchmark, at 0.2% across the three facilities.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.22	
Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency	
Comments	
Skin inspections were conducted in accordance with the policy, and compliance rates in the clinical area were witnessed to be high. The audit dashboard, however, did not specify if the skin inspection was conducted in a timely manner.	
Suggestion(s) for Improvement	
Audit tool clearly specifies the timeliness of the skin inspection to meet best practice. Confirmation of timeliness is encouraged.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.23	
The health service organisation providing services to patients at risk of pressure injuries ensures that: a. Patients, carers and families are provided with information about preventing pressure injuries b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries	
Comments	
Information about pressure injury prevention is available and provided to patients and their carers. This information was reviewed by the assessors and found to be user friendly and appropriate. Equipment, products, and devices, including pressure relieving mattresses and heel boots, for example, were readily available, and staff were able to describe when they would use this equipment and why.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.24	
The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: a. Falls prevention b. Minimising harm from falls c. Post-fall management	
Comments	
Policy 'Falls Prevention and Management' was available to all staff and evidence based. This document describes the process for risk assessment of falls, prevention, harm minimisation, and post falls management. Audits are conducted throughout the organisation to ensure a high level of compliance. Staff were very familiar with strategies to minimise patient harm from falls, and this was appropriately documented in the clinical record. Incident data across the organisations for falls were below benchmark at 0.33%.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.25	
The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls	
Comments	
Equipment, devices, and strategies were evident in the clinical areas to prevent falls from occurring. Members of the assessment team witnessed the use of appropriate levels of a variety of these in the clinical area. The care planned was in accordance with the level of risk identified on screening.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.26	
Clinicians providing care to patients at risk of falls provide patients, carers and families with information about reducing falls risks and falls prevention strategies	
Comments	
Information was available for patients and carers about falls prevention and risk management strategies. This information was user friendly and deemed appropriate by the assessors.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.27
The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice
Comments
Patients are assessed for their nutritional needs and risk of malnutrition on admission and regularly if they are a long stay patient. Referral processes are clear to engage the support of a dietitian if risks are identified and special dietary requirements need to be put in place. The assessors saw risk screening conducted and referrals to dietitians in the clinical areas. Documentation in the clinical records supported this process. Staff awareness of patient nutritional needs was raised during a Malnutrition Week program lead by the Dietitians.

Rating	Applicable HSF IDs
Met	All

ACTION 5.28
The workforce uses the systems for preparation and distribution of food and fluids to: a. Meet patients' nutritional needs and requirements b. Monitor the nutritional care of patients at risk c. Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone d. Support patients who require assistance with eating and drinking
Comments
The organisation supports the nutritional needs of the patients through risk screening and tailoring the menu and supplements to address individual requirements. Patients identified as 'at risk,' or who require support at mealtimes, were witnessed by the assessors to have been referred to a dietitian, had individual meal and supplement plans developed, and help was provided to eat and drink. The kitchen staff were able to describe the process for plating of specific meal requirements and a robust quality checking system was observed on the plating line. The clinical staff observed and documented food and fluid intake of those patients at risk and assessed the need to alter the plan of care accordingly to meet their nutritional needs.

Rating	Applicable HSF IDs
Met	All

ACTION 5.29
The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation
Comments
Cognition screening is undertaken on admission as part of the history taking and risk assessment process. Evidence-based policies and procedures were in place, which included best practice prevention and management strategies. Appropriate care plans were seen to be in place in the clinical area for those patients identified through screening. The clinical staff, including pharmacists and medical officers, were able to describe the risks of inappropriate use of antipsychotics and other medicines in this at-risk group. Regular audits of cognition screening are undertaken across all three sites, and reports provided to the Patient Care Committee for follow up and actioning. The organisation has met the requirements of Advisory AS18/12 in this assessment.
Suggestion(s) for Improvement
Audit of the use of antipsychotic drug prescribing to verify utilisation rates.

Rating	Applicable HSF IDs
Met	All

ACTION 5.30
Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. Recognise, prevent, treat and manage cognitive impairment b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care
Comments
Documentation and clinical observation indicated that there are systems and processes in place to care appropriately for patients with cognitive impairment. Screening is undertaken using the Risk Assessment tool, and the assessors viewed the completion of these at almost 100% on the wards visited. The documentation audit, however, showed varying degrees of completion across different wards, although on the whole, the completion rates were seen to be higher in 2023 than in 2022, showing an improvement over time.

ACTION 5.30
Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. Recognise, prevent, treat and manage cognitive impairment b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care
Assessors reviewed the Patient Literature available to families and carers to assist in raising awareness of the risks of cognitive decline and advise on how to help their loved ones in this situation. This was in user friendly language and was evidence-based. The assessors are satisfied that the Delirium Care Standard has been met at this organisation.
Suggestion(s) for Improvement
Increase the rate of auditing for a short duration to ensure sustained improvement in completion of the entire Risk Screening tool across all three sites.

Rating	Applicable HSF IDs
Met	All

ACTION 5.31
The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed
Comments
Screening tools are in place to identify patients at risk of self-harm and / or suicide. Staff were able to describe the strategies that they would implement if a patient were identified as being at risk, and appropriate actions and referrals pathways were articulated. Referral pathways were internally to the medical officer caring for the patient, social worker (if appropriate), and externally to psychology services. Transferring to a specialised care setting would also be considered, if appropriate.

Rating	Applicable HSF IDs
Met	All

ACTION 5.32	
The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts	
Comments	
Referral and follow up services for patients that have been identified at risk of self-harm, who have self-harmed, or expressed suicidal thoughts, were described by the clinical staff to the assessors. Referral documentation would be provided to the referrer after discussion with the patient / carer, verbally and via a letter. Appropriate transfer to another care setting would be organised according to the level of risk identified.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.33	
The health service organisation has processes to identify and mitigate situations that may precipitate aggression	
Comments	
The risk of patient aggression is identified via the Risk Assessment tool and staff were able to describe the strategies that they would put in place to mitigate aggression and manage any aggression that may arise. Clinical and non-clinical staff are supported by appropriate Policies and Procedures and training programs.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.34	
The health service organisation has processes to support collaboration with patients, carers and families to: a. Identify patients at risk of becoming aggressive or violent b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce	
Comments	
The organisation has processes and strategies in place to identify, manage, and de-escalate aggression. This includes collaborating with the multidisciplinary team and family and carers to minimise harm to all involved in the care of the patient. Staff were able to describe their actions and assess their effectiveness. A robust reporting system is in place across all sites to report aggression and any harm sustained. This data is reported regularly to the governance structure.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.35	
Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of restraint b. Govern the use of restraint in accordance with legislation c. Report use of restraint to the governing body	
Comments	
Policies and processes were in place to support and guide staff to minimise the use of restraint. Effective alternative strategies, such as appropriate positioning of a patient within the ward setting, close observation with additional clinical staff, and frequent behavioural assessments, were described to the assessors. If any restraint were assessed as being required, the medical officer would prescribe the restraint and an incident would be logged in RiskMan to monitor all occurrences. This report would then be reviewed by the governing structure. Staff stated that restraint was very rarely utilised in their care settings, and no restraint was witnessed at the time of assessment.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.36		
Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of seclusion b. Govern the use of seclusion in accordance with legislation c. Report use of seclusion to the governing body		
Comments		
Not applicable as ACHA does not have any Registered Mental Health Services.		
Rating	**Applicable HSF IDs**	
NA	All	**NA Comment:** ACHA does not have a registered Mental Health Service. **Verified During Assessment:** Yes **Complies with AS 18/01:** Yes **Approved by ACSQHC:** No

Standard 6 - Communicating for Safety

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

ACTION 6.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication	
Comments	
Policies and procedures are in place to support effective clinical communication, including handover, with KPIs documented. These policies identify risk management strategies and also the training requirements / expectation of all staff in support of effective clinical communication. Adverse events are reported though RiskMan and a quality action plan is developed and implemented. Assessors viewed supporting documentation, and staff interviewed were able to describe the processes for clinical communication.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes	
Comments	
Incidents relating to a failure in clinical communication are reported through the incident management system and identified in patient feedback. This has led to improvements and changes in communication strategies and processes. The effectiveness of clinical communication, including handover, is monitored through feedback and audit. There is evidence of quality improvement strategies implemented to address feedback and audit results.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.03	
Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
The organisation has policies that supports the engagement of patients, their carers, and families in their own care and shared decision-making. Patients are involved in clinical handover, and the assessors witnessed handover supporting this across all ACHA sites. Patients who were interviewed reported being engaged in their care and noted that they had information available to them to make informed decisions about their care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.04	
The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes	
Comments	
Policies and processes based on best practice are in place to support appropriate identifiers being used in procedure matching, transfer of care, handover, discharge, and where changes in clinical care / patient risk profile are identified. Documentation viewed by the assessors supports the use of specified identifiers in these situations. Assessors observed efficient and professional handover processes conducted on patients with complex conditions throughout all hospitals.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.05	
The health service organisation: a. Defines approved identifiers for patients according to best-practice guidelines b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated	
Comments	
ACHA has policies that define the use of three approved identifiers. Staff interviewed by the assessment team were able to describe how and when these are used. Patients were also able to describe the questions asked to confirm their identity, and the assessors witnessed this when observing staff interactions with patients / carers across all ACHA hospitals.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.06	
The health service organisation specifies the: a. Processes to correctly match patients to their care b. Information that should be documented about the process of correctly matching patients to their intended care	
Comments	
The assessors noted the use of approved patient identifiers as noted in Action 6.05. Additionally, processes are in place for surgical / procedural time-out, and this is documented and audited, with compliance at 89% over the three sites. A limited review of clinical documentation supported these findings.	
Suggestion(s) for Improvement	
Continue to monitor and audit compliance across all ACHA hospitals.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.07		
The health service organisation, in collaboration with clinicians, defines the: a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines b. Risks relevant to the service context and the particular needs of patients, carers and families c. Clinicians who are involved in the clinical handover		
Comments		
Clinical handover documentation contains the required minimum content, relevant risks and needs of the patient, and the clinicians involved in handover. Compliance with these requirements is audited and reported. Staff could explain their respective roles in clinical handover, and the processes used to support this, including the minimum information communicated at clinical handover. This supported the clinical handovers witnessed by members of the assessment team.		
Suggestion(s) for Improvement		
Continue to audit the compliance with clinical handover documentation and target areas of low compliance.		
Rating	**Applicable HSF IDs**	
Met	All	

ACTION 6.08		
Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care		
Comments		
The assessment team witnessed clinical handover that was structured using the ISOBAR tool, and effectively engaged with patients, their carers and families in defining goals of care and decision-making. The processes in place for clinical handover ensure the relevant clinicians are actively engaged in the process, and members of the multidisciplinary team are encouraged to be involved, as necessary. Both patients and staff were able to articulate the process of handover and provide confirmation of patients, carers and family being involved in decision-making. Clinical handover is audited regularly, and incidents relating to ineffective handover are investigated with lessons learn shared and disseminated. It was noted by assessors that medical discharge summaries audited demonstrated low compliance across all ACHA hospitals.		
Rating	**Applicable HSF IDs**	**Recommendation(s) / Risk Rating & Comment**

ACTION 6.08		
Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care		
MWR	All	**Comment:** Medical discharge summary audit report (late 2022) demonstrated low compliance between 18-50% across all ACHA hospitals. An eQuaMS quality action plan was developed during the assessment to ensure discharge summary letters undertaken in the VMO rooms are added to the patient medical record. **Recommendation:** ACHA to ensure that the action plan undertaken by the organisation is implemented, and that the percentage of medical discharge summaries is monitored until it consistently reaches organisational and Healthscope targets. **Risk Rating:** Low

ACTION 6.09	
Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient	
Comments	
The organisation has policies and procedures to guide staff in effective communication and handover of critical information, including risks and alerts. Both patients and staff were able to describe to the assessors how this worked and how patients, their carers, and families were involved when they wanted / needed to be. Clinical handover is audited, and incidents / feedback related to communication issues are addressed appropriately.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.10	
The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians	
Comments	
Documentation shows communication processes are in place for patients, carers and families to directly communicate critical information and risks about care. Clinicians and patients / carers interviewed confirmed this, and the assessors observed information available to support and facilitate this process. It was acknowledged by assessors that patients with high-risks / complex needs were clearly identified and an appropriate level of handover and documentation was available for the continuity of care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.11	
The health service 87rganization has processes to contemporaneously document information in the healthcare record, including: a. Critical information, alerts and risks b. Reassessment processes and outcomes c. Changes to the care plan	
Comments	
Clinical documentation reviewed by the assessors confirmed compliance with the organisation's process to ensure complete, accurate, and up-to-date information is recorded in the healthcare record. Members of the clinical team could describe this process. Comprehensive clinical documentation audits are conducted annually.	
Rating	**Applicable HSF IDs**
Met	All

Standard 7 - Blood Management

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

ACTION 7.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management	
Comments	
Blood and blood products are managed in accordance with best practice guidelines and ACHA and Healthscope policies and procedures. These procedures are consistent with National Best Practice and Blood Safety. The governance of blood safety is overseen by the ACHA Blood & Clinical Deterioration Committee which meets quarterly and reports up to the ACHA Executive Committee via regular reports which incorporate both safety and quality data and information on the management of associated risks. Lessons learned within Healthscope also form part of the governance structure and provides another focus for the prevention of errors related to blood and blood product transfusions and focuses the attention on prevention rather than remediation of problems arising. Training is provided to eligible clinical staff with compliance reported at 89%, but understandably, only staff who have competed training are able to be part of the blood transfusion checking and administration process.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of the blood management system b. Implementing strategies to improve blood management and associated processes c. Reporting on the outcomes of blood management	
Comments	
The ACHA Blood & Clinical Deterioration Committee monitors the blood management process in terms of blood and blood product utilisation, the quality and safety systems, compliance with improvement of blood management, maximisation of a patient's own blood resources, and most importantly, patient outcomes. These reports are provided to the Medical Advisory Committee, the ACHA, and individual clinicians.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.03	
Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
Consumers wishes are always respected. If a patient refuses a blood or blood product transfusion, for religious or other beliefs, their care is modified as far as practical to get an equivalent outcome wherever possible. The organisation engages with consumers in care related to blood management, including shared decision-making and informed consent. Patients who had received blood / blood products were available for interview and confirmed their engagement in informed consent and shared decision-making process. Of particular note, was the 'Yarning about Blood' brochure which was developed with the assistance of Tamaru, a local Aboriginal Elder), to address the cultural needs for Aboriginal and Torres Strait Islander People. This document contained colourful Indigenous artwork which was very appealing to the eye and was very much appreciated by Aboriginal patients and their families.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.04	
Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products by: a. Optimising patients' own red cell mass, haemoglobin and iron stores b. Identifying and managing patients with, or at risk of, bleeding c. Determining the clinical need for blood and blood products, and related risks	
Comments	
ACHA and Healthscope policies and internal processes support the effective and efficient use of blood and blood products for those patients requiring this treatment. Utilisation is monitored and reported through the Blood & Clinical Deterioration Committee. There is no wastage of blood or products due to the wonderful relationship between ACHA and the local pathology services, which automatically monitor blood supply to minimise any risk of blood expiring, which would result in wastage. The inappropriate use of blood and blood products is closely monitored, and action is taken to ensure strict compliance with best practice utilisation of blood.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.05	
Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record	
Comments	
The regular internal auditing of transfusion records identified that there were problems with documentation of transfusion prescriptions, decision making, and transfusion details. However, when assessors reviewed a limited number of transfusion records in the clinical records, they found evidence to support that documentation processes were in fact very good. It was obvious that the previous audit tool had design flaws (such as not having a 'not applicable' option, leaving the auditor no choice but to rate 'unacceptable'). The organisation made the required changes to the blood prescription form, which included these 'n/a' options, bringing the standard right up to the high level which a limited number of record reviews confirmed.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.06	
The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria	
Comments	
ACHA and Healthscope best practice blood and blood product prescribing, utilisation, and transfusion policies were found to be consistent with the national guidelines and criteria for the prescription and administration of blood and blood products, and were readily available to clinicians. There have been no incidents related to blood management over the past three years.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.07	
The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria	
Comments	
ACHA have policies and processes to support the compliant reporting of transfusion related adverse events. The Blood & Clinical Deterioration Committee receive and monitor these reports and take action if required.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.08	
The health service organisation participates in haemovigilance activities, in accordance with the national framework	
Comments	
ACHA contributes to the National Haemovigilance Program, including any adverse events arising from any blood or blood product transfusion or ABO incompatibility.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.09	
The health service organisation has processes: a. That comply with manufacturers' directions, legislation, and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer	
Comments	
ACHA have a very healthy and helpful relationship with the local pathology services which allows the most appropriate system and processes to be available for the storage, distribution, and compliance with legislative and regulatory requirements, along with the ability to trace blood and blood products. Processes are monitored and reported through the Blood and Acute Deterioration Committee. Any incidents related to inappropriate handling of blood or blood products is reported and managed through the incident management system. See also information under action 7.04.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.10	
The health service organisation has processes to: a. Manage the availability of blood and blood products to meet clinical need b. Eliminate avoidable wastage c. Respond in times of shortage	
Comments	
As stated under 7.04 and 7.09, ACHA and their pathology providers have excellent processes in place to manage the availability of blood and blood products, eliminate wastage, and respond to shortages. As stated earlier, the use of blood and blood products is monitored and reported through the Blood and Acute Deterioration Committee. Great care is taken to preserve the patient's own resources, as well as those resources of the donated blood pool. There are strict policies in place for a 'Massive Blood Transfusion' to ensure the most efficient and effective utilisation of the precious and finite resource of donated blood. The organisation has strategies in place to manage a shortage of blood and blood products should that arise.	
Rating	**Applicable HSF IDs**
Met	All

Standard 8 - Recognising and Responding to Acute Deterioration

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

ACTION 8.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration	
Comments	
Staff have access to evidence-based policies and procedures on the ACHA intranet. Evidence was reviewed to confirm there are policies and procedures on the emergency response system for adults, neonates, paediatrics, maternity services, and medical emergencies in non-inpatient areas, to name a few. It is acknowledged that a concerted effort has been made to address Standard 8 across ACHA. As per Action 5.11, validated tools are used to assess for skin integrity, falls, nutritional status, and cognition. Social assessments are undertaken for all admitted patients. Assessors noted that these assessments are completed within ACHA's identified timeframes. High compliance (94%) of completed assessments was confirmed by documentation of audit results. Risks identified are documented in the care plan, and timely referrals are made to appropriate clinicians to provide further assessment and ongoing care. Incidents from the risks identified are reported on RiskMan, and these are regularly reviewed with strategies identified to reduce or remove the risk. These risks are reported through the ACHA Blood & Clinical Deterioration Committee which meets quarterly and reports up to the ACHA Executive Committee, and incorporates Safety & Quality data. Mandatory training has been identified for all staff. ACHA-wide compliance is very good with overall compliance at 89% at the time of writing. Basic Life Support for Adults is at 83% and Basic Life Support for Neonates was noted to be at 85%.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems c. Reporting on effectiveness and outcomes of recognition and response systems
Comments
The Quality Audit Reporting System (eQuams) is the organisation-wide repository for audit data and corresponding action plans. Results are reported at unit and executive level and through key governance committees. The Incident Management System (RiskMan) follows the same reporting structure. Rapid Response KPI data is reported to the ACHA Blood & Clinical Deterioration Committee. Hospital Acquired Complications (HAC) data is also collected and analysed to determine trends related to the effectiveness of recognition and responses systems. As per Action 6.04, the comprehensive care plan and the Standard Adult observation Chart (SAGO) have inbuilt processes for requesting clinical reviews, with this communication enabling timely clinical reviews as part of the clinical escalation process. Clinicians stated that this supports prioritisation of need, ease of communication, and they can readily use this functionality to assist in the management of their workloads.

Rating	Applicable HSF IDs
Met	All

ACTION 8.03
Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Comments
Clinical handover processes involve patients and their families at the bedside. Consumer representation is present on peak governance committees. As detailed in Action 6.03, partnering with consumers has been an ongoing focus for ACHA. Patient information is provided via a broad range of brochures and documents, as well as visual displays on television screens in main reception areas at ACHA. Interpreter services are promoted and utilised. Health literacy projects have involved consumer feedback to ensure that brochures contain information that is relevant and easy to understand. Linking back to Action 6.10, assessors noted that there are several methodologies being used to support the communication process for patients, to ensure that critical information is shared and risks to clinicians minimised. These methodologies comprise, but are not limited to, the use of the ISOBAR handover tool with consumer involvement, clinical risk assessment identification involving input from consumers, use of the 4AT for those people with cognitive deficits, and the PACE process for escalation of care by concerned patients and family members. Robust governance processes, supported by accessible evidence-based policies and procedures, are in place to support informed consent and the development of patient management plans.

ACTION 8.03	
Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Once again, as detailed in Action 6.03, assessors observed respectful and inclusive engagement with patients, carers, and families in many areas. The team were impressed with the kind approach that was demonstrated towards those people with cognitive impairment. Staff used many strategies to support engagement with these people in the handover process; they were respectful and caring during the clinical handover process. There was also evidence of family and carers being involved with shared decision-making in areas such as paediatrics and in the emergency department. Patients were encouraged to engage in handover processes and be an equal partner in their care journey.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.04	
The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient	
Comments	
Vital sign thresholds (calling criteria) for escalation are well established across ACHA for adult inpatients, maternity patients, neonates, and paediatrics. Standard calling criteria are incorporated into the Standard Adult Observation Chart (SAGO). Observations are undertaken in response to each patient's individual circumstances and the chart highlights potential clinical deterioration and the need for escalation / intervention. Clinical rapid response teams with advanced life support skills are in place at ACHA. There were 1,593 rapid response calls in 2022, an increase of >20% in comparison to previous years. Documentation audits validate high compliance, with clinicians effectively monitoring adults, neonates, and paediatrics through their individualised monitoring plan.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.05
The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d. Determine the required level of observation e. Document and communicate observed or reported changes in mental state
Comments
Policies and procedures support staff in identifying acute deterioration, including delirium. Assessment and care planning documentation reviewed by assessors also supported that assessment drives the establishment of individualised and appropriate management plans for patients with acute physical deterioration and / or delirium. Clinical documentation is audited regularly and compliance with cognition screening is reported as being >90%. Processes are in place to support timely communication among members of the treating team and the patient, carers and family members, as detailed in Standard 6. The requirements of Advisory AS19/01 referring to actions 8.05, 8.06 b, c, d and e and action 8.12 have been met.

Rating	Applicable HSF IDs
Met	All

ACTION 8.06
The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration
Comments
The organisation monitors performance of the identification and management of acute physiological, mental status, pain, and / or distress and concerns raised by staff, patients, carers, and families through clinical documentation audits, incident management, and clinical review. Staff and patients interviewed were aware of these processes and were able to describe them to members of the assessment team, including the process for escalation of care where needed. Documentation reviewed identified contemporary evidence-based policies and procedures are in place to support clinical staff in the management and escalation of clinical deterioration. The requirements of Advisory AS19/01 referring to actions 8.05, 8.06 b, c, d and e and action 8.12 have been met.

Rating	Applicable HSF IDs
Met	All

ACTION 8.07	
The health service organisation has processes for patients, carers or families to directly escalate care	
Comments	
Processes are in place for patients, carers, or families to directly escalate care. PACE actively promotes partnership among patients, their family, and carer/s, and the treating team, in recognising and escalating deterioration. This initiative encourages patients, their family, and carer/s to initially engage with their bedside nurse or medical team, if they are concerned that 'something is not right'. If they continue to be worried, they can then escalate their concerns by requesting a 'clinical review' knowing that this should occur within 30 minutes. Consumers are empowered to speak up for safety. PACE posters relevant to adults and children were displayed in public areas and in many wards and departments throughout ACHA. Interviews with clinical staff, patients, and carers confirmed this, and observation of the escalation system used across the organisation further supported this process.	
Rating	**Applicable HSF IDs**
Met	All

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

ACTION 8.09	
The workforce uses the recognition and response systems to escalate care	
Comments	
As per Action 8.04, clinical rapid response teams with advanced life support skills are in place at ACHA. There were 1,593 rapid response calls in 2022. The rapid response teams attend to adult inpatients as well as neonates and paediatric inpatients. Staff were able to describe the systems in place to escalate care consistent with the organisation's policy. Reports provided to the assessment team and reported through to the Blood and Clinical Deterioration Committee confirmed the effectiveness of these processes.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.10	
The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration	
Comments	
Education is provided to clinicians to support the timely and effective management of patients who acutely deteriorate. See comments under Actions 8.01 (Mandatory Training compliance rates). Highly trained and competent Rapid Response staff are supported to deliver timely evidence-based care by following the Rapid Response Algorithm, as well as accessing Standing Orders for the administration of emergency management drugs.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.11	
The health service organisation has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support	
Comments	
See comments under Action 8.07 (PACE program). The organisation provides access to clinicians with advanced life support skills and competency. Training records were made available to the assessors with compliance being >80%.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.12	
The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated	
Comments	
Interviews with clinicians confirmed the process for timely external referral to mental health services to ensure that these referrals can meet the needs of patients whose mental state has acutely deteriorated. Staff were able to articulate the referral process for these patients. The requirements of Advisory AS19/01 referring to actions 8.05, 8.06 b, c, d and e and action 8.12 have been met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.13	
The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration	
Comments	
There is a range of evidence-based policies, procedures, and guidelines on the ACHA intranet to support staff to enact rapid referrals to services that can provide definitive management of acute physical deterioration. Staff were able to explain these processes to members of the assessment team, and the effectiveness of escalation of care processes is monitored through the Blood and Clinical Deterioration Committee.	
Rating	**Applicable HSF IDs**
Met	All

Recommendations from Previous Assessment

Standard 1

ACTION 1.04		
The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Met with Recommendation	All	**Recommendation NS2 OWA 0919.1.04** Develop, in consultation with the Aboriginal and Torres Strait Islander (ATSI) Community, specific health related strategies and targets with appropriate monitoring and reporting systems for the goals in the Reconciliation Action Plan. **Risk Rating: Moderate**

Organisation Action taken	**Assessor's Response**
Review of the ACHA Reconciliation Action Plan was undertaken involving Aboriginal Consumer Representative. The existing Reconciliation Action Plan title was changed to Indigenous Engagement Plan following feedback and in consultation with the ACHA Board. The Indigenous Engagement Plan is reviewed annually and as part of the attestation statement. The plan is also on the ACHA Executive Committee Agenda as a standing agenda item. Development of an Acknowledgement to country video for ACHA, with consultation involving Aboriginal and Torres Strait Islander Consumer and staff, was completed in 2022. Educational packages were developed and allocated to staff: - Asking the Question *"Are you of Aboriginal or Torres Strait Island descent?"*. Compliance rate, 96% - ACHA Cultural Awareness and Sensitivity Learning Package. Compliance rate, 88% Healthscope National Committee Cultural Diversity and Inclusion; Representation by ACHA sites on the Committee Reviewed, updated and added resources available to staff and patients.	**Recommendation Closed:** Yes ACHA has undertaken a review of their Aboriginal 'Reconciliation Action Plan' (RAP) involving both the previous Aboriginal Consumer Representative (ACR) (Aunty Suzanne) and again with the new ACR (Uncle Tamaru). The original RAP was renamed as the 'Indigenous Engagement Plan' due to feedback from the community and in agreement with the ACHA Board, and there have been more strategies added to improve engagement in the future. This revised plan is reviewed at least annually and forms part of the annual Attestation Statement and is a standing agenda item on the Executive Committee agenda. In addition, ACHA has representation on the Healthscope National Cultural Diversity and Inclusion committee. ACHA has taken on board much of the feedback from their ACRs as well as

ACTION 1.04		
The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Completion Due By: 2021 **Responsibility:** ACHA Clinical Risk / QM / QMs / ADONs / DONs / GMs **Organisation Completed:** Yes		the local Indigenous community members who have assisted the organisation to develop their own local community art within each of the organisations, welcome signs at the entrance of each hospital including the local Aboriginal language, and most impressively, a welcome to country (and organisation) which features a local Aboriginal man in a video that is played throughout the organisation's hospitals at the start of each meeting and in waiting rooms for patients, families, and friends. Acknowledgement of country occurs in all meetings within the health service and Uncle Tamaru attends Executive Meetings to provide advice and suggestions to the organisation over a variety of normal business and is currently looking at more targeted strategies to be added to the Engagement Plan, such as the commissioned piece of Aboriginal Artwork for the 'Journey to the Heart Centre', a 20+ metre long mural designed by Aboriginal local artists, which demonstrates the healing relationship between the hospital and local and other Aboriginal and Torres Strait Islander patients. Other similar paintings have been commissioned for all three sites. All staff have been educated to ask all patients or their relative / carer, whether they identify as of Aboriginal or Torres Strait background with 96% of staff having completed this education package. The organisation also has a 'Cultural and Sensitivity' learning package online which has

ACTION 1.04			
The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people			
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**	
			been recently introduced with 88% of staff having already completed this education program. The most important achievement is a resource developed for staff who have to seek consent from Aboriginal or Torres Strait Islander patients in relation to receiving blood or blood product transfusions. The local Aboriginal community have developed a booklet titled 'Yarning about Blood' which helps explain the need for blood and blood products to those Aboriginal patients who may otherwise be afraid of using this therapy. ACHA fully complies with AS 18/04.

ACTION 1.09		
The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: a. The governing body b. The workforce c. Consumers and the local community d. Other relevant health service organisations		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Met with Recommendation	All	**Recommendation NS2 OWA 0919.1.09** Review the operation and reporting process of the Clinical Review Committee to ensure that the Board and the CEO receive timely reports on any data of concern, any reviews undertaken, and the outcomes of any such reviews. This needs to be added to the Annual Report from the committee which is the minimum prescribed by the legislation. **Risk Rating: Moderate**

Organisation Action taken	**Assessor's Response**
ACHA Clinical review Committee (CRC) increased the frequency of reporting to the ACHA Medical Advisory Committee (MAC). CRC recommendations are provided to the MAC when identified and are monitored. ACHA MAC standing agenda item includes CRC reporting. The ACHA Clinical Risk / Quality Manager has since increased frequency of reporting to the ACHA MAC and ACHA Board via a biannual report which was then to increased and provided quarterly. For the ACHA Board, it is titled ACHA Clinical Governance - Incidents, Risks and Complaints Report. The ACHA CEO, Hospital Operations monthly reporting to the ACHA Board, includes updating the Board on ACHA CRC recommendations. **Completion Due By:** June 2020 **Responsibility:** ACHA Clinical Risk / Quality Manager and CEO **Organisation Completed:** Yes	**Recommendation Closed:** Yes Interviews and documents reviewed during the assessment visit demonstrated how ACHA Health manages safety and quality. Reports are provided to various clinical committees and actions are taken and monitored. The frequency, format, and content of reporting on Safety and Quality to the Board was addressed by the ACHA Clinical Risk/Quality Manager. Board members interviewed were able to provide commentary on the types of reports and information provided to them, including recommendations from the Clinical Review Committee and the Medical Advisory Committee.

ACTION 1.10		
The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Met with Recommendation	All	**Recommendation NS2 OWA 0919.1.10** Review the risk management systems in place to ensure that actions which are planned and undertaken as a result of the identification of a non-compliance with policy requirements are allocated a risk level and time frame for action that is appropriate for the non-compliance identified. This review should include the governance and formal committee structure across ACHA Health which provides assurance that compliance is monitored, and action taken to address non-compliance across all the requirements outlined in ACHA Health policy and the National Safety and Quality Health Service Standards. The Terms of Reference of any oversight committee must clearly outline the responsibility and escalation where compliance remains below requirements. **Risk Rating: Moderate**

Organisation Action taken	Assessor's Response
1. Review the Risk Management System to ensure: *actions are planned and undertaken for low compliance *provided a risk level and timeframe for actions to be completed RiskMan upgrade includes the level of risk and timeframe for investigation in each incident. RiskMan incidents linked to Integrated Risk Register according to incident classification. Assessment of audit tool criteria against risk controls. Ongoing audit review nationally and integration of policy into audit tools. 2. Is monitored by the ACHA Executive Committee and hospital Safety and Quality Committees monthly Hospitals report on Risks and Risk Register MARS auditing system was implemented in 2022 and enables live reporting of audit results. 3. Reported up to the ACHA Board in accordance to the S Weekly incident review - National Director Clinical Risk and Safety and ACHA Clinical Risk and Quality Manager	**Recommendation Closed:** Yes The risk management system has been reviewed to ensure all risks on the risk register are assigned a specific manager to ensure they are monitored, the controls are appropriate, and all risks have a review date. The Corporate and facility risk registers were provided to demonstrate this. The risk registers are monitored by the ACHA Executive and the Safety and Quality Committees monthly to ensure capture and compliance with monitoring risks.

ACTION 1.10		
The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Clinical Incidents, Risks and Complaints Report quarterly to the ACHA Board 4.Reviewed the TOR and agenda for the ACHA Exec to ensure it captures and clearly outlines the responsibility and escalation of compliance **Completion Due By:** December 2021 **Responsibility:** ACHA Clinical Risk/Quality Manager / QMs / GMs **Organisation Completed:** Yes		

ACTION 1.16		
The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Met with Recommendation	All	**Recommendation NS2 OWA 0919.1.16** Medical staff compliance with the documentation requirements outlined in the ACHA Health Medical Services Regulations is enforced and action taken which is appropriate for the level and frequency of non-compliance. **Risk Rating: Moderate**

Organisation Action taken	**Assessor's Response**
1. Implement further education to VMO's as per the CDC's Guidelines Initial Education to VMOs provided during February 2019 Documentation audits tabled with recommendations at MAC. Ongoing annual auditing and reporting. 2. Table documentation audit results at the ACHA MAC and sub committees of MAC 3. Detail findings in the ACHA VMO Newsletter / other communications to address key issues more closely 4. Introduce the CDC role in ACHA to assist VMO documentation. Implementation of Clinical Documentation Specialists in March 2020 to Ashford and FPH. Key roles are to provide guidance and education to VMOs and nursing staff on coding related documentation. Identify medical staff documentation compliance on Integrated Risk Register. Medical officer documentation risk -GM ownership. Risk titled Medical Record documentation - inadequate **Completion Due By:** Dec 2021 **Responsibility:** CEO / GMs **Organisation Completed:** Yes	**Recommendation Closed:** Yes ACHA Health was able to demonstrate the work undertaken to improve medical documentation, including the introduction of the Clinical Documentation Specialists to provide education and guidance on medical documentation, particularly for procedure reports completed by the medical staff. Medical documentation audit results were provided to the Medical Advisory Committee and the ACHA VMO newsletter had provided further information on the importance of this documentation. Audit results undertaken in late 2022 indicated the medical discharge letter / summary was only present in the medical record between 18-50% of the time, depending on the hospital. This has been addressed as a quality initiative, implemented during our assessment visit, and is addressed in a recommendation in National

ACTION 1.16		
The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
		Standard 6, Action 6.8 relating to discharge communication.

ACTION 1.19		
The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Met with Recommendation	All	**Recommendation NS2 OWA 0919.1.19** ACHA Health include an explicit outline in the Board orientation of their specific role in quality and safety, and the expectations of their role as Board Director for ensuring quality and safety within ACHA Health. **Risk Rating: Moderate**

Organisation Action taken	**Assessor's Response**
1. Reviewed orientation program to the ACHA Board and new members of the Board. Orientation to the ACHA Board occurred August 2019, and December 2019. Ongoing orientation for Board members on Safety and Quality, board responsibilities and relationship with Healthscope. Annual presentation to the Board by the Clinical Risk Quality Manager 2. Board were provided information provided by the ACSQHC - Guide for Governing Bodies to the Board 3. Inform the Board of the obligations and responsibilities required of them as the ACHA Governing Body No new Board members in 2020-2023 Annual presentation to the Board by the Clinical Risk / Quality Manager 4. Provided details of the Governance Framework that ACHA operates under and how it links to Healthscopes Updated Governance and Committee Structures Updated Organisational Structure. Ongoing annual review. 5. Provide the attestation document with supporting evidence to assist in understanding this annual requirement, and obtain sign - off Attestation statement and supporting evidence was endorsed by the ACHA Board in December 2019	**Recommendation Closed:** Yes The orientation and ongoing presentations to the Board on Quality and Safety have been reviewed, and new reports have been developed and provided regularly to ensure the Board are informed of all issues relating to Quality and Safety and any associated risks. Board members interviewed could demonstrate a knowledge of the Quality and Safety reports and their roles and responsibilities relating to Quality and Safety.

ACTION 1.19		
The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Ongoing annual review and endorsement of site attestation statements 6. Review and update the monthly Sd Report 7. Provide ongoing Srts to the Board 8. Present directly to the ACHA Board on a regular basis Sentinel events provided to the Board monthly are presented by the Medical Practitioner on the Board **Completion Due By:** June 2020 **Responsibility:** CEO / ACHA Clinical Risk/Quality Manager **Organisation Completed:** Yes		

ACTION 1.20		
The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Met with Recommendation	All	**Recommendation NS2 OWA 0919.1.20** ACHA Health implement a Mandatory Training framework for VMOs that supports mutual recognition of appropriate training performed at other health services, and also develops specific Mandatory Training required of VMOS whose sole hospital appointment is with ACHA Health. **Risk Rating: Moderate**

Organisation Action taken	**Assessor's Response**
1. Review of accredited Visiting Medical Officers VMOs are not employed Medical Officers. AHPRA require submission of ongoing CPD evidence and professional bodies require auditing of their own practice. AHPRA registration is monitored through auditing of accredited medical practitioners. VMO training matrix considered. 2. VMO's participation in the below are audited and feedback/education in relation to non-compliance is provided (where able at the time of audit e.g., hand hygiene and aseptic technique); *Antimicrobial prescribing *Hand Hygiene *Aseptic Technique *Clinical Deterioration 3. Undertaken a risk assessment for the VMO's that are required to participate in BLS and Aseptic Technique, develop a training program to accommodate this group though the audit program as per the Mandatory Training Policy. Salaried Medical Officers undergo mandatory training and are monitored through the relevant manager of a unit and via the ACHA Patient Care Committee as part of routine monitoring of	**Recommendation Closed:** Yes The action plan to follow up on this recommendation was reviewed by the assessment team during the assessment visit. Actions included checking APHRA registration, checking compliance with hand hygiene and aseptic technique for VMOs on observation audits, developing a training program for salaried medical officers, and monitoring this for compliance. The action plan also included undertaking a risk assessment for VMOs that are required to participate in BLS and aseptic technique and develop a training program to accommodate this group through the audit program. There was also an action to implement a process to capture details for VMOs undertaking training in other settings to provide evidence. It was noted that 75% of VMOs at ACHA Health had a public hospital appointment.

ACTION 1.20		
The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
mandatory training compliance. MET/Code Blue teams responding to a clinical deterioration are employed staff. 4. Implementation of a process to capture details of the VMO's undertaking the education or have provided evidence of the education undertaken where requested is an ongoing process. **Completion Due By:** December 2020 **Responsibility:** CEO / ACHA Clinical Risk/Quality Manager **Organisation Completed:** No		A mandatory training framework for VMOs had not been implemented as it remained the view of ACHA Health and Healthscope that VMOs and surgical assistants were not employed medical officers and hence, were exempt from this action. During the assessment visit, clarification was sought from the Australian Commission on Safety and Quality in Healthcare on the status of VMOs and surgical assistants for the purpose of this action. It was confirmed that they are to be included as workforce in Action 1.20. This previous recommendation is ongoing. The action was rated Not Met in the current assessment and a new recommendation was made for 1.20 in the body of the report.

ACTION 1.21		
The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Met with Recommendation	All	**Recommendation NS2 OWA 0919.1.21** ACHA Health seek guidance from the Aboriginal Consumer on the appropriateness of the Cultural awareness and sensitivity learning package and ensure active engagement from Aboriginal consumers in further enhancements to the program. **Risk Rating: Low**

Organisation Action taken	**Assessor's Response**
1. Review the ACHA Cultural Awareness and Sensitivity Learning Package with Aboriginal Consumer involvement The Healthscope / ACHA eLearning was referred to an Indigenous representative for review The ACHA Indigenous Engagement Plan is a standing agenda item on the ACHA Executive Committee ACHA sought new Consumer Representative in 2023 2. Include any changes that have been identified and provided by the Aboriginal Consumer(s) The Indigenous Engagement Plan is reviewed annually and was retitled in 2021 from Reconciliation Action Plan following feedback. An acknowledgement of country review and video was developed with consumer and staff input in 2022 3. Learning package available on eLearning for staff to complete The eLearning package 'Asking the Question" is in place - compliance of 96% in April 2023 ACHA Cultural Awareness activity Learning Package - compliance of 88% in April 2023 **Completion Due By:** April 2021 **Responsibility:** Quality Managers **Organisation Completed:** Yes	**Recommendation Closed:** Yes An Aboriginal and Torres Strait Islander Cultural Awareness program (Cultural Awareness and Sensitivity Training) is now part of mandatory training for staff. The program has been reviewed by Healthscope Aboriginal advisors and advice has been sought from local Aboriginal Elders to implement more localised 'on country' training. The program and training records were reviewed by assessors, and current attendance rates are currently being monitored to meet KPI of 92%. (See also Action 1.21).

ACTION 1.22		
The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Met with Recommendation	All	**Recommendation NS2 OWA 0919.1.22** ACHA Health implement a Performance Review framework for VMOs and surgical assistants that is linked to clinical outcomes and compliance with Medical Services Regulations. **Risk Rating: Moderate**

Organisation Action taken	**Assessor's Response**
1. Reviewed and updated Cgov -eCredentialing system to include the updated ACHA Medical Services Regulations. The ACHA Medical Services Regulations (MSR) were reviewed and updated and endorsed by the ACHA Board in December 2019. The MSR was updated in the system in January 2020. 2. Provide education / orientation to the ACHA Medical Advisory Committee of the Cgov module on Peer Review for accredited Visiting Medical Officer's. Ongoing education as a quality initiative and include in pack for new members to the Medical Advisory Committee 3. Implement the process with the ACHA MAC The ACHA CRC review incidents and trends, and a peer review process is in place via the Committee. Recommendations from CRC are provided to the MAC within the Terms of Reference of the Committee and in maintaining privilege of the Committee. In addition; Clinical audits across specialities are conducted; linked to incident trends. The ACHA MAC from time to time may request additional audit information from VMOs. ACHA MAC provide peer review on credentialing matters. e.g., scope of practice and credentialing requirements **Completion Due By:** December 2020 **Responsibility:** CEO / GM / ACHA Clinical Risk/Quality Manager **Organisation Completed:** Yes	**Recommendation Closed:** Yes Actions relating to this recommendation were reviewed during the assessment visit and the CGov system was demonstrated. The Medical Advisory Committee (MAC) Chair confirmed the importance of performance review being part of the reappointment of medical officers. Two peer medical referees must provide a written report, including the professional activities, technical skills, educational activities, peer review, and clinical quality activities for the applicant to progress their appointment. Medical officers must also sign they have read and agree to the Medical Services regulations which outlines these expectations. There is a new recommendation to ensure the referee reports are always appropriate to meet performance requirements and are checked by an appropriate senior manager at ACHA Health before they progress to the MAC.

Standard 3

ACTION 3.16		
The health service organisation has risk-based processes for preventing and managing infections in the workforce that: a. Are consistent with the relevant state or territory work health and safety regulation and the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare b. Align with state and territory public health requirements for workforce screening and exclusion periods c. Manage risks to the workforce, patients and consumers, including for novel infections d. Promote non-attendance at work and avoiding visiting or volunteering when infection is suspected or actual e. Monitor and manage the movement of staff between clinical areas, care settings, amenity areas and health service organisations f. Manage and support members of the workforce who are required to isolate and quarantine following exposure to or acquisition of an infection g. Provide for outbreak monitoring, investigation and management h. Plan for, and manage, ongoing service provision during outbreaks and pandemics or events in which there is increased risk of transmission of infection		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Met with Recommendation	All	**Recommendation NS2 OWA 0919.3.16** ACHA Health to ensure compliance with its Antimicrobial Stewardship Framework. **Risk Rating: Moderate**

Organisation Action taken	**Assessor's Response**
Implemented audit and audit review processes for compliance with Antimicrobial Stewardship (AMS) Program. Audit results are reviewed and actioned accordingly. **Completion Due By:** Dec 23 **Responsibility:** GM / MAC **Organisation Completed:** Yes	**Recommendation Closed:** Yes The assessors were provided with audits for compliance with the Antimicrobial Stewardship (AMS) Program to comply with policy and the current Australian therapeutic guidelines. AMS is discussed by the surgeon and anesthetist prior to incision and "Antibiotic given" or N/A is part of the Surgical Safety and Risk Checklist. Across the sites, ACHA has demonstrated continual increased improvement with the point prevalence audit for National Antimicrobial Prescribing, the Surgical National Antimicrobial Prescribing Survey as required in the Antimicrobial Stewardship Clinical Care Standard.

Standard 4

ACTION 4.01		
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Met with Recommendation	All	**Recommendation NS2 OWA 0919.4.01** 1. Implement the measures identified in the Medication Actions Plan with ongoing monitoring and outcomes reported to the relevant committee. 2. As per the recommendation in Action 1.10, conduct a risk assessment as to whether a more formal Medication Governance Committee would provide assurance to the organisation to meet the safety and quality requirements of the Medication Standard. **Risk Rating: Moderate**

Organisation Action taken	**Assessor's Response**
1. Developed and implemented an ACHA Medication Safety Working Party. Each hospital has implemented a dedicated Medication Safety Committee. The Committees each have; *Terms of Reference *Appropriate membership *Key Performance Indicators The hospital Medication Safety Committees reports to the sites Safety and Quality Committee. Hospital Safety and Quality Committees report to the ACHA Executive Committee. 2. Review of the education program for Medication Safety was undertaken nationally. Mandatory eLearning is in place. Hospital Pharmacy Services (HPS) pharmacist education provided in consultation with sites and Education staff, examples include medication governance, i.e., safe storage, comprehensive medication discharge planning, AMS and common/less used infusion rates. Education provided by HPS is included in Clinpod reports. ACHA Clinical Risk / Quality Manager presented to the SA Consumer Focus Group in 2022 A new Med+Safe program was launched in February 2023	**Recommendation Closed:** Yes 1. ACHA has implemented a Medication Safety Committee at each site, and this committee reports to the Safety and Quality Committee and through the reporting structure to Executive and the Board. 2. A risk assessment was completed, and the Medication Safety Committees implemented at each site with Terms of Reference to provide assurance to the organisation to meet the safety and quality requirements.

ACTION 4.01		
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Additional education and training sessions scheduled by hospital educators and are shared with staff via education calendars 3. Review of all policies associated with Medication Governance and updated accordingly 4. Audit program to include increased auditing of practice and patient care outcomes An auditing policy, national schedule and guides are available and in place. 5. Report monthly to the ACHA Executive Committee of actions and outcomes Hospitals reported monthly via a Quality 'Top 5 Report' and minutes of hospital Safety and Quality Committee meeting minutes are provided to the ACHA Executive Committee Riskman Incident Data Sets (RIDS) data is presented annually to the ACHA Executive Committee (ACHA) 2021 and 2022 CR/QM review of Medication Safety - presentation slides 2022; presented to SA Consumer Committee, ACHA Executive Committee **Completion Due By:** June 2020 **Responsibility:** GMs / DONs / Quality Managers **Organisation Completed:** Yes		

ACTION 4.02		
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Met with Recommendation	All	**Recommendation NS2 OWA 0919.4.02** Review the audit process for medication safety to provide assurance that low levels of compliance are identified, actioned, monitored, reviewed and outcomes reported in a timely manner. **Risk Rating: Moderate**

Organisation Action taken	**Assessor's Response**
1. Review the audit program to include increased auditing of practice and patient care outcomes The auditing policy was revised and most recently reviewed in 2022, which include guidance on frequency of auditing. Education and training sessions on auditing has been provided by Healthscope and ongoing support is available, including scheduling, reporting, resources available, and monitoring. A new electronic auditing system for completion of audits, reporting and monitoring was introduced in 2022 - MARS. Audits are reported on and benchmarked nationally. Healthscope national committees receive benchmarking reports across clinical indicators, quality KPIs and trend reporting. 2. Identify a process to ensure each audit is conducted according to the ACHA audit policy Audits have policy references included. An auditing guide is available as a resource to staff completing audits, including examples of all audit tools. 3. Any reported outliers that remain unresolved to be reported individually to the ACHA Executive **Completion Due By:** June 2020 **Responsibility:** GMs / DONs / Quality Managers **Organisation Completed:** Yes	**Recommendation Closed:** Yes ACHA had undertaken a series of medication safety audits in accordance with the annual audit schedule to monitor the effectiveness and performance of medication management. The overall ACHA compliance for the 2021 and 2022 audits showed 39% and a spot audit conducted during assessment for 2023 was 68%. However, the small improvement in the 2023 spot audit of the NSMC documentation shows the results are below the ACHA compliance targets. Consequently, a new recommendation has been made.

ACTION 4.15		
The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Met with Recommendation	All	**Recommendation NS2 OWA 0919.4.15** Develop and implement a structured framework for the monitoring and review of high-risk medicines. **Risk Rating: Moderate**

Organisation Action taken	Assessor's Response
1. A review of the current high risk medication framework was completed and an update with identified gaps completed. Policies are in place for Medication Safety Governance and high-risk medication protocols. A High-risk medications list was last reviewed in March 2023 in consultation with Hospital Pharmacy Services (HPS) Each hospital has a site-specific Medication Safety Committee and reporting to site Safety and Quality Committees. 2. Provide education to all clinical staff regarding the high-risk medications relevant to the ward / department. HPS pharmacist education ongoing and examples include medication governance, i.e., safe storage, comprehensive medication discharge planning, AMS evidence in clinpod reports and HPS email outs. High-risk medications list was reviewed in consultation with Hospital Pharmacy Services (HPS), in March 2023 and available to staff. Education staff schedule additional training and monitor eLearning. A new Med+Safe program was released in Feb2023. 3. Ensure high risk medication audits are included in the audit program at each hospital. High-risk medications are monitored through auditing (included in the national audit schedule), Quality KPIs and quality activities are added to the hospital Quality Action Plans (in eQuaMs) related to ongoing outliers. Tallman lettering is in place and medication safety reviewed in scheduled Executive Medication Safety Walkarounds	**Recommendation Closed:** Yes A structured framework for the monitoring and review of high-risk medicines has been developed in conjunction with HPS, reporting to the Medication Safety Committees and education provided to clinicians.

ACTION 4.15		
The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Medication storage room upgrades identified, planned or completed where necessary. 4. Ensure all outliers are reported, actioned and followed up on through the site and ACHA meetings Ongoing outliers are identified and entered into an electronic quality monitoring system, eQuaMs. Medication Safety is reported on monthly at site Safety and Quality Committees Each site has in place a Medication Safety Committee, established in 2020 **Completion Due By:** June 2020 **Responsibility:** DON / Quality Managers **Organisation Completed:** Yes		

Standard 5

ACTION 5.17		
The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Met with Recommendation	All	**Recommendation NS2 OWA 0919.5.17** Develop processes to receive, document and provide access to Advance Care Directives. **Risk Rating: Moderate**

Organisation Action taken	**Assessor's Response**
ACHA processes around Advanced Care Directives are the same for each hospital. 1. Developed a process to receive, document and provide access to Advanced Care Directives (ACD) Policy reviewed to inform staff on the appropriate management of patients with Advanced Care Directives End of life care pathway and MOLST forms were implemented in 2020. An ACD question was added to pre-admission form in 2023. Alert sheet / record is accessible at point of care, identifying if the patient has a known ACD 2. Education for all appropriate staff on ACD's An End-of-Life tool kit was released by Healthscope and adopted by ACHA 3. Processes included that each patient is informed about ACD's and where they can obtain the information. Brochures and resources for patients are reviewed and updated as needed. **Completion Due By:** April 2023 **Responsibility:** DONs / Quality Managers **Organisation Completed:** Yes	**Recommendation Closed:** Yes It was noted that ACHA has developed standardised processes across its three hospital sites to receive, document, and provide staff with access to patients' Advanced Care Directives (ACD). The policy has been reviewed to ensure that staff clearly understand how to appropriately care for patients who have ACD. The End-of-Life Care pathway and MOLST forms that were implemented in 2020 were reviewed, and there was evidence that the ACD question is being asked on admission. Staff have received relevant education and there is widespread adoption of the End-of-Life toolkit. Staff stated that they were confident to inform patients and their families about the ACD form and they knew how to locate this form on the ACHA intranet. Advance Care Planning brochures were sighted as were other relevant evidence-based resources for patients and their families.

ACTION 5.19		
The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Met with Recommendation	All	**Recommendation NS2 OWA 0919.5.19** Implement processes for evaluating the safety and quality of end-of-life care. **Risk Rating: Moderate**

Organisation Action taken	**Assessor's Response**
1. Developed a process to ensure all patients who require End of Life Care (ELC) receive ELC as per the tool kit. The Healthscope End of Life (EOL) tool kit is available for staff. Consumer Representatives reviewed from each site/ SA Consumer Focus Group. At ACHA, each hospital also has a Chaplain available to assist and support both patients and family members. 2. Education for all appropriate staff on ELC. Education for staff was provided with the rollout of the toolkit and is ongoing as needed. 3. Patient information is available about ELC A review of the hospital's website/compendium/brochures has been undertaken. Information is available for patients and staff. 4. Developed an audit or review process to identify the process was implemented appropriately for each patient that received this care Patient/family journey and follow up after death of loved one occurs through feedback opportunities and an EOL survey is available for staff to use for families who have passed away. ELC is reviewed by the ACHA Patient Care Committee. 5. Shared learnings report to assist each hospital in developing further in this process is an ongoing initiative. Feedback received (in various forms) is reviewed and discussed at a site level and via the ACHA Patient Care Committee as a sub-committee of the ACHA Executive Committee. **Completion Due By:** December 2020 **Responsibility:** DONs / Quality Managers **Organisation Completed:** Yes	**Recommendation Closed:** Yes The assessors were able to validate that ACHA has implemented processes to evaluate the safety and quality of end-of-life care. An audit is undertaken of all deaths and this information is reported to the ACHA Patient Care Committee. The National Qualtrix survey is generated on discharge, and this survey has the Quality Manager's name and contact details on the bottom of the form. Documentation audits also collect relevant end-of-life care data from the Comprehensive Care Plan and the Comfort Care observation chart.

Standard 7

ACTION 7.01		
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Met with Recommendation	All	**Recommendation NS2 OWA 0919.7.01** In reference to the recommendation in Action 1.10, conduct a risk assessment as to whether a more formal committee would provide assurance to the organisation to meet the safety and quality requirements of Standard 7. **Risk Rating: Moderate**

Organisation Action taken	**Assessor's Response**
1. Developed and implemented an ACHA Blood Management Committee including; *Terms of Reference *Appropriate membership *Key Performance Indicators Blood Governance was included in the ACHA Deteriorating Patient Committee, the Committee is combined and titled ACHA Blood Management and Clinical Deterioration Committee. The ACHA Blood and Clinical Deterioration Meeting is a sub-committee of the ACHA Executive Committee; minutes provided to the Committee. 2. Review of the current education program for Blood Management. Site based blood education on handling and storage requirements for blood in addition to mandatory eLearning is scheduled as required. Resources are available for informed consent for consumers, including distribution of education material on transfusion in multiple languages. 3. Review all policies for Blood Management and update accordingly. All Policies are reviewed in line with ACHA Document Control review cycle. An ACHA Emergency Blood Management Plan (EBMP) was developed in addition to policies. The EBMP was endorsed by the ACHA Medical Advisory Committee and ACHA Executive Committee. The ACHA Emergency Blood Management Plan (EBMP) outlines the process to be followed should South Australia be faced with a blood or blood product supply shortage or crisis.	**Recommendation Closed:** Yes ACHA, to ensure this recommendation was not only closed, but provided safe care to its patients, developed and established an ACHA Blood Management Committee, and amalgamated this with the existing ACHA Deteriorating Patient Committee. This combined Committee (called the ACHA Blood Management and Clinical Deterioration Committee) has TOR, membership appropriate to both standards, and a suite of appropriate KPIs. This committee reports to the ACHA Executive Committee via minutes of the meeting. During this process, the Education Program for Blood Management and the Blood Management Policy were reviewed and implemented for all three sites. This review identified the need for an ACHS Emergency Blood Management Plan (in case of a blood shortage in SA), which has been endorsed by the ACHA Executive and the Medical Advisory Committee (MAC). The national policy

ACTION 7.01			
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management			
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**	
4. Audit program to include increased auditing of practice and patient care outcomes A national policy for auditing was revised, released and adopted by ACHA. A national audit schedule was released outlining mandatory requirements by quarter to supplement the policy. Blood appropriateness audit is scheduled annually. 5. Report monthly to the ACHA Executive Committee of actions an outcomes Hospitals report to the site Safety and Quality Committee and report to the ACHA Executive Committee any outliers. An action plan and quality activities are recorded electronically in eQuaMs for ongoing outliers. **Completion Due By:** December 2020 **Responsibility:** DONs **Organisation Completed:** Yes			for auditing of appropriate use of blood and blood products was adopted by ACHA and the blood appropriateness audit is conducted at least annually.

ACTION 7.06		
The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Met with Recommendation	All	**Recommendation NS2 OWA 0919.7.06** Ensure compliance with policy in regard to appropriate documentation associated with prescribing and administration of blood and blood products and in accordance with the audit schedule. **Risk Rating: Low**

Organisation Action taken	**Assessor's Response**
1. Review the audit program to include increased auditing of practice and patient care outcomes Consent compliance reported quarterly in KPI report and bi-annually in Clinical Indicator submission. 2. Identify a process to ensure each audit is conducted according to the ACHA audit policy Blood appropriateness audit is on the audit schedule and reported through site Safety and Quality committees and ACHA Blood Management and Deteriorating Patient Committee. An electronic auditing system was introduced in 2022 to assist in monitoring of auditing compliance. In 2023 reports have been developed and are linked to the relevant national standard. A national audit schedule is now in place. 3. Any reported outliers that remain unresolved to be reported individually to the ACHA Executive QKPIs, Clinical Indicators, reported to ACHA Executive Committee with actions addressed. eQuaMs was introduced in 2022, where hospitals are able to add in Quality Activities as part of action plans to address ongoing outliers. **Completion Due By:** December 2020 **Responsibility:** Quality Managers / DONs **Organisation Completed:** Yes	**Recommendation Closed:** Yes The audit results, that appear to be outliers, seemed to be a result of the Blood Prescription Audit Form, which has now been modified to ensure such things as a 'not applicable' rating is recorded rather than 'not met' rating. The difference between the recently produced and implemented blood prescription form, and the old form includes a 'N/A' rating for both transfusion history and history of transfusion reaction(s). There is also a new field called 'other' which allows the documentation of Albumin and Immunoglobulin, for example. The form also includes other important information such as 'Impairment' (which includes Cardiac, Pulmonary and Cerebrovascular) and 'Altered Oxygen Requirements' (including Hypoxia, Sepsis and Anaesthesia). The form also includes a 'Pre-Transfusion Checklist' and the 'Correct Procedure Time Out Process'. Although still in its early implementation phase, the completed forms visualised by the assessors for patients who were having blood or blood transfusion at the time of

ACTION 7.06			
The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria			
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**	
			the assessment or in the one or two weeks prior, demonstrated full compliance with the ACHA Blood Transfusion Policy, allowing this recommendation to be closed.

Standard 8

ACTION 8.01		
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Met with Recommendation	All	**Recommendation NS2 OWA 0919.8.01** As per the recommendation in Action 1.10, conduct a risk assessment as to whether a more formal Governance Committee would provide assurance to the organisation to meet the safety and quality requirements of the Recognising and Responding to Acute Deterioration Standard. **Risk Rating: Moderate**

Organisation Action taken	**Assessor's Response**
1. Developed and implemented an ACHA Clinical Deterioration Working Party, including development of; *Terms of Reference *Appropriate membership *Key Performance Indicators ACHA established a combined Committee in 2020; ACHA Blood and Clinical Deterioration Committee, which is a sub-committee of the ACHA Executive Committee and includes representatives from all hospitals. Ashford Hospital has a site-specific Clinical Deterioration Committee where auditing and data is regularly reviewed. Monthly MET call data reports are available and monitored through hospital Safety and Quality Committees. 2. Review of the current education program for Rapid Response cal Deterioration A review of and revised education package, including documentation of deterioration escalation was completed. In addition, adoption of sepsis pathways and education after COVID-19 preparedness progressed.	**Recommendation Closed:** Yes It was noted that ACHA set up a Clinical Deterioration Working Party and has successfully implemented a combined Blood and Clinical Deterioration Committee in 2020. Terms of reference, agendas, and minutes of this committee were sighted. Monthly MET call data reports are monitored and reported through ACHA's Safety and Quality Committee. The rapid response education program has been reviewed, as have all of the observation charts. Simultaneously, the audit program has also been refreshed. A new electronic auditing system (MARS) was rolled out in 2022 with education and training provided by Healthscope. Checklists on emergency trolleys have been standardised across the three hospitals. Flow charts have been updated and detail the how to escalate process.

ACTION 8.01		
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
3. Review of all ACHA Observation charts An Observation chart Working Party convened Sep 2020 and audit tool reviewed to include outcomes. A review of the ICU chart ASH and FPH and level 2 ICU chart TMH was completed. 4. Audit program to include increased auditing of practice and patient care outcomes. A National audit schedule is in place. A new electronic auditing system, MARS was rolled out in 2022 with education and training provided by Healthscope. The system enables Managers to view audits by area and links audits to the relevant national standard. In 2023, the national audit schedule identifies mandatory auditing to be completed each quarter. In addition, the audits tools are linked to policy. CALS/ALS education pathways were reviewed. CALS policy was released by Healthscope and has been adopted by ACHA in 2023. Monthly RRT review/MET reports are presented at relevant committees. Critical Care education Day / Professional Development Days are provided to supplement mandatory eLearning Hospitals report to the ACHA Executive Committee and Quality Activities are added to hospital Quality Action plans in eQuaMs where ongoing outliers are identified. **Completion Due By:** December 2020 **Responsibility:** DONs **Organisation Completed:** Yes		

ACTION 8.09		
The workforce uses the recognition and response systems to escalate care		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Met with Recommendation	All	**Recommendation NS2 OWA 0919.8.09** ACHA Health ensure compliance with the escalation of observations in the white zone of the Rapid Detection and Response Observation Chart, as per the ACHA Health Clinical Deterioration Recognising and Responding to 8.45 Policy. **Risk Rating: Moderate**

Organisation Action taken	**Assessor's Response**
ACHA established a combined Committee in 2020; ACHA Blood and Clinical Deterioration Committee, which is a sub-committee of the ACHA Executive Committee and includes representatives from all hospitals. Ashford Hospital has a site-specific Clinical Deterioration Committee where auditing and data is regularly reviewed. Additional actions in relation to the recommendation are below; 1. Review of the audit program to include increased auditing of practice and patient care outcomes. The Healthscope and ACHA policy in relation to auditing was reviewed and has been revised. Internal auditing is one method of monitoring quality. Audits are an essential part of the Clinical Governance Framework, and provide a mechanism for assessing compliance with standards, policies, and procedures. The policy identifies responsibilities and requirements for internal audits and ensures a best practice approach to the planning and conducting of internal audits, reporting audit results, and maintaining records. 2. Identify a process to ensure each audit is conducted according to the ACHA audit policy. In addition to policy review, a national audit schedule is in place and each site schedule audits by quarter. A new electronic auditing system was introduced nationally at Healthscope and ACHA. Monitoring of audits occurs at a site level and reporting to ACHA Executive Committee and via the Healthscope National Clinical Deterioration Committee. 3. Reported outliers that remain unresolved to be reported individually to the site Safety and Quality Committee.	**Recommendation Closed:** Yes The assessors observed high compliance with escalation of observations charted outside the white zone of the Standard Adult General Observation (SAGO) Chart. Clinical deterioration was the most common incident (1,593) reported in 2022. The review of the audit program is noted, as is the implementation of the national audit schedule.

ACTION 8.09		
The workforce uses the recognition and response systems to escalate care		
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**
Outliers are added to the hospital Quality Action Plan in eQuaMs (Electronic Quality and the ACHA Executive **Completion Due By:** December 2020 **Responsibility:** DONs **Organisation Completed:** Yes		