Report of the ACHS National Safety and Quality Health Service (NSQHS) Standards Survey

La Trobe Private Hospital

Bundoora, VIC

Organisation Code: 22 66 21

Survey Date: 12-13 July 2016

ACHS Accreditation Status: **ACCREDITED**

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About The Australian Council on Healthcare Standards

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

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

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

- a customer focus
- strong leadership
- a culture of improving
- evidence of outcomes
- striving for best practice.

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

What is Accreditation?

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

How to Use this Survey Report

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

- provide feedback to staff
- identify where improvements are needed
- compare the organisation's performance over time
- evaluate existing quality management procedures
- assist risk management monitoring
- highlight strengths and opportunities for improvement
- demonstrate evidence of achievement to stakeholders.

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

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

5 Standard Ratings Summary Report

1 Survey Team Summary Report

Consists of the following:

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

Ratings

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

The rating levels are:

NM – Not Met
The actions required have not been achieved

SM – Satisfactorily Met
The actions required have been achieved

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

Action Recommendations

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

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

- E: extreme risk; immediate action required.
- H: high risk; senior management attention needed.
- M: moderate risk; management responsibility must be specified.
- L: low risk; manage by routine procedures

High Priority Recommendations (HPR) -

A High Priority Recommendation (HPR) is given to an organisation when:

- consumer / patient care is compromised and / or
- the safety of consumers / patients and / or staff is jeopardised.

Surveyors complete a risk assessment to validate their decision to allocate a HPR, which should be addressed by the organisation in the shortest time possible.

2 Actions Ratings Summary Report

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

3 Summary of Recommendations from the Current Survey

Recommendations are highlighted areas for improvement due to a need to improve performance under a particular action.
Recommendations are structured as follows:
The action numbering relates to the Standard, Item and Action.

4 Recommendations from Previous Survey

This section details the recommendations from the previous onsite survey. The actions taken by the organisation and comments from the survey team regarding progress in relation to those recommendations are also recorded.
The action numbering relates to the month and year of survey and the action number. For example recommendation number NSQHSS0613. 1.1.1 is a recommendation from a NSQHS Standards Survey conducted in June 2013 with an action number of 1.1.1

5 Standards Ratings Summary Report

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

Organisation : La Trobe Private Hospital
Orgcode : 226621

Survey Report

Survey Overview

La Trobe Private Hospital (La TPH) opened in July 2015 as a 34 bed facility and provides medical services. Currently, six of the beds are leased for sleep studies. The number of admissions since opening of the facility has been increasing and the average occupancy achieved is reported to be approximately 50%. Further growth in admissions is projected with the opening of the Northpark Private Hospital Emergency Department scheduled to occur in November, 2016. The survey team was advised that a new 150 bed hospital is planned to be constructed on the La Trobe Campus within the next three years.

La TPH is part of the Healthscope (HSP) organisation and the Victorian Northern Cluster which includes Northpark Private Hospital and North Eastern Rehabilitation Hospital. The HSP National team provides support to La TPH through policies, guidelines and frameworks and opportunities to participate in benchmarking with facilities in the HSP Group. La TPH is closely linked to Northpark Private Hospital and provides support to the organisation.

This Organisation-Wide Survey includes assessment on progress made by La TPH with implementation of Standards 1-10 (excluding Standard 7).

It is evident that the La TPH Executive and staff are striving for excellence in the standard of healthcare provided. A distinct focus is evident on the engagement of the hospital's workforce to ensure safe and quality care is provided for consumers.

Good progress has been made in the implementation of all of the applicable NSQHS Standards. All core and majority of the developmental actions are assessed as Satisfactorily Met (SM). Core actions 3.10.1 and 9.6.1 are assessed as fully met. In Standard 2 Developmental actions 2.5.1 and 2.9.1 are assessed as Not Met (NM) and recommendations made. The Executive and staff are congratulated on their achievements.

STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

The La TPH governance arrangements that manage safety and quality for the period July 2015 to February 2016 LTPH activities were addressed under the NPPH/La TPH committee structure. In March 2016 an independent Committee structure was established for La TPH with the exception of a joint NPPH/La TPH Consumer Consultative Council which was established to facilitate consumer partnership activities across the hospitals. The La TPH Quality and Risk Committee is the peak clinical quality and safety committee and reports to the La TPH Leadership Committee. Both Committees meet regularly and have standing quality and safety agenda items. At the time of survey the terms of reference of some of the La TPH committees were awaiting finalisation and endorsement. The organisation is encouraged to ensure that all terms of references are finalised and mechanisms are established for formal evaluation of the effectiveness of all of the committees.

The development and review of policies, procedures and clinical guidelines which are relevant to the operations of La TPH are undertaken at HSP Corporate and La TPH levels. HICMR (Healthcare Infection Control Management Resources) policies are in use for infection control. Processes are well-established for ensuring currency of documents, legislative compliance and alerts when legislative changes occur and for communicating new and revised policy documents to the workforce. Compliance with policies occurs via audits and incident monitoring. Accessibility to policies and procedure documents by end-users occurs via the HSP intranet.

Consideration of patient safety and quality of care is incorporated in La TPH Strategic and operational plans.

A range of quality and safety audits are conducted and supported with an audit schedule. A suite of safety and quality key performance indicators is used to monitor performance by the Quality and Risk, and Leadership committees and are incorporated in safety and quality reports which are subject to ongoing review. Clinical Quality KPI Reports are regularly submitted to HSP Corporate and the National Safety and Quality Committee and performance is benchmarked with other HSP Hospitals.

Position descriptions indicate workforce responsibilities for safety and quality. The La TPH organisation chart clearly outlines reporting lines and responsibilities of staff. Systems are well-developed for orientation, mandatory and in-service education programs and provide information related to workforce safety and quality responsibilities. These are provided via e-learning and face-to-face education sessions, and are supported with educational resources. Records show very high levels of workforce compliance with the mandatory training programs that address the requirements of the NSQHS. Competencies assessments of nursing staff are well-addressed and include aseptic technique, Basic Life support, Advanced Life Support and medications.

Appropriate mechanisms are established for orientation of agency staff and locum staff. The survey team was advised that there is limited use of agency staff and no locum staff are used.

The risk management system is overseen by the Executive and is supported with policies which provide the framework for risk management across the organisation, the use of RiskMan and staff education in risk management. The risk register incorporates clinical and corporate risks and reflects issues arising from incidents, inspections and reviews. There is evidence of risk rating, use of controls and risk mitigation activities, ongoing review and monitoring of outcomes.

The quality system demonstrates linkage with the risk management system and is supported with La TPH and Unit quality plans which indicate a range of quality activities related to the NSQHS are being implemented and ongoing monitoring of progress and outcomes is occurring.

Clinical practice

Clinical guidelines are available via the HSP intranet and a generic nursing care plan is in use and subject to daily review. Risk assessments are incorporated in the pre-admission and admission assessment processes and include falls, malnutrition, pressure injury, and infection, cognitive status, allergies, venous thromboembolism (VTE) and medication and discharge risk. Alerts are documented in the patient record, the electronic administration information system and in other communication tools. Management plans are developed for patients identified at risk. Audit results show improved compliance with completion of risk assessments and management plans.

An effective system for escalating care is established and includes the use of track and trigger observation charts, availability of alarms at bedside in clinical areas, very high compliance levels of the workforce with mandatory BLS training and mechanisms established for clinical reviews, responses by a MET team and review of events.

Hard copy integrated records are available at the point of care. A suite of policies provide the framework for management and documentation of patient clinical records. All patients have a unique identifier. Processes are well developed for timely retrieval of records and tracking of records. The design of records allows for NSQHS related audits to be completed. Results of clinical record documentation audits show evidence of good compliance with documentation requirements. Action plans have been developed for areas identified as requiring improvement. Records sampled by the surveyors were found to be generally well-documented. However, there was evidence of variable compliance with documentation of medical and workforce names (printing of names and designations). The organisation is encouraged to ensure that this aspect is addressed. Nursing Discharge summaries are comprehensively documented but a minimalist approach to documentation in medical discharge summaries was evident. It is suggested that the organisation include copies of medical officer discharge letters in the clinical records.

Performance and skills management

Credentialling and defining scope of practice for medical officers occurs within the framework of the HSP By-Laws and the La TPH clinical services capability and is being overseen by the La TPH Medical Advisory Committee which was established in March 2016. E-credentialling has been introduced recently and includes use of a database. Results of HSP external audit results show 100% compliance.

AHPRA Registrations of Medical Officers, nursing and allied health are subject to regular review Performance review of medical officers includes monitoring working within approved scope of practice, incidents, clinical outcomes and conduct. Annual performance development and review is undertaken for other workers, with 100% compliance reported.

Incident and complaints management

The systems for management of incidents and complaints are well-developed and supported with policy/procedures and use of RiskMan. There is evidence of reporting, categorisation, risk rating, and follow-up of incidents and complaints and Mechanisms are established for clinical reviews Sentinel events, and as required provision of supported by the National Risk Compliance Manager. Information on how to make a complaint is included in the bedside information directories. A register of complaints and compliments is maintained in RiskMan. The organisation reported a very low level of incidents and complaints and a high level of compliments.

The organisation had provided Medical Officers with written advice regarding their responsibilities in Open Disclosure Evidence was available showing that 100% of the staff had completed e-learning Open disclosure education.

Patient rights and engagement

Information regarding patient rights and responsibilities is consistent with the National Charter of Healthcare rights and is available in the patient information directory, brochures, the HSP website and posters displayed throughout the facility and is incorporated in the admission process. Access to interpreters is available. Results of the Patient Impression surveys July-December 2015 show high levels of patients understanding of their rights and responsibilities.

Patients and carers are involved in the planning of treatment from the time of referral and assessment. Systems are well-developed for obtaining Financial Consent and consent for release of information. Results of clinical record audits show 100% compliance in consent documentation. The existence of advance care directives is included in the standard intake and assessment documentation.

Hard copy clinical records are stored securely within the Medical Records Department with only Clinical Information staff and designated nurses able to access and distribute records. A privacy policy is available and staff undertake privacy training through orientation and in-service education. Access to all electronic information systems by staff is via restricted password protected procedures.

There is regular evaluation of patients' satisfaction via patient impression surveys. Patient Centred Care survey results for the period February to May 2016 show high levels of satisfaction. An action plan is being developed to address an area identified for improvement regarding timeliness of communication responses by the clinical workforce. The organisation is congratulated on the high level of patient satisfaction received across the services.

NSQHSS Survey

Organisation : La Trobe Private Hospital
Orgcode : 226621

Governance and quality improvement systems

Ratings

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

Clinical practice

Ratings

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

Performance and skills management

Ratings

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

Incident and complaints management

Ratings

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

NSQHSS Survey

Organisation : La Trobe Private Hospital
Orgcode : 226621

Patient rights and engagement

Ratings

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

STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

The governance arrangements for Consumer partnership occur within the framework of the HSP Partnering with Consumers Policy. A Consumer Consultant Council was established I March 2016 and is chaired by the NPPH and La TPH Quality Manager with Northern Cluster GM in attendance. The committee is the very early formative stage of development and terms of reference are awaiting finalisation. The organisation is strongly encouraged to clearly define the reporting lines of the committee and its relationship to La TPH and formally evaluate the effectiveness of the committee.

The survey team was advised that there has been recruitment of new consumer representatives, the total number of representatives being now seven, and also that orientation of new members has occurred. It is suggested that the organisation formally evaluate the effectiveness of the orientation of consumer representatives to their roles and implement follow-up actions for areas identified as requiring strengthening.

The organisation is encouraged to ensure there are well-developed mechanisms established for communicating the activities of the consumer representatives and the Consumer Council to patients and carers and the Executive and La TPH workforce.

Evidence was available to demonstrate mechanisms have been established for communicating strategic planning activities to consumer representatives, that they have been consulted in the development of publications/patient information materials, and that information obtained from feedback had been incorporated in documents.

Evidence was also provided showing that a consumer representative had attended the NPPH/La TPH Quality and Risk Committee meetings. The Quality Manager advised that it was planned to rotate attendance of consumer representatives at each meeting La TPH Quality and Risk Committee. The survey team suggested that consumer representative membership on this La TPH Quality and Risk Committee be for a minimum of 1 year to enable development of consumer skills and knowledge in aspects related to safety and quality and evaluation of performance.

Consumer partnership in designing care

Mechanisms for participation in designing and redesigning care are yet to be established, and has resulted in 2.5.1 being assessed as NM and a recommendation made.

Evidence provided showed 100% participation of the workforce in patient-centred care education at orientation and in e-learning programs. Education of the workforce includes involvement of a consumer representative in orientation programs. Further work is planned to involve additional consumer representatives in workforce orientation programs.

Consumer partnership in service measurement and evaluation

Mechanisms have been established for provision of the community and consumers with information on the La TPH safety and quality performance and include display of information in the hospital reception area and in a newsletter. Plans are in place for inclusion of information relating to La TPH performance on the My Healthscope website with estimated target time of completion 22 July 2016.

Evidence was provided that showed attendance of a consumer representative at NPPH/ La TPH Quality and Risk Committee meetings where La TPH safety and quality data is reviewed. Plans are in place for presentation of safety and quality performance data to the Consumer Consultation Council. An example where consumer representatives had participated in a quality activity is in the identification of the content of information to be included on patent bedside information boards. It is suggested that the organisation identify additional quality improvement projects which could be undertaken in consultation with consumers.

No evidence was available to show formal mechanisms have been established to enable participation of consumers and/or carers in implementation of quality activities relating to patient feedback data and has resulted in. 2.9.2 being assessed as NM and a recommendation made.

The survey team suggests that a La TPH Consumer Partnership Plan be developed to assist in progressing implementation of Standard 2.

Consumer partnership in service planning

Ratings

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

Consumer partnership in designing care

Ratings

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

Action 2.5.1 Developmental

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

Surveyor Comment:

Mechanisms have not been established for involving consumers and/or carers in the design and redesign of LTPH services.

Surveyor's Recommendation:

Identify and implement a mechanism for the involving of consumers and/or carers in the design and redesign of the health service.

Risk Level: Low

Consumer partnership in service measurement and evaluation

Ratings

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

Action 2.9.2 Developmental

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

Surveyor Comment:

Evidence was not available to show that formal mechanisms have been identified for participation of consumers and carers in implementation of quality activities relating to patient feedback data.

Surveyor's Recommendation:

Identify and implement a mechanism to enable consumers and carers to participate in the implementation of quality activities relating to patient feedback data.

Risk Level: Low

STANDARD 3
PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Surveyor Summary

Governance and systems for infection prevention, control and surveillance

La TPH infection prevention and control activities are overseen by Infection Control Committee (ICC) and supported by a part-time Infection Control Nurse (ICN) and Healthcare Infection Control Management Resources (HICMR) who provide a Level 3 consultancy service. ICC membership is multidisciplinary and meetings are scheduled second monthly. HICMR policies/procedures are available online for staff to access via a hospital wide login and are subject to ongoing review and maintenance of currency, with document control maintained by HICMR.

There is a documented Infection Control Plan and well-developed audit and surveillance programs are in place. External audits have been undertaken by a HICMR Consultant and internal audits by the La TPH staff to assess compliance with infection control policies. Results show very high levels of compliance and there is clear evidence of implementation of follow-up actions for areas identified as requiring improvement. Performance monitoring and review is undertaken by the ICC and the Quality and Risk Committee. A very low level of hospital acquired infections is reported.

Infection prevention and control strategies

A number of appropriate strategies are in place to allow for the prevention and control of healthcare associated infections. The main infection prevention and control strategy, Hand Hygiene (HH) is being monitored to assess the compliance rate. The HH Audit is undertaken 3 times per year and the compliance from April – June 2016 as 85.71%. HH is supported by the strategic placement of numerous hand gel stations throughout the facility. A general Handcare Program is extended to all staff to care for their hands and reduce the number of cuts and scratches.

Monitoring of the use of Personnel Protective Equipment (PPE) occurs. The rate of PPE compliance in March 2016 wad 89%. Protocols provide direction for the management of occupational exposure incidents including access to an Infectious Disease Physician.

Education on aseptic technique and invasive device technique is available for staff. Assessment of clinician competency of aseptic technique occurs and compliance is high. Action 3.10.1 is assessed as SM and is fully met.

A staff immunisation program is in place and a database to record immunisations has been established.

Managing patients with infections or colonisations

Standard and transmission based precautions consistent with current national guidelines, are in use. Auditing of compliance has commenced. A number of mechanisms are in place to enable the identification of pre-existing infections. These include the nursing history assessment form, alerts used in patient notes and discussion at the time of clinical handover. Ongoing audits occur across a range of areas including hand hygiene, sharps, linen, waste and clinical waste. The compliance rate for Standard Precautions in March 2016 was 95%.

The opportunity for patient management is enhanced by the high volume of single rooms available at the site.

Antimicrobial stewardship

Antimicrobial stewardship (AMS) is still in its infancy at La TPH. The staff have easy access to the current Therapeutic Guidelines at all times. Implementation and monitoring of an AMS governance strategy, in accordance with the National Safety and Quality Health Service (NSQHS) Standards is well underway but a recent audit of antibiotic usage has shown only a 33% compliance with the Therapeutic Goods Administration (TGA) Antibiotic Guidelines.

It is suggested that monitoring of antibiotic usage and resistance should occur across the top three (3) admitted Diagnostic Related Groups (DRGs) requiring antibiotic therapy and focus on those illnesses and establish protocols for treatment. The organisation could also look at the need to have clearly defined lists of restricted and non-restricted antibiotics specific to the high activity conditions.

It is noted that the organisation now has access to a Pharmacist and is hopeful of recruiting the services of an Infectious Disease Physician which would strengthen the ability to better manage the antimicrobial stewardship onsite.

Cleaning, disinfection and sterilisation

Maintenance and cleaning schedules are in place and environmental auditing is undertaken with results indicating a high level of compliance. The surveyors observed that all facilities were clean and that storage rooms allowed for appropriate cleaning to occur.

Cleaning and disinfection is conducted as per the procedures set out. There is a single use item policy and this is adhered to. No sterilisation is undertaken onsite.

Communicating with patients and carers

Staff communicate with patients and carers and provide them with education on infection prevention and control in the home as required. La TPH infection control performance data is displayed in the hospital reception area. The survey team was advised that it is planned to include information related to HPH performance on the Healthscope website which is currently being upgraded. Evidence was available to demonstrate that the consumers have been consulted in the development of publications/patient information materials and that information obtained from feedback had been incorporated in documents.

Governance and systems for infection prevention, control and surveillance

Ratings

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

Infection prevention and control strategies

Ratings

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

Action 3.10.1 Core

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

Surveyor Comment:

This transitional action is assessed as being fully met.

Surveyor's Recommendation:

No recommendation

Managing patients with infections or colonisations

Ratings

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

Antimicrobial stewardship

Ratings

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

Cleaning, disinfection and sterilisation

Ratings

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
3.19.1	SM	SM
3.19.2	SM	SM

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

Healthscope has 31 National Policies covering the legislative requirements and professional guidelines to support governance and the safe use of medicines. La TPH has a robust clinical incident monitoring system is in place to minimise the risk to patients.

The recent establishment of a Pharmacy Committee provides a quarterly interdisciplinary forum for discussion and a review mechanism through which hospital- wide pharmaceutical and medication issues are monitored and recommendations made to the relevant hospital committees and personnel. This will also include review of medication incidents and adverse reactions/events that are notified. A draft Terms of Reference has been developed and will be ratified at the next meeting of the committee.

The Pharmacy Committee reports to the Hospital Leadership Committee and will strengthen the ability to undertake and review quality improvement activities.

Documentation of patient information

Comprehensive medication histories are taken on admission and recorded on the National Inpatient Medication Chart. There is good compliance with this. Recording of alerts and allergies also occurs in the medical record.

Ongoing medication reviews are undertaken by the visiting Pharmacist and any issues noted are raised with the admitting doctor.

Medication management processes

Staff have good quality access to information and decision support tools. eMIMS is accessible and is utilised to provide information to staff.

Drug storage is well managed with Pharmacist support. Drugs requiring refrigeration are currently stored in a bar fridge with thermometer. Temperature monitoring occurs on a twice daily basis and is recorded. No alarm system is in place and resetting the thermometer is the solution if the temperature rises or falls below the 2–8 degree level. The surveyors strongly suggest the facility purchases a compliant drug fridge with an alarm system for medication storage.

High Risk Medication was stored separately and clearly labelled. Consideration is being given to changing the storage receptacle colour to red to better identify the High Risk Medication.

S8, S11 and patient medications are checked and signed on shift changeover to check levels are identical. No discrepancies were identified.

Continuity of medication management

Continuity of medication is well managed and patients receive a visit from the Pharmacist prior to discharge and a medication profile is attended. On discharge patients are provided with the medications which they brought in (if still relevant) and any new medications required on discharge. Any medications which have been ceased will be placed in the Returned Unused Medication (RUM) bin, removed and disposed of by the Pharmacist. Patients all receive a discharge medication summary. Any patients who may be unable to self-administer their medications will be offered a Webster medication system to assist them with medication compliance and safety.

Communicating with patients and carers

There is good access to patient information tools enabling staff to provide patient specific medicine information. The development of a Medication Management Plan in partnership with the Pharmacist, patients and carers is consistent across the facility.

Governance and systems for medication safety

Ratings

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

Documentation of patient information

Ratings

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

Medication management processes

Ratings

Action	Organisation	Surveyor
4.9.1	SM	SM
4.9.2	SM	SM
4.9.3	SM	SM
4.10.1	SM	SM
4.10.2	SM	SM
4.10.3	SM	SM
4.10.4	SM	SM

4.10.5	SM	SM
4.10.6	SM	SM
4.11.1	SM	SM
4.11.2	SM	SM

Continuity of medication management

Ratings

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

Communicating with patients and carers

Ratings

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

STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

An organisation-wide patient identification system is regularly monitored. La TPH has a well-established range of systems and mechanisms in place to ensure that all patients are correctly identified and matched in accordance with the Healthscope policy. All necessary policies and guidelines are in place and available for all staff to utilise.

Every patient has a unique identifier Unit Medical Record Number (UMRN). The nationally specified white name band is utilised for patient identification and four approved identifiers to match patients which complies with the current National Standard. A red identification band is used in the instance where a patient has an identified risk.

Processes to transfer care

ISOBAR patient handover, transfer and discharge processes all involve using three patient identifiers. Clear, concise, appropriate ISOBAR handovers occur during transfer of patients to other facilities. There are paper based tools used to check patient identification.

Documented policies and guidelines that outline the processes of matching a patient to their intended care or treatment are in place.

Processes to match patients and their care

There are documented policies and guidelines that outline the processes of matching a patient to their intended care or treatment. This occurs during medication rounds and where patients require procedures to be undertaken. Patient Identification also occurs during the bedside handover.

Patient identification audits occur and results demonstrate high compliance.

NSQHSS Survey

Organisation : La Trobe Private Hospital
Orgcode : 226621

Identification of individual patients

Ratings

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

Processes to transfer care

Ratings

Action	Organisation	Surveyor
5.4.1	SM	SM

Processes to match patients and their care

Ratings

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

Organisation : La Trobe Private Hospital
Orgcode : 226621

STANDARD 6
CLINICAL HANDOVER

Surveyor Summary

Governance and leadership for effective clinical handover

Clinical policies and processes that have been developed for clinical handover are in place. Relevant staff have received education on all these guidelines and this is also covered at new staff orientation. Compliance with guidelines is reviewed and evaluated with reports presented to the relevant committees.

The use of the ISOBAR tool is embedded at all sites for all handover processes. All clinical staff interviewed indicated this worked well. Handover occurs three times a day at shift change, with the bedside handover occurring at 1400hrs only.

Clinical handover processes

There are excellent documented systems for effective, timely, relevant and structured clinical handover that supports safe patient care.

There is a systematic process for clinical handover. One surveyor attended bedside handover and reviewed documentation. All patients visited had wristbands in place and these were checked during the bedside handover process. This was observed by a surveyor.

Patient and carer involvement in clinical handover

The La TPH includes patients and carers in the clinical handover processes if the patient agrees. There are no formal established mechanisms for this.

Patients are involved during the bed to bed handover and introduction of the next shift person. Patients interviewed indicated they were involved and knew what was happening to them and who the staff caring for them were. Patients were encouraged to ask questions and gain information from staff, for example discharge arrangements. This was observed to occur by the surveyor attending a bedside handover.

Governance and leadership for effective clinical handover

Ratings

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

Clinical handover processes

Ratings

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

Patient and carer involvement in clinical handover

Ratings

Action	Organisation	Surveyor
6.5.1	SM	SM

Organisation : La Trobe Private Hospital
Orgcode : 226621

STANDARD 7
BLOOD AND BLOOD PRODUCTS

Surveyor Summary

Standard 7 is not applicable to this organisation.

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

Ratings

Action	Organisation	Surveyor
7.1.1	N/A	N/A
7.1.2	N/A	N/A
7.1.3	N/A	N/A
7.2.1	N/A	N/A
7.2.2	N/A	N/A
7.3.1	N/A	N/A
7.3.2	N/A	N/A
7.3.3	N/A	N/A
7.4.1	N/A	N/A

Documenting patient information

Ratings

Action	Organisation	Surveyor
7.5.1	N/A	N/A
7.5.2	N/A	N/A
7.5.3	N/A	N/A
7.6.1	N/A	N/A
7.6.2	N/A	N/A
7.6.3	N/A	N/A

Managing blood and blood product safety

Ratings

Action	Organisation	Surveyor
7.7.1	N/A	N/A
7.7.2	N/A	N/A
7.8.1	N/A	N/A
7.8.2	N/A	N/A

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
7.9.1	N/A	N/A
7.9.2	N/A	N/A
7.10.1	N/A	N/A
7.11.1	N/A	N/A

STANDARD 8
PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and systems for the prevention and management of pressure injuries

Evidence-based systems to prevent pressure injuries and to manage them when they occur have been implemented and are supported with HSP policies and procedures for the prevention and management of pressure injuries that provide the framework. Policies and procedures are consistent with national evidence-based guidelines for the prevention and management of pressure injuries and incorporate screening and assessment tools including screening of nutritional status. There was evidence of incidence of community acquired pressure injuries but no hospital acquired pressure injury incidents at La TPH. The systems ensure that community acquired pressure injuries are identified when patients are admitted, and appropriate management plans are put in place. Processes are established for review of results of audits, clinical indicator data and reported incidents of both hospital and community acquired pressure injuries by the Quality and Risk Committee and reporting to Healthscope Corporate. Benchmarking of performance occurs within HSP hospitals. The Quality Manager represents the hospital on the HSP Pressure Area Prevention Clinical Cluster Committee.

Preventing pressure injuries

A modified Waterlow Pressure Risk Assessment tool is available for assessment of patients. Audit results show that there is good compliance with completion of risk assessments at time of admission and in follow-up management plans for patients assessed as high risk. Identified high risk patients have a comprehensive skin integrity assessment and a daily management plan completed by the nursing team. The introduction of Hourly Rounding has supported the encouragement of patients to move position.

Managing pressure injuries

Strategies for the prevention and management of pressure injuries include the use of pressure relieving devices. Evidenced based wound management guidelines and products are available. All occurrences are reported via RiskMan. Wound charts are used for all patients with wounds or skin integrity issues. High risk patients, as part of their care plan are commenced on pressure relieving devices. Ongoing education is available for all nursing staff.

Communicating with patients and carers

The Move, Move, Move patient information sheet on prevention and management of pressure injuries is provided to patients and carers. There is evidence of pressure injury management plans being developed in partnership with patients and/or carer.

Governance and systems for the prevention and management of pressure injuries

Ratings

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

Preventing pressure injuries

Ratings

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

Managing pressure injuries

Ratings

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
8.9.1	SM	SM
8.10.1	SM	SM

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

Surveyor Summary

Establishing recognition and response systems

The La TPH has a clear framework of policies, procedures and protocols to manage clinical deterioration. The use of the Adult General Observation Chart which includes parameters and colour coding (white, yellow and red) guides the nursing staff to initiate an appropriate response when a patient's recordings deviate from the white zone. The escalation criteria and the actions to be taken are clearly defined.

There have been no deaths in the La TPH so no Morbidity and Mortality reviews have been undertaken.

Recognising clinical deterioration and escalating care

Staff are trained in the use of the Adult General Observation Chart and how to escalate care. All cases where care is escalated are entered into RiskMan and case review is conducted by the Nurse Unit Manager and the Quality/Risk Manager to assess correctness of process and care. Feedback is provided to staff involved.

Responding to clinical deterioration

An appropriate rapid response system is in place given there is no resident medical staff at the La TPH. All staff are trained in Basic Life Support (BLS) measures and the majority of nursing staff have now been trained in Advanced Life Support (ALS) measures. ALS training was a strong suggestion from the previous survey team.

Rosters are managed appropriately to ensure that appropriately trained staff are available to provide an effective response.

Communicating with patients and carers

The policy related to advanced care planning, limitation of treatment and refusal of medical treatment is comprehensively documented. The formal procedures to be followed are clearly documented, including when treatment is to be refused for persons who are not capable of making their decisions. An Advance Care Directives brochure is available and provided to patients as required Documentation of plans and alerts are incorporated in the clinical records.

Information on how to communicate and escalate concerns about a patient's condition is incorporated in a brochure,' Escalation of Care' and in admission processes, and availability of a bedside patient call system and signage indicating location of an emergency buzzer support patients family, visitors or carers to escalate care needs. Given the low number of patients, staff are always available to talk to family and friends about patient needs.

Establishing recognition and response systems

Ratings

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

Recognising clinical deterioration and escalating care

Ratings

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

Responding to clinical deterioration

Ratings

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

Action 9.6.1 Core

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

Surveyor Comment:

This transitional action is assessed as being fully met.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

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

STANDARD 10
PREVENTING FALLS AND HARM FROM FALLS

Surveyor Summary

Governance and systems for the prevention of falls

Appropriate evidence-based processes are in use to reduce falls and minimise harm from falls and are supported with HSP policies/protocols. The hospital has a representative on the HSP 'Falls Clinical Cluster Committee'. Compliance with the protocols is regularly audited. A distinct focus to monitor and investigate all falls, and implement specific strategies to reduce the falls incidents, and the severity of falls injury is evident. Falls incidents are reported in RiskMan and to the Quality and Risk Committees and HSP Corporate. Benchmarking of performance occurs within the HSP hospitals and via the ACHS Clinical Indicator program. The organisation undertakes analysis of falls data with a view to determining the causes of falls in the facility.

Incident data shows that that rate of falls has decreased and that there have been no significant injuries related to a fall.

Screening and assessing risks of falls and harm from falling

Risk assessments using the evidenced based FRAMT tool are undertaken on all patients on admission and daily during their inpatient stay. The use of risk assessment is regularly monitored to ensure all at-risk patients are appropriately screened/assessed for falls and harm from falling and that assessment occurs following a fall. Audit results show a very high level of compliance in completion of risk assessments.

Preventing falls and harm from falling

Falls prevention management plans are implemented for management of patients, particularly those identified high risk fall patients. Strategies include the use of bedside Traffic Light Safety charts, high/low beds, hourly rounding of patients, coloured non-slip grip socks, alarm mats, mobility equipment, referrals to a physiotherapist, and medication reviews. Patients assessed as having a high risk of falling are assessed specifically for consideration of providing them with a pair of grip socks. Evidence provided shows increased d compliance in documentation of Traffic Light Safety Charts and management plans. Discharge planning includes referrals to allied health and to falls and balance programs and rehabilitation services. April Falls Awareness week conducted by the organisation in 2016 focused on falls prevention and management strategies and included review of the Traffic Light Safety Chart. Falls education for staff is undertaken via orientation and eLearning programs.

Communicating with patients and carers

Patient education brochures are available for patients and carers. The My Healthscope website provides very good information regarding prevention of falls. There was evidence that falls prevention plans are developed in partnership with patients and/or their carer. Bedside clinical handover supports frequent communication on falls prevention with patient and carers.

Governance and systems for the prevention of falls

Ratings

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

Screening and assessing risks of falls and harm from falling

Ratings

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

Preventing falls and harm from falling

Ratings

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.9.1	SM	SM
10.10.1	SM	SM
10.10.1	SM	SM

Organisation : La Trobe Private Hospital
Orgcode : 226621

Actions Rating Summary

Governance for Safety and Quality in Health Service Organisations

Governance and quality improvement systems

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

Clinical practice

Action	Description	Organisation's self-rating	Surveyor Rating
1.7.1	Agreed and documented clinical guidelines and/or pathways are available to the clinical workforce	SM	SM
1.7.2	The use of agreed clinical guidelines by the clinical workforce is monitored	SM	SM

1.8.1	Mechanisms are in place to identify patients at increased risk of harm	SM	SM
1.8.2	Early action is taken to reduce the risks for at-risk patients	SM	SM
1.8.3	Systems exist to escalate the level of care when there is an unexpected deterioration in health status	SM	SM
1.9.1	Accurate, integrated and readily accessible patient clinical records are available to the clinical workforce at the point of care	SM	SM
1.9.2	The design of the patient clinical record allows for systematic audit of the contents against the requirements of these Standards	SM	SM

Performance and skills management

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

Incident and complaints management

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

1.15.2	Systems are in place to analyse and implement improvements in response to complaints	SM	SM
1.15.3	Feedback is provided to the workforce on the analysis of reported complaints	SM	SM
1.15.4	Patient feedback and complaints are reviewed at the highest level of governance in the organisation	SM	SM
1.16.1	An open disclosure program is in place and is consistent with the national open disclosure standard	SM	SM
1.16.2	The clinical workforce are trained in open disclosure processes	SM	SM

Patient rights and engagement

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

Partnering with Consumers

Consumer partnership in service planning

Action	Description	Organisation's self-rating	Surveyor Rating
2.1.1	Consumers and/or carers are involved in the governance of the health service organisation	SM	SM
2.1.2	Governance partnerships are reflective of the diverse range of backgrounds in the population served by the health service organisation, including those people who do not usually provide feedback	SM	SM
2.2.1	The health service organisation establishes mechanisms for engaging consumers and/or carers in the strategic and/or operational planning for the organisation	SM	SM
2.2.2	Consumers and/or carers are actively involved in decision making about safety and quality	SM	SM

2.3.1	Health service organisations provide orientation and ongoing training for consumers and/or carers to enable them to fulfil their partnership role	SM	SM
2.4.1	Consumers and/or carers provide feedback on patient information publications prepared by the health service organisation (for distribution to patients)	SM	SM
2.4.2	Action is taken to incorporate consumer and/or carers' feedback into publications prepared by the health service organisation for distribution to patients	SM	SM

Consumer partnership in designing care

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

Consumer partnership in service measurement and evaluation

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

Preventing and Controlling Healthcare Associated Infections

Governance and systems for infection prevention, control and surveillance

Action	Description	Organisation's self-rating	Surveyor Rating
3.1.1	A risk management approach is taken when implementing policies, procedures and/or protocols for: • standard infection control precautions • transmission-based precautions • aseptic non-touch technique • safe handling and disposal of sharps • prevention and management of occupational exposure to blood and body substances • environmental cleaning and disinfection • antimicrobial prescribing	SM	SM

	• outbreaks or unusual clusters of communicable infection • processing of reusable medical devices • single-use devices • surveillance and reporting of data where relevant • reporting of communicable and notifiable diseases • provision of risk assessment guidelines to workforce • exposure-prone procedures		
3.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
3.1.3	The effectiveness of the infection prevention and control systems is regularly reviewed at the highest level of governance in the organisation	SM	SM
3.1.4	Action is taken to improve the effectiveness of infection prevention and control policies, procedures and/or protocols	SM	SM
3.2.1	Surveillance systems for healthcare associated infections are in place	SM	SM
3.2.2	Healthcare associated infections surveillance data are regularly monitored by the delegated workforce and/or committees	SM	SM
3.3.1	Mechanisms to regularly assess the healthcare associated infection risks are in place	SM	SM
3.3.2	Action is taken to reduce the risks of healthcare associated infection	SM	SM
3.4.1	Quality improvement activities are implemented to reduce and prevent healthcare associated infections	SM	SM
3.4.2	Compliance with changes in practice are monitored	SM	SM
3.4.3	The effectiveness of changes to practice are evaluated	SM	SM

Infection prevention and control strategies

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

3.9.1	Education and competency-based training in invasive devices protocols and use is provided for the workforce who perform procedures with invasive devices	SM	SM
3.10.1	The clinical workforce is trained in aseptic technique	SM	SM
3.10.2	Compliance with aseptic technique is regularly audited	SM	SM
3.10.3	Action is taken to increase compliance with the aseptic technique protocols	SM	SM

Managing patients with infections or colonisations

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

Antimicrobial stewardship

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

Cleaning, disinfection and sterilisation

Action	Description	Organisation's self-rating	Surveyor Rating
3.15.1	Policies, procedures and/or protocols for environmental cleaning that address the principles of infection prevention and control are implemented, including: • maintenance of building facilities • cleaning resources and services	SM	SM

• risk assessment for cleaning and disinfection based on transmission-based precautions and the infectious agent involved
• waste management within the clinical environment
• laundry and linen transportation, cleaning and storage
• appropriate use of personal protective equipment

3.15.2	Policies, procedures and/or protocols for environmental cleaning are regularly reviewed	SM	SM
3.15.3	An established environmental cleaning schedule is in place and environmental cleaning audits are undertaken regularly	SM	SM
3.16.1	Compliance with relevant national or international standards and manufacturer's instructions for cleaning, disinfection and sterilisation of reusable instruments and devices is regularly monitored	SM	SM
3.17.1	A traceability system that identifies patients who have a procedure using sterile reusable medical instruments and devices is in place	SM	SM
3.18.1	Action is taken to maximise coverage of the relevant workforce trained in a competency-based program to decontaminate reusable medical devices	SM	SM

Communicating with patients and carers

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

Medication Safety

Governance and systems for medication safety

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

4.5.1	The performance of the medication management system is regularly assessed	SM	SM
4.5.2	Quality improvement activities are undertaken to reduce the risk of patient harm and increase the quality and effectiveness of medicines use	SM	SM

Documentation of patient information

Action	Description	Organisation's self-rating	Surveyor Rating
4.6.1	A best possible medication history is documented for each patient	SM	SM
4.6.2	The medication history and current clinical information is available at the point of care	SM	SM
4.7.1	Known medication allergies and adverse drug reactions are documented in the patient clinical record	SM	SM
4.7.2	Action is taken to reduce the risk of adverse reactions	SM	SM
4.7.3	Adverse drug reactions are reported within the organisation and to the Therapeutic Goods Administration	SM	SM
4.8.1	Current medicines are documented and reconciled at admission and transfer of care between healthcare settings	SM	SM

Medication management processes

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

Continuity of medication management

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

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
4.13.1	The clinical workforce provides patients with patient specific medicine information, including medication treatment options, benefits and associated risks	SM	SM
4.13.2	Information that is designed for distribution to patients is readily available to the clinical workforce	SM	SM
4.14.1	An agreed medication management plan is documented and available in the patient's clinical record	SM	SM
4.15.1	Information on medicines is provided to patients and carers in a format that is understood and meaningful	SM	SM
4.15.2	Action is taken in response to patient feedback to improve medicines information distributed by the health service organisation to patients	SM	SM

Patient Identification and Procedure Matching

Identification of individual patients

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

Processes to transfer care

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

Processes to match patients and their care

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

Clinical Handover

Governance and leadership for effective clinical handover

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

Clinical handover processes

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

6.4.2	Action is taken to reduce the risk of adverse clinical handover incidents	SM	SM

Patient and carer involvement in clinical handover

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

Blood and Blood Products

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

Action	Description	Organisation's self-rating	Surveyor Rating
7.1.1	Blood and blood product policies, procedures and/or protocols are consistent with national evidence-based guidelines for pre-transfusion practices, prescribing and clinical use of blood and blood products	N/A	N/A
7.1.2	The use of policies, procedures and/or protocols is regularly monitored	N/A	N/A
7.1.3	Action is taken to increase the safety and appropriateness of prescribing and clinically using blood and blood products	N/A	N/A
7.2.1	The risks associated with transfusion practices and clinical use of blood and blood products are regularly assessed	N/A	N/A
7.2.2	Action is taken to reduce the risks associated with transfusion practices and the clinical use of blood and blood products	N/A	N/A
7.3.1	Reporting on blood and blood product incidents is included in regular incident reports	N/A	N/A
7.3.2	Adverse blood and blood product incidents are reported to and reviewed by the highest level of governance in the health service organisation	N/A	N/A
7.3.3	Health service organisations participate in relevant haemovigilance activities conducted by the organisation or at state or national level	N/A	N/A
7.4.1	Quality improvement activities are undertaken to reduce the risks of patient harm from transfusion practices and the clinical use of blood and blood products	N/A	N/A

Documenting patient information

Action	Description	Organisation's self-rating	Surveyor Rating
7.5.1	A best possible history of blood product usage and relevant clinical and product information is documented in the patient clinical record	N/A	N/A
7.5.2	The patient clinical records of transfused patients are periodically reviewed to assess the proportion of records completed	N/A	N/A
7.5.3	Action is taken to increase the proportion of patient clinical records of transfused patients with a complete patient clinical record	N/A	N/A
7.6.1	Adverse reactions to blood or blood products are documented in the patient clinical record	N/A	N/A
7.6.2	Action is taken to reduce the risk of adverse events from administering blood or blood products	N/A	N/A

7.6.3	Adverse events are reported internally to the appropriate governance level and externally to the pathology service provider, blood service or product manufacturer whenever appropriate	N/A	N/A

Managing blood and blood product safety

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

Communicating with patients and carers

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

Preventing and Managing Pressure Injuries

Governance and systems for the prevention and management of pressure injuries

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

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Preventing pressure injuries

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

Managing pressure injuries

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

Communicating with patients and carers

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

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Recognising and Responding to Clinical Deterioration in Acute Health Care

Establishing recognition and response systems

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

Recognising clinical deterioration and escalating care

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

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Responding to clinical deterioration

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

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
9.7.1	Information is provided to patients, families and carers in a format that is understood and meaningful. The information should include: • the importance of communicating concerns and signs/symptoms of deterioration, which are relevant to the patient's condition, to the clinical workforce • local systems for responding to clinical deterioration, including how they can raise concerns about potential deterioration	SM	SM
9.8.1	A system is in place for preparing and/or receiving advance care plans in partnership with patients, families and carers	SM	SM
9.8.2	Advance care plans and other treatment-limiting orders are documented in the patient clinical record	SM	SM
9.9.1	Mechanisms are in place for a patient, family member or carer to initiate an escalation of care response	SM	SM
9.9.2	Information about the system for family escalation of care is provided to patients, families and carers	SM	SM
9.9.3	The performance and effectiveness of the system for family escalation of care is periodically reviewed	SM	SM
9.9.4	Action is taken to improve the system performance for family escalation of care	SM	SM

Preventing Falls and Harm from Falls

Governance and systems for the prevention of falls

Action	Description	Organisation's self-rating	Surveyor Rating
10.1.1	Policies, procedures and/or protocols are in use that are consistent with best practice guidelines (where available) and incorporate screening and assessment tools	SM	SM
10.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
10.2.1	Regular reporting, investigating and monitoring of falls incidents is in place	SM	SM
10.2.2	Administrative and clinical data are used to monitor and investigate regularly the frequency and severity of falls in the health service organisation	SM	SM

10.2.3	Information on falls is reported to the highest level of governance in the health service organisation	SM	SM
10.2.4	Action is taken to reduce the frequency and severity of falls in the health service organisation	SM	SM
10.3.1	Quality improvement activities are undertaken to prevent falls and minimise patient harm	SM	SM
10.4.1	Equipment and devices are available to implement prevention strategies for patients at risk of falling and management plans to reduce the harm from falls	SM	SM

Screening and assessing risks of falls and harm from falling

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

Preventing falls and harm from falling

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

Communicating with patients and carers

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

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Recommendations from Current Survey

Standard: Partnering with Consumers
Item: 2.5
Action: 2.5.1 Consumers and/or carers participate in the design and redesign of health services

Surveyor's Recommendation:

Identify and implement a mechanism for the involving of consumers and/or carers in the design and redesign of the health service.

Standard: Partnering with Consumers
Item: 2.9
Action: 2.9.2 Consumers and/or carers participate in the implementation of quality activities relating to patient feedback data

Surveyor's Recommendation:

Identify and implement a mechanism to enable consumers and carers to participate in the implementation of quality activities relating to patient feedback data.

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Standards Rating Summary

Organisation - NSQHSS V01

Core

Standard	Not Met	Met	N/A	Total
Standard 1	0	44	0	44
Standard 2	0	4	0	4
Standard 3	0	39	0	39
Standard 4	0	31	0	31
Standard 5	0	9	0	9
Standard 6	0	9	0	9
Standard 7	0	0	20	20
Standard 8	0	20	0	20
Standard 9	0	15	0	15
Standard 10	0	18	0	18
Total	**0**	**189**	**20**	**209**

Standard	SM	MM	Total
Standard 1	44	0	44
Standard 2	4	0	4
Standard 3	39	0	39
Standard 4	31	0	31
Standard 5	9	0	9
Standard 6	9	0	9
Standard 7	0	0	0
Standard 8	20	0	20
Standard 9	15	0	15
Standard 10	18	0	18
Total	**189**	**0**	**189**

Developmental

Standard	Not Met	Met	N/A	Total
Standard 1	0	9	0	9
Standard 2	0	11	0	11
Standard 3	0	2	0	2
Standard 4	0	6	0	6
Standard 5	0	0	0	0
Standard 6	0	2	0	2
Standard 7	0	0	3	3
Standard 8	0	4	0	4
Standard 9	0	8	0	8
Standard 10	0	2	0	2
Total	**0**	**44**	**3**	**47**

Standard	SM	MM	Total
Standard 1	9	0	9
Standard 2	11	0	11
Standard 3	2	0	2
Standard 4	6	0	6
Standard 5	0	0	0
Standard 6	2	0	2
Standard 7	0	0	0
Standard 8	4	0	4
Standard 9	8	0	8
Standard 10	2	0	2
Total	**44**	**0**	**44**

Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 1	0	53	0	53	Met
Standard 2	0	15	0	15	Met
Standard 3	0	41	0	41	Met
Standard 4	0	37	0	37	Met
Standard 5	0	9	0	9	Met
Standard 6	0	11	0	11	Met
Standard 7	0	0	23	23	Met
Standard 8	0	24	0	24	Met
Standard 9	0	23	0	23	Met
Standard 10	0	20	0	20	Met
Total	**0**	**233**	**23**	**256**	**Met**

Standard	SM	MM	Total	Overall
Standard 1	53	0	53	Met
Standard 2	15	0	15	Met
Standard 3	41	0	41	Met
Standard 4	37	0	37	Met
Standard 5	9	0	9	Met
Standard 6	11	0	11	Met
Standard 7	0	0	0	Met
Standard 8	24	0	24	Met
Standard 9	23	0	23	Met
Standard 10	20	0	20	Met
Total	**233**	**0**	**233**	**Met**

NSQHSS Survey

Organisation : La Trobe Private Hospital
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Surveyor - NSQHSS V01

Core

Standard	Not Met	Met	N/A	Total
Standard 1	0	44	0	44
Standard 2	0	4	0	4
Standard 3	0	39	0	39
Standard 4	0	31	0	31
Standard 5	0	9	0	9
Standard 6	0	9	0	9
Standard 7	0	0	20	20
Standard 8	0	20	0	20
Standard 9	0	15	0	15
Standard 10	0	18	0	18
Total	**0**	**189**	**20**	**209**

Standard	SM	MM	Total
Standard 1	44	0	44
Standard 2	4	0	4
Standard 3	39	0	39
Standard 4	31	0	31
Standard 5	9	0	9
Standard 6	9	0	9
Standard 7	0	0	0
Standard 8	20	0	20
Standard 9	15	0	15
Standard 10	18	0	18
Total	**189**	**0**	**189**

Developmental

Standard	Not Met	Met	N/A	Total
Standard 1	0	9	0	9
Standard 2	2	9	0	11
Standard 3	0	2	0	2
Standard 4	0	6	0	6
Standard 5	0	0	0	0
Standard 6	0	2	0	2
Standard 7	0	0	3	3
Standard 8	0	4	0	4
Standard 9	0	8	0	8
Standard 10	0	2	0	2
Total	**2**	**42**	**3**	**47**

Standard	SM	MM	Total
Standard 1	9	0	9
Standard 2	9	0	9
Standard 3	2	0	2
Standard 4	6	0	6
Standard 5	0	0	0
Standard 6	2	0	2
Standard 7	0	0	0
Standard 8	4	0	4
Standard 9	8	0	8
Standard 10	2	0	2
Total	**42**	**0**	**42**

Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 1	0	53	0	53	Met
Standard 2	2	13	0	15	Met
Standard 3	0	41	0	41	Met
Standard 4	0	37	0	37	Met
Standard 5	0	9	0	9	Met
Standard 6	0	11	0	11	Met
Standard 7	0	0	23	23	Met
Standard 8	0	24	0	24	Met
Standard 9	0	23	0	23	Met
Standard 10	0	20	0	20	Met
Total	**2**	**231**	**23**	**256**	**Met**

Standard	SM	MM	Total	Overall
Standard 1	53	0	53	Met
Standard 2	13	0	13	Met
Standard 3	41	0	41	Met
Standard 4	37	0	37	Met
Standard 5	9	0	9	Met
Standard 6	11	0	11	Met
Standard 7	0	0	0	Met
Standard 8	24	0	24	Met
Standard 9	23	0	23	Met
Standard 10	20	0	20	Met
Total	**231**	**0**	**231**	**Met**