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

Newcastle Private Hospital

New Lambton, NSW

Organisation Code: 12 06 43

Survey Date: 18-20 July 2017

ACHS Accreditation Status: ACCREDITED

Disclaimer:
The information contained in this report is based on the evidence provided by the participating organisation at the time of the accreditation survey and information that the organisation supplied through the reporting and editing process. Accreditation issued by ACHS/ACHSI does not guarantee the safety, quality or acceptability of an organisation or its services or programs, or that legislative and funding requirements are being met, or will be met.

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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 Actions Rating Summary Report
3 Recommendations from Current Survey
4 Recommendations from Previous Survey
5 Standards Rating 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

2 Actions Rating Summary Report

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

3 Recommendations from 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 Rating Summary Report

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

Organisation: Newcastle Private Hospital
Orgcode: 120643

Survey Report

Survey Overview

Management and staff of Newcastle Private Hospital presented well for the NSQHS Standards survey undertaken over three days from 18 to 20 July 2017, demonstrating evidence of their achievements in improving care and services for patients. Located across two buildings the hospital is well appointed, clean and aesthetically pleasing.

Newcastle Private Hospital provides a wide range of surgical, endoscopic, obstetric, ICU, cardio-thoracic, cardiac/vascular, oncology and rehabilitation services.

Since the last survey the hospital has expanded to a 174 bed facility with a level 2 ICU, 24 hour CMO coverage in ICU and wards, and is now a cardiac surgical licensed facility with an additional operating theatre designed specifically for cardio-thoracic surgery (opened March 2017). At the time of survey stage one of a Healthscope $54 million expansion of the hospital was nearing completion to provide an additional 16 beds, an additional Cath Lab and five recovery bays. The survey team visited this impressive state of the art new area that is all but ready for occupation.

Newcastle Private Hospital clearly benefits from the Healthscope Corporate support through the policy and clinical governance framework, shared learnings and involvement in all of the Healthscope Cluster Working Groups which continue to focus on the requirements of each of the NSQHS Standards. Significant work has been undertaken in the last year under the leadership of a revised executive team to equip managers and staff with the knowledge and expertise to prepare for the completion of stage one expansion and increasing activity and service delivery.

The surveyors were impressed with the high degree of team work and the integration of new services for patients. Multidisciplinary team work in both falls and pressure injury prevention has resulted in injury rates well below peer average which is most impressive. Management and staff continue to demonstrate commitment to the process of increasing involvement of consumers. The organisation is encouraged to continuously monitor established systems and processes to ensure there is ongoing quality improvement and sustainability in all aspects of clinical outcomes.

Overall Newcastle Private Hospital has performed well and staff are congratulated on their enthusiasm and achievements demonstrated during this NSQHS Standards survey.

STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

Established Healthscope (HSP) organisation-wide policies and processes are in place in Newcastle Private Hospital (NPH) and include the development, implementation and regular review of locally based clinical and non-clinical policies and procedures. There are good processes for document control, including receipt of, distribution and implementation of HSP Policy, NSW Health Policies and Guidelines, Legislation, Australian Standards and relevant Clinical Guidelines. During survey, staff demonstrated to the survey team their ability to access required corporate and local policies through the intranet.

The NPH Business Strategic Plan has a business focus with clear reference to the HSP Corporate Strategic Plan. The HSP Capital Expenditure Business Case template used for all hospital equipment purchases and building projects considers patient and safety quality aspects of all proposals.

The HSP corporate and committee structures provide the Clinical and Corporate Governance Framework to monitor operations across all HSP facilities including the requirement to demonstrate compliance with the HSP quarterly audit cycle of Key Performance Indicators. An annual governance review audits components of the quality system.

NPH organisational and committee structures have been reviewed and updated since the introduction of cardio-thoracic services in 2016.

The NPH Quality and Safety Management System is well defined and comprehensive to comply with HSP requirements and to regularly monitor patient clinical outcomes.

Staff position descriptions and training records indicate high levels of exposure to the principles of quality and safety and the content of the 10 NSQHS Standards. The survey team suggests, however, that there is further scope for improving staff application of quality and risk methodology into day-to-day clinical practice.

HSP clinical performance indicators and ACHS clinical indicator data provide opportunities to benchmark with peer HSP facilities and other peer hospitals nationally. NPH results are generally within the determined targets. There were however, during survey, identified opportunities to strengthen the hospital quality program to ensure results of all audits, surveys and patient feedback indicating less than optimal performance, are reviewed with the same rigour and frequency required for HSP KPIs.

The integrated risk management system, RiskMan, is well established through a comprehensive collection and classification of risk rated data and analysis by management and staff. The risk register is used to monitor and reduce the level of risk for the organisation. All risks have a clearly identified owner and the tracking of risks is transparent.

Clinical practice

Appropriate agreed and implemented clinical guidelines are available to the clinical workforce. NPH Patient Management Guidelines which are clinician-based patient management preferences have been introduced since the last survey. These are developed and annually reviewed in consultation with the relevant individual VMO or VMO group.

The use of clinical guidelines is closely monitored through peer review and Morbidity and Mortality reviews including sentinel event review. It is suggested that these reviews be extended to provide evidence of clinical care documentation content audits to demonstrate continuous, effective and appropriate patient care across the multidisciplinary continuum of care.

The pre-admission process is well established given the high percentage of elective patient admissions. Patients complete a comprehensive simple language clinical history which is reviewed in the pre-admission phase by a skilled nurse who commences the development of individual patient plans where 'at risk' factors are identified. Patient risk screening and assessment are used to identify patients 'at risk' of falling, injury to skin integrity, deep vein thrombosis, medication and other allergy or potential risk. A pre-admission clinic with anaesthetist support is available for identified at risk patients.

Appropriate systems are in place to escalate care when there is an unexpected deterioration of patients. A hospital rapid response program is well established and regularly reviewed. The rapid response team operates out of the Level 2 ICU under the directorship of the Director of ICU and supported by 24 hour CMO coverage.

The NPH Hospital Information Management Committee oversees the standard of clinical record accuracy, integration and accessibility to the clinical workforce at the point of care. The Webpas system tracks all inpatient and stored records to ensure that every record is easily located at any point in time.

A HSP documentation audit is conducted and benchmarked across Healthscope facilities annually. This audit does not address the requirements of a clinical content audit referred to above. Notable improvements made from the 2016 documentation audit included the improvement in documentation of patient admission and discharge from ICU. Other opportunities for improvement in this audit identified by less than optimal compliance were not evident to the survey team.

Performance and skills management

NPH has good systems in place that monitor and review all areas of scope of practice for the medical staff, both Visiting Medical Officers (VMO) and Career Medical Officers (CMO). The Medical Advisory Committee (MAC), as is the case in the majority of private hospitals, acts as the credentialing authority for the VMO staff. The accreditation and credentialing process is robust and there are checks and balances in place to ensure that the staff fulfil their requirements regarding registration and insurance status. Audits are available that show staff with 100% compliance in these two key areas. Performance review is well done as it applies to clinical staff and involves nursing staff as well. Note is taken that some other areas have lower performance appraisal rates and NPH management is encouraged to work on those areas to increase the performance appraisal. There are processes in place to monitor all new services and this was illustrated in the case of Trans Aortic Valve Insertion (TAVI) with a proctorship in place from experts in the field to monitor and train staff in this technique. NPH is proactive in training of nursing staff as well, with secondment to other hospitals to gain experience.

Incident and complaints management

RiskMan is the electronic incident and accident reporting mechanism used by NPH. It is obvious that the staff are aware of how to use this software and the requirement to report incidents. Reports are generated by the program which keep the Unit Managers aware of incidents as they happen. Senior Management is notified if a sentinel event occurs. There is a process to follow when this occurs. Reporting mechanisms are in place to ensure incidents are reported up as required and they are reviewed at appropriate committees. Sentinel events are risk rated and added to the risk register if deemed appropriate.

Complaints, however received, written or verbal, are managed at the required level. Complaints are always responded to within the required time frames. One person is designated to be the contact person for that complaint. This ensures that all reviews are completed within the required time frame and the complainant is not getting conflicting information from different people.

Staff are provided with education relating to Open Disclosure at orientation and as an eLearning package to reinforce this information.

Patient rights and engagement

There is a charter of rights for patients that is included in the pre-admission paperwork given to each patient. The cohort of patients that NPH services are people with English as their first language. This means that the use of interpreter services is not required. However, there are mechanisms in place to access interpreter services as needed. Again, there are protocols and processes in place to enable End of Life and Advance Care Directives to be

accepted. It is suggested that further use of patient feedback regarding their care be continued and encouraged. Inspection of a number of patient files showed good consent processes in place for continuation of patient care.

NSQHSS Survey

Organisation: Newcastle Private Hospital
Orgcode: 120643

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

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

Organisation: Newcastle Private Hospital
Orgcode: 120643

STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

The consumers that are part of Newcastle Private Hospital (NPH) have only been there for a short period of time and as the new building had been planned and well on the way prior to their commencing, they have not had any input into this new building. However, they are part of the review of feedback provided by the regular patient satisfaction surveys. While this has not resulted to any changes in services, they will be involved in ongoing evaluation of the extended services with the opening of the new building in a few weeks (early-mid August).

There is a Consumer Reference Group that meets quarterly. This meeting reviews patient satisfaction survey data, and items like incident and complaints reports.

At this point in time, there are no consumer representatives on the Quality and Risk Committee, due to time constraints for the current members. However, it is hoped that with the new representatives commencing in early August this will change.

The representatives the surveyors met expressed appreciation for the time spent with them in explaining the health system and giving them the opportunity to go away for training time. The organisation stated that this will also occur with the new consumers.

Both consumers stated that they had been patients or carers with the hospital. They had both been involved in the review of documents that are provided to patients. These documents had a symbol that indicated consumer involvement in their review or development.

Consumer partnership in designing care

While there is no formal process relating to the design of care, the organisation runs a number of focus groups across the organisation and the year. The information provided by these groups has resulted in changes to the way some services are delivered to the patients. This particularly relates to Oncology and Maternity. The Maternity experience was that there were a number of families where the breadwinner was a fly in/fly out worker, so the antenatal classes were provided at times that suited this group of families.

The organisation is currently looking for scripts and companies that can produce a video made by the consumers relating to the patient experience at NPH including speaking about Patient Centred Care. It is planned that this would be shown at orientation and be available for staff to view at other times as well.

Consumer partnership in service measurement and evaluation

NPH has a website that provides information about the organisation to interested persons. There are a number of safety and quality indicator data on this site and suggestions as to where this may be found and/or how to compare NPH with other hospitals' data. Consumers stated that they are provided with data in a meaningful way and time is spent with them explaining it if they need that assistance. However, at this point in their progress, evaluation opportunities are limited. The consumers are encouraged to make comment and provide feedback on the data that is provided; inclusion in decisions relating to quality activities is currently not sought from them, but it is felt that given time this will occur.

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	NM
2.3.1	SM	SM
2.4.1	SM	SM
2.4.2	SM	SM

Action 2.2.2 Developmental

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

Surveyor Comment:

The current consumers are unable to attend the Quality and Risk meeting. However, new consumers are expected to be able to participate in that process after commencing in August.

Surveyor's Recommendation:

Identify and implement a mechanism for involving consumers and/or carers in decision making about safety and quality.

Risk Level: Low

Consumer partnership in designing care

Ratings

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

Action 2.5.1 Developmental

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

Surveyor Comment:

While there is an expanded service development underway, the consumer consultants have had no say in them as they were not on board at the commencement of the project. However, there has been some involvement in redesign of some parts of the Maternity and Oncology services, but this has been limited.

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

Action 2.6.2 Developmental

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

Surveyor Comment:

The time constraints of the current consumers limit what they are able do, however the organisation is currently looking at scripts and companies which will enable them to make a video relating patient experiences and talking about Patient Centred Care which will be shown at orientation and will be available for staff to view on the internal web pages. It is hoped that this will be completed within the next six months.

Surveyor's Recommendation:

Identify and implement a mechanism for the involving of consumers and/or carers in the training of the clinical workforce.

Risk Level: Low

Consumer partnership in service measurement and evaluation

Ratings

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

Action 2.8.1 Developmental

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

Surveyor Comment:

Currently, there is not a consumer on the Quality and Risk Committee. This will change when the new consumers commence in August. It may take a little time before the consumer is able to actively participate in the analysis of this data.

Surveyor's Recommendation:

Identify and implement a mechanism to engage consumers and/or carers in the analysis of the health service's safety and quality performance.

Risk Level: Low

Action 2.8.2 Developmental

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

Surveyor Comment:

While consumers stated they were able to provide feedback on planned activities, they are not involved in the implementation of these.

Surveyor's Recommendation:

Identify and implement a mechanism to engage consumers and/or carers in the planning and implementation of quality improvements.

Risk Level: Low

Action 2.9.2 Developmental

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

Surveyor Comment:

While this has not yet happened, there are plans for the consumer consultants to be more actively engaged with the collection and analysis of patient feedback data and then how the use of that data is implemented.

Surveyor's Recommendation:

Identify and implement a mechanism to enable consumers and/or 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

Governance and management systems for healthcare associated infections are supported by relevant HSP and NPH policies. Access to HICMR policies and newsletters are available to staff on the intranet.

An Infection Control Coordinator (CNC) is responsible for supporting and implementing systems and processes of the infection control system. There are Link Nurses who assist with hand hygiene auditing currently. It is suggested that the hospital would benefit by extending the scope of this important role in clinical units through education and training opportunities.

The current infection prevention and control plan is comprehensive and endorsed by NPH. The opportunity for shared learning through the Healthscope Infection Prevention and Control Cluster is positive.

The surveillance system of Hospital Acquired Infections (HAI) is well established to provide data as required for ACHS indicators and Healthscope KPIs. A recently introduced IT Surveillance Program (RL Solutions) is yet to be fully utilised. The effectiveness of the Infection Prevention and Control (IPC) system is regularly reviewed by the NPH Infection Control Committee and NPH Executive.

Infection prevention and control strategies

Hand Hygiene (HH) audit results have improved steadily with an overall compliance of 87% for the last audit period. More recently hand hygiene audits have included medical staff which is an important initiative. Hand gel and hand washing sinks are appropriately located throughout all clinical areas.

A workforce immunisation program consistent with the current national guideline currently has variable compliance. Whilst there is a requirement for all new staff to demonstrate compliance prior to employment, there has been a low compliance demonstrated by existing staff to date. The overall hospital compliance rate at the time of survey is less than 50%. Similarly, staff take up rate of flu vaccination provided remains very low. Following discussions with hospital executive in regard to NSW DOH PD 2011-005 which requires private hospitals in NSW to 'have regard for this policy' action was taken to address the high-risk area of antenatal, perinatal and postnatal staff (Cat A) to ensure staff pertussis immunity. As a result, an appropriate action plan was developed and immediately implemented. It is suggested that this same rigour be applied to all other clinical units to ensure that both patient and staff safety is not compromised.

Staff compliance with the use of personal protective equipment (PPE) is monitored. Staff meetings and noticeboards are used to promote strategic work health and safety infection prevention messages, results of audits and introduction of new products and procedures.

There is an established system for the introduction, use and management of invasive devices. However, a list of all current invasive devices used in the hospital was not able to be provided. Whilst compliance with the policy and compliance audit tool for Intravenous Cannulation Insertion and Removal has been consistently increasing from 50% in 2014 to 73% in 2016 (last audit period) there was no evidence sighted of a specific action plan to work towards achieving full compliance (refer to overall comment in Standard 1 summary).

The established ANTT program which is aligned with HSP Policy 8.38 has four components: one off DVD training, one off completion of ANTT workbook, annual mandatory ANTT competency and annual handwashing competency. At the time of survey the hospital overall average of the combined four steps is 68% compliant. Whilst 78% of relevant staff have viewed the introduction to ANTT training DVD at the time of survey, only 61% of overall staff have demonstrated ANTT competency. An organisation risk analysis of aseptic technique has been repeated

recently identifying CMO, Recovery, Surgical and ICU staff as working in high risk areas. Consequently, action 3.10.1 is assessed as SM at the transitional level and there is a recommendation made to address this action.

Managing patients with infections or colonisations

Guidelines for standard and transmission-based precautions are available for all clinical and non-clinical staff as required. There is evidence of staff training and compliance monitoring of both standard and transmission-based precautions. Regular CNC involvement in overseeing the implementation of standard and transmission-based precautions appears to occur, however there was no documented evidence to support this regular activity. Opportunities for increasing the IFC Link Nurse role by randomly undertaking and recording observational audits of staff compliance with standard and transmission-based precautions, were discussed during the survey.

Completion of the pre-admission patient information form ensures that patients with an infection or colonisation are identified to facilitate appropriate patient placement on admission and transfer. The Webpas electronic system available in all clinical units, including operating theatre, identifies patient's requiring transmission-based precautions.

Antimicrobial stewardship

Stewardship is done well at NPH. There is a committee in place with input from infection control and various members of the nursing staff. NPH is fortunate to have a dedicated and committed microbiologist to oversee this committee. There is not a computer program in place to monitor the use and efficacy of antibiotics. However, NPH has an extremely good system with auditing of the use of such medications, again with input from the pharmacy. The use of the so-called traffic light system with antibiotics graded into the red, yellow and green area is well done.

Cleaning, disinfection and sterilisation

Policies and procedures for environmental services are available to ensure the principles of Infection Prevention and Control are practised in cleaning, waste management, on site laundry and linen transportation, processing and storage. The large onsite commercial laundry currently relies on external contractors to maintain and monitor washers, dryers and levels of washing solution automatically dispensed into each machine. It is suggested that a compliance audit of the hospital's onsite laundry be undertaken to determine compliance with AS/NZS 4146:2000 Laundry Practice.

In addition to washing, drying, storage and transportation of linen, staff in the laundry are responsible for theatre linen processing and packing prior to sterilisation by CSSD. The use of linen drapes and gowns has not been recommended international best practice for some time and should be phased out.

Clinical cleaning, as well as environmental cleaning, schedules are well established. A HICMR Facility Wide Environmental Audit in 2016 indicated 92% compliance. A HICMR Clinical Waste audit in 2016 indicated overall 98% compliance. Current material data sheets are readily available to staff.

The surveyors observed both the Operating Theatre and CSSD departmental flows to be very appropriate. The practice of covering all used surgical instrumentation prior to being transferred into the CSSD cleaning area is appropriate. Clean to dirty flows were observed to be consistently appropriate in all 14 operating theatres and the CSSD. The Endoscopy Unit clean up in the Croudace Building is extremely small and requires very strict controls to ensure processed scopes are not contaminated by dirty scopes being delivered for cleaning. Staff indicated awareness of the risk and need for appropriate steps to mitigate this risk.

A Gap Analysis to determine the current level of compliance with AS/NZS 4187:2014 has been undertaken and well documented. A corresponding detailed implementation plan and Gant timeline chart were completed and provided to the organisation. Consequently, action 3.16.1 has been rated as SM.

A manual tracking system is used to trace instruments, trays and scopes to individual patients. The integrity of the sterilisation is rigorously monitored and correct in accordance with AS/NZS 4187:2014. Staff awareness of CJD infection in the management of instruments and trays for neurosurgical patients was evident.

Staff allocated responsibility for the decontamination, disinfection and/or sterilisation in CSSD and endoscopy are appropriately trained and competency assessed.

Communicating with patients and carers

Appropriate brochures are available for patients and families on the management and reduction of healthcare associated infections, together with signs prompting visitors to wash their hands and use appropriate cough etiquette. The “My Healthscope” website provides public access to NPH Clinical Outcome performance for infection rates and Hand Hygiene compliance rates of staff and doctors. Patient and consumer feedback on the usefulness of information provided is sought and used for improvement. More recently an action plan has been developed to develop appropriate information for patients and families about antibiotic therapy; however this still remains work in progress.

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:

Significant effort has been achieved in both the Delivery Suite and Oncology to ensure 100% of relevant clinical staff has completed all four components of the hospital's Aseptic Technique program. Other clinical areas are yet to demonstrate full compliance. Consequently, the overall hospital result is 68.2% at the time of survey. Therefore, this action is only met at the transitional level and a new recommendation is made.

Organisation: Newcastle Private Hospital
Orgcode: 120643

Surveyor's Recommendation:

Establish a detailed action plan to ensure all relevant staff complete ANTT mandatory training and annual competency assessment.

Risk Level: Moderate

Risk Comments:

Inadequate or incorrect aseptic technique increases the potential to compromise safe patient care and increases the risk of acquired infection.

Managing patients with infections or colonisations

Ratings

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

Antimicrobial stewardship

Ratings

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

Cleaning, disinfection and sterilisation

Ratings

Action	Organisation	Surveyor
3.15.1	SM	SM
3.15.2	SM	SM

3.15.3	SM	SM
3.16.1	SM	SM
3.17.1	SM	SM
3.18.1	SM	SM

Action 3.16.1 Core

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

Surveyor Comment:

A Gap Analysis to determine the current level of compliance with AS/NZS 4187:2014 has been undertaken and well documented. A corresponding detailed implementation plan and Gant timeline chart were completed and provided to the organisation. Consequently, action 3.16.1 has been rated as SM.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
3.19.1	SM	SM
3.19.2	SM	SM

Organisation: Newcastle Private Hospital
Orgcode: 120643

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

NPH has both corporate and local policies in place to monitor governance of safety in medication. Evidence is viewed that demonstrates an acceptance of the need for safety. Adverse events are monitored and reported monthly. The survey team was able to speak with staff on the wards who indicated an understanding of medication usage. It is noted that an incident of inappropriate dosage of hydro-morphine has occurred. This was reported to the Medication Safety Committee which took appropriates steps to address this issue. It is suggested that quality still needs to be in the forefront of activities not only in this specific area but in other areas, as well as outlined in the summary under Standard 1. Evidence has been viewed that shows medical authorisation is satisfactory.

Documentation of patient information

NPH has very good processes in place to document medication usage. However, across the organisation implementation of this is patchy and further work needs to be ongoing in this area. Allergies and adverse reactions are documented and noted both within the patient record and with the use of the alert red name bracelet. NPH has carried out the latest MSSA audit and work is proceeding to address a small number of issues arising from this report. It is accepted that NPH has a large cohort of day admission and discharge patients and the use of a detailed medication history is difficult to comply with. However, it is suggested that NPH continue to address this issue. The pharmacy group has a dedicated pharmacist five days a week with an after-hours call service on weekends. There is also a good consultative system in place, whereby patients over 65 with co-morbidities and more than four drugs being used are assessed by the pharmacist.

Medication reconciliation and discharge medication is patchy across the organisation. Certain areas such as the Rehabilitation Ward and ICU have very good figures of compliance with this criterion whereas other areas have lesser figures of compliance. Work needs to continue to achieve much better compliance. It is noted that the National Inpatient Medication Chart is to be replaced with the hospital PBS chart starting in November. NPH is aware of this and has contingencies in place for education and roll out.

Medication management processes

NPH conforms to all legislative requirements pertaining to the distribution, control and storage of medications. Temperature storage is monitored well. A number of chemotherapeutic drugs are mixed on site within a controlled environment with all safety aspects covered for the use of hazardous chemicals. The disposal of unwanted and out-of-date drugs is well done. This applies to dangerous drugs with documentation inspected. There are locked dangerous drug cabinets in each of the fourteen theatres. NPH needs to rigorously enforce the policy of single use and sign out for each individual patient episode, rather than a bulk sign out at the beginning of an operating list. Inspection of the CHARM usage in the Oncology Unit confirmed enhancement of patient care within this area. It is noted that NPH has locked drawers in each room dedicated to ongoing medication of the patients and does not use a drug trolley to dispense medications.

Continuity of medication management

As noted above previously, areas such as ICU and Rehabilitation Ward have excellent processes in place for the generation of lists of medications that are used in each patient episode. Again as noted, the cohort of patients at NPH is predominantly day only surgery cases and this documentation is less well done. NPH has a dedicated on-site pharmacy service, at least for the working week. Discharge medication lists are able to be generated for patients who are aged over 65, with four or more drugs used. On weekends this becomes problematical and relies on a copy of the discharge summary being given to the patient. Evidence was viewed, particularly in discharge, from the ICU and Rehabilitation Ward that discharge planning relating to medication is well done.

Communicating with patients and carers

Again it is noted this is done extremely well in the ICU and Rehabilitation Ward and less well in other areas. NPH is encouraged to continue to monitor this area and improve the other areas so they approach the excellence of the aforementioned units. It is noted throughout this standard that more work needs to be done to engage patients and carers in this criterion.

NSQHSS Survey

Organisation: Newcastle Private Hospital
Orgcode: 120643

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

Patient identification is well developed within NPH as would be expected in a predominantly surgical hospital. The use of the three identifiers was obvious on documentation and when interacting with the patients.

If a mismatch of patients does occur, it is quickly identified and rectified. The reason for the mismatch is sought, identified and actioned to ensure no further issues are found that lead to the mismatch. A recent example was identified at admission where patients were being called using their Christian names only. This has now been addressed and when walking back to the desk, the date of birth is also checked if there is more than one patient with the same name or a middle name is used as well.

The processes of identification checking are explained to patients and families on admission so they understand why this is constantly being completed.

Processes to transfer care

Patients spoken with by surveyors stated that they often had name bands checked, and were asked their name and date of birth to ensure correct person. The surveyors observed this process in action, both at handover and prior to transfer to theatre.

It was noted that when speaking with some of the surgeons, it was stated that during Team Time Out (TTO) in theatre the patient is not always awake. However, it was also explained that the patient identity and procedure had been checked with the patient prior to them being anaesthetised. TTO should include the whole team with the patient awake.

Processes to match patients and their care

There is an explicit process that is followed to ensure patient care is provided as expected. Mismatches are investigated and corrected.

NSQHSS Survey

Organisation: Newcastle Private Hospital
Orgcode: 120643

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: Newcastle Private Hospital
Orgcode: 120643

STANDARD 6
CLINICAL HANDOVER

Surveyor Summary

Governance and leadership for effective clinical handover

There are policies and procedures relating to clinical handover within NPH. The tool iSHARED is in use within the facility and from the surveyors' observations its use is followed but the process of "how it is done" is patchy. Different staff go through the process in different ways. It is understood that the tool is due to be reviewed within the next six months with a planned evaluation to be completed first. The organisation stated that ISBAR is the tool currently used in most Healthscope hospitals and that is the tool currently under consideration.

Clinical handover processes

The surveyors sighted two audits that had been conducted using an audit tool designed against the ISHARED tool, both of which had patches that were below 50%. An action plan had not been developed for the 2015 audit that was sighted, but a plan is in place for the 2017 audit. One issue was that while the surgical units carried out bedside handover at the afternoon change of shift, the maternity unit completed this process at 0700. The other issue was the identity and wound checks on mothers who had had caesarian sections and the checking of arm bands on mothers and babies. These are both carried out during the postnatal checks that are completed during the course of the morning care. It may be that this unit needs to have a maternity-specific process. Despite these limitations, it was felt by the survey team that patient handover was robust and ensured the safety of the patient.

Patient and carer involvement in clinical handover

The process of clinical handover is explained to the patient on admission. The survey team spoke with a number of patients and observed patient handover. On all occasions the patient and family, if present, were involved in the process and the patients stated that they felt involved and that it was a great thing in which to be involved.

NSQHSS Survey

Organisation: Newcastle Private Hospital
Orgcode: 120643

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: Newcastle Private Hospital
Orgcode: 120643

STANDARD 7
BLOOD AND BLOOD PRODUCTS

Surveyor Summary

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

Governance systems are in place and are regularly monitored. There is an active haemovigilance committee which includes the off-site pathology service provider. The prescribing and clinical use of blood and blood products is monitored and regularly audited to ensure compliance with national guidelines. Risks associated with blood and blood products use are identified and minimised as much as possible. Incidents and near misses are reported through the RiskMan incident reporting program. These are followed up and action taken to mitigate them. Incidents are reported up through the organisation to the appropriate level. Harm to patients is minimised as much as possible by appropriate checking, monitoring and the provision of patient information.

Documenting patient information

A recent audit of patient medical records indicated that the majority of patients who had received blood or blood products had a comprehensive blood history recorded. Adverse reactions were recorded in progress notes as well as through the incident management program. The haemovigilance committee reviews all adverse events relating to blood and blood products. These are reported to the appropriate governance committee, including an action plan to address any arising issues.

Managing blood and blood product safety

Surgeons have a preference for which pathology service providers the patients attend to have blood work-ups completed prior to surgery. This can create problems for NPH, however the service providers work together to minimise the risks associated with this and to ensure that blood and/or blood products are available when and as required for the patients. Some service providers, if the likelihood of the patient requiring blood or blood products is high, will send the collected specimens to the in-house provider for them to cross-match. This decreases the risk to the patient of there being any delay in getting blood or blood products when required during or after surgery.

The pathology service providers work together to reduce the blood and blood products wastage rates. These have been greatly reduced over the last few years with the providers rotating these products to ensure all are used within the end-use dates. Wastage rates are regularly monitored across all service providers and are currently less than 2%.

Communicating with patients and carers

Patient information is not always given to patients with a recent audit indicating that of the medical records audited, less than 50% indicated that written information had been provided. However alternatives, benefits and risks were documented. Plans for care had included the patient and patients indicated that they understood what the information meant to them.

Consent for the use of blood and blood products, while in place, was sometimes included with the surgical consent. It is becoming a more accepted practice for blood consent to be separated from surgical consent.

NSQHSS Survey

Organisation: Newcastle Private Hospital
Orgcode: 120643

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

Ratings

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

Documenting patient information

Ratings

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

Managing blood and blood product safety

Ratings

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

NSQHSS Survey

Organisation: Newcastle Private Hospital
Orgcode: 120643

Communicating with patients and carers

Ratings

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

STANDARD 8
PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and systems for the prevention and management of pressure injuries

Governance and systems for the prevention and management of pressure injuries are underpinned by evidence-based guidelines. A local NPH policy identifies the requirements for pressure area prevention in the neonate whilst a well-established HSP policy identifies the requirements for all adult patients. Both policies incorporate appropriate screening and assessment tools; The Waterlow Pressure Risk Assessment Tool for adult inpatients, a skin integrity risk screening tool for day surgery and short stay adult patients, and a modified Braden Q Scale for neonates are used.

A very proactive multidisciplinary Preventing and Managing Pressure Injuries Committee is responsible for effective governance across the organisation.

Preventing pressure injuries

The Waterlow Pressure Risk Assessment has been used consistently since 2014. Similarly the Modified Braden Q Risk Assessment for Neonates is used consistently in the Special Care Nursery. Audit results indicate that patients are screened and assessed on admission and a Management Plan completed for all patients identified as being 'at risk'. The prevention plan includes referral to the appropriate allied health team and the provision of appropriate equipment based on the assessment result

There are relatively small numbers of both hospital and community acquired pressure injuries. All pressure injuries are appropriately staged, documented in the clinical record using a pressure injury sticker, and reported as an incident in RiskMan. All hospital acquired pressure injuries are reported monthly to the Patient Care and Quality Risk Committee. Pressure injuries stage 2 and higher are reported quarterly as HSP KPIs with a benchmark of 0.4%. NPH results are consistently below the HSP benchmark since the last survey and lower than peer hospitals in the ACHS Clinical Indicator Program.

This impressive continuous low incident and severity rate coupled with the consistent use of the Pressure Injury Risk Assessment/Management Plan (HMR 7.5), and the provision of appropriate equipment to 'at risk' from the NPH Equipment Inventory have contributed to the surveyors' unanimous decision to rate action 8.2.4 as MM.

Managing pressure injuries

Management of both pressure injuries and wounds is consistent with evidence-based guidelines, namely the Pan Pacific Guidelines. Staff demonstrated their knowledge and ability to access these guidelines on the hospital intranet during the survey.

A wound management assessment and ongoing care form (HMR 7.12) is used to document all wounds.

Clinical staff appeared to be well informed about pressure injury and wound management in all clinical units.

Communicating with patients and carers

Specific written information is available for patients on admission and discharge as required. Patient feedback indicates a high level of satisfaction with the information provided to them.

Organisation: Newcastle Private Hospital
Orgcode: 120643

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	MM
8.3.1	SM	SM
8.4.1	SM	SM

Action 8.2.4 Core

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

Surveyor Comment:

A proactive multidisciplinary team has overseen the hospital's implementation, review, compliance monitoring and continuous improvement for a number of years. Consistently low acquisition rates of hospital acquired pressure areas has been achieved since the last survey, as evidenced by the continuous below peer average rates achieved for ACHS clinical indicator 3.1. The survey team concurs that this level of achievement meets an MM rating for this action.

Surveyor's Recommendation:

No recommendation

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

There is a raft of policies in use across all clinical areas involving escalation and monitoring of clinical deterioration during an episode of acre. This begins with the pre-admission documentation and is carried through all facets of the patient experience. Inspection of a number of clinical charts confirmed good noting of clinical signs and symptoms which were legible. The use of the so-called Between the Flags in clinical charts is noted. There are processes in place to escalate care and these were noted. Auditing revealed good understanding by the staff of their responsibilities in this area with over 87% of respondents to a staff survey indicating their knowledge of the system of escalation. Audits were viewed of review of unexpected deaths. Each craft group has Mortality and Morbidity meetings at least quarterly and minutes of those meetings have been inspected and viewed. Adverse results are reported on the RiskMan tool. Response to these reported incidents is timely and appropriate.

Recognising clinical deterioration and escalating care

There are well documented thresholds in place for escalating care. These parameters are monitored. Audits revealed compliance of over 80% of patient charts with documented observations. NPH is encouraged to continue and improve these results. Emergency care is easily called for and the results of such calls are discussed and audited. It is noted that inappropriate call out of the emergency response team is not an issue. No evidence was observed relating to failure to act on an emergency. Discussion with the emergency medical team showed a positive culture in the use of call out. The members of the team are sourced from ICU and include a medical officer and nurse, both trained and accredited in advanced life support.

Responding to clinical deterioration

The emergency team from ICU is available within two minutes to respond to a medical emergency. As noted, the team is comprised of a medical officer and nurse trained in advanced life support. NPH has Career Medical Officers rostered twenty-four hours a day to respond to such emergencies. NPH has continual on-site access to medical and nursing staff trained and proficient in advanced life support (ALS). NPH is able to act as a training hub for ALS as it has staff who are qualified and licensed to train their staff in ALS. This action is therefore fully met in its entirety. NPH has achieved very good compliance with the number of staff who have achieved competency in Basic Life Support of over 93%. This action is fully met as the Commission has mandated.

Communicating with patients and carers

Advance Care Directives (ACD) and End-of-Life Policies follow the NSW Government standards. The use of such ACD is limited due to the cohort of patients treated at NPH. A higher uptake of these directives was noted within the Oncology Unit which is understandable. It is noted that escalation of care information begins with the pre-admission forms and extends through to the ward. The use of REACH is noted in the wards but more public display of these criteria would be advantageous. It is noted the poster above each bed is quite small and difficult to read.

Purposeful Patient Responding (PPR) is noted in the wards. This involves continual checking and noting of such checking over and above the normal handover. It is not limited to the rostered nurse but includes allied health staff, such as physiotherapists, to note and sign when seeing to patient needs.

Organisation: Newcastle Private Hospital
Orgcode: 120643

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:

NPH has achieved very good compliance with the number of staff who have achieved competency in Basic Life Support of over 93%. This action is fully met as the Commission has mandated.

Organisation: Newcastle Private Hospital
Orgcode: 120643

Surveyor's Recommendation:

No recommendation

Action 9.6.2 Core

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

Surveyor Comment:

NPH has continual on-site access to medical and nursing staff trained and proficient in advanced life support (ALS). NPH is able to act as a training hub for ALS as it has staff who are qualified and licensed to train their staff in ALS. This action is therefore fully met in its entirety.

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

Policies and procedures, both locally developed and corporate, are available for staff to use and readily accessible. NPH uses a nationally recognised screening tool to identify those patients at risk of falls. This is completed on admission for all patients and if identified as high risk appropriate strategies are put in place.

RiskMan reports are monitored and falls are followed up to ensure that a repeat falls assessment is carried out and necessary follow-up is completed. It was noted that all staff are very aware of those patients at risk of falls who were monitored closely and the falls risk assessment was completed more regularly.

There is a very active multidisciplinary falls committee which monitors the falls history of patients and ensures equipment is available for their protection.

Quality activities are completed which help to reduce the number and severity of falls across the organisation.

Screening and assessing risks of falls and harm from falling

The Falls Risk Assessment Tool (FRAT) is completed on all new admissions. If the person's risk is assessed as moderate or high strategies are put in place to help reduce that risk. The traffic light system is used to identify those at risk. In the rehab ward this is supplemented by the red light system which ensures those patients are identified quickly. The FRAT is completed if a patient has a fall or a near miss. The surveyors observed these processes in place and included when speaking with patients.

Retrospective audits of the use of this tool indicate a very high compliance rate with completion on admission and as required.

Considering that about 90% of NPH patients are day stay, this completion rate is very good.

Preventing falls and harm from falling

The FRAT is completed on admission to assess the risk of falls for that individual. If this is assessed to be moderate or high appropriate and individualised strategies are developed and put in place to help minimise the risk of falls or injuries from same.

The incident reports from RiskMan are monitored by the Falls Committee to ensure appropriate follow-up is completed.

The organisation has ready access to equipment for use to help minimise falls. This equipment is available for all patients and is in use across the facility.

A "pre-hab" program is in place and used for some people requiring joint replacement. "Pre-hab" is used to support those people at greater risk with co-morbidities prior to surgery. This program is usually completed in the two weeks leading up to the planned surgery. The aim is to have reduced the risks associated with co-morbidities and the number of patients needing rehabilitation post-surgery. Currently approximately 20% of joint surgery patients require hospital-based rehabilitation. This successful program has helped to reduce this number of patients.

The Allied Health team is part of the Falls Prevention Program, and is involved with a person who is identified as being at risk from the start of their stay. The Occupational Therapist will complete home visits to ensure safety at home once discharged. There is a strong relationship with other hospitals within the region which helps identify if one of their patients has had a fall at home and has returned to hospital.

As NPH has a fairly large catchment area, the Falls team has developed relationships with providers of falls support services within that catchment area. As a result, on discharge, patients are able to return to their homes with support which ensures their ongoing safety.

The falls rate for NPH over the past three years has been constantly low.

Communicating with patients and carers

There are a number of patient information brochures available to patients. These are NSW Ministry of Health, HSP and locally produced brochures. The locally developed brochures have been reviewed by the consumer consultants.

Patients spoken with stated that falls risk reduction plans were developed in consultation with them.

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	MM
10.7.2	SM	MM
10.7.3	SM	MM
10.8.1	SM	MM

Action 10.7.1 Core

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

Surveyor Comment:

Despite approximately 90% of admissions to NPH being day stay patients, the compliance rate with the completion of the Falls Risk Assessment Tool (FRAT) is very high and has remained so since last survey. If a person is identified as a moderate to high risk of falls, a management plan is developed and documented in the medical record.

Surveyor's Recommendation:

No recommendation

Action 10.7.2 Core

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

Surveyor Comment:

NPH has a multidisciplinary active and proactive Falls Management Committee which regularly reviews the effectiveness of the developed programs. Harm minimisation is paramount within this organisation. All reported incidents are reviewed to ensure follow-up is effective and appropriate.

Surveyor's Recommendation:

No recommendation

Action 10.7.3 Core

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

Surveyor Comment:

NPH uses various strategies to minimise falls and harm from falls. This is evidenced by the below state average falls rate maintained since last survey. This data can be seen as part of the ACHS Clinical Indicator suite.

At-risk patients are identified and personalised strategies are put in place to reduce their risk.

Surveyor's Recommendation:

No recommendation

Action 10.8.1 Core

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

Surveyor Comment:

The Falls Committee includes the Allied Health team. The Occupational Therapist will often do home visits to assist families with planning for a person's care after discharge. Discharge planning commences on admission and referrals

to external services are completed when appropriate. Distance is not an obstruction to discharge planning with NPH as it has established links with a number of external services.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

Organisation: Newcastle Private Hospital
Orgcode: 120643

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	NM
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	NM

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	NM
2.8.2	Consumers and/or carers participate in the planning and implementation of quality improvements	SM	NM
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 • outbreaks or unusual clusters of communicable infection • processing of reusable medical devices • single-use devices	SM	SM

	• 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 • risk assessment for cleaning and disinfection based on transmission-based precautions and the infectious agent involved	SM	SM

• 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

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Continuity of medication management

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

Communicating with patients and carers

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

Patient Identification and Procedure Matching

Identification of individual patients

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

Processes to transfer care

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

Processes to match patients and their care

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

Clinical Handover

Governance and leadership for effective clinical handover

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

Clinical handover processes

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

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

Patient and carer involvement in clinical handover

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

Blood and Blood Products

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

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

Documenting patient information

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

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

Managing blood and blood product safety

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

Communicating with patients and carers

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

Preventing and Managing Pressure Injuries

Governance and systems for the prevention and management of pressure injuries

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

8.4.1	Equipment and devices are available to effectively implement prevention strategies for patients at risk and plans for the management of patients with pressure injuries	SM	SM

Preventing pressure injuries

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

Managing pressure injuries

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

Communicating with patients and carers

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

Recognising and Responding to Clinical Deterioration in Acute Health Care

Establishing recognition and response systems

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

Recognising clinical deterioration and escalating care

Action	Description	Organisation's self-rating	Surveyor Rating
9.3.1	When using a general observation chart, ensure that it: • is designed according to human factors principles • includes the capacity to record information about respiratory rate, oxygen saturation, heart rate, blood pressure, temperature and level of consciousness graphically over time • includes thresholds for each physiological parameter or combination of parameters that indicate abnormality • specifies the physiological abnormalities and other factors that trigger the escalation of care • includes actions required when care is escalated	SM	SM
9.3.2	Mechanisms for recording physiological observations are regularly audited to determine the proportion of patients that have complete	SM	SM

	sets of observations recorded in agreement with their monitoring plan		
9.3.3	Action is taken to increase the proportion of patients with complete sets of recorded observations, as specified in the patient's monitoring plan	SM	SM
9.4.1	Mechanisms are in place to escalate care and call for emergency assistance	SM	SM
9.4.2	Use of escalation processes, including failure to act on triggers for seeking emergency assistance, are regularly audited	SM	SM
9.4.3	Action is taken to maximise the appropriate use of escalation processes	SM	SM

Responding to clinical deterioration

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

Communicating with patients and carers

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

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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	MM
10.7.2	The effectiveness and appropriateness of the falls prevention and harm minimisation plan are regularly monitored	SM	MM

10.7.3	Action is taken to reduce falls and minimise harm for at-risk patients	SM	MM
10.8.1	Discharge planning includes referral to appropriate services, where available	SM	MM

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

Organisation: Newcastle Private Hospital
Orgcode: 120643

Recommendations from Current Survey

Standard: Partnering with Consumers
Item: 2.2
Action: 2.2.2 Consumers and/or carers are actively involved in decision making about safety and quality

Surveyor's Recommendation:

Identify and implement a mechanism for involving consumers and/or carers in decision making about safety and quality.

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

Surveyor's Recommendation:

Identify and implement a mechanism for the involving of consumers and/or carers in the training of the clinical workforce.

Standard: Partnering with Consumers
Item: 2.8
Action: 2.8.1 Consumers and/or carers participate in the analysis of organisational safety and quality performance

Surveyor's Recommendation:

Identify and implement a mechanism to engage consumers and/or carers in the analysis of the health service's safety and quality performance.

Standard: Partnering with Consumers
Item: 2.8
Action: 2.8.2 Consumers and/or carers participate in the planning and implementation of quality improvements

Surveyor's Recommendation:

Identify and implement a mechanism to engage consumers and/or carers in the planning and implementation of quality improvements.

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/or carers to participate in the implementation of quality activities relating to patient feedback data.

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

Surveyor's Recommendation:

Establish a detailed action plan to ensure all relevant staff complete ANTT mandatory training and annual competency assessment.

Organisation: Newcastle Private Hospital
Orgcode: 120643

Recommendations from Previous Survey

Standard: Partnering with Consumers
Criterion: Consumer partnership in service planning
Action: 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

Recommendation: NSQHSS Survey 0814.2.2.1

Recommendation:

Identify and implement a mechanism for involving consumers and or carers in strategic and operational planning.

Action:

The Consumer Engagement Reference Group (CERG) was established in March 2014 and meetings are conducted quarterly.

This Committee provides a forum to actively engage consumers in the strategic and operational services/planning, decision making regarding safety and quality initiatives and quality improvement activities at NPH.
Currently there are three Consumer Consultants as members of this Committee. Their presence at the Committee has been sporadic in 2015 due to personal and work commitments however the QRM keeps in regular contact with the Consumer Consultants to advise of any operational changes and seek advice on patient information and publications.

Completion Due By:

Responsibility:

Organisation Completed: Yes

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

The Consumer Resource Committee has been established and meets quarterly. While the number of consumers involved is currently limited, Newcastle Private Hospital is utilising multiple strategies to recruit more. Two new consumers were due to commence shortly after survey.

NSQHSS Survey

Organisation: Newcastle Private Hospital
Orgcode: 120643

Standard: Partnering with Consumers
Criterion: Consumer partnership in designing care
Action: 2.5.1 Consumers and/or carers participate in the design and redesign of health services

Recommendation: NSQHSS Survey 0814.2.5.1

Recommendation:

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

Action:

The Consumer Engagement Reference Group (CERG) was established in March 2014 and meetings are conducted quarterly.

This Committee provides a forum to actively engage consumers in service planning which includes redesign of the health service. The hospital continues to expand and undergo refurbishments and the Consumer Consultants have been provided information at the CERG. Opportunity is provided to allow consumer feedback regarding design of new services.
Currently there are three Consumer Consultants as members of this Committee.
Focus groups have been held in Maternity, Oncology and Surgical Services which provide appropriate forums for end-users of our service to provide feedback regarding facility design. Significant feedback has been provided through these forums and via the quarterly Patient Satisfaction Surveys with regard car-parking and this has definitely been taken into consideration with the design of the new building.

Completion Due By:

Responsibility:

Organisation Completed: Yes

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

The development and furnishing of the new cardiac building had little or no input from the consumers, mostly because they had not long joined the consumer groups.

Standard: Partnering with Consumers
Criterion: Consumer partnership in designing care
Action: 2.6.2 Consumers and/or carers are involved in training the clinical workforce

Recommendation: NSQHSS Survey 0814.2.6.2

Recommendation:

Identify and implement a mechanism for involving of consumers and or carers in the training of the clinical workforce.

Organisation: Newcastle Private Hospital
Orgcode: 120643

Action:

The involvement of Consumers in the training of the clinical workforce has continued to be challenging for NPH. Whilst we have employed the services of three Consumer Consultants who are able to attend our key Committees, time and commitment restraints have prevented any active involvement in the training of the clinical workforce. Progression of this recommendation continues to be of paramount importance to NPH. It is proposed that a training DVD will be made with the input of the Consumer Consultants and this will be shown at Orientation. This is currently a work in progress as we work towards developing scripts for same.

Completion Due By: July 2017

Responsibility: Consumer Engagement Reference Group

Organisation Completed: No

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

While there are plans in place, this has not yet been developed further.

Standard: Partnering with Consumers
Criterion: Consumer partnership in service measurement and evaluation
Action: 2.8.1 Consumers and/or carers participate in the analysis of organisational safety and quality performance

Recommendation: NSQHSS Survey 0814.2.8.1

Recommendation:

Identify and implement a mechanism to engage consumers and carers in the analysis of the health service's safety and quality performance.

Action:

The Consumer Engagement Reference Group (CERG) was established in March 2014 and meetings are conducted quarterly.

This Committee provides a forum to actively engage consumers in the strategic and operational services/planning, decision making regarding safety and quality initiatives and quality improvement activities at NPH. One of the core agenda items on the CERG is quality/data reporting. The quarterly Key Performance Indicators are tabled and discussed at this meeting and the Patient Care Committee which is attended by one of the Consumer Consultants.

Completion Due By:

Responsibility:

Organisation Completed: Yes

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

Development of consumer knowledge, skills and time availability to be able to actively participate in the analysis of safety and quality performance, has been limited.

Standard: Partnering with Consumers
Criterion: Consumer partnership in service measurement and evaluation
Action: 2.8.2 Consumers and/or carers participate in the planning and implementation of quality improvements

Recommendation: NSQHSS Survey 0814.2.8.2

Recommendation:

Identify and implement a mechanism to engage consumers and carers in the planning and implementation of quality improvements.

Action:

The Consumer Engagement Reference Group (CERG) was established in March 2014 and meetings are conducted quarterly.
This Committee provides a forum to actively engage consumers in the strategic and operational services/planning, decision making regarding safety and quality initiatives and quality improvement activities at NPH. One of the core agenda items on the CERG is quality/data reporting.

Completion Due By:

Responsibility:

Organisation Completed: Yes

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

This remains a work in progress.

Standard: Partnering with Consumers
Criterion: Consumer partnership in service measurement and evaluation
Action: 2.9.1 Consumers and/or carers participate in the evaluation of patient feedback data

Recommendation: NSQHSS Survey 0814.2.9.1

Recommendation:

Identify and implement a mechanism to enable consumers and carers to participate in the evaluation of patient feedback data.

Action:

Patient feedback and patient satisfaction results are discussed at the CERG and the Patient Care Committee which has consumers in attendance. Input has been provided by the Consumers in the redesign of the patient satisfaction brochure to ensure the language is easily understood and will encourage patients to provide feedback regarding their care at NPH.

Completion Due By:

Responsibility:

Organisation Completed: Yes

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

Consumers stated they were engaged and involved in decision making relating to the evaluation of patient satisfaction feedback.

Standard: Partnering with Consumers
Criterion: Consumer partnership in service measurement and evaluation
Action: 2.9.2 Consumers and/or carers participate in the implementation of quality activities relating to patient feedback data

Recommendation: NSQHSS Survey 0814.2.9.2

Recommendation:

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

Action:

Consumer advice and input has been sought for a variety of patient information leaflets and brochures to ensure the language is easily understood by patients. The following patient information are some examples where consumer input has been provided and documents amended:

- Bronchoscopy and endoscopy pulmonary valves - Patient information
- How to provide feedback to NPH
- National Standards Information for Consumers and Carers Pamphlet - available in all the patient areas
- Cardiothoracic Patient Satisfaction Survey
- A General Guide to Admission and Discharge (Adult and Paediatric) - brochure developed to provide concise information for patients regarding admission and discharge processes at NPH
- Cardiac Surgery Patient Information Booklet
- Going Home after Elective Coronary Angioplasty/Stenting Brochure
- Activity Guidelines for Patients after a Heart Attack
- Surgical Procedure Preadmission Information
- Orthopaedic Procedure Preadmission Information

These quality activities have arisen from patient feedback provided and discussed at the CERG and Patient Care Committees.

Completion Due By:

Responsibility:

Organisation Completed: Yes

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

While the consumer consultants felt they were consulted regarding the implementation of quality activities arising from patient feedback, it was more related to the activity itself rather than how it would be carried out or their role in that.

Standard: Preventing and Controlling Healthcare Associated Infections
Criterion: Infection prevention and control strategies
Action: 3.10.1 The clinical workforce is trained in aseptic technique

Recommendation: NSQHSS Survey 0814.3.10.1

Recommendation:

Ensure that the newly created risk matrix and plan for 100% compliance with aseptic non-touch technique is implemented and monitored.

Action:

Compliance with all three elements of the ANTT program continues to be a work in progress. An improvement has been noted since the survey period in 2014. In 2016 the ANTT workbook was available electronically to all appropriate staff on the ELMO eLearning system:

Overall compliance in December 2014 - May 2015 = 49%

Overall compliance in June 2015 - May 2016 = 57%

Results will continue to be monitored and reported at the appropriate governance Committees.

Completion Due By: July 2017

Responsibility: IFC CNC

Organisation Completed: No

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

Significant effort has been achieved in both the Delivery Suite and Oncology to ensure 100% of relevant clinical staff has completed all four components of the hospital's Aseptic Technique program. Other clinical areas are yet to

demonstrate full compliance. Consequently the overall hospital result is 68.2% at the time of survey. Therefore, this action is only partially met at the transitional level and a new recommendation is made.

Standard: Medication Safety
Criterion: Communicating with patients and carers
Action: 4.14.1 An agreed medication management plan is documented and available in the patient's clinical record

Recommendation: NSQHSS Survey 0814.4.14.1

Recommendation:

Ensure that an agreed medication management plan is documented and available in the clinical record for identified patients including those attending chemotherapy clinics.

Action:

The Healthscope generic Medication Management Plan (MMP) is utilised in the clinical areas. CHARMRDS medication management system is utilised in both Day Oncology and the Oncology Inpatient areas. CHARM is a computer programme that allows for the generation of an ELECTRONICALLY PRINTED ONCOLOGY DRUG CHART. The information included consists of all treatment drugs from pre-medications through treatment to discharge home supportive medications. This provides an electronically generated drug chart with the treatment plan documented. This system has assisted in reducing the risk of drug errors due to handwritten drug charts (flowsheets). It is mandatory that only 1 CHARM drug chart is in circulation at any time reduce the risk of error from multiple copies being in circulation.

Completion Due By:

Responsibility:

Organisation Completed: Yes

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

The use of the CHARM system in the oncology ward is noted. The medication reconciliation in the ICU and Rehabilitation ward is also well done. NPH is aware that other areas need continual work to increase the numbers of medication action plans and reconciliation in medication.

NSQHSS Survey

Organisation: Newcastle Private Hospital
Orgcode: 120643

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	20	0	20
Standard 8	0	20	0	20
Standard 9	0	15	0	15
Standard 10	0	18	0	18
Total	**0**	**209**	**0**	**209**

Developmental

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

NSQHSS Survey

Organisation: Newcastle Private Hospital
Orgcode: 120643

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

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

NSQHSS Survey

Organisation: Newcastle Private Hospital
Orgcode: 120643

Combined

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

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

NSQHSS Survey

Organisation: Newcastle Private Hospital
Orgcode: 120643

Surveyor - NSQHSS V01

Core

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

Developmental

Standard	Not Met	Met	N/A	Total
Standard 1	0	9	0	9
Standard 2	6	5	0	11
Standard 3	0	2	0	2
Standard 4	0	6	0	6
Standard 5	0	0	0	0
Standard 6	0	2	0	2
Standard 7	0	3	0	3
Standard 8	0	4	0	4
Standard 9	0	8	0	8
Standard 10	0	2	0	2
Total	**6**	**41**	**0**	**47**

Standard	SM	MM	Total
Standard 1	44	0	44
Standard 2	4	0	4
Standard 3	39	0	39
Standard 4	31	0	31
Standard 5	9	0	9
Standard 6	9	0	9
Standard 7	20	0	20
Standard 8	19	1	20
Standard 9	15	0	15
Standard 10	14	4	18
Total	**204**	**5**	**209**

Standard	SM	MM	Total
Standard 1	9	0	9
Standard 2	5	0	5
Standard 3	2	0	2
Standard 4	6	0	6
Standard 5	0	0	0
Standard 6	2	0	2
Standard 7	3	0	3
Standard 8	4	0	4
Standard 9	8	0	8
Standard 10	2	0	2
Total	**41**	**0**	**41**

NSQHSS Survey

Organisation: Newcastle Private Hospital
Orgcode: 120643

Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 1	0	53	0	53	Met
Standard 2	6	9	0	15	Met
Standard 3	0	41	0	41	Met
Standard 4	0	37	0	37	Met
Standard 5	0	9	0	9	Met
Standard 6	0	11	0	11	Met
Standard 7	0	23	0	23	Met
Standard 8	0	24	0	24	Met
Standard 9	0	23	0	23	Met
Standard 10	0	20	0	20	Met
Total	**6**	**250**	**0**	**256**	**Met**

Standard	SM	MM	Total	Overall
Standard 1	53	0	53	Met
Standard 2	9	0	9	Met
Standard 3	41	0	41	Met
Standard 4	37	0	37	Met
Standard 5	9	0	9	Met
Standard 6	11	0	11	Met
Standard 7	23	0	23	Met
Standard 8	23	1	24	Met
Standard 9	23	0	23	Met
Standard 10	16	4	20	Met
Total	**245**	**5**	**250**	**Met**