NSQHS Standards Second Edition Version 2 Organisation-Wide Assessment

Final Report

Canberra Health Services

Canberra, ACT

Organisation Code: 810004
Health Service Organisation ID: A1010001
Assessment Date: 27/06/2022 to 01/07/2022

Accreditation Cycle: 1

Contents

Preamble

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

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

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

A rating report is provided for each health service facility.

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

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

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

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

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

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

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

Executive Summary

Canberra Health Services underwent a NSQHS Standards Second Edition Version 2 Organisation-Wide Assessment (NS2.1 OWA) from 27/06/2022 to 01/07/2022. The NS2.1 OWA required 10 assessors for a period of 5 days. Canberra Health Services is a public health service. Canberra Health Services was last assessed between 19 – 23/03/2018.

Canberra Health Services (CHS) was formed on 1 October 2018 when ACT Health was separated into two separate directorates. CHS is responsible for the provision of public health services, including inpatient acute care, rehabilitation, extended and in-home care, and a range of ambulatory services, including dental, and mental health care. The Chief Executive Officer is responsible directly to the Minister for Health. The Governance Committee (CHSGC) comprises 6 Independent members (one of which is the Chairperson), the Chief Executive Officer, the Chief Operations Officer, Chief Financial Officer and Deputy Chief Executive. The CHSGC oversees strategic and operational performance and ensures that CHS is delivering on their goal of creating exceptional health care.

The assessment revealed a workforce culture that is closely aligned to the CHS vision, values, Clinical Governance Framework and Exceptional Care Framework. Many staff commented on the significant improvement in communications and staff morale since that last on-site organisational-wide Accreditation Assessment. All clinical areas and many clinical and non-clinical support areas were visited.

All recommendations arising from the previous organisational wide assessment have been satisfactorily addressed and were closed and three new recommendations were provided in Actions 1.29, 4.10 and 4.15.

Assessors noted the passion and enthusiasm in which staff approached the assessment process and the willingness to share their successes particularly given the constraints and issues that COVID-19 has brought.

CHS has implemented a Risk Management Framework supported by policies, procedures, and guidelines to provide staff with clear information about safety and risks associated with their consumers. Action 1.29 was rated as Met with Recommendation due to the planned preventive system for bio-medical equipment being significantly behind schedule.

The work undertaken in strengthening relationships and partnerships with local and other relevant Aboriginal and Torres Strait Islander people is noted and is documented in each of the five Actions within this Report. Significant work has been done to ensure inclusion of Aboriginal and Torres Strait Islander Peoples in strategic planning and organisational design. Additionally, employment of Aboriginal and Torres Strait Islander staff is representative of the Canberra population.

Discussion with patients and carers indicated total inclusion of them in care planning and delivery of care. Consent for care and interventions was 100% across the Organisation. Health literacy has been addressed including significant work with consumers to develop a new website.

Infection Prevention and Control is governed by a multidisciplinary committee and suite of policies and procedures. Identified infection control risks are well mitigated but it is noted the risk related to the reprocessing department at Mitchel will only be fully achieved with the capital development of the Theatre and CSSD complex. Advisories AS20/01 and AS20/02 relating to audit of hand hygiene and on data collection during pandemic is met. The organisation has managed COVID 19 planning and implementation well, and importantly has kept patients and consumers updated with the facts. It is acknowledged that environmental services have played a pivotal role in the pandemic response.

The gap analysis and actions plan in relation to Australian Standard AS/NZS 4187 are being closely tracked by the CEO, and the current requirements of Advisory AS18/07 in relation to reprocessing are met, with further work to do according to established timelines. The Assessment team note that Canberra Health Services has been granted an extension which requires the health service to meet the requirements of Advisory AS18/07 by 30 June 2024.

The Antimicrobial Stewardship (AMS) sub-committee monitors AMS and November 2020 National Antimicrobial Prescribing Survey (NAPS) data demonstrated substantial improvements to its level of compliance. Advisory AS18/08 relating to AMS / surgical prophylaxis is met.

CHS has a team of pharmacists who form the backbone of the medication safety program. Best possible medication history and reconciliation are carried out by the pharmacists thereby ensuring a consistent process. Most clinicians are aware of the need for medication review. A recommendation is provided in Action 4.10 as it was noted that this was only consistently undertaken by clinical pharmacists. There is a good reporting culture about adverse reactions, and these reports are monitored by the appropriate committees. There are some challenges with the management of High-Risk medications in circumstances where both electronic and paper forms are in concurrent use, and therefore a recommendation in Action 4.15 is provided.

Assessors reviewed the processes that are in place to guide the delivery of comprehensive care. Staff interviewed described their commitment to providing the best possible care and demonstrated their work within a multidisciplinary team framework. The collaboration of staff of all disciplines in providing this care was observed by Assessors. Also of note is the authentic partnerships staff routinely establish with patients and their carers, and families in care planning and delivery. A coordinated multidisciplinary approach was evident, with the aim to meet the individual needs and wellbeing of the patient. In the main, care is aligned with the expressed goals of care from the patient taking into consideration the impact on their choice and wellbeing. There is evidence to demonstrate that care systems and processes are routinely evaluated.

Health risk screening and associated care planning is undertaken very well across all divisions. The delivery of comprehensive care across the organisation is supported by policy, clinical pathways, and a wide range of other clinical resources, readily accessible to staff via the intranet. End-of-life care is particularly well managed, with patients and their families as active partners in decision-making.

There is a comprehensive suite of policies that are embedded to ensure communication for safety.

The Assessors interviewed a sample of all disciplines of clinical staff and found that the use of ISBAR for structured handover, and ISOAP for structured documentation is common terminology and routine practice. This demonstrates the culture of active engagement from all clinical disciplines to ensure safe communication of patient care at all entry, transfer, and discharge points during the continuum of care. There are numerous tools and processes observed that actively encourage participation of the patient / carer in their care, for example handover, multidisciplinary case reviews, and the Patient Whiteboard Communication Tool. Quality and safety audit and monitoring processes at departments are reported via clinical governance and used constructively to identify opportunities for improvement.

The Assessors observed consistent use of three approved identifiers at every site visited, and at all points of entry, transfer of patients and at interventions for patient care. Patient journey through the theatres, demonstrated compliance with 'Time Out' in the theatres and procedural areas is well managed under the leadership of the medical and nursing staff. Patients and carers interviewed by the Assessors were familiar with the processes to communicate critical information about their care.

A progressive approach and pioneering work has been undertaken to ensure patients receive optimal care when administered blood and/or blood products. There has also been extensive collaboration and ongoing work with external partners.

Assessors were able to verify that organisation-wide systems are in place to ensure early recognition of deterioration across all age cohorts with appropriate well tested and regularly evaluated response mechanisms. This applies to both physiological changes as well as changes to cognition and mental state.

Comprehensive processes are in place to ensure safe and effective responses to deterioration in a person's mental state with mechanisms for rapid referral when required. Advisory AS19/01 was introduced to allow sufficient time for organisations to establish effective processes for the mental state component with a timeframe for full implementation by 30 June 2022. The assessment team was able to verify the full implementation of these requirements with achievements in the elements of evidence-based screening tools and escalation protocols tailored to specific age cohorts.

Many departments such as the Sexual Health Centre and Paediatric Adolescent Unit were able to reflect on their increasing admissions from the LGBTIQ+ Community. Suggestions were made to staff in all areas interacting with this community and seeking the reassurance of 'inclusivity' to consider the benefits of applying for accreditation against the Rainbow Tick Standards.

Summary of Results

At Canberra Health Services' Organisation Wide Assessment 3 Actions were rated Met with Recommendation across 8 Standards. The following table identifies the Actions that were rated Met with Recommendation and lists the facilities to which the rating applies.

Actions Rated Met with Recommendations

Facilities (HSF IDs)	NS2.1 OWA 27/06/2022 - 1/07/2022
	MwR
Canberra Health - Community Health-A101000102	1.29
Canberra Health - Dental-A101000104	1.29
Canberra Hospital, The-100425	1.29, 4.10, 4.15
Centenary Hospital for Women and Children-O100278	1.29, 4.10, 4.15
Dhulwa Secure Mental Health Unit-O100280	1.29, 4.10, 4.15
Gawanggal-O100279	1.29, 4.10, 4.15
University of Canberra Hospital-101999	1.29, 4.10, 4.15

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

Sites for Assessment
Canberra Health Services

Site	HSFID	Address	Visited
Canberra Health - Community Health	A101000102	ACT 2600	
Belconnen Health Centre		Benjamin Way (Cnr Swanson)	Yes
Bimberi Youth Justice Centre		Morisset Road	Yes
CAMHS South - Callum Office		13 Easty Street	Yes
City Health Centre		1 Moore Street	Yes
COVID-19 Surge Centre		123 Kitchener Street	Yes
COVID-19 Testing Clinic - Nicholls (Gold Creek)		Perce Douglas Memorial Playing Fields	No
Dickson Health Centre		111 Dickson Place	No
Gungahlin Health Centre		Cnr Ernest Cavanagh Street & Fussell Lane	Yes
Holder Centre		26 Weingarth Street & Blackwood Terrace	No
Hume Health		10400 Monaro Highway	No
Kambah COVID-19		Jenke Circuit	No
Phillip Health Centre		Corinna Street	Yes
Sterilising Services		9 Stanford Street	Yes
Tuggeranong Health Centre		Anketell Street	Yes
Village Creek Centre		37 Kingsmill Street	No
Site	HSFID	Address	Visited
Canberra Health - Dental	A101000104	ACT 2600	
Belconnen Health Centre		Benjamin Way (Cnr Swanson)	Yes
City Health Centre		1 Moore Street	Yes
Gungahlin Health Centre		Cnr Ernest Cavanagh Street & Fussell Lane	Yes
Phillip Health Centre		Corinna Street	Yes
Tuggeranong Health Centre		Anketell Street	Yes
Site	HSFID	Address	Visited
Canberra Hospital	100425	Yamba Drive GARRAN ACT 2605	Yes
Site	HSFID	Address	Visited
Centenary Hospital for Women and Children	O100278	Yamba Drive GARRAN ACT 2606	Yes
Site	HSFID	Address	Visited
Dhulwa Secure Mental Health Unit	O100280	30 Mugga Lane SYMONSTON ACT 2609	Yes
Site	HSFID	Address	Visited
Gawanggal	O100279	50 Mary Potter Circuit BRUCE ACT 2617	Yes
Site	HSFID	Address	Visited
University of Canberra Hospital	101999	20 Guraguma Street BRUCE ACT 2617	Yes

Standard 1 - Clinical Governance

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

ACTION 1.01
The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews reports and monitors the organisation's progress on safety and quality performance
Comments
A review of available documentation (Consistent with the requirements of the ACSQHC Checklist for Assessors – Reviewing information accessed and actioned by the Governing Body), supported by observation and interviews with key clinical governance leaders across CHS, demonstrated that a culture of safety and quality improvement had been established. This was reinforced by CHS Governance Committee (CHSGC) who set CHS strategic direction and ensures it is clearly communicated. A Clinical Governance Framework describes the governance related roles and responsibilities across the services and supports staff to effectively partner with patients and families. A Committee Structure has been established to monitor the effectiveness of the clinical quality system through audit, data analysis and incident reporting. A risk management approach underpins all aspects of clinical safety and quality. The Planning Framework Maturity Self-Assessment for 2022 shows a significant increase in all four elements since 2021 which indicates an established maturity in consumer representatives on CHS Committees. Assessors noted that Policies and Procedures, Framework documents and minutes are version controlled but not all reports or terms of reference for committees are version controlled and a suggestion has been made to address this issue.
Suggestion(s) for Improvement
CHS develop a consistent approach for Version Control for all relevant documents.

Rating	**Applicable HSF IDs**
Met	All

ACTION 1.02	
The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people	
Comments	
Members of the CHSGC were able to describe how the specific health needs of Aboriginal and Torres Strait Islander people are being addressed. Documentation reviewed by Assessors supported that the CHS has addressed this as a priority and specifically focused on areas of inequity in service provision and outcomes for Aboriginal and Torres Strait Islander people. Assessors were impressed with the involvement of the Aboriginal and Torres Strait Islander Steering Committee in the development of the 'Together-Forward' document which clearly documents the collaboration processes at a governance and coal face level between CHS and the Aboriginal and Torres Strait Islander people how it will be achieved. The requirements of Advisory AS18/04 have been met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.03	
The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality	
Comments	
The CHS Governance Committee and staff in key clinical governance leadership roles were able to describe the Clinical Governance Framework 2020-2023 (the Framework). Senior managers were able to demonstrate to Assessors how the Framework is used, and how its effectiveness is monitored and reported, with changes made where indicated. The Clinical Governance Framework Maturity Self-Assessment for 2022 shows an increase in all four elements of maturity since 2021 which indicates a developing maturity particularly in governance leadership and culture.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.04	
The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people	
Comments	
Interviews with staff and managers were supported by observation and documentary evidence confirming that the CHS has strategies in place to monitor the effectiveness of quality and safety initiatives aimed at improving health outcomes for Aboriginal and Torres Strait Islander people. There have been demonstrated gains in a number of areas: the 'Hear Listen Yarn' Plum and Hats program; General Practitioners and Surgeons working together to reduce waiting times for surgery; Breast Screen Beautiful Shawls project; and the month of Yarning. Assessors were impressed with the following CHS data: 70.2 % babies born with Healthy weight; 97.2% Category 1 elective surgery patients are seen on time; and patient discharge against medical advice is 1.9%. There have been demonstrated gains in the specific areas of liaison with the Winnunga Aboriginal and Torres Strait Island Health Service.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.05	
The health service organisation considers the safety and quality of health care for patients in its business decision-making	
Comments	
Document review including relevant committee minutes, along with interviews with the CHSGC confirmed that issues of safety and quality are key factors in the CHS business decision making e.g., new Clinical Services Block, COVID-19 Walk in Clinics; the introduction of the 12hr Unit.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.06	
Clinical leaders support clinicians to: a. Understand and perform their delegated safety and quality roles and responsibilities b. Operate within the clinical governance framework to improve the safety and quality of health care for patients	
Comments	
Improvements noted at this assessment clearly indicate the sustainability and effectiveness of the clinical governance framework to assist with the collection report analysis and review of all safety and quality information with good evidence of feedback. Examples were provided of clinicians' duty statements demonstrating delegated roles and responsibilities complemented by leadership commitment to utilising training needs analysis to meet staff training needs. At interview, staff confirm that they understood their clinical safety and quality responsibilities and were able to articulate how the organisation monitors, reports and evaluates performance. Quality and safety boards are evident in all units and included data dashboard review at Divisional meetings. Clinical leadership is evident in the development of well described, integrated values and culture agenda aligned to quality and safety goals and improvement in the patient experience. Staff roles and responsibilities are linked to Fostering Organisational Culture Improvement Strategy, Exceptional Care Framework and other organisational strategic pillars. The revised clinical governance framework includes a hierarchy of Divisional and unit- based meeting minutes with quality and safety agenda through local Our Care Committees. Assessors reviewed minutes and noted action statements describing and array of safety and quality of health care agenda, including data reports, clinical audit, HRT data reports and review of exceptional care conversations, benchmarking reports, incident review, morbidity and mortality meetings, risk management review and document governance.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.07	
The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements	
Comments	
Documents reviewed, plus interviews with the senior managers demonstrated how policy documents, procedures and protocols are managed to ensure that they are current, comprehensive, effective, appropriately referenced and comply with legislation and regulations, along with Australian Capital Territory requirements. Compliance is monitored through incident reporting and trends influence the revision of specific policies, procedures and protocols where indicated. A risk management approach was evident in defining the scheduled revision of key documents-Corporate Plan; Risk Management Framework 2020-2023; Planning Framework 2021-2024; Resource Management Framework 2022-2025; and annual Divisional Business Plans.	

ACTION 1.07	
The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.08
The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems
Comments
CHS has a defined Performance Reporting and Monitoring Framework 2022-2024 that produces performance and outcome data. Staff confirmed that they received information on quality and safety performance and that it is actively managed with minutes of meetings at all levels throughout CHS supporting this. Outcome data and information is used to drive improvements through the clinical governance structure and is made available to staff, consumer representatives, the community and other stakeholders who are engaged in performance evaluation. CHS has adopted a standard format for Quality Boards: Our care; Our performance, Patient experience; Our staff. Assessors noted Boards in each service/ward visited and were impressed at the way the data is presented - easy to read and easy to understand. In all cases staff were very enthusiastic in talking about their Quality Board. Assessors noted that most committees do not have evaluation as part of their Terms of Reference and a suggestion has been made to address this issue. CHS has developed a comprehensive internal Audit Timetable to systematically audit all NSQHS Standards. Discussions during the Assessment indicated that the number of audits and the frequency of audits is considerable and time consuming and that a review had recently occurred. Notwithstanding, there may be the possibility to combine some audits.
Suggestion(s) for Improvement
1. CHS include an evaluation process to the Terms of Reference for each committee. 2. CHS review the current Audit Schedule and the time frames for Audits using a risk management approach.

ACTION 1.08	
The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.09	
The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: a. The governing body b. The workforce c. Consumers and the local community d. Other relevant health service organisations	
Comments	
Senior staff confirmed during interviews how CHS manages the safety and quality system. Reports are provided to the CHSGC and senior management, the workforce, consumers, and other stakeholders. Reporting is undertaken through a range of appropriate mechanisms, and in formats that are appropriate to the intended audience(s). Also see comments in Actions 1.01 and 1.08.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.10	
The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters	
Comments	
Management and staff explained how risks are identified and managed and how this is influenced by staff, patients, and carers. Information from a broad range of sources informs the CHSGC and leadership teams to define and operationalise the risk management system. The system is reviewed and refined as needed to ensure it remains effective in managing both corporate and clinical risks. The risk management system includes business continuity plans to support service delivery in the case of an emergency or disaster. Assessors saw evidence that the system is actively managed, evaluated and improved as needed. Risk management reports are regularly provided to the CHSGC, management, staff, and the broader community.	

ACTION 1.10
The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters
The Risk Management Framework Maturity Self-Assessment for 2022 shows a slight increase in all four elements since 2021 which indicates the risk management is developing particularly in performance management and staff training. The current Risk Register is a 'living' document and as such is a very lengthy document. Whilst this is a relevant process for the Audit and Risk Committee which monitors the risks monthly the CHSGC may want to consider having a condensed version to review.
Suggestion(s) for Improvement
The CHSGC review the Risk Register with an aim of deciding how they want to monitor the risks.

Rating	Applicable HSF IDs
Met	All

ACTION 1.11
The health service organisation has organisation-wide incident management and investigation systems, and: a. Supports the workforce to recognise and report incidents b. Supports patients, carers and families to communicate concerns or incidents c. Involves the workforce and consumers in the review of incidents d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems
Comments
Documents reviewed, plus interviews with staff, confirmed that all staff are encouraged to report any incidents or "near misses" through the incident reporting system. A review of the In-patient Experience Survey 2021-2022 indicated that 86% of patients said that their concerns were listened to. The CHSGC provides analysis and feedback to all staff and key committees on incident reporting and trends. Trend analysis of incidents drives quality improvement activities and are reflected CHS 's Risk Register. Information on the outcomes of incident investigations is reviewed at the individual incident and aggregate levels to ensure the system is functioning as intended and to inform improvements where indicated. There is a no-blame culture in place at CHS. Sentinel events are reviewed by the Mortality and Morbidity Committee. Assessors reviewed the RCA process for one incident and noted that all policy processes were implemented and clinical practice has been changed as a result of the incident.

ACTION 1.11	
The health service organisation has organisation-wide incident management and investigation systems, and: a. Supports the workforce to recognise and report incidents b. Supports patients, carers and families to communicate concerns or incidents c. Involves the workforce and consumers in the review of incidents d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.12	
The health service organisation: a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework b. Monitors and acts to improve the effectiveness of open disclosure processes	
Comments	
CHS has established an open disclosure program which is consistent with the Australian Open Disclosure Framework. CHS monitors how, why and when open disclosure occurs, and records of open disclosure were viewed by Assessors. Staff were able to articulate their role in open disclosure and considered they were supported in initiating and participating in open disclosure. Assessors reviewed a number of cases and noted that the processes detailed in the Open Disclosure Policy were implemented.	
Suggestion(s) for Improvement	
CHS monitor the documentation to ensure all elements of the Open Disclosure Policy are followed.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.13	
The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems	
Comments	
CHS uses a variety of mechanisms to seek and respond to feedback from patients, carers, families and staff about the quality of care provided by CHS. Feedback is analysed, trended, reported and used to inform quality improvement strategies. The Partnering with Consumers Framework Maturity Self-Assessment for 2022 shows an increase in all four elements of maturity since 2021 which indicates a developing maturity particularly in sharing information with consumers, and carers. A review of the CHS Inpatient Experience Survey Report July 2021 to June 2022 indicated that 85% of patients rated their care as good or very good.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.14	
The health service organisation has an organisation-wide complaints management system, and: a. Encourages and supports patients, carers and families, and the workforce to report complaints b. Involves the workforce and consumers in the review of complaints c. Resolves complaints in a timely way d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e. Uses information from the analysis of complaints to inform improvements in safety and quality systems f. Records the risks identified from the analysis of complaints in the risk management system g. Regularly reviews and acts to improve the effectiveness of the complaints management system	
Comments	
Assessors were able to review CHS complaints management policy and processes. This demonstrated that an CHS -wide complaints management system is established, which supports patients, carers and the workforce to report complaints. These policies are regularly reviewed. Documentation shows that staff and consumers are appropriately involved in the review of complaints, which are resolved in a timely way. Feedback is provided to the CHSGC, the workforce and consumers on the analysis of complaints and action is taken to inform improvements both in response to individual complaints where indicated and based on identified trends which also inform the Risk Register. A review of the CHS Inpatient Experience Survey Report July 2021 to June 2022 indicated that compliments were 24.8% greater than complaints.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.15
The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher risk groups into the planning and delivery of care
Comments
CHS identifies diversity of consumers using its services through analysis of sociodemographic data and in routine assessment for admission to care. Staff provided evidence of completion of diversity training and review of case studies representing knowledge of the importance of supportive interaction between staff and consumers who identify barriers to access to care. Assessors reviewed evidence demonstrating CHS commitment to reducing stigma associated with groups more commonly associated with barriers to services, examples but not exclusively, sexual health where changes made to services include provision of a defined building setting, extensive consultation on service planning, improved access to telehealth and prophylaxis and collaboration with Emergency Medicine to update presentation and assessment procedures. Examples of improvements to delivery of care for Aboriginal and Torres Strait Islander peoples are referred to elsewhere in this report. Evidence also describes Adult and Child and Adolescent Mental Health collaboration with First Nations consumer groups as does Renal Network consultation relationship building. Other examples of high-risk group identification include engagement with NGO's in engaging homeless persons through What's New on the Streets meetings, provision of mobile phones, food vouchers and swags for consumers and ensuring safe discharge communication with community from Emergency. Women's, Youth and Children services have improved first booking-in services for culturally and linguistically diverse populations to include pre-booking interpreter services and award winning "in-language" childbirth classes.

Rating	Applicable HSF IDs
Met	All

ACTION 1.16
The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used
Comments
CHS hybrid health care record systems await the implementation of a comprehensive Digital Health Record, go-live date November 2022. Assessors however, validated that the healthcare record is readily available to clinicians at the point of care, hardcopy supported by on-line records integrating, comprehensive and timely documentation systems with patient investigation report, specific service platforms, medicines management and prior scanned record. Clinicians were able to describe how they use the healthcare record. Records reviewed at Assessment indicate good standards of clinical notation and reasonable representation of completion of clinical care coordination and pathways where they are utilised. Health Information Services (HIS) are commended for timely records scanning completion, the utilisation of efficient bar-coding systems and improving whole of service integration of records and appropriateness of disposal systems. HIS provides excellent support to forms management, commitment to support clinical research, documentation standards review and the maintenance of oversight of secure records systems, compliance with privacy legislation and systematic review of clinical information and validated coding practices.

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

ACTION 1.17	
The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that: a. Are designed to optimise the safety and quality of health care for patients b. Use national patient and provider identifiers c. Use standard national terminologies	
Comments	
CHS completed a gap analysis and Roadmap Plan to include clinical portal upload of discharge summaries aligned to meeting requirements of Advisory AS18/11. Assessors confirmed that full functionality of the patient administration system and patient master index, provider index, pathology and medical imaging systems and in concert, preparation for the pharmacy system integration remains work in progress. CHS demonstrates that it is actively pursuing upload of clinical information into the My Health Record System. Integration includes assuring that systems are clinical document architecture level 3 compliant and utilise standard national terminologies. Advisory AS18/11 requirements January 2022 are met, the organisation having completed a gap analysis and developed a detailed plan.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.18	
The health service organisation providing clinical information into the My Health Record system has processes that: a. Describe access to the system by the workforce, to comply with legislative requirements b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system	
Comments	
Upload to the My Health Record system is supported by junior staff commitment to completing the Learning Management Training module. Information currently uploaded is compliant with legislative requirements and regular review confirms accuracy and completeness. Assessors confirmed that barriers to progressing increased information upload include functionality and migration issues, integration with EPIC total health care system, Medical Imaging, Pathology and Emergency Department systems. Advisory AS18/11 January 2022 requirements, however, are met.	

ACTION 1.18	
The health service organisation providing clinical information into the My Health Record system has processes that: a. Describe access to the system by the workforce, to comply with legislative requirements b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.19	
The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation	
Comments	
Assessors verified that members of the governing body are provided with an array of clinical and corporate governance orientation documentation. The updated 2022 CHS Governance Committee membership includes consumer and carer membership. Members were provided with orientation on roles and responsibilities of committee membership, key priorities and documentation on the strategic goals for “Creating Exceptional Health Together” and “Delivering Exceptional Care Quality and Safety”. Evidence demonstrated that on-boarding and orientation of clinical and non-clinical staff, volunteers, agency, locum appointments is comprehensive and for contractors, safety and quality requirements described in contract documentation. Good examples were evidenced throughout however, Assessors noted and commend the Allied Health, Physiotherapy welcome and e-learning Essential Education Check List 2022 with courses completion requirements detailed and aligned to each National Standard. Orientation training schedules and information provided to junior clinical staff is also very well described.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.20	
The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce’s participation in training	
Comments	
Attendance records demonstrate good compliance with meeting Mandatory Training requirements. The Mandatory Training framework clearly identifies requirements for all staff, either to meet statutory, legislative and/or National Safety and Quality Health Service Standards requirements. Training including elements of safety and quality roles, basics of auditing practice, tools for that purpose, data analysis and how to utilise data for improvement. General educational opportunity is stratified and integrated through an e-learning pathway, Assessors noting that survey demonstrated that 70% of staff seek experiential learning opportunity.	

ACTION 1.20	
The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training	
Educational frameworks are based upon assurance of baseline clinical standard practise, professional development, commitment to evidenced based practise, positive learning opportunity and focus on personal effectiveness and patient outcomes. Support services training is well described utilising procedural based paper and online training with excellent compliance rates demonstrable. Junior medical staff education is based upon meeting learning and development or accreditation and training portfolio requirements, the calendar of which includes Grand Rounds, specialty sessions, mortality and morbidity attendance, senior peer group meetings and clinical care portfolio review experience as may be sought or required. Nursing learning objectives include area specific nursing stages of development, career development opportunity and committed competency assessment. Examples were evident of orientation, e-learning, competency assessment and supportive learning opportunity reviews undertaken across the clinical and support services spectrum.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.21	
The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients	
Comments	
An Aboriginal and Torres Strait Islander Cultural and Competency education program is part of mandatory training for staff. The program and training records were reviewed by Assessors and current attendance rates are 83%. CHS has 9 Aboriginal Liaison Officers (ALO's) to assist in ensuring staff understand and implement the 'Together-Forward' Strategy. In addition, ALO's to provide any assistance needed to Aboriginal and Torres Strait Islander inpatients/outpatients/carers and families.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.22
The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system
Comments
Performance review encompasses learning plans linked to individual's training and development goals. In response to a 2019 review which identified gaps in pre-existing processes for educational opportunity, ongoing staff development and specifically leadership development, a redesigned program was put in place. The recently established Strength Engagement and Development (SED) program aligns to the CHS Integrated Learning portfolio and Values and Action pillar, Reliable, Progressive, Respectful and Kind goals. Progress described at staff interview including senior medical staff, confirmed high level satisfaction with this framework as compared to previous practice. Early evaluation demonstrates overall 83% staff satisfaction with the revised process. Staff performance reviews are conducted annually, on completion of appointment cycles of senior medical staff and routinely half-term and end of term for junior medical staff. Examples were provided of services with staff meeting 100% completion rates. At Assessment review of staff performance review files including those of senior medical staff, Assessors were able to verify satisfactory completion of documentation. Medical Accredited training program requirements have universally been met with few substantive recommendations. In concert with the revised SED program, CHS has updated the e-learning platform and progress is being made to implement a full human resource information management system (HRIMS).

Rating	Applicable HSF IDs
Met	All

ACTION 1.23
The health service organisation has processes to: a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan b. Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered
Comments
Evidence demonstrated that CHS utilises National Guidelines for credentialing and defining scope of practice for senior medical staff. CHS solely defines core scope of practice for senior practitioners, although Assessors noted that the downloaded table of practitioners' scope documentation describes some practitioners with scope beyond core to include specific elements. Assessors noted examples where scope had not been defined beyond core where Faculty guidelines could enhance specific element description. This remains work in progress. Interviews with clinical leaders confirmed that processes ensure that clinicians are working within their agreed scope consistent with the defined capability of the organisation. Interview confirmed that no evidence of breech of scope by an individual practitioner has been identified. Access to the file of core scope of all senior practitioners is readily accessible on-line for all senior front-line staff. Documentation was provided outlining proceduralists confirmation of certification or seeking re-certification, for the meeting of colonoscopy scope of practice requirements. Assessors confirmed that CHS meets requirements of Advisory AS18/12. Nursing and Allied Health scope of practice processes are well defined,

ACTION 1.23	
The health service organisation has processes to: a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan b. Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered	
structured and periodically reviewed. Assessors confirmed that nursing scope aligns to registration requirements and skill set as defined by enrolled nurse, graduate, registered and advances skill practitioners ensuring ongoing professional responsibility and accountability. In accordance with policy, well-described documentation is required to be completed and confirmed in order to accommodate new or altered procedures or technologies.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.24	
The health service organisation: a. Conducts processes to ensure that clinicians are credentialed, where relevant b. Monitors and improves the effectiveness of the credentialing process	
Comments	
CHS policy, guidelines and processes ensure clinicians are appropriately credentialed, Assessors confirming through file documentation review that effective organisational business practices ensure qualifications, experience and competencies of appointed staff are appropriate to the capability of the organisation. Centralised credentialing process enables well-structured management, monitoring and audit of practitioners' registration status, appointment, identification of scope of practice and privileges. Professions subject to professional registration requirements are monitored and checked on the AHPRA database.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.25	
The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff	
Comments	
At appointment, staff are referred to position descriptions and appointment contract which clearly describe safety and quality responsibilities. Support to understanding accountability is evident in policy documents about access to, and use of, best-practice guidelines, pathways, decision support tools and clinical care standards that reflect best available evidence. Agency and locum staff are required to comply with on-boarding requirements which include evidence of understanding of CHS' expectation in terms of meeting safety and quality roles in the workplace.	

ACTION 1.25	
The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.26	
The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate	
Comments	
CHS demonstrates a range of strategies focused appropriately for clinical and non-clinical staff supervision. Assessors confirmed that clinical discipline supervision acknowledges not only the meeting of required standards of practice but also safety and quality and individual well-being. A substantive portfolio of supervision exists in the organisation. Evaluation of supervision includes objective driven review, individual self-appraisal in consultation with supervisor leaders and oversight governance by each clinical and non-clinical service. Impressive supervision portfolios were observed in JRMO, Allied Health and Nursing portfolios, inclusive of the meeting of both internal and external supervision requirements, aligned to education and training programs. Assessors noted, but not exclusively, an impressive “Clinical supervision for professional development, a role model for midwives” documentation. Allied Health has created guidelines, a supervisors training calendar and a set of resources, ensuring minimum standards for provision of supervision for all allied health professionals in CHS.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.27	
The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care	
Comments	
Assessors verified that CHS clinicians can easily access a range of tools, best practice guidelines, care pathways and clinical care standards in support of their clinical practice. Verification confirmed that clinicians have implemented several best practice clinical pathways based upon best available evidence. Assessors reviewed healthcare records and noted adherence to documentation in this regard. Assessors confirmed that mandatory clinical care standards GAP analysis had been undertaken and work plans generated including respective Quality Statements and Sets of Indicators. CHS demonstrates the meeting colonoscopy indicator benchmarks.	

ACTION 1.27	
The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care	
Assessors commend CHS for including processes for review and implementation of a number of non-mandatory ACSQHC work-in-progress clinical care standards. Assessors confirmed that CHS is compliant with the requirements of Advisory AS18/12 (1.27b) and ACSQHC Fact Sheet 11.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.28	
The health service organisation has systems to: a. Monitor variation in practice against expected health outcomes b. Provide feedback to clinicians on variation in practice and health outcomes c. Review performance against external measures d. Support clinicians to take part in clinical review of their practice e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems f. Record the risks identified from unwarranted clinical variation in the risk management system	
Comments	
Clinical pathway applications include monitoring and analysis alerting clinicians to variation in clinical practice and risk. Examples noted at Assessment included but not exclusively, Trauma, Acute Coronary Syndrome, Physiotherapy and Hip Fracture, Heavy Menstrual Bleeding, Perineal Tear, Chest Surgery, Stroke, and Oncology Neutropenic pathways. Comprehensive bedside audits focus on data collection aligned to, but not exclusively to National Standards. Peer group comparison includes National Registry data monitoring, outliers flagged for investigation and potential for improvement. Health Roundtable data dashboards are regularly reviewed. One example of data review included Physiotherapy Rheumatology long wait times and implementation of a multidisciplinary triage assessment pathway and access of patients to an e-triage system. Multidisciplinary morbidity and mortality meetings minutes and standardised reporting documentation describes formal process of review. Where clinical variation is identified a risk management approach is used to minimise future harm. Evidence demonstrated a committed CHS and University collaborative research portfolio including participation in multi-centred trials. Assessors noted, but not exclusively, well-established research portfolios in the Women's' Youth and Children Division, Cardiology, Orthopaedics, ICU, Trauma and Oncology services. As previously noted in this report, Assessors confirmed that GAP analysis and work plans are in place for each of the relevant Clinical Care Standards Quality Statements and collection and analysis of Sets of Indicators. The organisation is compliant with the requirements of Advisory AS18/12 (1.28a).	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.29
The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose
Comments
A review of safety and quality documentation substantiated staff interviews and observations by Assessors that the preventative and reparative maintenance of buildings, plants, equipment, utilities, devices and other infrastructure is undertaken to ensure that they are fit for purpose with the exception of preventive maintenance program for Bio-Medical Equipment. The Asset Management Policy requires that all assets are fit for purpose and meet CHS requirements. The Planned Preventive Maintenance Program includes all bio-medical equipment having to be checked once a year. Assessors noted during the Assessment that some bio-medical equipment was out of date and overdue for the annual check- Birthing Suite 2, resuscitaire machines, Birthing Centre 4 resuscitaire machines and in Cardiology 6 out of 9 ResMed Stellar BIPAP machines and body protection equipment at the Philip Health Centre. Discussion with the nursing staff in the Birth services confirmed that they check the resuscitaire machines before use. This was also confirmed by the Medical Director of the Service. Assessors reviewed the Bio-Medical Preventive Maintenance Program data and noted there are 50 clinical services that have Bio-Medical equipment which requires annual safety checking. As at, 1 July 2022, 23 services were fully compliant and 27 services were either partly compliant or there was no data to confirm compliance. Discussion with the Manager of the Health Technology Management service confirmed that the Preventive Maintenance System was currently not effective in that there is no follow-up process in place if an item was missed during the routine annual inspection. Safety of the environment is considered in service planning and design of the new facilities. Assessors confirmed that at the date of the assessment there were eleven major projects across the CHS. Assessors were impressed that Capital Works Project Control Groups have consumer, clinical and non-clinical staff involvement in design concepts. Quiet rooms/spaces are provided in clinical areas. All CHS facilities provide a welcoming and calming internal and external environment.

Rating	Applicable HSF IDs	Recommendation(s) / Risk Rating & Comment
MWR	All	**Recommendation:** Canberra Health Services implement a system that ensures that all bio-medical equipment has a safety inspection annually and that the data is regularly reviewed to ensure that the equipment is fit for purpose. **Risk Rating:** High

ACTION 1.30	
The health service organisation: a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required	
Comments	
CHS has developed strategies to identify areas that have a high risk of unpredictable behaviours and also has processes to ensure emerging risk areas can be appropriately identified. Strategies have been developed to ensure that people are treated in appropriate areas and risks associated with unpredictable behaviours are considered. Processes are in place to minimise the risk of harm to consumers and staff by unpredictable behaviours. Some examples are: Code Black responses in the Adult Mental Health Unit have decreased mainly due to the employment of a ward's person being employed 24 hours, 7 days per week; extra staff training in de-escalation; ICU has introduced an Occupational Violence Management Matrix to assist with the management of patients of concern; staff are offered counselling after each episode; duress alarms are in place in relevant CHS facilities.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.31	
The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose	
Comments	
Directional signage internally and externally is clear and fit for purpose. Assessors were able to successfully navigate an unfamiliar environment. Whilst the building process is in place CHS has employed staff to assist consumers in finding their way around the hospital buildings. Consumers on the Consumer and Carer Sub-committee, the Aboriginal and Torres Strait Islander Consumer Reference Group have participated in 'wayfinding 'projects.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.32	
The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so	
Comments	
Flexible visiting arrangements are in place. Patients reported satisfaction with visiting arrangements. COVID-19 innovative management for palliative care and end of life care was noted. Assessors were impressed by the innovative ways staff have arranged for families to visit loved ones who are in palliative care. Assessors noted the establishment of the 'Walk in Medical' Centres for consumers with COVID-19 who also have medical conditions that need treatment. These clinics are managed by Nurse Lead clinicians in line with best practice approved Protocols. Assessors were impressed that current redirection rate is 9% which demonstrates the effectiveness of the Centres.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit
Rating	**Applicable HSF IDs**
NA	Canberra Health - Community Health, Canberra Health - Dental

ACTION 1.33	
The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people	
Comments	
CHS demonstrates a welcoming environment and genuinely recognises the importance of the cultural beliefs and practices of the Aboriginal and Torres Strait Islander people. Specific examples include: Impact Statement/Declaration throughout CHS facilities; the establishment of a Kinship Room which is a large room that allows families to discuss end of life planning; the establishment of a Yarning Circle; the Aboriginal Dreaming Quilts Project; National Reconciliation Week Art work throughout CHS facilities; and First Nations Food Menu. Art Works throughout facilities includes an explanation of what the item of ART represents- memory, history or healing. Assessors were very impressed at the way in which CHS has worked with Aboriginal and Torres Strait Islander people in respect of all Standard 1 Actions. The requirements of Advisory AS18/04 have been met.	
Rating	**Applicable HSF IDs**
Met	All

Standard 2 - Partnering with Consumers

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

ACTION 2.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for partnering with consumers b. Managing risks associated with partnering with consumers c. Identifying training requirements for partnering with consumers	
Comments	
Interviews with staff and patients together with a review of policies and procedures supporting partnering with consumers, show that the principles of safety and quality are applied when these documents are developed. Consumers are engaged in policy development, implementation and training. They assist the organisation in identifying risks associated with partnering with consumers and inform risk mitigation. Training is provided to staff and attendance rates are 86%. Compliance with NSQH Fact Sheet /Brochure 2021 particularly noted by immediate and effective response to COVID 19 outbreaks. Discussion with staff demonstrated cohesive planning and action with a 'surge centre' being built within thirty-seven days. Subsequently and ongoing are the 'Rapid Assessment Units' and 'Walk in Units'. These facilities are staffed by Nurse Practitioners and multidisciplinary Teams and work very effectively at reducing presentations to Emergency Departments and General Practitioners.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring processes for partnering with consumers b. Implementing strategies to improve processes for partnering with consumers c. Reporting on partnering with consumers	
Comments	
A review of documentation and interviews with staff and consumers confirmed that the organisation aims to improve partnerships with consumers at all levels. The Assessors observed how these strategies are monitored and how the organisation reports on partnering with consumers. The Assessors observed significant improvement in partnerships with consumers/at all levels. Annual Consumers and carer surveys confirmed this observation. Subsequent to surveys, recommendations are tabled and action plan developed.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.03	
The health service organisation uses a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights b. Easily accessible for patients, carers, families and consumers	
Comments	
A review of the health service demonstrated that the Charter of Rights (consistent with the Australian Charter of Healthcare Rights) is readily available throughout, and that action is taken to ensure that it can easily accessed and understood. Significant work has been undertaken with staff and consumers to ensure both literacy levels are appropriate and that the document is available in many languages. The Brochure is colourful and readily available to patients and consumers.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.04	
The health service organisation ensures that its informed consent processes comply with legislation and best practice	
Comments	
Interviews with staff indicated that they understood their responsibilities with respect to informed consent. The consent policy and processes comply with legislation, and reference best practice. Overall Compliance with consent is audited and compliance is reported as 100% at all areas. However, it was noted there is an opportunity for improvement in the Endoscopy department. The requirements of Advisory AS18/10 have been met with respect to informed financial consent. Noted in both Radiation Department and Oncology Day Unit consent is obtained prior to each and every treatment.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.05	
The health service organisation has processes to identify: a. The capacity of a patient to make decisions about their own care b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves	
Comments	
A review of documentation shows there are processes in place to establish a patient's capacity to make decisions regarding their own care, plus the process to be followed if a substitute decision-maker is required. Staff were able to articulate this process and access the relevant policy. This process is sensitively managed by the Multidisciplinary Team. Audits of the supported decision-making process for patients being cared for in Mental Health Care Units are attended with 100% completion rates of relevant components of decision making capacity.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.06	
The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care	
Comments	
Interviews with patients and clinicians confirmed that staff work with patients, or a substitute decision-maker, in shared decision making about their care planning and goals of care. Partnerships with patients & consumers in Intensive Care Unit was observed to be of very high standard. A comprehensive check list in relation to patient understanding and information preferences and goals of care has been initiated. A recent improvement in the Acute Mental Health Unit has been the development of a new staff station which enhances consumer staff interaction point. This has been found to enhance mutual discussion and review of patient goals of care.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.07	
The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care	
Comments	
Staff and patients were able to describe to the Assessors how patients are actively involved in their care. Patients and carers interviewed confirmed this, and satisfaction surveys undertaken by the organisation also support that patient are satisfied with the level of engagement in their care. A specific Partnering with consumers at the bedside quality improvement audit in relation to 'health including care rights and what is important to me today has been developed and demonstrated to the Assessors. Positive feedback, issues to solve and plan to address same are tabled. Audits reviewed by Assessors and on discussion with patients demonstrated excellent partnerships between patients and staff. Results of audits are placed on Quality Boards which were observed throughout the Organisation.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.08	
The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community	
Comments	
A review of information provided to consumers through a wide range of mechanisms demonstrated that significant action has been undertaken to align communications with the needs of the patients, carers and their families. The diversity of the local community has informed communication and information that is available that reflects this diversity. Patient satisfaction with communication and information provided to them is included in satisfaction surveys and reported positively. This was also corroborated by patient interviews.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 2.09	
Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review	
Comments	
Documentation reviewed by the Assessment Team, and interviews with consumer representatives confirmed that any internally developed information has been reviewed by consumers to ensure that it is understandable and meets their needs. Consumers are represented on most if not all Committees and spoke of the respect and value of their input by the Organisation.	
Rating	**Applicable HSF IDs**
Met	All

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

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

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

ACTION 2.13
The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs
Comments
The organisation has pursued a range of activities to better partner with local Aboriginal and Torres Strait Islander communities, and to better understand and meet their specific and unique healthcare needs. Staff interviews and a review of documents confirmed that organisation actively engages with members of the local Aboriginal and Torres Strait Islander communities and seeks their input into service planning and care.

ACTION 2.13	
The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs	
Significant work has been attended to ensure absolute inclusion and representation in Committees of Aboriginal & Torres Strait Islander people at all levels throughout the organisation. Further to this several Aboriginal Torres Strait Islander people have been employed with the organisation equal to the percentage per population.	
Rating	**Applicable HSF IDs**
Met	All

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

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

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

ACTION 3.01	
The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for infection prevention and control b. Identifying and managing risks associated with infections c. Implementing policies and procedures for antimicrobial stewardship d. Identifying and managing antimicrobial stewardship risks	
Comments	
Assessors reviewed the CHS infection control documents which were consistent with the safety and quality systems from the Clinical Governance Standard. These principles underpin the implementation of policies and procedures, risk management and determining training requirements for preventing and controlling healthcare associated infections, and antimicrobial stewardship. CHS staff were able to describe how they operationalise infection control related policies and procedures, how associated risks are managed and undertake training in antimicrobial stewardship, and preventing and controlling healthcare-associated infections. HAI rates are reported as 1.3%. The Infection Control and Management policies have been updated to incorporate the requirements of the 2021 edition of the Preventing and Controlling Infection Standard. The ACT Covid -19 Clinical Care Standard and associated risk reduction strategies were observed to be in place and were escalated in accordance with community prevalence and ACT requirements. The organisation is compliant with Advisory AS20/02.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.02
The health service organisation: a. Establishes multidisciplinary teams to identify and manage risks associated with infections using the hierarchy of controls in conjunction with infection prevention and control systems b. Identifies requirements for, and provides the workforce with, access to training to prevent and control infections c. Has processes to ensure that the workforce has the capacity, skills and access to equipment to implement systems to prevent and control infections d. Establishes multidisciplinary teams, or processes, to promote effective antimicrobial stewardship e. Identifies requirements for, and provides access to, training to support the workforce to conduct antimicrobial stewardship activities f. Has processes to ensure that the workforce has the capacity and skills to implement antimicrobial stewardship g. Plans for public health and pandemic risks
Comments
The Infection Prevention and Control, and AMS committees are multidisciplinary, and have Terms of Reference that clearly describe their responsibilities of monitoring and improving infection prevention, and the effectiveness of the surveillance system and workforce training. Monthly reporting to the Infection Prevention and Control Committee occurs, the Delivering Exceptional Care – Quality & Safety Report includes Infection Indicators. The Covid 19 Plan and The ACT Covid -19 Clinical Care Standard includes a risk-based tiered response approach that is responsive to the Community based risk level.

Rating	Applicable HSF IDs
Met	All

ACTION 3.03
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of infection prevention and control systems b. Implementing strategies to improve infection prevention and control systems c. Reporting to the governance body, the workforce, patients and other relevant groups on the performance of infection prevention and control systems d. Monitoring the effectiveness of the antimicrobial stewardship program e. Implementing strategies to improve antimicrobial stewardship outcomes f. Reporting to the governance body, the workforce, patients and other relevant groups on antimicrobial stewardship outcomes g. Supporting and monitoring the safe and sustainable use of infection prevention and control resources
Comments
The CHS has a comprehensive schedule for auditing, including Infection prevention and control systems. Audit results are provided to individual clinical units, and aggregate data is provided through the governance structure and relevant dashboards. Infection control and prevention and antimicrobial stewardship are discussed at craft committee and operational meetings, and strategies were noted to be documented in committee records to improve performance where gaps are identified. There has been a commendable increase in number of antimicrobial microbial stewardship (AMS) rounds per week in intensive care.

Rating	Applicable HSF IDs
Met	All

ACTION 3.04	
Clinicians use organisational processes consistent with the Partnering with Consumers Standard when assessing risks and preventing and managing infections, and implementing the antimicrobial stewardship program to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
CHS patients and staff interviewed by members of the Assessment Team were able to describe the actions taken to involve and inform them about infection prevention and control, and AMS measures. Information is available to patients, carers and families in a format that is easily understood. Health record documentation shows evidence of patient discussions about treatment decisions, including use of antimicrobials. Brochures on relevant topics such as Caring for your Canulae, CMV in Pregnancy, and How to look after your PICC, were noted to be available for appropriate patients.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.05	
The health service organisation has a surveillance strategy for infections, infection risk, and antimicrobial use and prescribing that: a. Incorporates national and jurisdictional information in a timely manner b. Collects data on healthcare-associated and other infections relevant to the size and scope of the organisation c. Monitors, assesses and uses surveillance data to reduce the risks associated with infections d. Reports surveillance data on infections to the workforce, the governing body, consumers and other relevant groups e. Collects data on the volume and appropriateness of antimicrobial use relevant to the size and scope of the organisation f. Monitors, assesses and uses surveillance data to support appropriate antimicrobial prescribing g. Monitors responsiveness to risks identified through surveillance h. Reports surveillance data on the volume and appropriateness of antimicrobial use to the workforce, the governing body, consumers and other relevant groups	
Comments	
The CHS monitors and collects data on healthcare related infections and antimicrobial use as well as broader infection control surveillance data. Reports on healthcare related infections and antimicrobial use are provided to clinicians and reported through the clinical governance structure via reports and dashboards. Current data that supports the effectiveness of the organisations strategies includes surgical deep and superficial wound infections, line associated infections, and other invasive device or procedure infections, and transmission between staff and patients. The organisation is compliant with Advisory AS20/02.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.06	
The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare, jurisdictional requirements, and relevant jurisdictional laws and policies, including work health and safety laws	
Comments	
The CHS infection control documents reviewed indicated that processes consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare for standard and transmission-based precautions are in place. The Assessors noted that signage and other resources were consistent with the Australian Guidelines for the Prevention and Control of Infection in Healthcare.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.07	
The health service organisation has: a. Collaborative and consultative processes for the assessment and communication of infection risks to patients and the workforce b. Infection prevention and control systems, in conjunction with the hierarchy of controls, in place to reduce transmission of infections so far as is reasonably practicable c. Processes for the use, training, testing and fitting of personal protective equipment by the workforce d. Processes to monitor and respond to changes in scientific and technical knowledge about infections, relevant national or jurisdictional guidance, policy and legislation e. Processes to audit compliance with standard and transmission-based precautions f. Processes to assess competence of the workforce in appropriate use of standard and transmission-based precautions g. Processes to improve compliance with standard and transmission-based precautions	
Comments	
CHS organisational-wide policy and processes for management of organisms-specific risks, including prevalence in the community are in place that are consistent with jurisdictional and Public Health advice. In response to ACT infection risks present in the communities served by the organisation, a tiered organisation response has been developed. Handover, transfer of care and discharge processes include the requirement for documentation and communication of infectious status. Brochures and pre-admission information are utilised to advise patients, carers and visitors on management processes in place. A competency-based training program is in place for the appropriate use of standard and transmission-based precautions.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.08	
Members of the workforce apply standard precautions and transmission-based precautions whenever required, and consider: a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated during care b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs and patient placement to prevent and manage infection risks d. The risks to the wellbeing of patients in isolation e. Environmental control measures to reduce risk, including but not limited to heating, ventilation and water systems; work flow design; facility design; surface finishes f. Precautions required when a patient is moved within the facility or between external services g. The need for additional environmental cleaning or disinfection processes and resources h. The type of procedure being performed i. Equipment required for routine care	
Comments	
Procedures are available for implementing standard and transmission-based precautions and all staff (including non-clinical staff) are provided with education appropriate to their role. CHS staff were able to confirm their use and understanding of these measures and risk screening procedures. Facilities are designed to effectively manage infection risks. Environmental management and cleaning practices are consistent with policy.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.09	
The health service organisation has processes to: a. Review data on and respond to infections in the community that may impact patients and the workforce b. Communicate details of a patient's infectious status during an episode of care, and at transitions of care c. Provide relevant information to a patient, their family and carers about their infectious status, infection risks and the nature and duration of precautions to minimise the spread of infection	
Comments	
Communication of a patient's infectious status is included at transfer of care / handover points across CHS and compliance is monitored. Patients, carers, families and visitors are alerted to precautions that are required with posters describing the required precautions at the entry of patient rooms.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.10	
The health service organisation has a hand hygiene program that is incorporated in its overarching infection prevention and control program as part of standard precautions and: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with benchmarks and the current National Hand Hygiene Initiative c. Provides timely reports on the results of hand hygiene compliance audits, and action in response to audits, to the workforce, the governing body, consumers and other relevant groups d. Uses the results of audits to improve hand hygiene compliance	
Comments	
The Hand Hygiene program is consistent with the current National Hand Hygiene (HH) Initiative and jurisdictional requirements. There has been a recent focus on hand hygiene compliance, noted from a consumer committee representative. The organisation has access to gold standard Hand Hygiene auditors, including a new initiative with senior medical officers as auditors. This initiative showed an increase in medical hand hygiene compliance to 81%. Regular compliance and observational audits are undertaken and provided to staff and through the governance structure, reports and dashboards. Current overall compliance rates are 84%. The organisation is compliant with the requirements of Advisory AS20/01.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.11	
The health service organisation has processes for aseptic technique that: a. Identify the procedures in which aseptic technique applies b. Assess the competence of the workforce in performing aseptic technique c. Provide training to address gaps in competency d. Monitor compliance with the organisation's policies on aseptic technique	
Comments	
Processes for aseptic technique are in place. CHS staff are appropriately trained, and competency / compliance is monitored by the Quality Improvement & Innovation Team. Audit results indicate excellent compliance with the requirements of aseptic technique.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.12	
The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare	
Comments	
CHS training and assessment for the management of invasive devices are available to staff and align with the current best practice. Associated infection rates are monitored and reported. Line associated infection is noted to be 1.4%.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.13	
The health service organisation has processes to maintain a clean, safe and hygienic environment – in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare and jurisdictional requirements – to: a. Respond to environmental risks, including novel infections b. Require cleaning and disinfection using products listed on the Australian Register of Therapeutic Goods, consistent with manufacturers' instructions for use and recommended frequencies c. Provide access to training on cleaning processes for routine and outbreak situations, and novel infections d. Audit the effectiveness of cleaning practice and compliance with its environmental cleaning policy e. Use the results of audits to improve environmental cleaning processes and compliance with policy	
Comments	
Cleaning procedures and schedules are in place with regular auditing and reports made available through the governance structure. Cleaning standards are consistently at or above benchmark targets. 100% of the eligible staff observed have completed training on cleaning processes for routine, outbreak situations and novel infections.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.14	
The health service organisation has processes to evaluate and respond to infection risks for: a. New and existing equipment, devices and products used in the organisation b. Clinical and non-clinical areas, and workplace amenity areas c. Maintenance, repair and upgrade of buildings, equipment, furnishings and fittings d. Handling, transporting and storing linen e. Novel infections, and risks identified as part of a public health response or pandemic planning	
Comments	
CHS has infection control processes, policies, and procedures to respond to infection risks for equipment, devices, products, buildings, and linen that is responsive to novel infections risks and pandemic planning. New products are reviewed and assessed for infection related risk.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.15	
The health service organisation has a risk-based workforce vaccine preventable diseases screening and immunisation policy and program that: a. Is consistent with the current edition of the Australian Immunisation Handbook b. Is consistent with jurisdictional requirements for vaccine preventable diseases c. Addresses specific risks to the workforce, consumers and patients	
Comments	
There is a comprehensive workforce immunisation program in place that complies with the ACT policy and national guidelines. Immunisation status is captured during the recruitment process.	
Suggestion(s) for Improvement	
The workforce immunisation procedure requires revision to include Covid screening, vaccination and exclusion requirements.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 3.16
The health service organisation has risk-based processes for preventing and managing infections in the workforce that: a. Are consistent with the relevant state or territory work health and safety regulation and the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare b. Align with state and territory public health requirements for workforce screening and exclusion periods c. Manage risks to the workforce, patients and consumers, including for novel infections d. Promote non-attendance at work and avoiding visiting or volunteering when infection is suspected or actual e. Monitor and manage the movement of staff between clinical areas, care settings, amenity areas and health service organisations f. Manage and support members of the workforce who are required to isolate and quarantine following exposure to or acquisition of an infection g. Provide for outbreak monitoring, investigation and management h. Plan for, and manage, ongoing service provision during outbreaks and pandemics or events in which there is increased risk of transmission of infection
Comments
There is an annual influenza vaccination program vaccination program in place however this is not mandated and annual take up is low at this stage at 66%. 100% of the workforce are fully vaccinated for COVID-19. There are policies and procedures consistent with jurisdictional regulations to prevent and manage infections in the workforce. Records of workplace allocation include both appointed and locum staff. The program for workforce screening and workplace exclusion is aligned with ACT Health directions. A tiered approach to outbreak and pandemic planning and management is in place.

Rating	Applicable HSF IDs
Met	All

ACTION 3.17
When reusable equipment and devices are used, the health service organisation has: a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying • the patient • the procedure • the reusable equipment, instruments and devices that were used for the procedure c. Processes to plan and manage reprocessing requirements, and additional controls for novel and emerging infections.
Comments
Available infection control documents indicate that processes are in place for quality management of reprocessing reusable equipment, instruments and devices. A progress plan is in place to address the Australian Commission on Safety and Quality in Health Care (ACSQHC) Advisory AS18/07 regarding compliance to AS4187. CHS has been granted an extension which requires the health service to meet the requirements of Advisory AS18/07 by 30 June 2024. Interviews with management and staff involved in reprocessing reusable medical devices confirmed that relevant national standards are followed at both offsite and on-site services. The Assessors observed that facilities, equipment and sterile stock storage were mostly compliant with the requirements of the ACSQHC Advisory AS18/07.

ACTION 3.17
When reusable equipment and devices are used, the health service organisation has: a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying • the patient • the procedure • the reusable equipment, instruments and devices that were used for the procedure c. Processes to plan and manage reprocessing requirements, and additional controls for novel and emerging infections.
A traceability process is in place that facilitates routine monitoring and recall when required.
Suggestion(s) for Improvement
1. Relocate all Sterile RMDs to a compliant RMD store from the Mitchel Centre due to penetrating ceiling tiles in the clean room and areas of cracked linoleum flooring in the store area 2. Instrument trays be changed to trays without sides to enable more effective decontamination 3. Transport instrument boxes used by the off-site sterilising centre to be replaced with compliant sealable containers that prevent risk of contamination during external transportation between sites 4. Improve storage of sterile stock in some units, e.g. Intensive Care, to fully comply by the end of 2022.

Rating	Applicable HSF IDs
Met	All

ACTION 3.18
The health service organisation has an antimicrobial stewardship program that: a. Includes an antimicrobial stewardship policy b. Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing c. Has an antimicrobial formulary that is informed by current evidence based Australian therapeutic guidelines and resources, and includes restriction rules and approval processes d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard e. Acts on the results of antimicrobial use and appropriateness audits to promote continuous quality improvement
Comments
CHS has established an antimicrobial stewardship program that is guided by evidenced based policy. Resources are available to staff and processes are in place to define the restriction and rules with respect to antimicrobial use. The organisation complies with the requirements of Advisory AS18/08 and ACSQHC Fact Sheet 11 (3.15d).

Rating	Applicable HSF IDs
Met	All

ACTION 3.19	
The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy and guidance • areas of action for antimicrobial resistance • areas of action to improve appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing • the health service organisation's performance over time for use and appropriateness of use of antimicrobials	
Comments	
Documentation showed that the antimicrobial stewardship program included the review of antimicrobial prescribing and use and surveillance data on antimicrobial resistance. The program is evaluated, and performance is monitored with reports provided to clinicians and the Clinical Governance Committee. CHS Clinicians interviewed were able to describe the processes in place to evaluate antimicrobial use and how surveillance data on local antimicrobial resistance is used to support appropriate prescribing. The requirements of the Advisory AS18/08 have been met.	
Rating	**Applicable HSF IDs**
Met	All

Standard 4 - Medication Safety

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

ACTION 4.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management	
Comments	
The governance of medication management is defined by policies and procedures that apply a risk-based approach to effectively minimise incidents and harm. Staff are provided with medication management training that is commensurate with their roles. Medication management is overseen by the Medication Safety Committee and reports through the governance structure of the organisation to staff and management.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management	
Comments	
The organisation monitors the effectiveness of the medication management system through incident reporting. Reports are provided through the governance structure and strategies are identified to improve performance when issues are identified.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.03	
Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
The organisation aims to involve patients in their care by providing appropriate information about medications and treatments, fostering shared decision making within the constraints of the person's legal status or capacity. Patients interviewed indicated that medication management was discussed with them and that they felt involved in the process and were able to understand the information provided.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.04	
The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians	
Comments	
Scope of practice with respect to medication management is defined in policy and, where appropriate, in position descriptions for clinicians. The Director of Pharmacy is involved in those deliberations.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.05	
Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care	
Comments	
A best practice medication history (BPMH) is undertaken as soon as practicable and documented in the clinical record. Compliance with completing the BPMH is 83% in May 2022. This is monitored monthly by the Pharmacy. A dip in numbers in early 2022 was linked to COVID related absences of pharmacists.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.06	
Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care	
Comments	
Interviews with clinicians together with a review of documentation and observations made by the Assessors confirmed that current medications are reviewed for accuracy and congruence with the best possible medication history on presentation and at transition points.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Canberra Health - Community Health, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit
Rating	**Applicable HSF IDs**
NA	Canberra Health - Dental

ACTION 4.07	
The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation	
Comments	
The process for identifying and documenting medication allergies and adverse drug reactions is well defined and monitored. Records reviewed by members of the Assessment Team confirmed their consistent use. Compliance with documenting medication related alerts is reported as 100%. A project is in place to increase the detection of adverse reactions using coding.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.08
The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system
Comments
Adverse drug reactions are reported through the incident management system and the organisation as a strong culture of reporting incidents and near misses.

ACTION 4.08	
The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system	
Medication related incidents are reviewed by the Adverse Drug Reaction Reporting Committee.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.09	
The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements	
Comments	
The organisation has established processes for reporting adverse drug reactions to the TGA where required. There have been 23 notifications over the period February to April 2022.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.10
The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result
Comments
The process for indicating the need for a medication review is evidence based and based on risk and clinical need. Responsible clinicians were able to describe this process, how it is documented and how actions taken in response to the review are followed through. Clinical documentation reviewed by Assessors supported reviews being done in many predominantly outpatient areas, and in some inpatient areas such as geriatrics. However, there is limited evidence of the reviews being done in all in-patient areas. A recommendation has been made to address these issues.

ACTION 4.10		
The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result		
Rating	**Applicable HSF IDs**	
Met	Canberra Health - Community Health	
Rating	**Applicable HSF IDs**	
NA	Canberra Health - Dental	
Rating	**Applicable HSF IDs**	**Recommendation(s) / Risk Rating & Comment**
MWR	Canberra Hospital, The, University of Canberra Hospital, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit	**Recommendation:** Implement a process across all in-patient areas so that medication reviews are carried out for all in-patients prioritised as being high risk, irrespective of the availability of pharmacy resources. **Risk Rating:** Moderate

ACTION 4.11	
The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks	
Comments	
Information for patients on specific medications is available to clinicians and appropriate to the patient population. Patients reported being able to understand information about medications that was provided to them.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Canberra Health - Community Health, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit
Rating	**Applicable HSF IDs**
NA	Canberra Health - Dental

ACTION 4.12	
The health service organisation has processes to: a. Generate a current medicines list and the reasons for any changes b. Distribute the current medicines list to receiving clinicians at transitions of care c. Provide patients on discharge with a current medicines list and the reasons for any changes	
Comments	
Staff interviews and document reviews confirmed that a list of current medications can be produced whenever a patient is discharged or transferred. A medication list is provided to patients and their GP on discharge. Performance is audited and compliance is 50%. However, the percentage for those with more medications increases to 68% in those with 3 or more medications. This is actively monitored by the Pharmacy.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.13	
The health service organisation ensures that information and decision support tools for medicines are available to clinicians	
Comments	
Clinicians have access to information and medication management support tools via the Health Services Hub. Clinicians reported being able to readily access this information. In some areas clinicians are actively researching protocols and proposing changes to decision support tools.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.14	
The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the: a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted or expired medicines	
Comments	
The organisation monitors compliance with manufacturers' directions, legislation, and jurisdictional requirements for the safe and secure storage (including cold chain management), distribution and disposal of medications. Incidents are reported through the incident management system to the Medication Safety Committee.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.15		
The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely		
Comments		
Interviews with staff and a review of documents supported the Assessors observation that high-risk medications are clearly identified and that there is an appropriate management system in place for the storage, dispensing and administration of those medications. Because some high-risk medications are administered from paper charts (heparin, insulin, complex infusions), there are instructions to clinicians to look at both the eMMS and the paper chart. A system to flag the presence of a paper chart on eMMS has been designed (EMM (MedChart) – INSULIN Paper Chart Reference and Alert), which offers the option of an alert or a reference: however, alerts were not found to be used in the wards visited, and the reference was found in only one ward. A recommendation has been made to manage this issue.		
Rating	**Applicable HSF IDs**	
Met	Canberra Health - Community Health, Canberra Health - Dental	
Rating	**Applicable HSF IDs**	**Recommendation(s) / Risk Rating & Comment**
MWR	Canberra Hospital, The, University of Canberra Hospital, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit	**Recommendation:** Engage with clinicians to ensure a uniform implementation of systems to alert clinicians viewing the EMMS about insulin and other medications that are charted on paper. **Risk Rating:** Moderate

Standard 5 - Comprehensive Care

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

ACTION 5.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for comprehensive care b. Managing risks associated with comprehensive care c. Identifying training requirements to deliver comprehensive care
Comments
Comprehensive Care at CHS is delivered according to the patient's clinical assessment. CHS documentation demonstrates a variety of processes that are well embedded into practice for the management of comprehensive care. This is monitored by the Our Care Committee. Documents reviewed include well developed models of care, pathways, policies, processes and screening tools to support the management of clinical risks, intervention strategies and training requirements for staff and consumers. During the various interviews with the clinical teams, the team members were able to describe the process for improvement including a knowledge of outcomes to support the review of CHS safety and quality systems. This process ensures that consumers were engaged in the development of care, and this was practice was observed by the Assessment Team. In addition, the Assessment Team reviewed many medical records to confirm that processes are recorded for managing risks associated with coordinated care planning. Training on comprehensive care is provided through various sessions. Current training compliance has fluctuated due to COVID and limitations on face-to-face learning opportunities. One particularly innovative idea for the Comprehensive Care Champions utilised the concept of comprehensive care recipes are particularly novel approach to getting the point of comprehensive care concept in an easy way to the various health care disciplines.

Rating	**Applicable HSF IDs**
Met	All

ACTION 5.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care
Comments
There has been a significant range of quality improvement activities completed to demonstrate that improvement and evaluation of comprehensive care in regularly occurring. These were proudly displayed on the various ward quality improvement boards (Action 1.7). Many improvements registers were reviewed during the various department visits. Staff interviewed were able to demonstrate key improvements for their department and plans for activities to improve compliance. The Our Care Committee and a range of key working groups oversee the requirements of comprehensive care for example the Fall Working group and the Nutrition Working Groups. These working groups are multidisciplinary each with a formalised terms of reference to outline the roles and responsibilities to support the management outcomes of compliance to the NSQHS Standards. On review of these terms of references it was noted that there was no reference to key performance outcomes therefore no review of any variations to health outcome (Action 1.28) as part of the committee/working group evaluation process. It is suggested that a range of performance indicators be established to ensure these groups are effectively managing their performance outcomes to identify any areas of practice that may vary from recognised best practice standards.
Suggestion(s) for Improvement
Review the various comprehensive care committees and working groups terms of reference to ensure that an annual review of the function and outcomes of these committee identifies an assessment of agreed quality indicators as part of the committee annual evaluation process.

Rating	Applicable HSF IDs
Met	All

ACTION 5.03
Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Comments
There are many processes established to ensure that patients are partnered in their care and included in the decision-making process for their care outcomes. Staff were able to describe to the Assessors how they actively achieve engage the consumer in their care and patients reported that they felt actively engaged in and informed about their care (Action 6.3). This was observed during the many bedside handovers observed by the Assessment Team during this assessment. The CHS Bedside audit presented during this assessment demonstrate a compliance rate of 82.35% for consumers who had indicated that they had been involved in the decision-making process about their treatment and care.

ACTION 5.03	
Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.04	
The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify, at all times, the clinician with overall accountability for a patient's care	
Comments	
CHS is currently working on a fully integrated eMR which will incorporate developed care plans. In the meantime, during this assessment, the Assessors noted many care plans, models of care and pathways specifically targeting the required plan of care as per the patient's clinical assessment. The Patient Flow Manager program provides support for safe and effective patient flow and admission according to the required specialty. The installation of the electronic Journey Board assists with timely referral to allied health, recognition of an estimated discharge date, referral to both internal and external services as part of the discharge planning process (Acton 6.4). Of note is the significant amount of work that has been undertaken to assist with mental health patients being fully informed of their advanced agreements therefore the provision of allocated peer worker, education and audit review with the aim to target an 80% level of compliance.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.05	
The health service organisation has processes to: a. Support multidisciplinary collaboration and teamwork b. Define the roles and responsibilities of each clinician working in a team	
Comments	
Multidisciplinary teams and communication strategies are evident across the organisation to deliver comprehensive care that is safe and continuous from admission to discharge. Each clinician has a defined role and responsibility as part of their job function.	

ACTION 5.05	
The health service organisation has processes to: a. Support multidisciplinary collaboration and teamwork b. Define the roles and responsibilities of each clinician working in a team	
The Assessment Team observed many examples of where care was coordinated by the multidisciplinary team through meetings to streamline the treatment and discharge planning process (Acton 6.4).	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.06	
Clinicians work collaboratively to plan and deliver comprehensive care	
Comments	
Clinicians from the various clinical groups work together and routinely collaborate with the patient, carers and their family members to communicate clear and shared goals as required as part of the development of the comprehensive plan of care and ongoing care as required. There are a range of policies and procedures available to assist with the process of shared decision making which is particularly important for the effective collaboration with the patient, care and family as noted with many processes identified during this assessment to support endo-of-life planning and minimising patient harm. Staff training on various aspects of teamwork and communication are evident and supported with various communication tools such as handover sheet and checklists.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.07
The health service organisation has processes relevant to the patients using the service and the services provided: a. For integrated and timely screening and assessment b. That identify the risks of harm in the 'Minimising patient harm' criterion
Comments
Processes are in place to screen and assess patients for risks aimed at minimising preventable harm. Clinicians were able to describe the risk assessment process and evidence was sighted in the CHS clinical documentation. There are processes in place which includes tools and fields in the medical records that allow for an integrated screening and assessment process on admission and during the patient journey when indicated by a change in status.

ACTION 5.07	
The health service organisation has processes relevant to the patients using the service and the services provided: a. For integrated and timely screening and assessment b. That identify the risks of harm in the 'Minimising patient harm' criterion	
Screening processes consider cognitive, behavioural, mental, and physical conditions and risks encountered by patient population groups; in addition to the risks of harm identified in the minimising patient harm actions. Regular audits are undertaken to support that timely and comprehensive risk screening and patient assessment is completed. The organisation is compliant with the requirements of Advisory AS18/14 Screening and assessment for risk of harm.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.08	
The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems	
Comments	
Assessors observed processes in place to routinely ask patients if they identify as Aboriginal and/or Torres Strait Islanders. This information is entered into administrative and clinical information systems. Clinicians and administrative staff interviewed confirmed eLearning modules are provided to support and compliance is audited.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.09
Patients are supported to document clear advance care plans
Comments
CHS provides information to staff on Advanced Care Directives, which can be used to support consumers, and patients are asked if they have an Advanced Care Directive on admission. If there is an advanced care plan it is documented in the care plan, scanned into the patient portal, and included at the front of the medical record. Referrals are made to the Advanced Care Plan team who support patients to develop advanced care plans as required.

ACTION 5.09	
Patients are supported to document clear advance care plans	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Canberra Health - Community Health, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit
Rating	**Applicable HSF IDs**
NA	Canberra Health - Dental

ACTION 5.10	
Clinicians use relevant screening processes: a. On presentation, during clinical examination and history taking, and when required during care b. To identify cognitive, behavioural, mental and physical conditions, issues, and risks of harm c. To identify social and other circumstances that may compound these risks	
Comments	
A comprehensive and holistic assessment is conducted on admission and repeated when clinically indicated. This includes screening for a range of risks for preventable harm, including cognitive, behavioural, mental, physical risks and the social and other issues that may compound risk. Risk screening processes are subject to audit and reports are provided through the organisation's governance structure. A limited review of clinical documentation by the Assessment Team reinforced this. The organisation is compliant with the requirements of Advisory AS18/14.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.11
Clinicians comprehensively assess the conditions and risks identified through the screening process
Comments
Risks are identified using standardised screening tools which identify the level of risk and appropriate actions to mitigate them. Secondary assessments are structured, multidisciplinary and information generated from the assessment, is utilised to determine patient's individual healthcare needs, appropriate treatment options, and to develop the comprehensive care plan.

ACTION 5.11	
Clinicians comprehensively assess the conditions and risks identified through the screening process	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.12	
Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record	
Comments	
Risks identified during screening and assessment are documented with appropriate action plans developed as needed to mitigate them, including alerts and responses to identified risk. Outcomes of the comprehensive risk screening assessment are communicated to members of the clinical workforce through a range of clinical handover methodologies and contemporaneous documentation approaches. Assessors noticed that documentation of clinical screening and review were sometimes typed, and the page later added to the patient hard copy clinical record. It was unclear if a copy of the typed document was saved/retained elsewhere for example in the Clinical Patient Folder (CPF).	
Suggestion(s) for Improvement	
Review the CHS Clinical Records Management Policy (24/06/2022) to ensure guidance regarding the management of typed clinical records is clear.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.13	
Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies the support people a patient wants involved in communications and decision-making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and available f. Is consistent with best practice and evidence	
Comments	
Clinicians and patients interviewed across CHS were able to describe the role patients, carers and families play in their care and in determining patient centred goals and how the process aims to best meet their specific needs. A substantial number of clinicians have now attended the required training module for Comprehensive Care – A Patient Journey.	

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

ACTION 5.14
The workforce, patients, carers and families work in partnership to: a. Use the comprehensive care plan to deliver care b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care c. Review and update the comprehensive care plan if it is not effective d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur
Comments
CHS Comprehensive Care Policy (Aug 2021) describes roles and responsibilities and provides guiding principles for implementing and maintaining comprehensive care. Patients, their carers, and families were able to articulate their level of engagement in their care and expressed satisfaction that they were able to actively participate in decision making at all points of care and transition. Goals of care are monitored, and care planning modified in response to change in goals, changing clinical status needs or risk profile. The clinical records that were reviewed demonstrated changes to care plans in response to diagnostics, harm prevention plans, therapeutic interventions, and goals of care, which are made in real time and communicated to the clinical workforce. Bedside clinical handovers and patient bedside communication boards provide opportunities for interactive contemporaneous conversations between patients and staff to ensure care goals are appropriate. Quality assurance methodologies such as the CHS Comprehensive Bedside Audit, clinical outcome and death reviews, and incident analysis; monitor compliance, utility, and the effectiveness of the comprehensive care delivery process. Staff are provided with appropriate training and patients and carers are provided with information as required.

ACTION 5.14	
The workforce, patients, carers and families work in partnership to: a. Use the comprehensive care plan to deliver care b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care c. Review and update the comprehensive care plan if it is not effective d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.15	
The health service organisation has processes to identify patients who are at the end of life that are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care	
Comments	
Processes to define those patients at end of life are in place and clinicians interviewed were aware of these. The Goals of Patient Care Planning Tool – Adult, assists clinicians in determining if a patient is likely to be transitioning to an end-of-life status. CHS has effectively aligned its end-of-life processes to the National Consensus Statement: Essential elements for safe and high-quality end-of-life care.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Canberra Health - Community Health, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit
Rating	**Applicable HSF IDs**
NA	Canberra Health - Dental

ACTION 5.16
The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice
Comments
CHS wards and units have access to specialist palliative care services and advice through the Canberra Hospital specialist palliative care team. Clinicians interviewed were aware of how to access these services and provided examples of collaborative approaches in ICU, Neonatology, Maternity, and a range of wards.

ACTION 5.16	
The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Canberra Health - Community Health, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit
Rating	**Applicable HSF IDs**
NA	Canberra Health - Dental

ACTION 5.17	
The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record	
Comments	
A review of clinical documentation confirmed that copies of advance care plans are scanned into the electronic patient portal and are placed into the patient's healthcare record. Clinicians who were interviewed described the process in place to ensure that patients with an advance care plan are identified, and that care is provided in accordance with these plans.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Canberra Health - Community Health, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit
Rating	**Applicable HSF IDs**
NA	Canberra Health - Dental

ACTION 5.18	
The health service organisation provides access to supervision and support for the workforce providing end-of-life care	
Comments	
Supervision and support for staff providing end of life care is readily available through various mechanisms including the EAP service, Clinical managers, who have a guide developed to assist them in providing support for Ward and unit-based staff, and members of the People and Culture Unit who have been trained to provide psychological support to staff. Staff are aware of how to access the available support services. CHS has also introduced 'Blue Buddies' and 'Green Buddies' to support junior medical and nursing/midwifery staff respectively.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Canberra Health - Community Health, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit
Rating	**Applicable HSF IDs**
NA	Canberra Health - Dental

ACTION 5.19	
The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care	
Comments	
The CHS Goals of Patient Care document, is used to record a summary of goals resulting from patient care discussions. Goals of care for patients at end of life are documented in the CHS Comfort Care Pathway in the clinical record and established in collaboration with patients, their carers, and families. The planned goals are reviewed regularly, and changes documented in the Comprehensive Comfort Care Plan.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Canberra Health - Community Health, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit
Rating	**Applicable HSF IDs**
NA	Canberra Health - Dental

ACTION 5.20	
Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care	
Comments	
The organisation supports shared decision making about end of life care with patients, their carers, and families. These processes are supported by a comprehensive range of resources observed by the Assessors and are documented in the clinical record. Support for decision making is consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Canberra Health - Community Health, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit
Rating	**Applicable HSF IDs**
NA	Canberra Health - Dental

ACTION 5.21
The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines
Comments
CHS has a comprehensive Pressure Injury Management Screening policy that covers the continuum of care from neonates to adults. This document is based on the Prevention and Treatment of Pressure ulcer/injury: Clinical Practice Guidelines. The introduction of the Tissue Viability Unit has been an excellent initiative for AHS. This unit supports the management of pressure injuries, including staff education, auditing and assessment of all registered clinical incidents of pressure injuries as entered in the RiskMan system. Reports from these processes are reviewed by the Pressure Injury Working Group. On review of the terms of reference for the Pressure Injury Working Groups a suggestion to include additional evaluation measure would support the overall effective of the group. These should include agreed quality indicators for the monitoring and evaluation of performance of the processes and outcomes and to also include pressure injury incidence and prevalence.

ACTION 5.21	
The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines	
Suggestion(s) for Improvement	
Review of the terms of reference for the Pressure Injury Working Groups to include additional evaluation measures to support the overall effectives of the working group against best practice.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Canberra Health - Community Health, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit
Rating	**Applicable HSF IDs**
NA	Canberra Health - Dental

ACTION 5.22	
Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency	
Comments	
Risk assessments are routinely undertaking on all admissions using a range of risk screening tool depending on the age. For example, the Waterlow Risk Assessment Took for adults and the Braden Q risk assessment scale for children. Risk assessments are routinely reviewed daily and more frequently if the patient's condition deteriorate. Routine reports of pressure injuries risk assessment, and the incident of pressure injuries are provided to each department. In most departments these results are displayed on the board. An opportunity for improvement would be to consider reporting on the number of appropriate completions of individualised prevention plans of high-risk assessment and that this has been completed in collaboration with the patient, noting the modification of plans as required.	
Suggestion(s) for Improvement	
Include routine reporting for each department to support the monitoring of the required pressure injury risk assessment intervention strategies to ensure the appropriateness of care provide has been according to the rating scale.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Canberra Health - Community Health, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit

ACTION 5.22	
Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency	
Rating	**Applicable HSF IDs**
NA	Canberra Health - Dental

ACTION 5.23	
The health service organisation providing services to patients at risk of pressure injuries ensures that: a. Patients, carers and families are provided with information about preventing pressure injuries b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries	
Comments	
Information is available to patients, their carers / families about pressure injury prevention, this information is in a user-friendly format and staff were able to describe how they provide this to each patient. Significant work has been undertaken to review equipment particular equipment that may cause a “device related pressure injury”. Bed mattresses and other equipment, products, and devices are available to prevent and manage pressure injuries, the Assessors witness these products in use.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Canberra Health - Community Health, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit
Rating	**Applicable HSF IDs**
NA	Canberra Health - Dental

ACTION 5.24	
The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: a. Falls prevention b. Minimising harm from falls c. Post-fall management	
Comments	
CHS has a comprehensive Falls-Assessment, Management and Prevention procedure. Based on the ACSQHS Prevention Falls and Harm from Falls in Older People: Best Practice Guidelines for Australian Hospitals.	

ACTION 5.24
The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: a. Falls prevention b. Minimising harm from falls c. Post-fall management
Individualised Falls Prevention interventions are required to be introduced within four hours of admission and this is audited routinely as part of the bedside audit. Post-fall multidisciplinary huddles have been introduced to assist in the review of each patient fall. Issues include deterioration, medication and physical environment as examples of issue address to prevent a repeat occurrence. Alerts are entered into the eMR to alerts staff of the risk and noted on the Journey board for reference at each huddle or handover meeting. Flags are noted at the patient bedside to indicate fall risk.
Suggestion(s) for Improvement
1. Implement routine report for each department to demonstrate that the required fall prevention intervention strategies have been provided according to the rating scale. 2. Review of the terms of reference for the Falls Prevention Working Groups to include evaluation measure to support the overall effectives of the working group.

Rating	Applicable HSF IDs
Met	All

ACTION 5.25
The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls
Comments
There is a range of falls prevention equipment and support systems used across the organisation to assist with safe patient mobility.

Rating	Applicable HSF IDs
Met	All

ACTION 5.26	
Clinicians providing care to patients at risk of falls provide patients, carers and families with information about reducing falls risks and falls prevention strategies	
Comments	
Information is available to patients, their carers / families about falls prevention and risk management strategies. This information is in a user-friendly format.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Canberra Health - Community Health, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit
Rating	**Applicable HSF IDs**
NA	Canberra Health - Dental

ACTION 5.27	
The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice	
Comments	
Patients (adult and children) are routinely screened for the risk of malnutrition and other specific nutritional requirements, supported by a multidisciplinary team and monitored by the Nutrition Working Group. Nutrition assessment and plans are primarily the responsibility of the CHS Dietitians and Dietary Assistants. Referral notification and nutritional status is noted on the department Journey Boards with alerts for malnutrition and dysphasia and on the printed handover sheets. Swallowing screening is provided by the Speech Therapists.	
Suggestion(s) for Improvement	
Review of the terms of reference for the Nutrition Working Group to include evaluation measures to support the overall effectives of the working group.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Canberra Health - Community Health, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit

ACTION 5.27	
The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice	
Rating	**Applicable HSF IDs**
NA	Canberra Health - Dental

ACTION 5.28	
The workforce uses the systems for preparation and distribution of food and fluids to: a. Meet patients' nutritional needs and requirements b. Monitor the nutritional care of patients at risk c. Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone d. Support patients who require assistance with eating and drinking	
Comments	
The nutritional services at CHS have completed a vast array of quality improvements to assist with meeting the patients' nutritional requirements including, a review of the current diet, improving the nutritional intake of the aged care patients, surgical stress and trauma induces catabolism, unpacking barriers to nutrition for older adults as examples of some of the projects. Risk of allergens are documented in the patient medical record and there is a dedicated quarantine process in the kitchen for food preparation on notification of allergies. Patient satisfaction surveys are routinely completed with results continuing to improve over the last three years. Support systems are evident to assist patient who require assistance with food ordering provided by the Nutrition Assistance. Patients' trays are flagged as requiring assistance with eating and drinking.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Canberra Health - Community Health, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit
Rating	**Applicable HSF IDs**
NA	Canberra Health - Dental

ACTION 5.29
The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation
Comments
CHS has undertaken some considerable work to assist with the management of delirium and cognitive impairment. The current procedure references the ACSQHC Delirium Clinical Care Standard and other associated relevant resources. KPIs have been developed to assist in meeting the requirements of the Commissions Advisory AS22/01: Advice on implementing the updated Delirium Clinical Care Standard. Monitoring the prescription of antipsychotic and other psychoactive medications is routine in mental health patients. For general health patients this practice is currently work in progress with strategies to assist with non-pharmaceutical interventions and educations for staff and families. Significant education has been developed to support CHS clinicians to manage patient that may warrant the prescription of antipsychotic medications. A cognitive impairment screening point prevalence study using the recognised screening tools (4AT and Confusion Assessment Method) noted that 66% of patients had the required 4AT assessment completed with 19% having the Confusion Assessment completed. Key actions are to ensure that the screening is embedded into everyday practice. A suggestion is to report on cognitive screening for each of the relevant wards and departments routinely as is the case for falls and pressure injuries risk assessment completion and to ensure that the KPIs for the Delirium Care standards are embed as outcome measures for the Delirium Clinical Care Standard Implementation Working Group.
Suggestion(s) for Improvement
1. A suggestion is to report on cognitive screening to each of the relevant wards and departments routinely as is the case for falls and pressure injuries risk assessment competitions. 2. To ensure that the KPIs for the Delirium Care standards are embed as outcome measures for the Delirium Clinical Care Standard Implementation Working Group annual evaluation process.

Rating	Applicable HSF IDs
Met	Canberra Hospital, The, University of Canberra Hospital, Canberra Health - Community Health, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit

ACTION 5.29	
The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation	
Rating	**Applicable HSF IDs**
NA	Canberra Health - Dental

ACTION 5.30	
Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. Recognise, prevent, treat and manage cognitive impairment b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care	
Comments	
The use of screening tools is currently being monitored however this could be further enhanced with routine reporting back to wards and departments of risk assessment and intervention compliance reports. The introduction of the agitation scale by the Geriatric department has been and excellent initiative. Alert colours are used as part of the rating scale escalation process to assist with quick identification of escalation therefore enhancing clinical review.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.31
The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed
Comments
CHS has a really motivated mental health unit. There are mental health representatives based in the Emergency Department to support prompt risk assessment and transfer to the appropriate facility. Risk assessments are routinely competed in the mental health units and patients at risk are identified with plans of care introduced.

ACTION 5.31	
The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed	
In the mental health unit suicide vulnerability assessment reports are completed monthly. Staff are trained on the management of suicide prevention including ligature cutting procedures.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.32	
The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts	
Comments	
Where patients have self-harmed or reported suicidal thoughts clinicians have access to timely follow-up and refer to appropriate services. The Home Assessment and Acute Response Team are there to support staff within mental health, justice health, alcohol and drug services. Staff were able to clearly articulate how they would access mental health, justice health and alcohol and drug services.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Canberra Health - Community Health, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit
Rating	**Applicable HSF IDs**
NA	Canberra Health - Dental

ACTION 5.33	
The health service organisation has processes to identify and mitigate situations that may precipitate aggression	
Comments	
The organisation has policies that support the identification, mitigation and management of aggression and staff are aware of how these are used. Many of these are noted in Action 1.30. Significant work has been completed by the Work Health and Safety Unit to assist with supporting staff to identify and mitigate situations that can precipitate aggression.	

ACTION 5.33	
The health service organisation has processes to identify and mitigate situations that may precipitate aggression	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.34	
The health service organisation has processes to support collaboration with patients, carers and families to: a. Identify patients at risk of becoming aggressive or violent b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce	
Comments	
The organisation has strategies and processes in place to identify patients at risk of becoming aggressive including de-escalation strategies. The processes to manage aggression aims to minimise harm to patients, carers, families, staff and visitors and staff were able to describe how they collaborate with patients and others to implement these strategies effectively. Incidents of aggression are reported through the various committees including the Our Care Committee.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.35	
Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of restraint b. Govern the use of restraint in accordance with legislation c. Report use of restraint to the governing body	
Comments	
Policies and processes are in place to govern and manage the use of both chemical and physical restraint. These includes alternative strategies to minimise the use of restraint. The policy is consistent with the local legislation and includes processes for reviewing and reporting the use of restraint to the governing body. The Comprehensive Care Bedside Audit result for 2022 report 100% compliance for restraint in the general hospital (including the Emergency Department) with approximately 7 to 21 episode per month in mental health. The Emergency Department has implemented a restraint register.	

ACTION 5.35	
Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of restraint b. Govern the use of restraint in accordance with legislation c. Report use of restraint to the governing body	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit
Rating	**Applicable HSF IDs**
NA	Canberra Health - Community Health, Canberra Health - Dental

ACTION 5.36	
Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of seclusion b. Govern the use of seclusion in accordance with legislation c. Report use of seclusion to the governing body	
Comments	
Policies support that seclusion is only used to prevent harm and its use is compliant with the required legislation, monitored at the individual patient level and aggregate level and reported to the governing body. Reports on the use of seclusion were made available to the Assessment Team. Staff were able to describe strategies to minimise the use of seclusion and the processes followed where it is employed. There has been no episode of seclusion in general health with approximately seven in total for mental health services so far for this year.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit
Rating	**Applicable HSF IDs**
NA	Canberra Health - Community Health, Canberra Health - Dental

Standard 6 - Communicating for Safety

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

ACTION 6.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication
Comments
Policies and procedures are extensive to support effective clinical communication including handover. These policies identify risk management strategies and also the training requirements / expectation of all staff in support of effective clinical communication. The CHS policies are underpinned by specific policies that address risk by department, e.g. clinical notification of high-risk results by the clinical microbiologist, clinical handover in medical imaging, communication of urgent medical imaging reports, and risks identified via level 42 Sleep Study Handover Tool. Assessors viewed supporting documentation and staff interviewed were able to describe the processes for clinical communication, risk assessment and documentation of those risks / alerts on the patient whiteboard, journey boards, and medical records. The training program for Communicating for Safety has been evaluated and improved so that the previous three programs have now been into one eLearning program that was implemented 8 weeks ago. Whilst training remains work in progress at this stage, compliance is tracked by clinical discipline, and completion / incomplete is listed on the profile of individual clinical staff.

Rating	**Applicable HSF IDs**
Met	All

ACTION 6.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes
Comments
Incidents relating to failure in clinical communication are reported through the incident management system and identified in patient feedback. There have been no Harm Score 1 or 2 incidents reported re failure of communication. The extensive audit processes at each department engages staff to drive improvement to communication strategies and processes. The effectiveness of clinical communication, including handover is monitored via regular bedside audits, incidents and patient / carer feedback. Outcomes are reported via the system of clinical governance. The Assessors observed numerous quality improvement processes within the wards where improvements to handover via huddles and handover times have been effective.

ACTION 6.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.03	
Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
CHS policies and processes ensures engagement of patients, their carers and families in their own care and shared decision making. Patients are involved in clinical handover and the Assessors witnessed handover in numerous settings, supporting this. Patients interviewed reported being engaged in their care and that they had information available to them to make informed decisions about their care. The Dec 19 – June 22 audit reports 82.35% of patients were invited to participate in care. Patient / carers asked if they had any other questions / additional information at 89.04%. The Enhanced Recovery After Surgery (ERAS) daily goals pathways for a sample of surgeries, i.e. colorectal, hysterectomy engages patients to be actively involved in their care from preadmission to discharge. The program is supported with preadmission kits, booklets and goal setting that tracks day by day expected recovery strategies and progress. Outcomes are monitored, and feedback indicates improved patient satisfaction and reduced length of stay.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.04	
The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes	
Comments	
Policies and processes are in place to support approved identifiers which are used, in procedure matching, transfer of care, handover, discharge and where changes in clinical care / patient risk profile are identified. Compliance with positive patient identification policy, using three approved identifiers was observed across the organisation by the assessment team, and confirmed by the audit data reported at 92.86%. Procedure matching in the operating theatres is led by the surgeon and 'Time Out' is recorded electronically. The system facilitates easy audit. Outcomes are reported at 100%, although issues such as completing the documentation are promptly followed up.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.05	
The health service organisation: a. Defines approved identifiers for patients according to best-practice guidelines b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated	
Comments	
CHS has policies that define the use of three approved identifiers. Staff interviewed by the Assessors were able to describe how and when these are used. Patients interviewed could describe the questions asked to confirm their identity. This was confirmed by the Assessors when observing admission to the health service, transfer of care, discharge, medication and in provision of allied health / pathology / radiology treatments and investigations respectively. Audit of positive identification Jan 20- Jun 22 reports 95.3% compliance with three approved identifiers for all components of care, and 100% for clinical handover.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.06	
The health service organisation specifies the: a. Processes to correctly match patients to their care b. Information that should be documented about the process of correctly matching patients to their intended care	
Comments	
The Assessors noted the use of approved patient identifiers at all admission, transfer of care and procedural / treatment interventions. Additionally, processes are in place for surgical / procedural time-out, and this is documented and audited, with compliance at close to 100%. Issues of compliance in the perioperative services are audited, charted and posted monthly in the perioperative services. Opportunities for improvement are identified and promptly actioned.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.07	
The health service organisation, in collaboration with clinicians, defines the: a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines b. Risks relevant to the service context and the particular needs of patients, carers and families c. Clinicians who are involved in the clinical handover	
Comments	
Clinical handover documentation contains the required minimum content, risks / alerts; clinical care of the patient, and the clinicians involved in handover. Compliance with these requirements is audited, reported at 93.5%. The assessors interviewed a broad range of staff, including several medical staff, nurses, allied health, and pathology that demonstrated a good understanding of ISBAR and how it is used. The use of ISBAR has been adapted in several of the specialised units to ensure comprehensive handover information. A good example is the list of criteria matched to each item of ISBAR to prompt accurate and appropriate handover and transfer of patients from PACU to external healthcare providers and internal wards/ departments. The extensive audit processes, across the CHS, combined with observation by the assessors support high compliance with handover processes. The daily morning executive huddle, attended by the Assessors commences with identification of patient and staff risks. For example, risks of transmission of COVID-19 by visitors was identified, with appropriate actions for improvement, and communicated to all staff at CHS.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.08
Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care
Comments
The Assessors observed clinical handover, routinely structured using the ISBAR tool, that effectively engaged with patients, their carers and families in defining goals of care and decision making. The processes in place for clinical handover ensure the relevant clinicians are actively engaged in the process and members of the multidisciplinary team are encouraged to be involved as necessary. Both patients and staff were able to articulate the process of handover and provide confirmation of patients, care and family in decision making. The Patient Whiteboard Communication Tools provide a quick reference to patients, for staff changes, and patients 'goals and preferences'. Handover is adapted to meet the special needs of different patient cohorts. For example, the Assessors noted multidisciplinary handover, and changes to care plans at ICU ward rounds. Families are routinely informed of the outcomes of the ward rounds, and family meetings are arranged as required. Clinical handover is audited regularly in the clinical departments. There are numerous processes to ensure safe transfer of responsibility of care. Whilst huddles, journey boards, rounding and bedside handover are well established; other good examples observed by the assessors are transfer of care via the medical oncology weekend clinical summary; nutrition transfer of care enteral feeding regime, transfer of care occupational therapy and physiotherapy.

Rating	Applicable HSF IDs
Met	All

ACTION 6.09
Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient
Comments
CHS has policies and procedures to guide staff in effective communication and handover of critical information including risks and alerts. Clinical staff interviewed could describe the decision-making process to manage changes in patients' condition. For example, the ICU consultant informed the Assessors of the processes to manage ICU patients to ensure appropriate accountability and communication with the admitting consultant.

ACTION 6.09	
Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient	
Guidelines established for JMO handover from evening to night are well embedded. The Assessors observed posters 'Tell us if you or the patient you are visiting is getting sicker' and patients / carers interviewed confirmed their understanding of the process. Clinical handover is audited, and incidents / feedback related to communication issues are addressed appropriately. The Assessors observed processes for notifying urgent medical imaging and pathology results. The icons on the Patient Whiteboard Communication Tools are a quick reference for risks / alerts for patients / carers and staff.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.10	
The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians	
Comments	
A review of process for documentation shows communication processes are in place for patients, carers and families to directly communicate critical information and risks about care. Clinicians and patients / carers interviewed confirmed this and the Assessors observed posters in the clinical and public areas that draw attention to this process.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 6.11
The health service organisation has processes to contemporaneously document information in the healthcare record, including: a. Critical information, alerts and risks b. Reassessment processes and outcomes c. Changes to the care plan
Comments
Clinical documentation reviewed by the Assessors confirmed compliance with the organisation's process to ensure complete, accurate and up to date information is recorded in the healthcare record, inclusive of risks and alerts. Members of the clinical team could describe this process. Implementation of the Digital Medical Record scheduled for November will improve processes by replacing the current hybrid system.

ACTION 6.11	
The health service organisation has processes to contemporaneously document information in the healthcare record, including: a. Critical information, alerts and risks b. Reassessment processes and outcomes c. Changes to the care plan	
Improvements to documentation of handover via ISOAP (Identification, Subjective information, Objective, Assessment Information) was implemented to standardise the process to document clinical interventions in the nursing handover report. A review of outcomes from a sample of audits demonstrates improvement in compliance from the point of introduction to three months. ISOAP includes processes for documentation of colour coded risk rating. Several clinical departments have adapted the ISBAR and ISOAP tools to meet the special needs of their patients, for example the documented 'handover cross check' process that is aligned to clinical risk assessment and action at clinical handover in ICU. Compliance is audited via the CHS Clinical Audit Program every six months. Outcomes are consistent, above 90%. The Whiteboard Communication Tool ensures that patients / carers can easily view changes to care plans. This aligns well with the standard question 'what is important to you today', asked of all patients.	
Suggestion(s) for Improvement	
Review the use of accepted abbreviations with reference to laterality, ie left and right to ensure compliance with best practice.	
Rating	**Applicable HSF IDs**
Met	All

Standard 7 - Blood Management

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

ACTION 7.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management	
Comments	
Governance of this Standard is supported with the availability of the Policies and procedures consistent which are compliant with legislative, policy directives and the National Patient Blood and blood product management guidelines. Policies of note include: Goal directed (ROTEM)Critical Bleeding Massive Transfusion, Single Unit Blood transfusions etc. In addition, there is an overarching Blood Management Committee which has the responsibility of ensuring risks are identified, quality assurance processes and quality improvement systems are implemented. Organisation safety and quality systems for blood management and associated risks are in place to facilitate consistency of practice of across the organisation. Staff education requirements are met through BloodSafe eLearning and BloodSafe Transporting Blood mandatory training. Compliance rates are variable across divisions. Only staff who have completed the training are allowed to prescribe, administer or transport blood and blood products. Ongoing vigilance is encouraged to ensure mandatory training is completed by eligible staff prescribe, administer and transport blood and blood products. Product storage, alarm systems and supply were all managed and compliant with NATA accreditation standards.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Centenary Hospital for Women and Children
Rating	**Applicable HSF IDs**
NA	Canberra Health - Community Health, Canberra Health - Dental, Gawanggal, Dhulwa Secure Mental Health Unit

ACTION 7.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of the blood management system b. Implementing strategies to improve blood management and associated processes c. Reporting on the outcomes of blood management
Comments
CHS proactively explores avenues to continue to evaluate the effectiveness of the Blood Management systems.

ACTION 7.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of the blood management system b. Implementing strategies to improve blood management and associated processes c. Reporting on the outcomes of blood management	
Evidence presented reflects an environment of continuous improvement and the undertaking of pioneering work which includes Embedding Transfusion PPID in the Digital Health Record; Goal directed (ROTEM) protocol for Critical Bleeding Massive Transfusion; Development of a Video relaying steps in the undertaking of the Double Independent Checking Project and inclusion of consumers in the Patient Directed transfusion Research Project. Extensive work has also been to improve consent and rates have increased from 26% in 2019 to 100% in 2022. CHS monitors blood management process in terms of blood and blood product utilisation, quality and safety patient outcomes. It is also noted that there has been reduced rates of wastage of blood. Reports are provided to highest level of governance.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Centenary Hospital for Women and Children
Rating	**Applicable HSF IDs**
NA	Canberra Health - Community Health, Canberra Health - Dental, Gawanggal, Dhulwa Secure Mental Health Unit

ACTION 7.03	
Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
On assessment it was noted that Consumers are actively engaged in their care in relation to blood management. Patients interviewed at the time of assessment confirmed that they provided informed consent to the administration of blood and blood management products. Patients are also engaged in a research project and feedback was sought in the development of patient information brochures. Patients are provided with a general guide to a Blood Transfusion brochure which explains what a transfusion is, associated risks, informed consent and what to expect. This brochure is also provided in the perioperative information packs, wards, and clinic areas.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Centenary Hospital for Women and Children
Rating	**Applicable HSF IDs**
NA	Canberra Health - Community Health, Canberra Health - Dental, Gawanggal, Dhulwa Secure Mental Health Unit

ACTION 7.04	
Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products by: a. Optimising patients' own red cell mass, haemoglobin and iron stores b. Identifying and managing patients with, or at risk of, bleeding c. Determining the clinical need for blood and blood products, and related risks	
Comments	
Assessors confirmed that there is a high-level achievement of the adherence to the single unit policy which is reflected in the conservative use of blood usage and use of alternative product. The organisation's processes and policies support the clinically effective and efficient use of blood and blood products. Utilisation is monitored and action has been taken to minimise wastage and the inappropriate use of blood and blood products. It was noted that CHS has effectively, via active engagement with both patients and clinicians, increased the use of patients' own red cell mass, haemoglobin and iron stores. This is demonstrated via work undertaken by the CHS Iron Working group which explores alternative therapies to enable and support high quality care of patients own blood and the work undertaken to increase in cell salvage from 153 litres in 2020 to 193 litres in 2021. The results for 2022 to-date also indicate that CHS is on track to increase cell salvage from 2021.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Centenary Hospital for Women and Children
Rating	**Applicable HSF IDs**
NA	Canberra Health - Community Health, Canberra Health - Dental, Gawanggal, Dhulwa Secure Mental Health Unit

ACTION 7.05	
Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record	
Comments	
Following review of clinical records, the Assessors found evidence of effective documentation of decision making, transfusion history, patient involvement and indication for transfusion details. This information is consistent with the results noted in the regular audits undertaken of transfusion records.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Centenary Hospital for Women and Children

ACTION 7.05	
Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record	
Rating	**Applicable HSF IDs**
NA	Canberra Health - Community Health, Canberra Health - Dental, Gawanggal, Dhulwa Secure Mental Health Unit

ACTION 7.06	
The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria	
Comments	
CHS has relevant and appropriate Policies which are consistent with national guidelines and national criteria for the prescribing and administering of blood and blood products. These are readily available to clinicians. There have been no incidents relating to lack of wrong patient identification, nil consent or wrong transfusions over the past 2 years. Audits of prescribing and administration of blood and blood products demonstrates compliance with policies and procedures.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Centenary Hospital for Women and Children
Rating	**Applicable HSF IDs**
NA	Canberra Health - Community Health, Canberra Health - Dental, Gawanggal, Dhulwa Secure Mental Health Unit

ACTION 7.07	
The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria	
Comments	
Policy requires staff to report and manage incidents relating to Blood transfusion which includes all adverse reactions, near misses ensuring hemovigilance reporting obligations, all incidents are reported through the Blood Management committee and to the highest level of governance with lessons learnt shared across the facilities.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Centenary Hospital for Women and Children

ACTION 7.07	
The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria	
Rating	**Applicable HSF IDs**
NA	Canberra Health - Community Health, Canberra Health - Dental, Gawanggal, Dhulwa Secure Mental Health Unit

ACTION 7.08	
The health service organisation participates in haemovigilance activities, in accordance with the national framework	
Comments	
Policy documents identifying hemovigilance reporting obligations are in place. As a consequence, mandated reporting is in place to ensure all relevant incident notifications comply with said criteria. All transfusion related adverse events are investigated by the Clinical governance incident Management officer in consultation with ward based staff, and laboratory staff.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Centenary Hospital for Women and Children
Rating	**Applicable HSF IDs**
NA	Canberra Health - Community Health, Canberra Health - Dental, Gawanggal, Dhulwa Secure Mental Health Unit

ACTION 7.09	
The health service organisation has processes: a. That comply with manufacturers' directions, legislation, and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer	
Comments	
CHS complies with legislative and regulatory requirements with regards to the storage, distribution and management of blood and blood products. All relevant tracing procedures are monitored and reported through the Blood Management committee. Any incidents related to inappropriate handling of blood or blood products are reported and managed through the incident management system.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Centenary Hospital for Women and Children

ACTION 7.09	
The health service organisation has processes: a. That comply with manufacturers' directions, legislation, and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer	
Rating	**Applicable HSF IDs**
NA	Canberra Health - Community Health, Canberra Health - Dental, Gawanggal, Dhulwa Secure Mental Health Unit

ACTION 7.10	
The health service organisation has processes to: a. Manage the availability of blood and blood products to meet clinical need b. Eliminate avoidable wastage c. Respond in times of shortage	
Comments	
CHS have effective processes in place to efficiently manage blood and blood products availability, reduce blood wastage and implement systems to manage supply shortages of blood and blood products. CHS is actively engaged in collaborative research and improvement activities to explore the use of alternative therapies to reduce the use of blood and associated risks. Blood and blood usage together with blood shortages are monitored and escalated via governance reporting systems.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Centenary Hospital for Women and Children
Rating	**Applicable HSF IDs**
NA	Canberra Health - Community Health, Canberra Health - Dental, Gawanggal, Dhulwa Secure Mental Health Unit

Standard 8 - Recognising and Responding to Acute Deterioration

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

ACTION 8.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration	
Comments	
Policies and procedures are in place for recognising and responding to acute deterioration and staff were able to describe their role in such events, risks and training needs are identified, and training records were made available to the assessors.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems c. Reporting on effectiveness and outcomes of recognition and response systems	
Comments	
Systems are in place for monitoring the effectiveness of processes for identifying and managing acute deterioration and this is reported through the Recognising and Responding to Acute Deterioration (RRAD) Committee and to clinicians for the purposes of clinical review. In response to incidents related to clinical deterioration improvements have been made including the development of guidelines for Neonatal Resuscitation and Airway Management as well as the Management of the Deteriorating Paediatric Inpatient.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Canberra Health - Community Health, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit
Rating	**Applicable HSF IDs**
NA	Canberra Health - Dental

ACTION 8.03	
Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
Documents reviewed demonstrate that there is a process in place that supports partnering with consumers in recognising and responding to acute deterioration. The process involves a consumer representative on the key governance committee, meeting the information needs of patients and shared decision making. Interviews with staff and patients confirmed that patients are actively involved in planning and making decisions about the management of acute deterioration. Assessors observed multiple examples of shared decision making which was supported by interviews with both clinicians and patients.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Canberra Health - Community Health, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit
Rating	**Applicable HSF IDs**
NA	Canberra Health - Dental

ACTION 8.04	
The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient	
Comments	
Vital signs are monitored according to procedural instructions using the age-appropriate MEWS observation charts with compliance monitored by reviews of clinical documentation and bedside audit results. Observations are undertaken in response to each patient's individual circumstances and the observation chart highlights potential clinical deterioration and the need for escalation and/or intervention.	
Suggestion(s) for Improvement	
Consider updating the Vital Signs and Early Warning Scores Procedure to include the assessment of Pain Score in the set of core vital signs for any patient receiving pain management.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Canberra Health - Community Health, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit

ACTION 8.04	
The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient	
Rating	**Applicable HSF IDs**
NA	Canberra Health - Dental

ACTION 8.05	
The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d. Determine the required level of observation e. Document and communicate observed or reported changes in mental state	
Comments	
Policies and procedures support staff in identifying acute deterioration in mental state including the risk of delirium. Assessment and care planning documentation reviewed by assessors also supported that assessment drives the establishment of individualised and appropriate management plans for patients with acute mental state deterioration. Clinical documentation is audited and compliance with cognition screening is reported as ~74%. Processes are in place to support timely communication between members of the treating team and the patient, carers and family members. The requirements of Advisory 19/01 have been met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.06
The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration
Comments
The organisation monitors performance of the identification and management of acute physiological and mental state concerns raised by staff, patients, carers and families through clinical documentation audits, incident management and clinical review.

ACTION 8.06	
The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration	
Staff interviewed were aware of these processes were able to describe them to the assessors, including the process for escalation of care when needed. Documentation reviewed identified that policies and procedures are in place to support clinical staff in the management and escalation of clinical deterioration and they are current and reference best practice. The requirements of Advisory AS19/01 have been met.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Canberra Health - Community Health, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit
Rating	**Applicable HSF IDs**
NA	Canberra Health - Dental

ACTION 8.07	
The health service organisation has processes for patients, carers or families to directly escalate care	
Comments	
Processes are in place for patients, carers or families to directly escalate care. Interviews with clinical staff, patients and carers confirmed this and observation of the escalation system used across the organisation further supported this process.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Canberra Health - Community Health, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit
Rating	**Applicable HSF IDs**
NA	Canberra Health - Dental

ACTION 8.08	
The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance	
Comments	
The policy for escalation of care is clear and provides direction for staff to escalate care and respond to a clinical emergency. Staff were able to describe this process and assessors were provided with documentation to support the evaluation of these processes which are reported through the RRAD Committee.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Canberra Health - Community Health, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit
Rating	**Applicable HSF IDs**
NA	Canberra Health - Dental

ACTION 8.09	
The workforce uses the recognition and response systems to escalate care	
Comments	
Staff were able to describe the systems in place to escalate care consistent with the policy. Reports provided to the assessors and reported through the RRAD Committee confirmed the effectiveness of these processes.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.10	
The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration	
Comments	
Education is provided to clinicians to support the timely and effective management of patients who acutely deteriorate. Compliance with training is reported as ~78%.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.11	
The health service organisation has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support	
Comments	
The organisation provides access to clinicians with advanced life support skills and competency. Training records were made available to assessors with compliance reported at close to 100%. Where access to clinicians with advanced life support is not available 24/7 access is via '000' emergency response.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Canberra Health - Community Health, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit
Rating	**Applicable HSF IDs**
NA	Canberra Health - Dental

ACTION 8.12	
The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated	
Comments	
Interviews with clinicians confirmed the process for timely referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated. Staff were able to articulate the referral process for these patients. The requirements of Advisory AS19/01 have been met.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Canberra Health - Community Health, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit
Rating	**Applicable HSF IDs**
NA	Canberra Health - Dental

ACTION 8.13	
The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration	
Comments	
Policies and procedures are in place for the timely referral to definitive care for patients who physically deteriorate. Staff were able to explain these processes to the assessors and the effectiveness of escalation of care processes is monitored through the RRAD Committee.	
Rating	**Applicable HSF IDs**
Met	Canberra Hospital, The, University of Canberra Hospital, Canberra Health - Community Health, Centenary Hospital for Women and Children, Gawanggal, Dhulwa Secure Mental Health Unit
Rating	**Applicable HSF IDs**
NA	Canberra Health - Dental

Recommendations from Previous Assessment

Standard 1

ACTION 1.12				
The health service organisation: a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework b. Monitors and acts to improve the effectiveness of open disclosure processes				
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**	**Organisation Action taken**	**Assessor's Response**
Not Met	Canberra Health Services	**Recommendation NSQHSS Survey 0318.1.16.1** Implement a system to identify and track the closure process of an open disclosure following an investigation. **Risk Rating: Low**	The Open Disclosure procedure process is documented in the Open Disclosure Procedure on the Policy and Guidance Documents Register. The Open Disclosure process happens in parallel with the Incident Management process and is recorded in the RiskMan Incident Register. Reporting on the documentation of the open disclosure process of Harm score 1 or 2 incidents in the RiskMan Incident Register is reported on our quality dashboard and monitored at the Our Care Committee meeting monthly. Based on the data, further emphasis is placed on reminding teams to ensure the recording of open disclosure, particularly following an investigation. **Completion Due By:** n/a **Responsibility:** **Organisation Completed:** Yes	**Recommendation Closed:** Yes Assessors viewed four out of seven RCA's and noted that all the processes outlined in the Open Disclosure Policy had been implemented.

Standard 2

ACTION 2.11				
The health service organisation: a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community				
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**	**Organisation Action taken**	**Assessor's Response**
Not Met	Canberra Health Services	**Recommendation NSQHSS Survey 0318.2.1.1** Identify and implement a mechanism for involving consumers and or carers in the organisational governance of the health service. **Risk Rating: Low**	CHS has consumer and carer representatives on the Governance Committee. This committee is responsible for the strategic setting and monitoring of the organisation. Significant consumer input was also sought during the recent review of our governance committee structure. **Completion Due By:** n/a **Responsibility:** **Organisation Completed:** Yes	**Recommendation Closed:** Yes The Organisation has demonstrated commitment to inclusion of Aboriginal and Torres Islander people in Governance and Planning Committees. Additionally, several Aboriginal and Torres Strait Islanders have been employed by the Organisation. This Recommendation is closed.

ACTION 2.11				
The health service organisation: a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community				
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**	**Organisation Action taken**	**Assessor's Response**
Not Met	Canberra Health Services	**Recommendation NSQHSS Survey 0318.2.2.1** Establish mechanisms for engaging consumers and/or carers in both	A number of consumer reference groups have been established to help drive research, strategic planning and quality including	**Recommendation Closed:** Yes Consumer Committees now have significant representation of Aboriginal

ACTION 2.11				
The health service organisation: a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community				
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**	**Organisation Action taken**	**Assessor's Response**
		strategic and operational planning for the organisation. **Risk Rating: Low**	Cancer Consumer Reference Group Palliative Care Consumer Reference Group A number of community engagement strategies at the strategic planning level occurs utilising ACT Government platforms including Your Say. •. There has been widespread consultation with a range of consumers and consumers groups for the: o Master Plan o The Canberra Hospital Expansion - which has an ongoing consumer reference group Maternity Access Strategy Consumer and Carer reps are also present on the Governance Committee in addition to (under development) Consumer and Carer Sub-Committee, Aboriginal s Strait Islander Consumer Steering Committee Aboriginal s Strait Islander Consumer Reference Group **Completion Due By:** n/a **Responsibility:** **Organisation Completed:** Yes	and Torres Strait Islander People on these Committees and several changes in care delivery have been adopted to suitably and respectfully address the requirements of this Community. This Recommendation is closed.

Standard 4

ACTION 4.05				
Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care				
Rating	**Applicable**	**Recommendation(s) / Risk Rating & Comment**	**Organisation Action taken**	**Assessor's Response**
Not Met	Canberra Health Services	**Recommendation NSQHSS Survey 0318.4.14.1** CHHS develop a Medication Management Plan in partnership with the patients. **Risk Rating: Low**	The discharge summary template was amended to provide greater accuracy. 1/ The discharge summary was interfaced with the electronic medication management system. This provided greater accuracy in the discharge summary and enhanced continuity of care. 2/ A section was added that recorded details of whether there had been changes made to the patient's medicines during the admission and whether these had been documented and discussed with the patient. These pieces of work are complete, and we now turn our attention to how this information may be captured, and the collaborative decision making between clinician and consumer can be captured in the DHR. **Completion Due By:** n/a **Responsibility:** **Organisation Completed:** Yes	**Recommendation Closed:** Yes The assessors were able to verify the satisfactory completion of this recommendation.