National Safety and Quality Health Service Standards 2.1 Short Notice Assessment

Initial Assessment Final Report

Western Health

Footscray, VIC

Organisation Code: 210024
Health Service Organisation ID: F7070026
ABN: 61 166 735 672
Assessment Date: 04-08 December 2023

Accreditation Cycle: 1

Contents

Introduction

The Australian Council on Healthcare Standards
The Australian Council on Healthcare Standards (ACHS) is Australia's leading healthcare assessment and accreditation provider. ACHS is an independent, not-for-profit organisation dedicated to improving quality and inspiring excellence in health care. We accredit organisations according to either government standards, or our own established standards.

ACHS is approved to accredit the following standards

- National Safety and Quality Health Service (NSQHS) Standards including the Multi-Purpose Services Aged Care Module (MPS Module)
- National Safety and Quality Digital Mental Health (NSQDMH) Standards
- National Safety and Quality Primary and Community Healthcare (NSQPCH) Standards
- National Clinical Trials Governance Framework
- Royal Australian College of General Practitioners (RACGP) Standards for general practices (5th edition) and the RACGP Standards for point-of-care testing (5th edition)
- National Standards for Mental Health Services (NSMHS)
- Rainbow Tick Standards
- EQuIP Standards

Currently there are more than 1,600 healthcare organisations, including their associates, that undertake ACHS assessment and quality improvement programs. ACHS are proud to accredit the majority of all public and private hospitals in Australia.

With representation from governments, consumers and peak health bodies from throughout Australia, ACHS works with healthcare professionals, consumers, government and industry stakeholders to implement healthcare accreditation programs.

ACHS offers a variety of services including accreditation, education and training, data and benchmarking and consulting. We take a partnership approach to continuous improvement, tailored to the needs of individual services and health systems, using our expertise in accreditation, standards development and education.

Australian Commission on Safety and Quality in Health Care
The Australian Commission on Safety and Quality in Health Care (Commission) leads and coordinates national improvements in healthcare safety and quality. It works in partnership with patients, carers, clinicians, the Australian, state and territory health systems, the private sector, managers and healthcare organisations to achieve a safe, high-quality and sustainable health system.

Key functions of the Commission include developing national safety and quality standards, developing clinical care standards to improve the implementation of evidence-based health care, coordinating work in specific areas to improve outcomes for patients, and providing information, publications and resources about safety and quality.

The Commission works in four priority areas:

1. Safe delivery of health care
2. Partnering with consumers
3. Partnering with healthcare professionals
4. Quality, value, and outcomes

The Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme

Under the National Health Reform Act 2011, the Commission is responsible for the formulation of standards relating to health care safety and quality matters. This includes formulating and coordinating the Australian Health Service Safety and Quality Accreditation Scheme (the AHSSQA Scheme), which provides for the national coordination of accreditation processes.

The AHSSQA Scheme sets out the responsibilities of accrediting agencies in relation to implementation of the following safety and quality standards:

- National Safety and Quality Health Service (NSQHS) Standards including the Multi-Purpose Services Aged Care (MPS) Module
- National Safety and Quality Digital Mental Health (NSQDMH) Standards
- National Safety and Quality Primary and Community Healthcare (NSQPCH) Standards, and
- Any other set of standards that may be developed by the Commission from time to time

The National Safety and Quality Health Service (NSQHS) Standards were developed by the Commission in collaboration with the Australian Government, states and territories, the private sector, clinical experts, patients, and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met.

There are eight NSQHS Standards, which cover high-prevalence adverse events, healthcare associated infections, medication safety, comprehensive care, clinical communication, the prevention and management of pressure injuries, the prevention of falls, and responding to clinical deterioration. Importantly, the NSQHS Standards have provided a nationally consistent statement about the standard of care consumers can expect from their health service organisations.

Rating scale definitions

Whenever the NSQHS Standards (2nd ed.) are assessed, actions are to be rated using the rating scale outline below:

Rating	Description
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. If there are no not met actions across the health service organisation, actions rated met with recommendations will be assessed during the next assessment cycle. **Met with recommendations may not be awarded at two consecutive assessments where the recommendation is made about the same service or location and the same action. In this case an action should be rated not met.** In circumstances where one or more actions are rated not met, the actions rated met with recommendations at initial assessment will be reassessed at the final assessment. If the action is not fully met at the final assessment, it can remain met with recommendations and reassessed during the next assessment cycle. If the organisation is fully compliant with the requirements of the action, the action can be rated as met.

Rating	Description
Not met	Part or all of the requirements of the action have not been met.
Not applicable	The action is not relevant in the service context being assessed. The Commission's advisory relating to not applicable actions for the health sector need to be taken into consideration when awarding a not applicable rating and assessors must confirm the action is not relevant in the service context during the assessment visit.

For further information, see Fact sheet 4: Rating scale for assessment

Repeat Assessment

If a health service organisation has 16 or more percent of assessed actions **rated not met and /or met with recommendations**, and /or more than 8 actions from the Clinical Governance Standard not met at initial assessment and is subsequently awarded accreditation, the organisation is required to undertake a further assessment within six months of the assessment being finalised. All actions rated not met or met with recommendations from the initial assessment will be reassessed. The aim of the reassessment is to ensure the organisation has fully embedded the necessary improvements in their safety and quality systems to maintain compliance with the NSQHS Standards. This is a one-off assessment with a remediation period of 60 business days. **All actions must be met when the assessment is finalised for the organisation to retain its accreditation.**
For further information, see Fact Sheet 3: Repeat assessment of health service organisations

Safety and Quality Advice Centre and Resources

The Advice Centre provides support for health service organisations, assessors, and accrediting agencies on NSQHS Standards implementation, the Primary and Community Healthcare Standards, the Digital Mental Health Standards, the National General Practice Accreditation (NGPA) Scheme, the National Pathology Accreditation Scheme, and the National Diagnostic Imaging Accreditation Scheme.
Telephone: 1800 304 056
Email: AdviceCentre@safetyandquality.gov.au
Further information can be found online at the Commission's Advice Centre via https://www.safetyandquality.gov.au/

Authority to act as an Accrediting Agency

I, Dr Karen Luxford, CEO of the Australian Council on Healthcare Standards (ACHS) declare that ACHS has the approval from the Australian Commission on Safety and Quality in Health Care to conduct assessment to the *National Safety and Quality Health Service Standards 2.1 Short Notice Assessment*. This approval is current until 31st December, 2024.

Under this authority, ACHS is authorised to assess health service organisations against the Australian Health Service Safety and Quality Accreditation Scheme.

Conflicts of Interest

I, Dr Karen Luxford, declare that ACHS has complied with Australian Commission on Safety and Quality in Health Care policy on minimising and managing conflicts of interest.

No conflicts of interest were evident as part of this assessment and no Consultants or third parties participated in this assessment.

Dispute Resolution

A complaint was raised about an Assessor on the last day. The service reported that staff had felt intimidated and upset. I apologised and informed them that the Assessor did not mean to cause concern.

Assessment Team

Assessor Role	Name	Declaration of independence from health service organisation signed
Assessor	Andrea Taylor	Yes
Assessor	Debra Cutler	Yes
Lead Assessor	Dianne Knight	Yes
Assessor	Glenise Coulthard AM	Yes
Assessor	Helen Chalmers	Yes
Assessor	Jordan Kelly	Yes
Assessor	Julianne Clift	Yes
Assessor	Katherine Moore	Yes
Assessor	Nadja Hartzenberg	Yes
Assessor	Roslyn Chataway	Yes
Assessor	Sandra Polmear	Yes
Assessor	Xin Nee Chua	No

Assessment Determination

ACHS has reviewed and verified the assessment report for Western Health. A final assessment will be required before the accreditation determination can be made.

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

Western Health underwent a National Safety and Quality Health Service Standards 2.1 Short Notice Assessment (NS2.1 Short Notice Assessment) from 04/12/2023 to 08/12/2023. The NS2.1 Short Notice Assessment required 12 assessors for a period of five days. Western Health is a Public health service. Western Health was last assessed between 2 - 6/03/2020.

PICMoRS was used to conduct this assessment. 90% of available time was spent in operational areas during this assessment.

At Western Health twelve Assessors spent most of the time in clinical areas, utilising the PICMoRS methodology. Board, Executive, Clinical Leaders, staff and patients / consumers informed the results of this Assessment, as well as observational audits, including handovers of many disciplines, medication rounds, clinical reviews and during this Assessment, witness of responses to several codes. A review of patient files, access to "just in time" data that gave an overview of all patients with an EMR record, current status for risk assessments, policies and procedures and a range of minutes, quality notice boards and evidence of cascading communication frameworks.

The Board is well informed on the safety and quality of the services delivered across Western Health (WH). Risks are assessed at the organisation and divisional levels, controls are monitored, and where incidents are reported, consideration of risk continues. The Committee reporting structures provide robust data sets, inclusive of Health Round Table data, audit results, complaints and compliments, review of indicators and provision of a dashboard at the ward level to focus attention on achievements and identified risks. A high-risk scenario was conducted to determine the processes, improvements, consumer input, monitoring, and outcomes for malnutrition. WH's rates of identified malnutrition are above the peer group, and the Board, Executive, and Dietetics have a range of strategies to reduce malnutrition rates during admission.

There is an established performance review system with high completion rates. Variations in practice can be considered within the broad data sets that clinicians have access to. During this assessment, it was difficult to establish the completion rates for foundational training, and a review of the system will further strengthen the existing systems. Similarly, in a random check of medical officers credentialling, the Assessors and the WH Executive identified a breakdown in the credentialling process with 35 medical officers requiring interim and immediate credentialling during the week of assessment. The organisation undertook an analysis of incidents to determine risk, and there were no critical incidents during the time that credentialling rights were missed for any of the clinicians identified.

The support services provided across WH, both internal and external, work collaboratively with clinicians; an example is security services. Maintenance is prioritised, and ongoing capital works support growth and purpose-built facilities; a fine example is the Sunshine Mental Health unit and Drug Health rehabilitation service.

A strength of WH is consumer involvement across the health service industry, with over 100 consumer advisors. This enables input into the information provided to patients and committees, and the diversity of these advisors represents the community from Aboriginal and or Torres Strait Islander peoples, people with a lived experience of a health service, CALD and LGBTQI+. WH demonstrates a commitment to First Nations people with the growth of the Wilim Berrbang service, maternity services, an Aboriginal Health Liaison Officer, and a research officer to drive Aboriginal-led research.

The Assessment team identified champions for each of the clinical standards at the ward and the health service governance levels, and there was a range of information in the ward areas that informed patients and their visitors of priorities and achievements.

The Infection Control staff and many clinicians we spoke with are passionate about reducing the risk of patients and staff getting preventable healthcare-associated infections. During this assessment, the ongoing response to COVID-19 infections continues. Sound systems and processes are in place, and auditing supports monitoring compliance and identifying education opportunities. The Assessment team identified some challenges in older service areas, and planning and preparing for ongoing capital works will resolve these.

There are sound governance systems for medication safety, with excellent coverage of pharmacists across wards, with the recognition that expertise is needed after hours, particularly on weekends. The introduction of the robot at Sunshine Hospital strengthens the existing systems; dispensing from the pharmacy is robust; prior to dispensing, a check is undertaken of the electronic record for the appropriateness of the medication against the medical history. Stock control on the wards and the storage is at best practice.

Comprehensive care is linked to governance and quality systems. Patients and families highlighted the collaboration in a comprehensive care plan. During admission, identified risks are connected to the care plan. Many quality initiatives are driven by identified risks, e.g., a Volunteer Meal Assistant program for those at risk of malnutrition and the appointment of dietitians to address malnutrition highlighted as an ongoing risk from the Board to the ward. In addition, a video monitoring system has been developed for preventing falls; and a Maternity EVE App, which allows evidence-based information and alerts, and can enable a chat room for women. NICU also has cameras that connect families. During this assessment, the systems of comprehensive care have considered models of care from birth to end of life. Change is a constant; the recent inclusion of Corrections Health and Mental Health in the capital program contributes to support for patients and families from entry into Emergency Departments to admission and continued care in the community.

Risk assessments, review of data, least restrictive care, and information for patients through Your Healthcare Journey Safety and Rights across the service highlight action to take. Innovation has included using information on lanyards with a mirror to identify skin integrity issues.

Huddles, MDT Meetings, and clinical and procedural handovers were all observed, well organised, and clear, with critical information handed over. Patients confirmed that three points of identification are used, and this was evident during observational audits. "Knowing how we are doing," Boards were visible and gave patients, visitors, and staff information on various quality improvement activities. Team time-out was observed in theatres.

The blood product prescribing, storage, delivery, and administration systems were observed and done with the required diligence and consent. Staff were able to identify training in blood products to maintain competency.

The Call for Help protocol enables patients and families to escalate care. During this assessment, the team commented that many patients and families interviewed were clear that they knew how to raise concerns and were confident that they would be heard.

The systems to monitor observations, protocols, and policies to escalate care are in place, with the capacity for specialties to contribute to the parameters. The Assessors witnessed MET Calls and Resuscitation during this Assessment, and the protocol response times validated the most recent initiative of simulation training in "The First Three Minutes'.

During this assessment, the team had many discussions with clinicians and support staff across sites, including a tour of Western Health's recently joined colleagues in mental health and community services. The Assessors found passionate staff who are focused on patients. Dashboards inform priorities. Activity is high; there is a collaborative culture with all disciplines and staff focused on safety and quality.

Innovation is considered, and there were many examples during this Assessment. In the day-to-day, consideration of how to improve has led to exemplars, and the ongoing consideration of the sustainability of personal protective equipment has the potential to impact health services.

During this Assessment, the team visited all sites across the WH footprint, and no matter where the team visited, at all times, there was the comment about the achievements, the passion, dedication and commitment to deliver health services safely and to a high standard. Many times throughout the week, the drive to meet the community needs in an area that is growing at a fast rate was evident.

Summary of Results

At Western Health's Organisation-Wide Assessment, one Action was rated Not Met and one Action was rated Met with Recommendation across 8 Standards. The following table identifies the Actions that were rated Not Met and Met With Recommendation and lists the facilities to which the rating applies.

Summary of Recommendations Subject to the Final Assessment

Facilities (HSF IDs)	NS2.1 Short Notice Assessment 4/12/2023 - 8/12/2023	
	MwR	NM
Bacchus Marsh and Melton Regional Hospital-100039	1.20	1.24
Footscray Hospital-100662	1.20	1.24
Melton Health and Community Services (MH)-O100168	1.20	1.24
Sunbury Day Hospital-101813	1.20	1.24
Sunshine Hospital-100672	1.20	1.24
Western Health – Community Mental Health-F707002606	1.20	1.24
Williamstown Hospital, The-100674	1.20	1.24

Final Assessment Requirement

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

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

Sites for Assessment

Western Health

Site	HSFID	Address	Visited	Mode
Bacchus Marsh and Melton Regional Hospital	100039	29-35 Grant St BACCHUS MARSH VIC 3340 Australia	Yes	On Site
Site	**HSFID**	**Address**	**Visited**	**Mode**
Footscray Hospital	100662	Gordon Street FOOTSCRAY VIC 3011	Yes	On Site
Site	**HSFID**	**Address**	**Visited**	**Mode**
Melton Health and Community Services (MH)	O100168	195-209 Barries Rd MELTON WEST VIC 3337 Australia	Yes	On Site
Site	**HSFID**	**Address**	**Visited**	**Mode**
Sunbury Day Hospital	101813	Macedon Street next to the Rupertswood driveway SUNBURY VIC 3429 Australia	Yes	On Site
Site	**HSFID**	**Address**	**Visited**	**Mode**
Sunshine Hospital	100672	176 Furlong Road ST ALBANS VIC 3021	Yes	On Site
Site	**HSFID**	**Address**	**Visited**	**Mode**
Western Health – Community Mental Health	F707002606	VIC 3000		On Site
Albanvale - Community Mental Health		3/38 Evergreen Avenue	Yes	
Deer Park - Community Mental Health		54 Burnside Street	Yes	
Harvester - Community Mental Health		4A Devonshire Road	Yes	
Site	**HSFID**	**Address**	**Visited**	**Mode**
Williamstown Hospital, The	100674	77 Railway Crescent WILLIAMSTOWN VIC 3016	Yes	On Site

Contracted Services

The following contracted services are used by Western Health.

Provider	Description of Services	Verified During Assessment
Essential Property Services	Essential safety measure inspections	Yes
Maintenance Essentials	Fire protection maintenance and testing	Yes
ZircoData	Secure document storage and disposal	No
National Patient Transport	Non-emergency ambulance services	Yes
Melbourne Health Shared Food Services & Community Chef	Food Services	Yes
Ensign Linen Services (Spotless Linen Services)	Linen	No
Dorevitch Pathology Services	Pathology Services	Yes
Silver Chain Group	HealthLinks Program Support	No
Auslan, Language Loop	Language Services (additional to in-house services)	No
Partnership Agreement with Peter MacCallum Cancer Centre	Radiation Therapy Centre (Sunshine Hospital)	No
Melbourne Health Shared Service Agreement	IT Services (limited)	No

Western Health has reviewed these agreements for the listed services in the three years preceding this assessment.

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	
The governing body, the Western Health (WH) Board and the Executive, is engaged and leading by example for a culture of safety and quality promoted under the Best Care framework. This is demonstrably a Board to Ward framework. The WH Board is well informed, and papers and minutes are detailed. Awareness of changing trends and action to be taken was evident with recent examples including tears and occupational violence, as well as malnutrition. The Board has recently endorsed a new strategic direction for Western Health for the next three years, to replace the prior Strategic Direction, Western Health, 2021 – 2023. The operating and strategic environment is complex, with a rapidly changing and growing population of great diversity, multiple important capital developments, an appetite for the positive use of technology, and the recent introduction of new Mental Health and Custodial Health as well as Bacchus March hospital and Melton Health since the last accreditation. Board meetings start with a story reflecting the voice of a patient, a powerful connection to safety and quality and purpose. The Board sub committees are active and include Safety and quality, community advisory and Primary care and Population Health Advisory.	
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 Leadership team were able to describe how the specific health needs of Aboriginal and Torres Strait Islander people are being addressed. Interviews with the Wilim Berrbang Aboriginal Health Unit, together with documentation reviewed by the Assessors, supported that organisation has a strong commitment and has addressed this as a high priority and specifically focused on areas of inequity in service provision and outcomes for Aboriginal and Torres Strait Islander people through the Aboriginal Health Cultural Safety Plan 2022-2025. This plan was developed in partnership with the Aboriginal Health Steering Committee which meets bi-monthly. The organisation meets the requirements of Advisory AS18/04. WH has strategies and plans to improve cultural awareness and competency of the workforce, combined with increasing the employment of Aboriginal people in the workforce – they note the success of these strategies as being intrinsically linked. Monitoring is in place with a set of key indicators. WH is a signatory to the National Close the Gap statement of intent and is also committed to the Victorian Governments Aboriginal Health Wellbeing and safety plan 2017 – 2027.

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
There is a strong Clinical Governance framework under the Best Care banner and comprehensive processes for monitoring this. Best Care has been reviewed and updated and has been part of the overall strategy of the organisation for many years, giving continuity and familiarity for the workforce. It defines roles and responsibilities, and the five pillars used within it are echoed in numerous reports and structures. There is an overarching WH policy and framework for Best Care, which includes role statements and expected behaviours, and which is supported by numerous other policies. It is driven annually with a documented action plan and was reported against publicly for the last financial year. The innovative Best Care Improvement register is readily accessible to staff and is a helpful way to share best practice, trials, success, and failure with the workforce.

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 organisation 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. Aboriginal Health Steering Committee (AHSC) meetings are bi-monthly, with TOR and Minutes reviewed. An Aboriginal Health Cultural Audit tool has been developed to assess Western Health's physical environment to support access to their services for Aboriginal people and to review Western Health's support to staff to work effectively with Aboriginal patients and families. These initiatives are monitored through the Aboriginal Health Steering Committee and Aboriginal Health Cultural Safety Plan 2022-2025. Aboriginal and Torres Strait Islander Safety and Quality priorities have been established and are monitored by the Board. There is also good online information about a number of initiatives and actions underway.	
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	
There is a widespread adoption of dashboards with detailed information around safety and quality and trends overtime. There has been a significant investment in Power BI dashboards, which are readily accessible. These can be analysed in a myriad of different ways and are widely accessible to staff. There was evidence of a rapid response to a change in requirements for patient comfort and safety in several areas following trend data evident from the dashboards. It is worth remembering that not everyone will take time to seek out data and that some provision of data in other formats will sometimes be useful. There is extensive reporting to the Board and Executive with action plans and reporting in papers and minutes.	
Suggestion(s) for Improvement	
Information on safety and quality indicators and trends beyond Hand Hygiene could be displayed within units for the Footscray Hospital Site.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.06	
Clinical leaders support clinicians to: a. Understand and perform their delegated safety and quality roles and responsibilities b. Operate within the clinical governance framework to improve the safety and quality of health care for patients	
Comments	
The Best Care framework is helpful in describing the roles and expected behaviours of different parts of the organisations. There was evidence of heads of units and senior medical leaders having robust information and in-units visited, breaking information down to individual clinician level with discussions at unit meetings on current safety issues. The Best Care committee structure includes a steering committee with clinical representation, Clinical Council and Best Care performance committee, and the framework forms part of orientation.	
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	
There is an overarching process and policy for the creation and maintenance of policies, procedures, and guidelines, and the Board approves policies routinely. The introduction of Prompt in late 2022 to store policies procedures and guidelines has created good accessibility across the organisation and can be searched easily. A significant effort has gone into the update of policies, procedures, and guidelines, and the organisation noted over 95% compliance with timely review of these at the point of the assessment. Prompt also allows visibility of information within other health services allowing sharing of good practise and efficiency. The legislative review element is also resourced and in place. There is a unique dashboard for policy compliance.	
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
There is a strong correlation between the organisations strategy and priorities established under Best Care. It is helpful that the organisation promotes the consistent use of the Institute for Health care Improvement (IHI) model and the PDSA cycle. This supports the extensive project and innovation underway and, over time, will create common language and embedded skills. Training materials for these are also available. There has been significant investment in the use of dashboards to be widely available across Western Health, which are predominantly built in power BI and are simple to utilise and access. The dashboards are built to reflect the best care framework and organisational priorities. Some sites are proactively sharing information via noticeboards to help busy clinical staff have greater visibility of this. The annual People Matters survey has a patient safety culture metric that can be used longitudinally as can the Victorian Health Experience Survey, The best care quality account is also widely available. There is also online access to an improvement register that had extensive initiatives available for sharing with the workforce, as well as the clinical audit portal housing a wealth of information.

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
As noted above, there is evidence of timely reports on safety and quality systems to both the Board and the Executive, and the widespread access to dashboards means that large parts of the organisation can access information on demand. However, this is not always possible for busy clinicians, and the use of reports and shared information on walls and in shared areas could be valuable. Sunbury Hospital was an exemplar in the way performance information was shared with their workforce through the use of clear update to date information in different sections of the hospital and, perhaps, Footscray Hospital site could give this further consideration and supplement their trend information beyond Hand Hygiene which was the predominant information seen. The Quality Account 2022-2023, also badged under best care, 'live BEST CARE', is publicly available and there is also the Best Care Report for November 2022 to October 2023. 'You said, we did' stickers and posters were also displayed giving direct feedback to patients and their carers as well as staff about follow up of issues raised. 'Up to date anywhere' was also being advertised, free to all WH staff on an app or on computer, with medical, clinical, and drug database to access.

Rating	Applicable HSF IDs
Met	All

ACTION 1.10
The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters
Comments
The organisation has a clearly described set of high-level strategic risks held at Board level. These are reviewed annually with a plan to review more frequently and are grouped under the pillars of the best care policy. The Risk Management policy and procedure (the latter introduced in 2023) are supported by a risk framework. Risks are structured to reflect the organisation's matrix-based operational structure and also structured in tiers to reflect the complexity of effort required to resolve. There is also an operational risk register held in SharePoint to facilitate access. Staff feedback was that they preferred this to the RiskMan risk module for ease of access. SharePoint does facilitate the analysis of risks in different ways. There is a good linkage between the best care and risk reporting with information able to be imported into best care reports.

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	
There was also evidence of Business Continuity plans, external and internal audit process, and internal clinical and compliance audits.	
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	
Governed by the Clinical Incident Management, Investigation Notification and Reporting Policy, which was updated in September 2023, guidance is given for all incidents. Reporting is undertaken in the RiskMan system and senior staff report a culture of willingness to report and it is raised clearly at orientation. The lead group noted a focus on creating a just culture. It was positive to see the development of a digital recommendations register, developed in partnership with Victoria University. This houses and collates recommendations from sources such as adverse events, audits, coroners reports. There is recent resourcing to invest in incident management generally. There is unit, division and organisation-wide incident reporting, and action to follow up where needed was evident at high governance levels. Examples of follow through in adverse incidents were provided in the local SAPSE process and can be documented in the EMR. The Clinical Council (previously known as the Serious Adverse Events Committee) has access to information and data.	
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
In November 2022, Victoria introduced the Statutory Duty of Candour, a legislative requirement, outlined in section 128ZC of the Health Services Act 1988, that must be performed if a patient suffers a serious adverse patient safety event (SAPSE) in the course of receiving health care. Some 800 staff have been trained in this. The local policy was introduced in 2023 for events with moderate or severe harm. Evaluation of this has also been undertaken. There has been email communication with staff and presentations, however, there is likely to be a requirement for some just-in-time training for the workforce when engaged in this. There is support available from the Best Care team for this. Open Disclosure is also in place and used on a day-to-day basis.

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
There is an up-to-date overarching policy for the process of feedback and high levels of attention to this as a recent priority. Senior clinicians noted the recent efforts to bring complaints responses up to date and the good support available to achieve this. The Board and the Executive receive detailed information and analysis. Noticeboards displayed information with direct response to consumer feedback in the 'You said, we did' format.

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
WH has Best Care Coordinators to support the complaints process and an 1800 number and dedicated email address promoted locally. There is monitoring of compliance for completion within 30 days, currently over 90%, and a significant effort and investment in resource was made to bring this up to date in the last year. It was helpful to be able to see feedback and complaints on a dashboard at different tiers of WH as well as other media. This allowed good interrogation of data and trends and follow up of trends within senior governance committees. Compliments were also highlighted and celebrated locally. Records are maintained in RiskMan in a dedicated module.

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	
There is an impressive understanding of the diversity of the population, and the health care risks that can be associated with this. There is a well-written Diversity, Equity, and Inclusion framework. The growth in the community has been driven with an increase in young families and younger people in much of the area. All hospitals had information on display in many languages and ready access to interpreters, recognising that over half of the wonderful local population was raised in non-English speaking areas and households. There is significant socio-economic diversity, and additional navigation is needed and provided to help the community access healthcare. There is also a focus on the importance of primary health care to improve local health. The LGBTIQA community and disability community are also thoughtfully considered in the planning and understanding of the local area and more healthcare planning is underway.	
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	
The Oracle Cerner EMR has been through a significant upgrade, known as Phase 2.1, this year, serving the majority of the WH sites. Bacchus Marsh and Melton remain as hybrid sites with plans to follow next year. It is readily available to staff, some of whom are still adapting. The rollout includes ED, Theatres, Newborn services, Maternity, Specialist Clinics / outpatients, and ICU. The privacy and security of records are promoted within WH, and there is active clinician leadership across disciplines in this complex area, including within the digital health team. Significant attention is paid to cyber security and cyber risk, with internal and external systems.	
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
There is a My Health Record Access and Uploading organisational procedure, recently updated in 2023, which outlines uploading and viewing of records. The EMR facilitates access to My Health Record automatically and there is just-in-time training available on demand. Clinical information in My Health Record is readily available. A gap analysis has been completed for the access and operation of the MHR and monitoring and evaluation is underway. National Patient and provider identifiers are used as are standard terminologies. It would be helpful for WH to be able to count the number of users who access training for MHR. Access at Bacchus March and Melton is via the My Health Record website in a hybrid model until their EMR transition in 2024. WH had assessed their compliance against Advisory AS18/11 implementing systems that can provide clinical information into the My Health Record system, and had a gap analysis, monitoring and evaluation in place.
Suggestion(s) for Improvement
It would be helpful for WH to be able to count the number of users who access training for MHR.

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
Noting that all users on the EMR can access MHR, there is good access and availability and overarching policy and procedure, as well as just-in-time training and helpdesk support. Information is provided and received for data breaches and followed up with no evidence of inappropriate access. There is a review of the upload process and secure systems.

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
A Learning and Development policy and an Orientation procedure are in place and were reviewed. It is mandatory for all new employees and volunteers to attend a half-day organisational orientation program and complete the online orientation program. In addition, it is mandatory for all new nursing, midwifery, and selected allied health employees to attend the subsequent half-day orientation program. Each manager must also ensure that specific local departmental orientation is made available. Orientation data for a three-month period was sighted which indicated 800 people completed the online module with 625 new starters. Reporting limitations did not enable the data to be combined to attain a completion rate for a defined cohort of new starters. A Board Induction policy is included as part of the WH Board Charter which requires all Board members to undertake orientation. The induction program is structured around: Being a Director; All things Board; The Business; The People.

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
A WH Mandatory Training procedure is in place and was reviewed. Three training areas (Fire and Emergency Procedures, 89%; General Manual Handling, 90%; Occupational Violence and Aggression, 83% online) have been identified as mandatory for all staff and one (Basic Life Support, 84%) has been identified as mandatory for all clinical staff. A range of foundation training programs, aligned to the National Standards, has also been listed for different staff groups and frequencies. Training programs meet the requirements of the National Standards. Professional Development mechanisms support competency assessment and link back to training program development. Mandatory training is reported on dashboards and incorporated into Best Care reporting through the committee structure. Further dashboard reporting on foundation training is planned.

Rating	Applicable HSF IDs	Recommendation(s) / Risk Rating & Comment
MWR	All	**Comment:** It was not evident to Assessors how the foundation training (which incorporates a range of education relevant to the National Standards) was monitored and reported through the governance structure. There was limited visibility of foundation training completion rates at the organisational level. The component of the action the recommendation relates to is (d) monitoring the workforce's participation in training. **Recommendation:** Review how foundation training is monitored and implement a process integrated into the clinical governance structure to provide assurance of training completion. **Risk Rating:** Moderate

ACTION 1.21
The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients
Comments
A cultural awareness training program is in place via the We Learn platform. An Aboriginal Cultural Safety Plan was sighted as well as completion of cultural safety audits. WH is committed to achieving equality in health status between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians; and is an official signatory to the national Closing the Gap Strategy. WH has developed an Aboriginal Employment Plan that promotes employment strategies and initiatives to grow their Aboriginal workforce. WH is committed to providing employment opportunities and career pathways for Aboriginal and Torres Strait Islander people. One initiative is to provide culturally safe interviews; they encourage candidates to request an Aboriginal employee support person for the interview. This request can be made to the Panel Chair when the candidate is invited to an interview. There have been demonstrated gains in the specific areas of workforce recruitment and retention from 6 FTE in 2019 to 14 FTE in 2023. New identified positions like the Journey Walker role at WH is supporting Aboriginal and Torres Strait Islander patients, families, carers, and staff to improve health care outcomes and facilitate community care options. Research Fellow is a new dedicated role that will drive Aboriginal-led research to improve the health and wellbeing of Aboriginal and Torres Strait Islander patients. The flow on benefits of making a more welcoming and understanding environment for Aboriginal and Torres Strait Islander patients is palpable. Welcome to Country and Acknowledgment of Country policy provides practical advice to employees about Aboriginal Cultural protocols. WH has 3 layers of Cultural Safety Training for all new staff and managers. 1. We Learn Packages for all new staff sits at 90% since 2022. 2. Cultural Safety Audit steps and reviewed after 3 months. 3. Senior Leadership Team Training sits at 100% Aboriginal Cultural Awareness E-Learning modules for all new staff and managers and the Wilim Berrbang Aboriginal Health Unit provide face-to-face education via Inservice Training to Senior Leadership Staff in the Galinjera Maternity program, and Aboriginal Outpatient Clinic undergo tailored 1:1 cultural awareness training. Aboriginal Art and Signage is evident throughout the service with improvements arising from feedback from the community.

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	
A Performance and Development Management procedure is in place which requires a formal annual process as well as ongoing feedback mechanisms. A comprehensive intranet site is available with a range of guidance materials and tools to support managers and staff in the performance development process. There is a pathway to connect identified needs back into the development of training programs. A performance dashboard is available to monitor completion rates which currently sit at 90%.	
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	
A Credentialling and Scope of Practice policy consistent with the National Standards is in place. The process for defining scope of practice is monitored, reviewed, and is overseen by the relevant professional group. The CGov system is used to record the scope of practice and information available to ensure others are aware of the approved scope. Further detailed supporting information is available via an intranet site to guide the scope of practice and credentialling processes. A random sample of medical practitioners was selected, scope of practice reviewed, and all were found to be operating within the agreed scope. In line with the recommendation for Action 1.24, the thorough credentialling review should also ensure scope of practice is reviewed and updated as required. A Technology and Clinical Practice Committee is in place to review the introduction of new service, procedure, or technology and recommends credentialling to the relevant credentialling committees. The requirements of Advisory AS18/12 have been met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.24		
The health service organisation: a. Conducts processes to ensure that clinicians are credentialed, where relevant b. Monitors and improves the effectiveness of the credentialing process		
Comments		
WH has a Credentialling and Scope of Practice policy and procedures. Credentialling committees are in place for medical, nursing and midwifery, and allied health professionals, where required. The CGov information system is used to capture credentialling information and supports monitoring and reporting including automated checking against the AHPRA database. Credentialling processes are monitored and reviewed. Advisory AS18/12: Implementing the Colonoscopy Clinical Care Standard has been met with credentialling and scope of practice integrated into standard systems and strong evidence of variation monitoring and clinician feedback noted. This action has been rated as Not Met due to an identified recredentialling issue for some medical practitioners. Sample testing identified that practitioners were operating within the defined scope of practice.		
Rating	**Applicable HSF IDs**	**Recommendation(s) / Risk Rating & Comment**
NM	All	**Comment:** Current theatre lists across all sites were reviewed, and a random sample of 14 surgeons and anaesthetists was selected. Checks against the credentialling system identified two exceptions where credentialling had expired and were in a recredentialling process. In the other case, initial credentialling documentation had not been formally endorsed. Upon further review by WH, it was identified that there were 35 non-compliant medical practitioners with a system issue requiring the Head of Department to approve the initiation of the recredentialling process believed to be a contributing factor. Upon identification of the issue, WH undertook an immediate review process with the Chief Medical Officer signing off on interim credentialling for 21 practitioners. The review identified five were already credentialled but not reflected on the system. The Assessors were advised the remaining nine practitioners will not practice until credentialling is approved. A review of significant incidents was undertaken with WH, confirming none linked to the clinicians with expired credentialling. Based on the actions taken and assurance provided, the risk is rated as high.

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		
		Recommendation: 1. Complete a thorough review process to ensure that all clinicians, where required, are credentialled with a current scope of practice in a timely manner. 2. Review the credentialling system and process to ensure there are mechanisms to identify and escalate non-compliance risk, including periodic reporting and monitoring through the clinical governance structure. **Risk Rating:** High

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	
WH has a Best Care framework and policy and a supporting Best Care WeLearn module. The framework is structured around consumers, front line staff, managers, senior clinicians, Executive and Board. It outlines their role across domains of person-centred care; coordinated care; right care; and safe care. Orientation and training programs provide information for staff on safety and quality responsibilities. Staff interviewed by the Assessors were able to articulate their roles and responsibilities.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.26
The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate
Comments
Clinicians are provided with adequate supervision according to their designated roles and responsibilities. A range of discipline-specific clinical supervision models and education resources are in place. The design of the organisational structure supports appropriate supervision and escalation of issues as required.

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
WH provides clinicians with access to a range of tools, best practice guidelines, care pathways, and the clinical care standards to support their clinical practice. The Best Care Committee structure supports the adoption of evidence-based care and monitoring to ensure risk is managed. There is good awareness and adoption of the clinical care standards with monitoring and reporting in place. WH participates in a range of national clinical care registries. The EMR supports the incorporation of evidence-based care and integrated clinical pathways with decision support tools.

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
Reporting systems and dashboards for variation monitoring are in place both internally and externally to the Victorian Agency for Health Information. Benchmarking data is available for clinical performance measures at a State level as well as through Health Roundtable and Clinical Registries. A Monitoring Variation in Clinical Practice and Health Outcomes procedure is in place. The Best Care committee structure has established performance and variation reports linked in as part of the governance. The EMR supports real time variation monitoring and decision support. A range of reporting and analysis has also been used to identify areas for improvement which has fed back into alerts and triggers in the EMR. Where clinical variation is identified, a risk management approach is used to minimise harm from unwarranted variation.

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
Engineering preventative and reactive maintenance is performed by a mix of in-house staff and external contractors. A preventative maintenance schedule is in place. Work details are captured in the BEIMS system and are prioritised based on risk. Reporting and monitoring of job completion is in place and Business Continuity plans were sighted. The Assessors noted some examples where electrical tagging was not up to date as well as some general cleanliness, maintenance, and storage issues.

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	
Suggestion(s) for Improvement	
WH should consider undertaking thorough periodic environmental safety audits to ensure priority maintenance and cleaning work is complete with a mechanism to escalate and monitor.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 1.30	
The health service organisation: a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required	
Comments	
WH has a Prevention and Management of OVA procedure with oversight provided by the WH OVA Committee. A Security policy is also in place. Areas with high risk of unpredictable behaviours are identified and well understood with prevention and response protocols in place. Processes are in place to minimise the risk of harm to consumers and staff by unpredictable behaviours. The security team is operationally integrated and works well with clinicians to verbally de-escalate situations that may arise.	
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	
A Wayfinding and Signage policy is in place. Directional signage, internally and externally, is clear and fit for purpose, noting several of the facilities have been developed and expanded over the years.	
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		
A Visitor Management procedure is in place. Visitors with special circumstances can arrange, via the Unit Manager, visitation within patient care areas outside of normal visiting hours. There is a mechanism for complex situations to be risk-assessed.		
Rating	**Applicable HSF IDs**	
Met	Bacchus Marsh and Melton Regional Hospital, Footscray Hospital, Sunshine Hospital, Western Health – Community Mental Health, Williamstown Hospital, The	
Rating	**Applicable HSF IDs**	
NA	Melton Health and Community Services (MH), Sunbury Day Hospital	**NA Comment:** No patients overnight **Verified During Assessment:** Yes **Complies with AS 18/01:** Yes

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
The organisation demonstrates a welcoming environment and genuinely recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people. Specific examples include: • Acknowledgement Statements • Aboriginal and Torres Strait Islander Flags • Aboriginal and Torres Strait Art throughout the organisation, particularly at Urgent Care Baccus Marsh and the Galinjera Maternity rooms • Aboriginal and Torres Strait Islander consumer designed T-Shirts and art motifs on the Aboriginal Health Unit door for easy location A local Aboriginal artist was engaged to create beautiful artwork telling the story of health and wellbeing. The black and white dragon flies symbolise transformation, change, and life. In the centre are Aboriginal people coming together and joining with everyone to be well and safe. This artwork is depicted throughout the Aboriginal Health Cultural Safety Plan. Assessors viewed data that showed, in volume, most people who identify ad Aboriginal and Torres Strait Islander in Western Health catchment live in Brimbank, Hume, Melton and Wyndham, whereas in Melton and Moorabool they represent a higher proportion of the population to Victoria. It was noted the Aboriginal and Torres Strait Islander community has grown faster in Western Health LGA's (6.5% per year) compared to rest of Victoria (4.4% per year with Melton and Wyndham the fastest growing areas. Welcoming environments are continuously being assessed and artwork in Local areas and healthcare journeys on which the facilities are located will continue to be monitored by the Aboriginal Health Steering Committee. Each hospital will display its own dedicated artwork throughout the building structure to provide a culturally welcoming environment upon entry and navigation through the facilities health services. Aboriginal and Torres Strait Islander Health Workforce work across Western Health and provide a culturally informed, strength-focused approach to improving health outcomes for the Aboriginal and Torres Strait Islander consumers and community. Interviews with staff and review of plans and frameworks confirm Western Health has designed several Strategies. One example is the weekly Aboriginal Outpatient Clinic delivered by the General Medicine team in partnership with the Aboriginal Health Unit Wilim Berrbang. The clinic was shaped by asking Aboriginal patients and external service providers about the barriers and enablers to attending outpatient appointment at Western Health, The Aboriginal and Torres Strait Islander Team conduct an annual Service Area Observation to ensure the Health Service is creating and maintaining welcoming environments. Series of questions are asked with recommendations and suggestions to improve and ensure cultural consistency is evident throughout the health service.
Suggestion(s) for Improvement
Aboriginal and Torres Strait Islanders Flags, Australian and LGBTQI+ Flags to be changed regularly.

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	
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 and documentation supporting partnering with consumers, show that the principles of safety and quality are applied when these documents are developed. Consumers' voices are embedded into policy development, implementation, and training. Lived Experience Advisory role is employed to assist and ensure practices are embedded. Coffee with Conversations had to give and get information. Multiple mechanisms to address consumers include packages that predominantly promote the Best Care Framework throughout the organisation. Target area with Disability awareness: Hello, my name is Welcoming diversity, trans and gender diverse, and inclusive practice packages have been developed. The policies and procedures assist the organisation in identifying risks associated with partnering with consumers and inform risk mitigation strategies. Training is provided to staff. It is monitored by the Consumer First Committee which meets monthly.	
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 has strategies and monitoring processes in place to report, review, implement, and improve partnerships with consumers at all levels. The Best Care Framework has been designed in partnership with consumers and their families, building on the strengths of their clinical and health support staff and supported by managers, Executive, and the Board. The Best Care Framework has four components, and each component is included in strategic and operational plans. The Assessors observed how these strategies are monitored and how the organisation reports on partnering with consumers. Consumer Partnerships Manager monitors and provides the demographic data of the 101 Consumer Advisors (CA). Mandatory Training is provided along with the courses in PDF format for those with IT access issues. Data sets with Consumer diversity, age group, Consumer Advisors born outside of Australia are kept and reported to the Consumer First Committee. A total of 65 CA's speak several languages. CAs came with lived experience, Aboriginal and Torres Strait Islanders, LGBTIQ+, Disability and CALD.	
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 be accessed and understood. Welcome to Ward A or B, outlining the Nurse Unit Manager's name complete with a photo; Charter of Rights Posters and Brochures are on entry to all wards. Resources-developed 'Your Healthcare Journey Safety and Rights' is currently with the translation service. Western Health has selected the top five languages for each campus translated (x seven total). Assessors sighted the multi-language health care rights. QR code to the electronic version of the booklet is also available. Copies of Charter booklets and posters with QR codes are available in areas that are accessible to the public, such as main hospital thoroughfares or corridors, elevators, and inpatient wards across the organisation. Information and details on how to access a copy of the Charter are also available on the WH intranet and internet pages, with links to the documentation in multiple languages. Several systems support the measurement and review of WH practices supporting partnering with patients in their own care. Patients are asked about their satisfaction with involvement in care through the Victorian Healthcare Experience Survey VHES. VHES results are incorporated within WH Best Care dashboards that are reported through the WH Best Care Committee structure. The WH Patient Story Program has also proven an effective mechanism to review and improve the way we partner with consumers and carers in the delivery of care. WH clinical auditing activity encompasses a review of patient care partnerships through, for example, perioperative and blood management patient consent audits. The WH Best Care Committee structure supports the measurement and review of WH practices for partnering with patients in their own care, with WH's annual Quality Account publication supporting the sharing of related improvement activity.

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 practices. WH has a robust policy that articulates the process to be used by WH staff when seeking patient consent and how to escalate. Assessors reviewed the policy, which also encompasses provisions for obtaining consent when a patient does not have decision-making capacity but also captures the Victorian model for Advance Care Directives. The policy is accessible to staff through the policy procedure and guideline (PPG) site (PROMPT). The WH Electronic Medical Record (EMR) documents medical treatment decision maker or support people involved in care decisions. WH's organisation-wide orientation program focuses on partnering with consumers and WeLearn packages. One example of an initiative led by Surgeons for Consumers in Theatre is an extra line added on the Consent Form under Medical Terminology to include language consumers can understand. Compliance with consent is audited. The requirements of Advisory AS18/10 have been met with respect to informed consent.

Rating	Applicable HSF IDs
Met	All

ACTION 2.05
The health service organisation has processes to identify: a. The capacity of a patient to make decisions about their own care b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves
Comments
A review of documentation shows there are processes in place to establish patients capacity to make decisions regarding their own care, plus the process to be followed if a substitute decision-maker is required. Assessors reviewed policies, which also encompass provisions for obtaining consent when a patient does not have decision-making capacity, but also capture the Victorian model for Advance Care Directives. Strategies and projects to enhance partnering with patients in their own care are prompted by a combination of responses to external direction (e.g., legislative changes), proactive planning and response to monitoring activities. They are supported by the 'Live Best Care' approach for improvement and innovation. Changes to the Medical Treatment and Decisions Act came into effect in March 2018, and significant work was undertaken to prepare clinicians at WH. This included delivering training in clinical areas and updating related policies and procedures, including the patient Consent policy. More recently, Policy and Pathway development and implementation were undertaken to administer the Voluntary Assisted Dying Act (Vic).

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	
Western Health acknowledges the important role carers play in the care and support of consumers at home. The 'Carers Project' was developed and implemented in 2023 to work with carers to improve the consumer experience while in the hospital.' Staff could articulate this process and access the relevant associated policy / procedure.	
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 substitute decision-makers in shared decision-making about their care planning and goals of care. Through observations by the Assessors during clinical visits, the clinical workforce in clinical areas involves consumers throughout their care journey at occasions of the transfer of the responsibility and accountability of care, including a shift-to-shift handover. Interviews with consumers articulated the purpose of communication boards and their involvement and carers in their own 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	
Western Health acknowledges the important role carers play in the care and support of consumers at home. The 'Carers Project' was developed and implemented in 2023 with the aim of working with carers to improve the consumer experience while in the hospital. Staff and patients could describe to the Assessors how patients are actively involved in their care. Patients and carers interviewed confirmed this, and the organisation's satisfaction surveys also support that patients are satisfied with their level of engagement in their care. Results from surveys are distributed / displayed / actioned.	
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 the evidence provided and viewed reflects this diversity. The development and / or review of Patient Information is guided by a process. The procedure and process apply to all Western Health staff and volunteers who are involved in developing and reviewing consumer information. It is applicable to all information that is for distribution to consumers (patients, families, carers, community members, and visitors). Consumer Partnerships Manager monitors and provides the demographic data of the 101 Consumer Advisors. Mandatory Training is provided along with the courses in PDF format for those with IT access issues. These roles provide consultation / liaison / advice and links with multicultural services and interpreters as required.	
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 Advisors confirmed that consumers have reviewed any internally developed information to ensure that it is understandable and meets their needs. Within WH's Best Care Framework, quality and safety systems that support their staff to provide Best Care are grouped under headings (or pillars), with 'Consumer First' as the central pillar. 'Consumer First' strongly focuses on WH practices and improvement activities supporting communicating with consumers. 'Consumer First' focused practices supporting communication with patients, families, or significant others include a Patient Representative Service, Language Services and tools, and a Consumer Information 'Consumer Tick' review process. Staff who produce consumer information utilise templates and guidelines that instruct them to use plain English and consult with at least three patients, families, or carers from their own areas or members of the Consumer Information Review Panel (CIRP) before submitting written information to the WH Consumer Information Site. The CIRP consists of 12 consumers who review publications electronically, and they provide a final check and 'consumer approved tick' for submitted documentation. Consumers play a key consultation role when new or revised documentation is generated as part of improvement programs. WH is one of the most culturally diverse communities in Victorian, with 45% speaking a language other than English at home. Language services at WH receive approximately 4,000 requests for interpreters per month for about 80 different languages, including Auslan. WH's organisation-wide orientation program includes a focused section on partnering with consumers. Welearn packages such as 'Hello My Name Is' and 'Aboriginal Cultural Awareness' are available to support staff in communicating with patients and families. Training is also available to support staff in difficult conversations with patients and families e.g., breaking 'bad news' and a recent open disclosure training course for senior clinical leaders. A Bereavement Booklet Information and Support has been designed and reviewed and is currently in use. Communication with families is a vital aspect of health care and should occur throughout the patient journey. There are multiple ways for this to occur; family meetings are one option. WH has developed a Family Meeting guidelines. Family meetings provide an important formal, coordinated communication and decision-making opportunity for patients and their families / carers to actively participate in planning their care and treatment with the multidisciplinary team in the hospital. There is evidence that inpatient family meetings can be effective in reducing the psychological distress of family carers and meeting their needs. Family meetings at Western Health can occur in a variety of settings (inpatient, outpatient and in the community).

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	
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 to be high, as is their satisfaction with discharge planning. Patients who were interviewed also stated that they felt the information was provided to them in a manner and format they could understand. Assessors viewed the Consumer Information App, Leaflet, developed and led by WH's Colorectal Surgery head. It provides tailored information to Consumers in a simple-to-understand format. The Assessor viewed a QR code in the presentation to get a sample colonoscopy information module. WH has a Procedure and Consumer Library; each item has gone through its Consumer Info development process to ensure several consumers have reviewed the content.	
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 / meeting with Consumer Advisory members and Consumer First Committee TOR and Minutes confirm Western Heath's active role in the governance and evaluation of health care across this organisation. Meetings are held monthly. This engagement is supported by the role consumers play on a range of key committees and groups. Consumer Advisor co-chairs the Youth Group which meets every three months and feels supported in this role. 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 and volunteers confirmed they felt supported in their roles. This includes orientation for Consumer representatives / volunteers and ongoing education, where needed. Consumer representatives and Volunteers reported being satisfied with the level of support provided to them and stated that the organisation was responsive to their information needs in interpreting data / reports / documents and training. WH Volunteers are passionate and caring. Several Volunteers are bilingual and really enjoy their roles. All have lived experience as consumers or carers. Quote from Volunteer 'I want to give back, Kindness and Compassion' want to be here as long as I can speak and or stand.'

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 consumers and communities, and to better understand and meet their specific and unique healthcare needs. This partnering includes the establishment of the Aboriginal Cultural Safety Plan, which outlines Western Health's commitment to building on the efforts and progress that has been made through successful implementation of their past Aboriginal Health Cultural Safety and Employment Plans. Staff interviews and a review of documents confirmed that the heath service actively engages with members of the local Aboriginal and Torres Strait Islander communities and seeks their input into service planning and care. Sound partnerships with Victoria Aboriginal health services and Aboriginal services networks of the West was also noted. The Aboriginal Health Steering Committee has five consumers with 50% of the committee being Aboriginal and Torres Strait Islanders. A Culturally safe consumer participation guidelines has been developed and implemented. Welcome packs with essential items to assist patients with their unexpected admissions is well received. Welcome packs have native ingredients and information of where patients can seek further support services and information. All new capital projects at Western Health embed cultural safety in planning and implementation. Assessors observed Aboriginal signage and art strategy throughout clinical areas.

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. Within West Health's Best Care Framework, quality and safety systems that supports their staff to provide Best Care are grouped under headings (or pillars), with 'Consumer First' as the central pillar. Consumer First has a strong focus on WH practices and improvement activity supporting partnering with consumer in the design and governance of the organisation. Western Health has strategies to use patient stories within the organisation, including inviting consumers and carers to present on their experiences as part of continuing education sessions, e.g., disability awareness, interviewing patients and presenting stories at Best Care Committees, and using the voice of the patient and carer in events and forums. WH practices include having meaningful positions for consumers on committees at multiple levels of governance and operations, maintaining and continually adding to a WH Consumer Advisor Register. In recognition of their diverse population, WH supports a Board level Community Advisory Committee (CAC) and has dedicated committees recognising vulnerable communities such as First Nations people, people with disability and people from the LGBTIQ community, with consumers included in these committees. WH also has dedicated services to advocate for and support consumers from First Nations backgrounds - Wilim Berbang - the organisation's Aboriginal Health Unit; and people with disability - the Disability Liaison Service.

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
Western Health (WH) has a current, readily available, and accessible policy and procedure system, utilising a product called 'PROMPT.' WH staff were able to show the accessors relevant Infection prevention and control policies and procedures that cover the priority areas of infection prevention and control and antimicrobial stewardship. There are systems for the identification and management of risks associated with infections that include specific risks, including of Staphylococcus aureus bloodstream (SAB) infections, Biofilm, Non-compliant laundry storage, Disinfection of ultrasound transducers, Infectious Disease Screening, Needle stick injury, and Carbapenemase Producing Organisms (CPO) associated hospital infections. Policies, procedures, and risk management are used in line with auditing to determine training in general and targeted areas using results from auditing. Staff were able to describe and demonstrate how they operationalised infection control-related policies and procedures and how to use of auditing guides ongoing training and development. Medical Staff were able to describe the training at orientation on antimicrobial stewardship (AMS) and the process for ordering and as required, obtaining permission to use antibiotics on the restrictive schedule. The SAB rate in August 2023 was 0.5 per 10,000 bed days, with zero reported cases for October and November 2023. A COVID-Safe plan and associated risk reduction strategies were observed to be in place at all sites of WH and were escalated in accordance with community prevalence and Victorian requirements. WH utilises an 'Increase in community COVID transmission triggering escalation risk matrix,' and the use of this tool was demonstrated at the time of Assessment when the risk was downgraded to a status of 'green.'

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 the AMS committees 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, and the Board scorecard includes infection indicators. Membership of the committees is multidisciplinary and includes consumer representation, and each meeting is started with a 'patient story.' The AMS committee reports to the Infection Control and Prevention Committee. There are COVID zoning plans in place, and there is an annual Surveillance Plan for each facility. With the recent acquisition of the Bacchas Marsh campus, monitoring now includes aged care through auditing via the Aged Care National Antimicrobial Prescribing Survey (NAPS) and reporting to the Victorian Hospital Acquired Infection Surveillance System (VICNISS). Identified infection prevention and control risks result in quality improvement projects, for example, the below the elbow project, SAB Taskforce Improvement Plan and the review and implementation of strategies to reduce the risks associated with biofilm in sinks. This has included a design of sinks specifically to minimise the risks associated with splatter from sinks. Core training is conducted at orientation, and ongoing target training occurs based on auditing results to ensure that staff not meeting the required competencies receive ongoing training. AMS is a component of the medical staff orientation.

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	
WH has a comprehensive schedule of auditing and includes an online dashboard with results. 'Knowing how you're doing' boards are utilised for displaying results; this was particularly apparent for Hand Hygiene. Staff minutes include agenda items related to relevant results for that Unit. The Board of Directors receive detailed reports on infection control via a dashboard and explanation of results. AMS is discussed at relevant committees, and the AMS committee reports to the infection control committee meetings. There are a number of improvement activities that WH could demonstrate that have been implemented to improve performance where gaps are identified. For example, the 'bare below the elbow,' 'Not on the floor,' and 'improved location and maintenance of hand gel. WH was responsible for the development of the 'Hoods' utilised during COVID-19 that was adopted across the country.	
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
Each infection prevention and control meeting commences with a patient story. Patients and staff that the Assessor met with were able to confirm that they are actively involved in their own care and that staff, for example, were utilising hand hygiene products.' Those patients receiving antimicrobial treatment had treatment options discussed with them. Patient audits have highlighted infection control concerns, such as being isolated in a room, and improvement strategies have been implemented. Other options are investigated if a patient is intolerant of the COVID hoods. There are patient information and signage / posters to assist staff and patients with awareness of infection prevention and control best practices. WH's 'Your Healthcare Journey Safety and Rights' booklet covers areas such as 'making decisions together' and 'preventing infections.' The Assessor was shown other patient information on 'Clostridioides difficile,' 'Extended Spectrum Beta Lactamase,' and 'Vancomycin Resistant enterococci'. There are other strategies, such as using the TVs and various posters, that target information for the consumers.

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
There is an expert team of experienced infection control and prevention members that oversee a comprehensive schedule of auditing for infection prevention and control systems, and audit results are provided to individual units and aggregate data is provided through the governance structure. Infection control and prevention and AMS are discussed at relevant committee meetings, and target strategies and training are implemented based on audit results. For example, the placement of alcohol gel data demonstrated that improvement was required for the management and placement of the alcohol gel. The placement of alcohol gel at entrances and at the end of the beds was improved, and responsibility of maintaining filled containers was allocated to the Patient Services Assistants (PSA). Another improvement project related to ‘no more on the floor’ was as air mattresses were often blown up on the floor, new procedures were in place to ensure best practice. Current data that supports the effectiveness of the organisations strategies includes the VICNISS requirements related to surgical deep and superficial wound infections, line associated infections, and other invasive device or procedure infections, and transmission between staff and patients. WH monitors infections via agreed reporting requirements by the Victorian jurisdiction via the VICNISS system that forms part of their performance monitoring by the Department of Health and Board of Directors. Other initiatives include screen savers / TV usage to help consumers to be involved in cannular care.
Suggestion(s) for Improvement
It is suggested that while hand hygiene is well promoted and displayed, there is opportunity to utilise the ‘knowing how you are doing’ boards to display more infection prevention and control data to both the staff and the visitors to the organisation.

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 review of infection control documents indicates that processes are 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. There is a policy for 'Standard and Transmission based precautions procedure.' Signage and other resources are consistent with the Australian Guidelines and are available for the health services intranet site to print. Monitoring occurs through the following audits: Hand hygiene; Donning and doffing (including the training of visitors); and Competency assessment for aseptic technique for those staff identified at auditing as requiring further training and development. WH assesses compliance with the requirements of transmission-based precautions when applied to specific infection risks. At WH, this resulted in the development of the COVID hoods used to minimise the risk of transmission and shared across the country. There are systems to review surveillance data on healthcare associated infections. This resulted in the risks identified by biofilm that has developed in new buildings, some of the reasons related to minimising water flow / pressure for sustainability reasons, resulting in infection risks. Incident reports that relate to intravascular devices, occupational exposures, biological spills, and environmental cleaning are reviewed. WH has also reviewed their workforce education and has implemented core training as part of their orientation of new staff to the organisation. Further targeted training is applied based on auditing, risk management, and identification of training needs. Each area has an infection control link nurse who participates in hand hygiene audits and other infection control activities located in each area.

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
WH has policies and procedures for the management of organism-specific risks that links in with the Western Public Health Unit and the Department of Health. WH has introduced a 'Increase in community COVID transmission triggering escalation risk matrix,' as an example of an escalation process. This allows WH to monitor increase in antiviral prescriptions, positive tests in the community and increased outbreaks within local residential aged care facilities, and increases in metropolitan waste water levels if there is an increase in hospital and ICU admissions. Using this information in line with the escalation risk matrix, staff are guided to the level of precautions that are required to be utilised. The electronic Medical Record (eMR) allows for the identification and alter system that guides handover, transfer of care, and discharge processes by the identification of infectious status. There are a number of sources of information for both staff and patients including at pre-admission. The schedule of auditing guides the competence-based training program that is targeted based on the audit results, this includes 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 in place for commencing from standard and transmission-based precautions policies and procedures for all staff, and training and development is tailored to those commencing at WH and through areas identified via ongoing auditing. There are processes in place for the risk of infection or communicable disease to be assessed on admission or presentation to the organisation. The staff utilise an alert system to ensure communication of risks and to ensure appropriate precautions are in place. The use of the electronic medical record (eMR) ensures that relevant information can be assessed at each stage of the patients journey. Clinical areas and the infection control consultants work closely with environmental services to ensure appropriate cleaning regimens are in place during an admission and on discharge for the terminal clean. The cleaning service utilise ultra violet technology as part of the auditing process to ensure the terminal clean has been complete correctly. Results determine if the cleaning needs to be repeated. Lessons learnt through infection prevention and control are being incorporated into the new build for the Footscray Hospital. WH implemented the COVID Hoods to minimise the risk of COVID transmission.	
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 all transfer of care / handover points, and compliance is monitored. The eMR alert system assists staff with communication of a patient's infectious status and is included at the transfer of care (handover sheets) / handover points. Emergency Department (ED) bed requests single rooms as determined by the patients' alerts. The journey board outlines patient alerts related to infection control. Patients, carers, families and visitors are alerted to precautions that are required with A3 posters describing the required precautions at the entry of patient rooms. Visitor training in the use of Personal Protective Equipment (PPE) occurs when visiting high-risk patients with an infection alert. Various forms of patient information (as outlined in other actions) are available in a form consistent with the health literacy requirements. Interpreters and information in various languages are available. WH has a process in place to ensure that any infection alerts that are no longer relevant are reviewed and removed.

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. The organisation has access to Gold Standard Hand Hygiene auditors (Infection Control Link Nurses). Regular compliance and observational audits (monthly audits, three audit periods, reported twice a year) are undertaken and provided to staff and through the governance structure. Current compliance rates are 89% for WH overall. The Assessors noted the work that has been completed to ensure that there are conveniently located HH products in the clinical areas.
Suggestion(s) for Improvement
The Assessors observed the lack of conveniently located HH products in the Sunbury Campus, particularly in the temporary Chemotherapy area and suggest that this be audited and reviewed.

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. Staff are appropriately trained, and competency / compliance is assessed as part of the core training on staff commencement at WH. It is monitored via the auditing process, and additional training is conducted as required. Audit results indicate compliance with the requirements of aseptic technique. WH conducts promotions for infection prevention and control, and in October 2023, the focus was Peripheral intravenous cannulation (PIVC). As part of this focus, an IV-WISE tool was developed that lists key discussion points for clinicians and patients to involve patients in their care and prevent PIVC-related complications. Auditing consists of a minimum of 10 procedures a quarter per area. Training and development are conducted in response to the auditing and areas identified that require training. Monitoring for SAB is conducted, and all are investigated, and Blood Culture results are monitored. An example is the follow-up from a patient complaint regarding the process of IV insertion in the radiology department. This resulted in training and auditing in this area. Aseptic Technique's overall training compliance in July 2023 was 95%.

Rating	Applicable HSF IDs
Met	All

ACTION 3.12	
The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare	
Comments	
Training and assessment for the management of invasive devices are available to staff and align with the current best practice (see Action 3.09). Associated infection rates are monitored and reported. SAB infections are noted to be zero for October and November 2023. WH has also developed policy and procedure in regard to the difficult insertion of a device called 'DIVA.' The procedure outlines an escalation pathway to manage the difficult insertion of invasive devices. Invasive devices training in July 2023 was at 84%.	
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. WH has procedures that involve ultraviolet marking for outbreaks. UV auditing is conducted both proactively and reactively. If the result is not 100%, the room gets re-cleaned. There is also independent infection control ultraviolet checking of cleaning. There is an intranet site available for Safety Data Sheets. These are available for all products. OH&S can monitor their usage. Spill kits are available in appropriate areas. Staff were able to show the assessor how to access the chemical safety data sheets. Infection control is involved in building works; they audit and monitor as required.	

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
In new buildings, in response to infection control risks raised, WH has investigated suitable sinks to prevent biofilm; this includes a drain on the side of the sink to prevent splashing and a metal trap instead of a plastic trap (this was in response to a sentinel event from the transmission of Serratia marcescens related to clinical hand basins and the build-up of biofilm. Biofilms are difficult to remove and provide an ideal environment for emerging pathogens to reside). Policies have been updated to ensure that IV fluids are not disposed of down sinks and increased water flow (flows were reduced due to climate change and drought conditions). Cleaning standards are consistently at or above benchmark targets: Environmental Cleaning audits - October 2023 ranged from 99.7% at Bacchus Marsh to 94.6% at Williamstown and Joan Kirner Women and Children. The workforce has completed training on cleaning processes for routine outbreak situations and novel infections.
Suggestion(s) for Improvement
There are areas of the Sunshine Hospital Emergency Department that require some repairs. It is suggested that while the area is due for refurbishment, in the interim, remedial action be undertaken, i.e., sealing of wooden shelving, repair of walls, and painting / vinal of doors where paint has worn. On examination of bedside resuscitation equipment, there were a number of different systems and some areas with out-of-date stock. It is suggested that the system of maintaining bedside resuscitation equipment be reviewed to enable the maintenance of a single system across the organisation.

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
The organisation has infection control processes, policies, and procedures to respond to infection risks for equipment, devices, products, buildings, and linen that are responsive to novel infection risks and pandemic planning. All new products are reviewed and assessed for infection-related risks. Maintenance is both scheduled and responsive to failure. This was reflected in the PIVC project 'Hesitate before you cannulate.' WH has a daily dashboard that highlights the need for device removal. A policy that manages this area is 'Outbreak Management of Communicable Conditions.' New equipment is evaluated in relation to infection control. Infection Prevention and Control staff are actively involved in the maintenance, repair and upgrade of buildings, equipment, furnishings, and fittings. See the above action where sinks have been designed to manage biofilm. Issues identified with linen storage have resulted in WH making linen covers to ensure compliance with the relevant standards. There are plans in place to respond to infection prevention and control outbreaks.

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 Victorian policy and national guidelines. Immunisation status is captured during the recruitment process. The staff Clinic is responsible for surveying and following up on vaccination / immunisation status. WH has set KPIs for the onboarding of immunisation status to ensure the timeliness of recruitment. Due to the population of the patients and staff, screening for TB occurs. The Western Public Health is a site that staff can access to gain advice on vaccine-preventable diseases. There is a policy and procedure for this area, 'Immunisation for Health Care Workers.' COVID vaccinations were >99%, and staff have been offered up to five boosters. There is an annual influenza vaccination program, and a COVID-19 vaccination program is in place, with 98% of clinical staff and 96% of overall staff vaccinated for influenza in 2023. This high rate of vaccination was recognised via an award from VICNISS.

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
WH has an annual influenza vaccination program, with 96% of the staff vaccinated for influenza. There are programs designated to specific areas, such as maternity and paediatrics. Policies and procedures are in place that reflect the Victorian and Commonwealth (aged care) requirements for vaccination. There is a staff wellbeing clinic that is actively involved in the surveillance of this requirement. There is an outbreak management plan, and staff are assigned to track staff and patients as required. During the COVID period, a COVID response team supported staff; this has now moved to a survey of staff that provides advice and care and on return to work.

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 with AS4187. Regarding reverse osmosis (RO), the following have been implemented: Bacchus Marsh – RO Williamstown – RO washers (not in the CSSD) Sunshine – RO washers (not in the CSSD) Footscray – will be part of the current new build Sunbury – RO A gap analysis is used to manage the implementation of AS 4187. In theatre, plastic trays are currently being replaced with metal trays. There is a product evaluation committee, which includes work to improve the environmental impact and the development of new theatre wraps and drapes. WH has been using Scancare for 22 years, and its traceability system for critical and semi-critical equipment, instruments, and devices used for the procedure is in place. Auditing is conducted, and the auditing results are displayed on the 'Knowing how you are doing' boards in the CSSD departments. Water testing is conducted and reported by exception. There is education on all campuses and support for Certificate Three in instrument technician. There is a recycling program for wraps, metal, and recycling of single use metal. Interviews with management and staff involved in reprocessing reusable medical devices confirmed that relevant national standards are followed. The Assessors observed that facilities, equipment, and sterile stock storage complied with the ACSQHC Advisory AS18/07 requirements. Sterile room stock audits are conducted, the results are passed or failed, and failed items are taken out of circulation. New procedures have been introduced for cleaning ultrasound probes, including an electronic tracking system to track the cleaning. CSSD conducts protein testing for hand-washed items.

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.	
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
WH has a police and procedure for AMS that is guided by evidence-based practice. 'AMS and Restrictions to Antimicrobial use.' The AMS administration tracker monitors and approves orders. The medical staff have AMS training at orientation. An Infections Diseases Physician oversees the program. As part of the AMS program, each patient allergy is reviewed to determine its validity, and if determined there is no allergy, this is removed from the alert system in the eMR for the patient. The system has a traffic light system whereby approval is required for high-risk antimicrobials. There is an AMS website that provides patient information and the Therapeutic guidelines for staff use, other clinical resources such as the 'WH IV to oral switch pathway.' The National Antimicrobial Prescribing Survey results are also located on this site. All antimicrobials have an indication recorded. The eMR has a dashboard with every AMS and indicates those approvals that are required or are about to expire. Programs such as the 'Diabetic Foot' have a multidisciplinary approach and are reviewed for antimicrobial usage. WH has ensured that appropriate antimicrobials are used for certain procedures, for example, Hysterectomies. The organisation complies with the requirements of Advisory AS18/08 and ACSQHC Fact Sheet 11 (3.15d).

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	
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 Board of Directors. 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. WH participates in the Hospitals NAPS and the Aged Care NAPS (Bacchus Marsh). Footscray and Sunshine Hospital results are above the national average for compliance with guidelines and for appropriateness of the antimicrobials. Footscray recorded 91% in documenting an indication and Sunshine 97% in documenting an indication. In aged care, on the day of survey there were no residents prescribed one or more antimicrobials.	
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	
Western Health provides governance of medication through the clinical governance reporting structures, with a range of policies and procedures that support clinicians in prescribing and administering medication. Pharmacists are deployed in clinical areas to manage procurement and storage, support prescribing, and review medication errors. APINCH has been adopted, and it is evident in the medication rooms. Staff were well aware of high-risk medication, and there are alerts on shelves where medication is stored and electronically. Training modules and scope of practice have been considered in the safety and quality systems, with medication competency tested on employment and on an ongoing basis. The Medication Safety Committee (MSC) has overarching governance with subcommittees reporting to it, inclusive of the Chemotherapy Governance Committee and the Antimicrobial Stewardship Committee. Reports are provided to the Best Practice Committee, with indicator data presented at the MSC, Executive and Board levels.	
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
RiskMan is used to report medication incidents, with data analysis, including ward, type of error, and harm score rating forms the report. A review of the evidence from interviews with clinicians and senior leaders verifies that data drives quality improvements at the ward and service levels. There were many examples where an incident had led to further analysis by the pharmacist with the treating team, and education and support were available to minimise the impact of medication. The type of drug, time of day, incident type, and actions taken are all recorded on RiskMan and are inherent in the overarching governance of medication.

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
Patient Information Brochures are provided, and as the medication is administered, it was observed during the Assessment that, where possible, a person is asked about their knowledge of the medication being given. During discussions with patients by the Assessment team, when patients could not name the medication, they knew what it was treating. Patients stated on many occasions that care is inclusive, and clinicians spent time answering questions on medication, including the pharmacist. The organisation aims to involve patients in their care by providing appropriate information about medications and treatments and 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, that they felt involved in the process, and that they were able to understand the information provided. Patient information brochures are able to be provided in a range of languages.

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. An EN described being very clear about her scope of practice, likewise, nurse practitioners were interviewed during this Assessment. There is a suite of education packages available. Western Health has captured the recently ceased Commonwealth program that interns could access, which is included in orientation.	
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 possible, and medication reconciliation is monitored through the dashboard. The average completion during the Assessment was in the high 80% range across sites with EMR.	
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		
A team approach is undertaken to review medication, from dispatching medication from the central pharmacy to assessing medication against admitting history, knowledge gained through My Health Record, and, where possible, the regular community pharmacy a patient uses. Observational audits supported that medication administration includes checking with the patient what medication they routinely take, including time and dose.		
Rating	**Applicable HSF IDs**	
Met	Bacchus Marsh and Melton Regional Hospital, Footscray Hospital, Melton Health, and Community Services (MH), Sunshine Hospital, Western Health – Community Mental Health, Williamstown Hospital, The	
Rating	**Applicable HSF IDs**	
NA	Sunbury Day Hospital	**NA Comment:** Patient's medicines are not changed or altered during an episode of care. **Verified During Assessment:** Yes **Complies with AS 18/01:** Yes **Approved by ACSQHC:** No

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	
EMR document alerts and allergies and random reviews of online and hard copy files across those sites that remain on paper-based systems demonstrated a high level of compliance. The audit data captures that allergies, and adverse drug reactions are documented and, overall, meet the agreed benchmarks. Results are linked to the quality and safety systems to monitor ongoing improvements.	
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	
Medication errors are reported through RiskMan and trended for adverse reactions. A review of the data during Assessment and interviews with clinicians and managers supported that medication incidents are captured, and analysis provides an overview of the type of drugs and the number of reported incidents, which is monitored for variation, severity, and any ongoing issues. Reactions from an incident are reviewed at the service level, at clinical reviews, and through the governance committees, including medication governance committees, and Executive and Board level.	
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	
A central record of reports to the TGA is kept centrally at each pharmacy department; there is an opportunity to collate this data and report through governance structures.	
Suggestion(s) for Improvement	
Consider how to capture TGA reports on an annual basis.	
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	
Western Health has invested significantly in ensuring that clinical areas have access to pharmacists to enable a focus on medication reviews of high-risk patients. This approach enables the capacity to review prescribing and administration and provide ongoing education and support. Interviews with pharmacists, medical officers, clinical leaders, and clinicians on wards and services were able to describe the protocols. A review of the medication charts and the medical records supports a robust system.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.11	
The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks	
Comments	
Patients interviewed during this Assessment could describe how they were informed of any changes in medication and what medication information they had received, including a pharmacist discussing the type of medication and the intent of the medication. There is access to a range of languages and interpreters to provide medication information.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 4.12		
The health service organisation has processes to: a. Generate a current medicines list and the reasons for any changes b. Distribute the current medicines list to receiving clinicians at transitions of care c. Provide patients on discharge with a current medicines list and the reasons for any changes		
Comments		
During the Assessment, the preparation of discharge processes was observed, and the development of a discharge plan highlighted, in red, any changes / instructions in medication, as well as a list of medications. Completion of discharge summaries is monitored. As part of the discharge / transfer processes, medical officers interviewed could describe the requirements for developing the discharge plan. They could provide the level of detail and their achievements against timelines, which are monitored for timeliness. Pharmacists work closely with medical officers in the discharge process, and information is provided to the clients, their families, and primary care and community pharmacists, as appropriate.		
Rating	**Applicable HSF IDs**	
Met	Bacchus Marsh and Melton Regional Hospital, Footscray Hospital, Melton Health and Community Services (MH), Sunshine Hospital, Western Health – Community Mental Health, Williamstown Hospital, The	
NA	Sunbury Day Hospital	**NA Comment:** Patient's medicines are not changed or altered during an episode of care. **Verified During Assessment:** Yes **Complies with AS 18/01:** Yes

ACTION 4.13	
The health service organisation ensures that information and decision support tools for medicines are available to clinicians	
Comments	
Clinicians have a full range of electronic tools available to facilitate evidence-based prescribing. In addition, access to after-hours pharmacists further strengthens the resources available.	
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	
Across the health service, it is evident that systems are in place to ensure that Western Health meets manufacturers,' legislative, and Vic Health requirements. Improvement strategies have included the recent use of a robot in registering, storing, and supplying medication at Sunshine Hospital Pharmacy. In other sites, this process is undertaken to industry standards, including chemotherapy. Cold chain management is monitored centrally, and at the service level, daily checks are undertaken. This was variable in some sites. Nurse managers were able to describe how performance is communicated to improve compliance. Policies and procedures are available, and steps to be taken are clearly articulated should the cold chain process be compromised.	
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	
There have been considerable system improvements to identify high-risk medications, including mental health and APINCH posters, and identifying high-risk and similar products has electronic alerts. During the Assessment, ward stock included alerts on shelves at all levels of the supply chain. Data identifies incidents that include High-Risk medication. Observational audits in dispensing medications from the pharmacy noted an added safety mechanism, where for high-risk medications, e.g., psychotropic medication, a full review of the patient's clinical file is undertaken to ensure that there are no risks, e.g., evidence of delirium.	
Rating	**Applicable HSF IDs**
Met	All

Standard 5 - Comprehensive Care

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

ACTION 5.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for comprehensive care b. Managing risks associated with comprehensive care c. Identifying training requirements to deliver comprehensive care
Comments
Safety and Quality systems governing Comprehensive Care are reflected in Best Care policies and procedures, with those relating to Person-Centred care relating to the elements within Comprehensive care. Assessors noted a risk register is in place and a Comprehensive Care Risk profile that reflects data available on the Comprehensive Care Dashboards, including Falls, End-of-Life and Advanced Care Planning as High and Mechanical Restraint Very High. All risks have been reviewed, and controls are reported to be effective. Patient-Centred Care Steering Committee documents reflect that safety and quality systems are used to identify training requirements. WH had advised Assessors that eligible staff completed a suite of foundational training to support comprehensive care; the training included a broad range of skills-based learning and included: Essential elements of Comprehensive Care; AICED Program (Assessment A-E, Identify Patient Risk, Diagnosis and Goals, Care Planning, and delivery, Evaluate care, Document & Handover); and an A-E patient assessment. In addition, WH identifies training is available for Malnutrition, End-of-Life Essentials, Delirium Prevention, Self-Harm and Suicide Risk Assessment, Dysphagia Screening Tool, and Pressure Injury and Falls Prevention. Staff completion of foundational training for the above foundational modules was not available to Assessors. A recommendation is made in Action 1.20.
Suggestion(s) for Improvement
It is suggested that Western Health embed training rate compliance monitoring into the Terms of Reference and governance systems for the Person-Centred Care Committee and its sub-committees.

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
A comprehensive audit system is utilised within Western Health, with results noted to be communicated through the Comprehensive Care dashboard. Assessors noted this information, as well as adverse events monitoring, is used to identify areas requiring improvement at a local level with the Person-Centred Care Subcommittees monitoring outcomes. A sample of audit results that required improvement to meet targets was noted in the Best Care Action Plan and Quality Improvement register. The introduction of the recommendations register is reported to have assisted in the visibility of tracking outcomes resulting from incident review improvements. Assessors noted that outcomes of improvement initiatives and activities in progress are communicated to the staff, consumers, and governing bodies through "Improvement News," governance meetings, unit meetings, and "Knowing how we are doing boards."

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
Best Care Framework is well embedded throughout the organisation, with the Consumer first pillar underpinning activities related to all other pillars. Consumers are representatives on Committees. Examples of educational material developed and updated following consumer feedback were evidenced by Assessors. Models of Care have been improved through feedback from consumers with lived experience. Staff and consumers interviewed were able to explain processes in place to partner with patients and ensure patients are actively involved in their care. Formal and informal surveys provide further evidence of individuals and families.

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	
Care planned for patients by the multidisciplinary team was observed on the 'Miya' patient flow board, and the assessors observed this system being used to facilitate the delivery of comprehensive care. Referral processes are defined in procedures and occur through the eMR, which is then utilised to monitor timeliness. Allied Health staff interviewed reported that an improvement of 10% in 24-hour response times has recently occurred as a result of a quality initiative involving reviewed processes and increased resources. The clinician with overall responsibility for the patient is identified and communicated to staff through iPM and the eMR. Link roles allocated in some areas are the central point of contact between the multidisciplinary team and the patient and / or family and further enhance communication. The staff interviewed were able to confirm this.	
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	
Assessors observed multidisciplinary collaboration within the areas visited at Western Health. Case conferences attended included representation from different clinical specialties. Responsibilities are documented, and staff were able to verify this information when asked. The Victorian Healthcare Experience Survey from April to June 23 included a question, "Did staff work as a team to care for you?" and the response rate showed 76.5 % of patients said "Yes, definitely." Interviews with patients and their families by Assessors overwhelmingly displayed a culture of the clinical teams working together, with patients stating many times, when asked, that they do not get conflicting advice from disciplines and can ask any clinician a question and the relevant clinician will make themselves available.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.06	
Clinicians work collaboratively to plan and deliver comprehensive care	
Comments	
Assessors observed multidisciplinary team meetings where clinicians worked collaboratively to develop care plans for patients. Staff and patients were able to describe and provide examples of this occurring, and the documentation reviewed supported this evidence.	
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. Compliance is monitored and reported via online Performance Dashboards the Auditing Best Care (ABC) audit. Results show that the completion of risk assessments on admissions and during the patient's admission, according to the policy, has remained stable over the 2022-2023 period. These results are reported and monitored through the Best Care Committee. The organisation is compliant with the requirements of Advisory AS18/14.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.08
The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems
Comments
Western Health has an overarching policy and processes in place to identify patients who identify as being of Aboriginal or Torres Strait Islander origin. This information is recorded as a mandatory field on the IPM patient management system that integrates with the eMR. Interviews with staff and documentation review confirm the organisation asks the identity question. This question is asked at all points of admission. Recording identification of Aboriginal and Torres Strait Islander Patients, including Newborn procedures, outlines the systemic approach to ensure identification and recording in patient management systems. Western Health (WH) has communication material displayed in admission areas to inform patients about 'Asking the Question." The 'Don't Be Shy - Identify' posters are on the Welcome Boards in all Wards and Elevators. Training is provided for staff at WH about the importance of identifying Aboriginal and Torres Strait Islander inpatients. The Welcome Packs, received by all inpatients and readily available across WH, contain information on why asking about Aboriginal and Torres Strait Islander identity is important. The Wilim Berrbang Aboriginal Health Team conducts an annual Service Area Observation to ensure the Health Service creates and maintains welcoming environments. Questions are asked, along with recommendations and suggestions, to improve and ensure cultural consistency is evident throughout the health service.

Rating	Applicable HSF IDs
Met	All

ACTION 5.09		
Patients are supported to document clear advance care plans		
Comments		
The admission process supports patients to document advanced care plans. Staff interviewed and documentation reviewed verified this occurred. Resources are available in posters with QR codes and the "Your Healthcare Journey" booklet to support this process. Patients interviewed by the Assessors informed team members that they were aware of these resources.		
Rating	**Applicable HSF IDs**	
Met	Bacchus Marsh and Melton Regional Hospital, Footscray Hospital, Melton Health and Community Services (MH), Sunshine Hospital, Western Health – Community Mental Health, Williamstown Hospital, The	
NA	Sunbury Day Hospital	**NA Comment:** Does not apply in this setting. **Verified During Assessment:** Yes **Complies with AS 18/01:** Yes

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	
Western Health Risk screening policies and procedures are in place and guide practice. Staff interviewed were able to describe tools used for risk assessment, and completion of these according to the policy is monitored by utilising the dashboard. The staff interviewed explained the process for completion of risk assessment and monitoring systems to ensure compliance with policy. Documentation reviewed by assessors validated this feedback from staff. Person-Centred Care Committee monitors compliance with risk screening and, where necessary, takes action to improve compliance. The requirements of Advisory AS18/14 have been met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.11	
Clinicians comprehensively assess the conditions and risks identified through the screening process	
Comments	
Documentation reviewed by assessors provided evidence that clinical assessment occurs using evidence-based risk assessment tools. Examples include fall risk assessment, MST, and 4AT. The “Think about the link” initiative implemented at Western Health was reported by staff to reinforce the integration of risk assessment and comprehensive care planning.	
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	
Patients' risks are screened on admission as part of the admission assessment process, and this information is documented in the patient’s health care records. Medical records reviewed include risk screening and Alerts entered on iPM and then flowing onto the eMR. Staff interviewed were able to describe this process, and health care records reviewed by Assessors verified this process was followed.	
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. 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
Staff interviewed by Assessors were able to explain that information from the patient and family, as well as through clinical assessment at admission, is used to develop a care plan that meets the needs of the patient. Staff understood their role and responsibilities. Family meetings, case conferences, the virtual visiting program, ward rounding, and regular involvement of patients and families, described by staff, patients, and families across sites and specialties, supported the documented evidence. Information from the "ABOUT ME" form completed by patients and their families is used in developing the patient's care plan. Discharge planning forms part of the admission process and commences at admission. The complex discharge planning program and implementation of the non-weight bearing pathway have resulted in 1.7 to 2-day bed day-saving. Discharge documentation reviewed included clear referral and follow-up arrangements. The requirements of Advisory AS18/15 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	
The Comprehensive Care IPOC in EMR is utilised by in-patient wards at Western Health. The staff interviewed explained this is used to document patients' goals, medical orders, and planned interventions. Where not in EMR, paper-based forms are utilised. Staff explained how the goals of care are reviewed at the end of each shift and how managers are able to monitor compliance through the Ward Overview Report in "MaP." Patients and families interviewed were able to explain their plan of care and describe how they were able to participate in decisions about their care. The documentation reviewed included evidence of updated care planning in both electronic and hard copy files reviewed.	
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
End-of-life care screening forms part of the Admission Assessment. This information is then noted in IPM as an alert. Implementation of an action plan is in place following a gap analysis undertaken by the Western Health End-of-Life Committee against the National Consensus Statement: Essential elements for safe and high-quality end-of-life care identified. End-of-life definitions are consistent with the National Consensus Statement. Timeframes for improvements on the action plan are on track, and staff interviewed reported that processes are in place to escalate those actions identified that require higher level organisational support. Mental health has systems to support the end of life, particularly in community services, with the capacity to support a person into palliative care.
Suggestion(s) for Improvement
Assessors reviewed the gap analysis against National Consensus Statement: Essential elements for safe and high-quality end-of-life care and action plan developed. It is suggested that Western Health continue this work to ensure that data definitions within the eMR facilitate ongoing monitoring of clinical outcomes.

Rating	Applicable HSF IDs	
Met	Bacchus Marsh and Melton Regional Hospital, Footscray Hospital, Melton Health and Community Services (MH), Sunshine Hospital, Western Health – Community Mental Health, Williamstown Hospital, The	
NA	Sunbury Day Hospital	**NA Comment:** End-of-life care is not provided. **Verified During Assessment:** Yes **Complies with AS 18/01:** Yes **Approved by ACSQHC:** No

ACTION 5.16		
The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice		
Comments		
The eMR provides the ability for staff to refer patients to Palliative Care services. Specialist Palliative care is available during hours and on call 24 hours a day, 7 days a week. Staff interviewed reported guidelines are on the intranet that relate to discharge guidelines, symptom management, and management in ED; all have an escalation pathway to refer to Palliative Care, if required.		
Rating	**Applicable HSF IDs**	
Met	Bacchus Marsh and Melton Regional Hospital, Footscray Hospital, Sunshine Hospital, Western Health – Community Mental Health, Williamstown Hospital, The	
NA	Melton Health and Community Services (MH), Sunbury Day Hospital	**NA Comment:** End-of-life care is not provided. **Verified During Assessment:** Yes **Complies with AS 18/01:** No **Approved by ACSQHC:** Yes

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	
Advanced care plans are provided by patients on admission or during admission. These are flagged on the EMR, and an alert is placed on IPM. Staff reported that this is then updated as necessary and also reflected in the Resuscitation plan, as necessary. Review of care in accordance with the Advanced Care plans is incorporated in the Morbidity and Mortality review process with plans to explore benchmarking opportunities with Health Roundtable. Compliance with completion of this screening on admission is monitored through the End-of-Life Committee and reported to the Person-Centred Care Committee.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 5.18		
The health service organisation provides access to supervision and support for the workforce providing end-of-life care		
Comments		
Western Health provides education and support to staff delivering end-of-life care through EOLC modules in We Learn, as well as bedside teaching in accordance with EOLC and Advanced Care Planning policies and procedures. Staff report active engagement and support from the Pastoral Care team in the debrief process across all areas of Western Health. Staff discussed the effectiveness of having after-hours education support available to support junior nursing staff in end-of-life care. Staff completion of foundational training for end-of-life care modules was not available to Assessors. A recommendation is made in Action 1.20.		
Rating	**Applicable HSF IDs**	
Met	Bacchus Marsh and Melton Regional Hospital, Footscray Hospital, Sunshine Hospital, Western Health – Community Mental Health, Williamstown Hospital, The	
NA	Melton Health and Community Services (MH), Sunbury Day Hospital	**NA Comment:** End-of-life care is not provided. **Verified During Assessment:** Yes **Complies with AS 18/01:** No **Approved by ACSQHC:** Yes

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		
Assessors observed PCOC, PRISM, and internal auditing system data, e.g., ABC Audit and Dashboard information, which are reviewed to ensure end-of-life care is provided against planned goals. The staff interviewed were able to explain the results of the last PCOC Report. Staff reported that planned improvements include enhancement of data collection through improved integration into the eMR that will improve the ability to measure and monitor the timeliness of referral to being seen.		
Rating	**Applicable HSF IDs**	
Met	Bacchus Marsh and Melton Regional Hospital, Footscray Hospital, Sunshine Hospital, Western Health – Community Mental Health, Williamstown Hospital, The	
NA	Melton Health and Community Services (MH), Sunbury Day Hospital	**NA Comment:** End-of-life care is not provided. **Verified During Assessment:** Yes **Complies with AS 18/01:** No **Approved by ACSQHC:** Yes

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		
Policies related to end-of-life care and resuscitation plan requirements provide guidance to staff on the requirements of shared decision-making. Education programs are focused of communication so that a shared language is used in EOL planning. Out-of-hours ICU liaison and MET services provide support, and staff interviewed discussed the good relationships between the services. Staff interviewed were able to provide evidence of patient and family involvement in shared decisions relating to end-of-life care that was consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care.		
Rating	**Applicable HSF IDs**	
Met	Bacchus Marsh and Melton Regional Hospital, Footscray Hospital, Sunshine Hospital, Western Health – Community Mental Health, Williamstown Hospital, The	
NA	Melton Health and Community Services (MH), Sunbury Day Hospital	**NA Comment:** End-of-life care is not provided. **Verified During Assessment:** Yes **Complies with AS 18/01:** No **Approved by ACSQHC:** Yes

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		
WH's Pressure Injury Action Advisory Group (with recently reviewed terms of reference and membership) reporting through to the Person-Centred Care Committee underpinned by a 23/24 Plan oversights WH's strategic and reactive quality improvement actions supported by a group of passionate champions predominantly hospital based. RiskMan information, investigation and action on Skin Integrity issues sit at a Division level. There are a number of guidance procedures for staff providing care including for people who are Bariatric being admitted for care. Continuous improvement projects that have been implemented / are being implemented and been evaluated / in the process of being evaluated have significantly improved the person prone to skin integrity issues. Care journey projects include the introduction of Hybrid mattresses with a resultant significant decline in pressure injuries (November 2023 being the first month in one medical ward with these mattresses with nil pressure injuries), the substitution of alternate NG tube provision secondary to the number of pressure injuries evident associated with the ongoing insertion of these, and the introduction of a lanyard card with screening information on one side and a mirror on the other side to assist in the observation of heels. Health Round Table data indicates it is currently performing better than the Peer Average. Mental Health recently transitioned to WH (1/7/23) with an eighteen-month transition plan and currently utilises different screening tools that are paper-based and a separate audit system, which showed a high level of compliance. Detailed WH Wound Management Chart based on the Australian Wound Management Association and expertise are available across WH. Staff completion of foundational training data on skin integrity was not available to Assessors, hence a recommendation in Action 1.20.		
Rating	**Applicable HSF IDs**	
Met	Bacchus Marsh and Melton Regional Hospital, Footscray Hospital, Sunshine Hospital, Western Health – Community Mental Health, Williamstown Hospital, The	
NA	Melton Health and Community Services (MH), Sunbury Day Hospital	**NA Comment:** No incidence of pressure injuries over the preceding 12 months; Systems remain in place to capture pressure injuries. **Verified During Assessment:** Yes **Complies with AS 18/01:** No **Approved by ACSQHC:** Yes

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		
There is a formal procedure and comprehensive assessment forms that guide clinician practice. Audit data demonstrates good compliance, including screening for continence. People admitted to WH interviewed were able to report that they had a skin integrity review, felt a high level of respect was shown during the screening process, and were involved in the care planning. Complementing this has been targeted work on improving the WH healthcare experience for people with bariatric requirements. Skin integrity investigations are completed at a Divisional level and could be strengthened with the inclusion of the WH Skin Integrity experts.		
Suggestion(s) for Improvement		
Consideration is given to the formal engagement of Skin Integrity experts on Skin integrity investigations at a Divisional level.		
Rating	**Applicable HSF IDs**	
Met	Bacchus Marsh and Melton Regional Hospital, Footscray Hospital, Sunshine Hospital, Western Health – Community Mental Health, Williamstown Hospital, The	
NA	Melton Health and Community Services (MH), Sunbury Day Hospital	**NA Comment:** No incidence of pressure injuries over the preceding 12 months; Systems remain in place to capture pressure injuries. **Verified During Assessment:** Yes **Complies with AS 18/01:** No **Approved by ACSQHC:** Yes

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		
People admitted to WH facilities are provided with a WH "Your Healthcare Journey," which provides information in English on 'Preventing bed sores' that is easy to understand. Very limited pamphlet information was available across the facilities - an artefact of COVID. However, it was noted the drawing upon of good information from other jurisdictions, e.g., Aunty PIPA. WH has a contemporaneous equipment library that has a stepped process for clinical staff to access equipment and aids for people who are vulnerable to skin integrity issues and is regularly reviewed. The equipment library has descriptors of the equipment, what it is utilised for, internal management, and external providers when equipment is not available, including FMIS order details and procedural information. Staff report ease of use.		
Rating	**Applicable HSF IDs**	
Met	Bacchus Marsh and Melton Regional Hospital, Footscray Hospital, Sunshine Hospital, Western Health – Community Mental Health, Williamstown Hospital, The	
NA	Melton Health and Community Services (MH), Sunbury Day Hospital	**NA Comment:** No incidence of pressure injuries over the preceding 12 months. Systems remain in place to capture pressure injuries. **Verified During Assessment:** Yes **Complies with AS 18/01:** No **Approved by ACSQHC:** Yes

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		
WH's Falls Prevention Advisory Group reports through to the Person-Centred Care Committee underpinned by a 23/24 Falls Action Plan, which oversights WH's strategic and reactive quality improvement actions supported by a group of passionate falls champions predominantly hospital based. Secondary to the above peer average (HRT) incidence of falls, fractured NOFs, other fractures, and intracranial injury and most notably so post-COVID, there has been extensive analysis on who is falling (WH analysis indicates 53% of people who fall have a cognitive impairment) despite the fact that 90% of people admitted having a falls risk assessment (modified FRAT). There have been multiple interventions to address this mapped into the Falls Action Plan, including additional resources not just in falls expertise but in the complementary clinical specialties like continence, changes to models of care, implementation of brochures in ten different languages, and improved guidance to staff on bed rail usage. Units across WH were noted to have "non-slip socks" available and in use. Non-slip socks require careful consideration as they have the potential to harbour an infection control risk, and there is no strong or conclusive evidence in the evidence base that they contribute to fall prevention in hospitals. Staff completion of foundational training data on falls prevention was not available to Assessors, hence a recommendation made in Action 1.20.		
Rating	**Applicable HSF IDs**	
Met	Bacchus Marsh and Melton Regional Hospital, Footscray Hospital, Sunshine Hospital, Western Health – Community Mental Health, Williamstown Hospital, The	
NA	Melton Health and Community Services (MH), Sunbury Day Hospital	**NA Comment:** No incidence of pressure injuries over the preceding 12 months; Systems remain in place to capture falls. **Verified During Assessment:** Yes **Complies with AS 18/01:** No **Approved by ACSQHC:** Yes

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		
Western Health has a contemporaneous equipment library that encompasses skin integrity and falls with a stepped process for clinical staff to access equipment and aids for people who are vulnerable to falls and is regularly reviewed. The equipment library has descriptors of the equipment, what it is utilised for, internal management, and external providers when equipment is not available, including FMIS order details and procedural information. Staff report ease of use.		
Rating	**Applicable HSF IDs**	
Met	Bacchus Marsh and Melton Regional Hospital, Footscray Hospital, Sunshine Hospital, Western Health – Community Mental Health, Williamstown Hospital, The	
Rating	**Applicable HSF IDs**	
NA	Melton Health and Community Services (MH), Sunbury Day Hospital	**NA Comment:** No incidence of pressure injuries over the preceding 12 months; systems remain in place to capture pressure injuries. **Verified During Assessment:** Yes **Complies with AS 18/01:** No **Approved by ACSQHC:** Yes

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		
People admitted to WH facilities are provided with a WH "Your Healthcare Journey," which includes information in English on 'Preventing falls' and is supported by "Preventing Blood Clots," which is easy to understand. People admitted who were interviewed reported receiving this document. There was minimal pamphlet information available across the facilities, noting the WH Consumer Information Library and Falls Intranet Page have multiple Falls prevention pamphlets translated in WH top languages for download. However, the limited information available was pictorial and easy to follow, e.g., "WH Ditch the PJs and See Better Days," "Let's get dressed, get moving and get home," and brochures available in some areas in ten different languages.		
Rating	**Applicable HSF IDs**	
Met	Bacchus Marsh and Melton Regional Hospital, Footscray Hospital, Sunshine Hospital, Western Health – Community Mental Health, Williamstown Hospital, The	
NA	Melton Health and Community Services (MH), Sunbury Day Hospital	**NA Comment:** No incidence of falls over the preceding 12 months. Systems remain in place to capture falls. **Verified During Assessment:** Yes **Complies with AS 18/01:** No **Approved by ACSQHC:** Yes

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		
WH's Nutrition Advisory Group reports to the Person-Centred Care Committee underpinned by 23/24 Plan oversight of the organisation's strategic and reactive quality improvement actions supported by passionate dieticians, volunteers, and champions. Information on nutrition, hydration and wound management general and specialist training courses provided, and attendance (including in-services) were manually pulled against the number of staff and volunteers in the Volunteer Meal Assistance Program (VMAP) who had attended in-services and training. The VMAP volunteers were a very welcomed, well-respected, active group who expressed and demonstrated pride in their valuable role within WH. Feedback from people who required meal assistance was highly appreciated. A recommendation in Action 1.20 encompasses the management and reporting on organisational training. People admitted to WH facilities are provided with a WH "Your Healthcare Journey," which provides information in English on 'Your Nutrition" that is easy to understand around the importance of eating well, what to tell the nurse, and how to make sure they are eating well during their stay. Upon admission, over 60% of people are weighed with weekly weights at 84%, with the Malnutrition Screening Tool (MST) well utilised on admission for 85% of people and weekly for 89% underpinned by a clear procedure guiding staff. A PBI dashboard with regular updates reports on this for all units apart from Paediatrics was noted to be at 100%. Relevant staff complete a Dysphagia Screening Tool (DST) competency. Significant improvements have been noted, and resources have been made available with a clear plan for further innovative improvement activities in 2024.		
Rating	**Applicable HSF IDs**	
Met	Bacchus Marsh and Melton Regional Hospital, Footscray Hospital, Sunshine Hospital, Western Health – Community Mental Health, Williamstown Hospital, The	
NA	Melton Health and Community Services (MH), Sunbury Day Hospital	**NA Comment:** No patients overnight. **Verified During Assessment:** Yes **Complies with AS 18/01:** No **Approved by ACSQHC:** Yes

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		
WH has a dedicated dietetics and food support workforce, including passionate volunteers who are clearly committed to providing the correct meal / nutrition support to the right person and, where required, with support. Nutrition supplements were widely available and in use. For those people admitted to WH who are able to utilise a QR scanner on their mobile phone, they can order their hospital meal directly, and assistance is provided to those who do not have this capability. It was noted that the meal ordering system had a filter that ensured the ordering was based on individual needs and noted at the point of care. The meal tray printed advice clearly advised if there had been changes in accordance with requirements, e.g., for people with diabetes and people with dysphagia.		
Rating	**Applicable HSF IDs**	
Met	Bacchus Marsh and Melton Regional Hospital, Footscray Hospital, Sunshine Hospital, Western Health – Community Mental Health, Williamstown Hospital, The	
Rating	**Applicable HSF IDs**	
NA	Melton Health and Community Services (MH), Sunbury Day Hospital	**NA Comment:** Does not prepare and distribute food and fluids. **Verified During Assessment:** Yes **Complies with AS 18/01:** No **Approved by ACSQHC:** Yes

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
The WH Delirium and Cognition Advisory Group reports to the Person-Centred Committee. There is a 23/24 Action Plan, with notable progress against the actions and mapped to the requirements of the Delirium Clinical Care Standard. There is a dynamic Delirium CNC and Medical Lead for the entirety of WH and a number of Delirium Champions who are notable culture carriers supported by a range of procedures and work orders. Improvements are noted such as the development of electronic PBI delirium dashboard (remains work in progress at the time of assessment with notable underrepresentation of the assessments completed and a reliance on a secondary reporting system); implementation of the SQUID (Single Question to Identify Delirium) and are in the process of developing clinician side training to improve clinician skills in utilising it; the refreshment of the WH Delirium Guidelines; the development of Delirium Order set for medical staff; and updated Delirium We Learn module comprehensive care risk assessment and mapped into the IPOC. HRT data demonstrates Delirium per 10,000 episodes is 30.8 and WH was noted as 5th in the Peer comparison group. Staff completion of foundational training data on delirium was not available to Assessors. It was noted that there was a full-day training workshop run on Delirium and Cognitive Impairment during the assessment which was well attended by around 50 clinical staff. A recommendation in Action 1.20 encompasses this action. WH has an ethos of least restrictive care, which is evident through its procedures and practices and extends to the utilisation of anti-psychotics and other psycho-active medications. Consent for utilisation of these medications is via a Medical Treatment Decision Maker. The Assessors witnessed that the WH Pharmacy Departments have a thorough checking process prior to dispensing these medications, mapping to the person's 4AT and secondarily screening for interactions with current medications. The WH Delirium and Cognitive Improvement Plan 23/24 identifies work to commence in 2024 on the reconciliation of the utilisation of antipsychotics or psychoactive medications and the development of an antipsychotic dashboard for the organisation to view this. The ‘Psychotropic Medicines in Cognitive Impairment or Disability’ Clinical Care Standard, which has been under consultation in 2023 and is anticipated to be available in 2024, will provide guidance to WH on the requirements. WH monitors sedative, narcotic, and opioid utilisation via benchmarked health round table data.
Suggestion(s) for Improvement
WH develop a system that aligns with the Delirium Clinical Care Standard to capture, support, and report on appropriate prescribing of antipsychotic medicines in people with delirium at an aggregate level.

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**	
Met	Bacchus Marsh and Melton Regional Hospital, Footscray Hospital, Melton Health and Community Services (MH), Sunshine Hospital, Western Health – Community Mental Health, Williamstown Hospital, The	
NA	Sunbury Day Hospital	**NA Comment:** Does not admit patients who have cognitive impairment or are at risk of developing delirium. **Verified During Assessment:** Yes **Complies with AS 18/01:** Yes **Approved by ACSQHC:** No

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		
WH has a Delirium Guideline (May 2023) which provides clear guidance to staff with easy-to-follow Flow charts for delirium screening and management (for medical and nursing staff) and a Delirium Reference Sheet that supports the integration of people receiving health care and their loved ones into the management process, further supported by a PBI report (work in progress as noted in Action 5.29) which is refreshed at regular intervals daily. The guideline is currently silent on recompleting the 4AT for people who are in hospital for extended periods of time. A further review of the completion of the IPOC provides reassuring data that screening is being completed on people admitted to the health service. Mental Health currently sits outside of this system (secondary to a recent transfer to WH and is under an 18-month transfer process), and audits demonstrate a high level of compliance with screening. In addition, mental health services utilise an extensive array of cognitive tests, including MOCA, Addenbrook, NUCOG and RUDAS, as examples with a high level of compliance. WH has developed a very comprehensive delirium resource folder for staff. Easily understood information on Delirium is available in English in the WH “Your Healthcare Journey,” and a number of the NSW HEALTH ACI Delirium brochures were noted in pamphlet stands.		
Rating	**Applicable HSF IDs**	
Met	Bacchus Marsh and Melton Regional Hospital, Footscray Hospital, Melton Health, and Community Services (MH), Sunshine Hospital, Western Health – Community Mental Health, Williamstown Hospital, The	
NA	Sunbury Day Hospital	**NA Comment:** Does not admit patients who have cognitive impairment or are at risk of developing delirium. **Verified During Assessment:** Yes **Complies with AS 18/01:** Yes **Approved by ACSQHC:** No

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
WH has a Self-Harm and Suicide Advisory Group reporting to the Person-Centred Care Committee and underpinned by a 23/24 Plan, which is in the process of being implemented. This Group was incepted in 2019 and has made significant positive inroads into the identification, care and treatment or people at risk of self-harm and suicide. There are a number of training packages for the clinical craft groups across WH, with aggregate training data not able to be provided. A recommendation in Action 1.20 encompasses the availability of training data. A new procedure has been developed to provide easy-to-follow guidance to clinical staff on how to ask questions about screening for self-harm and suicide safely. This is in the process of being rolled out. There is a clear WH expectation that all people in the health service are asked the questions, and at the time of assessment, data indicated 88% compliance with this. There has been exceptional work completed in risk assessing and building new environments that effectively manage out, where possible, ligatures (the new mental health units) and annual ligature audits of high-risk environments with resultant risk acceptance or treatment. There is a mental health in-reach service that supports the facilities to effectively care for people who are experiencing psychological deterioration, self-harm, and suicidal ideation.

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		
WH has two HOPE Teams (Hospital Outreach Post-Suicidal Engagement), which engage and support people post-presentation to the health service to reduce the risk of further self-harm. This is a 12-week program that incorporates the development of an individualised safety plan and practical support. Information is available online and handed to people who require it.		
Rating	**Applicable HSF IDs**	
Met	Bacchus Marsh and Melton Regional Hospital, Footscray Hospital, Melton Health, and Community Services (MH), Sunshine Hospital, Western Health – Community Mental Health, Williamstown Hospital, The	
Rating	**Applicable HSF IDs**	
NA	Sunbury Day Hospital	**NA Comment:** Does not admit patients who are at risk of self-harm or suicide. **Verified During Assessment:** Yes **Complies with AS 18/01:** No **Approved by ACSQHC:** Yes

ACTION 5.33	
The health service organisation has processes to identify and mitigate situations that may precipitate aggression	
Comments	
WH has an OVA Advisory Group, which works closely with the Restrictive Practice Advisory Group and reports to the Person-Centred Care Committee. There was clear procedural guidance to staff and a culture of least restriction across WH through all clinical areas underpinned by a de-escalation ethos to manage acute behavioural disturbance. WH has recently recruited a senior OVA Clinical Consultant (neuro psychologist) to further enhance work in this space. OVA training is one of the four current mandatory training courses required for staff attendance, and WH training rates at the time of assessment were 83% (100% for security staff). It was also noted that there had been further extensive training of security staff working with clinical teams to manage acute behavioural disturbance and a recruitment and onboarding process to ensure security personnel were able to work effectively within the culture. WH hosted an OVA conference which was well attended, focusing on culture challenges, and increasing empathy. WH has been externally recognised for their work in OVA, winning multiple WorkSafe and Victorian Public Health Awards since 2019.	
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		
WH has a well-trained workforce, including security staff, supported by an exceptional workplace culture and innovation to enable the early identification of people at risk of or exhibiting signs of acute behavioural disturbance. The Safewards program, typically the domain of mental health services, is in the observable process of being implemented into medical wards in partnership with Melbourne University to support the management of the environment and recognition and response of acute behavioural disturbance. The implementation of Safewards in medical wards appears to be a first. There is good data around Code Grey and Black, and there has been an increase in planned Code Greys and a significant decrease in unplanned Code Greys. There are well-embedded models of care to support the clinical environment, noting the utilisation of BOC (Behaviours of Concern) in the Emergency Departments for seven years. WH has significantly focused on the newly built environment to enhance the inpatient unit ambience. The new mental health unit on the Sunshine Hospital site is an exemplar model of this with mood lighting, mood music, sensory rooms, well-considered common spaces, light, activity rooms, window seats, break-out spaces, etc.		
Rating	**Applicable HSF IDs**	
Met	Bacchus Marsh and Melton Regional Hospital, Footscray Hospital, Melton Health and Community Services (MH), Sunshine Hospital, Western Health – Community Mental Health, Williamstown Hospital, The	
NA	Sunbury Day Hospital	**NA Comment:** Does not admit patients who are at risk of aggressive or violent behaviour. **Verified During Assessment:** Yes **Complies with AS 18/01:** No **Approved by ACSQHC:** Yes

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		
WH Reducing Restrictive Interventions Advisory Group (new Advisory Group with two meetings to date) oversees WH's reduction, monitoring and response to restraint utilisation across the organisation and reports performance to the Person-Centred Care Committee. There is a draft 23/24 Plan that guides this Committee. Multiple procedures guided staff around managing restraint in WH care settings. These were titled (not a complete list): Chemical Restraint under the Mental Health Act 2022; Physical Restraint under the Mental Health Act 2022; Mechanical Restraint under the Mental Health Act 2022; Urgent Physical Restraint under the Mental Health Act 2022; Management of Clinical Aggression Procedure; Management of acute arousal 18-65 years – Guideline; Adult and Youth Acute Inpatient Clinical Risk Assessment and Management (CRAM) Guideline; Restrictive Interventions – Mechanical, Physical, Chemical Restraint Procedure; and Mental Health Nursing Practice Guide in the use of Restrictive Interventions. The relevant documents reference the legislation that is in application. Members of the Committee advised that it is early days for the Committee, and a plan is being developed to include improved reporting on chemical restraint. Restraint incidents across the organisation are reported via RiskMan through the Reducing Restrictive Interventions Committee and the Person-Centred Care Committee. Staff completion of foundational training data on acute behavioural disturbance was not available to Assessors, except for security, which demonstrates a very high level of training completion. A recommendation in Action 1.20 encompasses this action.		
Suggestion(s) for Improvement		
Consideration is given to aggregating the number of restraint procedures to simplify guidance to staff.		

Rating	**Applicable HSF IDs**	
Met	Bacchus Marsh and Melton Regional Hospital, Footscray Hospital, Melton Health and Community Services (MH), Sunshine Hospital, Western Health – Community Mental Health, Williamstown Hospital, The	
NA	Sunbury Day Hospital	**NA Comment:** Does not use restrictive practices (restraint). **Verified During Assessment:** Yes **Complies with AS 18/01:** Yes **Approved by ACSQHC:** No

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		
WH's Reducing Restrictive Interventions Advisory Group (new Advisory Group with two meetings to date) oversights Western Health's reduction, monitoring, and response to seclusion utilisation across the organisation, and reports performance to the Person-Centred Care Committee. During the Assessment, the procedure that provides guidance to staff was amended to include seclusion under the Mental Health and Wellbeing Act 2022 to encompass seclusion across the entirety of the organisation, noting seclusion being reported in small numbers outside of the mental health units. There is clear guidance to staff that seclusion is an intervention of last resort. Seclusion is being reported and recorded in different places, notably RiskMan and for the Mental Health services through to Royal Melbourne (secondary to the recent devolvement of mental health services to Western Health – 1/7/23 - with a structured 18-month transfer of responsibilities to Western Health) and through to the Office of the Chief Psychiatrist. It is noted that the recent transfer from the adult mental health units to a purpose-built building has seen a significant decrease in seclusion.		
Rating	**Applicable HSF IDs**	
Met	Bacchus Marsh and Melton Regional Hospital, Footscray Hospital, Melton Health and Community Services (MH), Sunshine Hospital, Western Health – Community Mental Health, Williamstown Hospital, The	
NA	Sunbury Day Hospital	**NA Comment:** Non gazetted service, does not use seclusion. **Verified During Assessment:** Yes **Complies with AS 18/01:** Yes **Approved by ACSQHC:** No

Standard 6 - Communicating for Safety

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

ACTION 6.01	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication	
Comments	
Western Health has policies, procedures and guidelines that facilitate appropriate communication and handover among clinicians, patients, family, and carers. The Western Health Communicating for Safety (CFS) Committee is multidisciplinary and has a Consumer representative designated in the Terms of Reference. The CFS provides appropriate governance for this standard and reviews data and reports tabled at the Best Care Steering Committee. This closes the loop through the Executive, Quality and Safety to the Board. Training is conducted via the electronic WeLearn education system and face-to-face, where required. The training provided supports applicable information being discussed and disseminated during the handover. Clinical and non-clinical staff could describe to Assessors the patient identification, communication, and handover process. Patients, family, and carers could articulate the process and why they were asked about identification so many times while in hospital.	
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
The RiskMan system is utilised for identifying and reporting incidents involving communication issues and is reviewed by the CFS Committee. Incident and Consumer feedback themes are monitored at a local level and used to drive local quality improvement activities. The 'Knowing How We Are Doing' Boards were visible across Western Health and provide staff, patients, family, and carers with information on relevant data, quality improvement projects, and audit results. Handover audit data viewed on SharePoint reported that 80-85% of patients who want to be involved in handover feel involved and supported. Quality Improvement projects have been initiated following communication incidents and feedback to improve the overall communication process. The new 'Patient Communication Board' were evident at most bedsides, with Maternity bedside communication boards being developed to suit this cohort of patients. Assessors spoke to several patients who were unaware they could write on the Communication Boards themselves. Recent audits have reported that the Patient Communication Boards are not being utilised as well as they could, so education and training continue to improve this situation. Consumer information was evident and available in different languages appropriate to the cultural profiles of Western Health.
Suggestion(s) for Improvement
The observational and documentation audits are large, and it is difficult to track trends and normal variation, when data is not displayed in graphical form. It is suggested that data on the 'Knowing How We Are Doing' Boards is presented as trended data charts (incident / result per 1000 bed days), instead of the raw numbers per month. Continue the quality improvement process to improve the understanding and use of the Patient Communication Boards by Consumers, family, and carers.

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	
Western Health has communication policies, procedures, and guidelines (PPG), including the Identify, Situation, Background, Assessment, Request (ISBAR) process to involve patients in their care. Patient Communication Boards further support the development and documentation of the patient's goals. Consumers interviewed by Assessors expressed feeling suitably involved in decision-making about their personal goals and felt empowered to ask questions and have discussions with all staff. Assessors spoke with patients, families, and carers who reported that they felt well-informed and comfortable making informed decisions about their care or their baby or child's care. The evolving EVE App in maternity encourages the dissemination of evidence-based information and assists with internal communication between pregnant mothers and Western Health.	
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	
Western Health PPGs describe where, along the patient journey, positive patient identification and procedure matching processes need to be undertaken, relaying critical information and risks, particularly between multidisciplinary teams. Effective communication is supported by these policies and procedures being embedded into practice. The Western Health' Your Healthcare Journey Booklet' was evident at many patient bedsides, with 'Communicating with Us' and 'Making Decisions Together' understood by patients, family, and carers interviewed by Assessors. Communicating Critical Information is clearly articulated in the Patient's Journey diagram, which staff could describe to Assessors. Assessors observed identification and procedure matching during a patient's admission, at handover and when a patient was transferred within the hospital. The Surgical team time-out is also clearly defined. Assessors observed good 'time outs' in theatres, with the surgeon leading the time-out process and all staff actively participating. The documentation audits confirm that processes are well established.	

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	
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	
Western Health PPGs describe the three approved identifiers for procedure matching, which was observed to be followed by Western Health staff. Gender diverse considerations have also been included, and the EMR includes pronouns and 'preferred' / 'known as' names. Clinical and non-clinical staff could accurately outline to Assessors when correct identification and procedure matching are required, and patients, family and carers confirmed that their wristbands were regularly checked by staff. The Assessors also noted patient wristband scanning where the EMR is in place. Photo Identification (with consent) is also utilised for dialysis, mental health, and aged care patients. Assessors observed Western Health staff checking the patient identifiers prior to commencing health appointments (including Dental services), on admission to outpatient clinics, day procedure, Radiology, during theatre time out, at nursing bedside handovers and prior to iron infusions, blood and medication administration.	
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
Assessors noted the use of approved patient identifiers, as outlined in Action 6.05. Additionally, processes are in place for surgical / procedural time-out, documented in the EMR, where available, and audited. Assessors observed time out in the Operating Theatres, and the process was completed as best practice on all occasions. Documentation audits of the surgical checklist and surgical time outs are undertaken, with good compliance across all areas. Data viewed on SharePoint indicating close to 100% compliance. Patient identification was also witnessed at the transfer of care into the operating theatre and medication administration across the hospital. All interactions followed policy, and staff could discuss this with the Assessment team.

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
Western Health PPGs describe the minimum data or information to be included in the handover. Handover documentation is also required to contain relevant risks, the patient's needs, and the names of the clinicians involved in the handover. ISBAR format is utilised at Western Health for clinical handovers, with education commencing for all staff during the induction and orientation process. A variety of Western Health staff could explain to the Assessors their respective roles in clinical handover and the processes they used to support this, including the minimum information communicated at clinical handover to maintain patient safety. Clinical handovers are audited in various ways, including observational audits, with SharePoint data demonstrating good compliance.

Rating	Applicable HSF IDs
Met	All

ACTION 6.08
Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care
Comments
Several Assessors observed handovers across Western Health sites, with clinicians using the EMR, where available, to facilitate the process. Bedside handovers, multidisciplinary team meetings and ward rounds observed by Assessors showed clinicians engaging well with patients, their families, and carers. They provided patients and family members, where appropriate, with an opportunity to talk about goals of care and future decision-making options. To highlight critical patient safety concerns, a quality improvement project has been initiated to embed The Daily Operating System (DOS) / tiered huddles and Team Leader Huddles. The bedside 'Patient Communication Boards' provide a place to document patient's goals. The boards have not been embedded, with some patients, families, and carers unsure whose responsibility it was to write on the board. A quality improvement project is underway, with ongoing education and training to improve the understanding and usage of the Patient Communication Boards across Western Health. Clinical handover is audited regularly, and incidents relating to ineffective handover are investigated with results displayed on the 'Knowing How We Are Doing' Boards for staff, patients, family, and carers to review. Interpreters were noted to be utilised across Western Health for CALD consumers, and information was available in a multitude of languages. The timeliness of discharge summaries within 48 hours has been identified as an issue by Western Health, with a quality improvement project looking at Medical Discharge Summaries underway to improve this KPI.

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
The Western Health Communicating for Safety Policy guides staff in effective communication and the handover of critical information, including risks and alerts, through various processes, including safety huddles, clinical handovers, and multidisciplinary team meetings. Both staff and patients could describe to Assessors how this worked and how patients, their families and carers were involved when requested or required. Recent documentation audits observed by Assessors on SharePoint reflect evidence of shared decision-making with the consumer across the organisation. Multidisciplinary Western Health staff reported to Assessors that the implementation of the EMR has provided a higher level of visibility around critical information and alerts to all staff across sites. Two sites without the EMR currently utilise the iPM to document critical information and alerts.

Rating	Applicable HSF IDs
Met	All

ACTION 6.10
The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians
Comments
Documentation reviewed by the Assessors across Western Health illustrates how communication processes are in place for patients, families, and carers to directly communicate critical information and risks about care. The Western Health 'Call for HELP' program was understood by patients, family and carers who spoke to Assessors, with relevant posters displayed in clinical areas and the contact number visible on the bedside Patient Communication Boards. Patients and families interviewed during this Assessment spoke of confidence that the clinical staff on the ward would listen and respond to any concerns raised. For longer-stay patients, multidisciplinary family meetings are often used to provide an opportunity to update and share information. The Allied Health Project for Autism Spectrum Disorder (ASD) families enables safer and more compassionate care whilst in the hospital.

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	
Western Health uses an electronic admission system for patient registration where patients can identify any allergies or alerts prior to admission. Western Health has processes to communicate critical information, alerts, and risks effectively. Staff reported to the Assessors that the implementation of the EMR has helped facilitate communication of this critical information, and Assessors noted the high visibility of alerts within the EMR. 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. Comprehensive clinical documentation audits are conducted, and results have been improved since the rollout of the EMR. The Assessors noted the requirement to scan some medical records and the organisation's risk mitigation strategies to ensure correct procedure matching of the paper-based and electronic medical records.	
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	
Western Health policies and procedures are in line with safety and quality systems for blood management. There are systems in place to manage risks associated with blood management. Various training modules are available for medical and nursing / midwifery staff. The transport of blood has been reviewed, and Western Health has developed a system of collection with buckets to enable the supply trail to be transparent and to reduce the length of time from collection to administration. Observation of the administration of blood occurred during this Assessment, and the nursing staff could demonstrate that they had received training. The scope of practice is also tested through the checking process.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.02	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of the blood management system b. Implementing strategies to improve blood management and associated processes c. Reporting on the outcomes of blood management	
Comments	
Western Health monitors its blood management process via a dashboard, which includes clinical incidents, appropriateness and documentation audit, and wastage benchmarking. Reports are tabled and discussed at the Blood Management Committee.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.03	
Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Comments	
Western Health provides patients with information before receiving blood / blood products. There is access to interpreters to enable information to be provided, and this process is also used to gain consent for those who do not have English as a first language. An observational audit during this Assessment involved a young woman with her mother, who did not speak English. A review of the chart demonstrated that interpreters and family members have been utilised to gather concerns and provide information as required. Other patients interviewed could describe the involvement in care and knowledge of blood products being used.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.04	
Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products by: a. Optimising patients' own red cell mass, haemoglobin and iron stores b. Identifying and managing patients with, or at risk of, bleeding c. Determining the clinical need for blood and blood products, and related risks	
Comments	
Western Health guidelines support the management of appropriate use of blood / blood products. The Blood Management Committee monitors utilisation with action plans to target areas to minimise wastage or inappropriate use. Cell salvage is rarely used and is via an external contractor.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.05	
Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record	
Comments	
The Assessors reviewed a limited number of transfusion records in the clinical records and found evidence to support the effective documentation of decision-making and transfusion details. This is supported by a regular audit of transfusion records, undertaken by a Clinical Nurse Consultant with oversight by the governance committee.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.06	
The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria	
Comments	
Western Health has a sound understanding of the national guidelines and criteria.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.07	
The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria	
Comments	
Policies and processes are in place to support compliant reporting of adverse events related to transfusions. These are monitored and reported through RiskMan. Any adverse events related to blood / blood product transfusion are monitored through the Blood Management Committee.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.08	
The health service organisation participates in haemovigilance activities, in accordance with the national framework	
Comments	
Western Health participates in the state-wide Blood Matters Program Serious Transfusion Incident Reporting (STIR) system.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.09	
The health service organisation has processes: a. That comply with manufacturers' directions, legislation, and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer	
Comments	
Storage, distribution, and management of blood / blood products are trackable and compliant with legislative and regulatory requirements. Fridge storage is temperature-monitored with contingency plans for any deviation from optimal temperature. Incidents are reported via the organisation's incident management system, RiskMan.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 7.10	
The health service organisation has processes to: a. Manage the availability of blood and blood products to meet clinical need b. Eliminate avoidable wastage c. Respond in times of shortage	
Comments	
Massive Transfusion Protocol is available. Processes are in place to respond to shortages with LifeBlood. The Blood Management Committee monitors blood / blood product wastage, and an action plan is in place to reduce wastage. Using buckets to transport blood is one such initiative to reduce wastage. There are alerts for supply issues.	
Rating	**Applicable HSF IDs**
Met	All

Standard 8 - Recognising and Responding to Acute Deterioration

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

ACTION 8.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration
Comments
WH has a range of policies and procedures to support the workforce in recognising and responding to clinical deterioration. Identified risks are added to the WH Deteriorating Patient Committee (DPC) risk register. These risks are evaluated as required and escalated to the WH Risk Register. The DPC committee reports to the WH Safe Care Committee. Training is mandatory for all staff with the current compliance for Basic Life Support (BLS) rate of 86% (Action 1.20). Those staff attending Medical Emergency calls are required to complete the Advanced Life Support (ALS) training for both adults and paediatrics.
Suggestion(s) for Improvement
• To review the current DPC Terms of Reference to include monitoring of Mental Health issues (episodes, referral, transfer out) as part of the committee KPIs. • There is a lot of innovation currently being undertaking including changes to the BLS training, consider how to reflect this in WH policy, procedures and guidelines, examples include the First Three Minutes training. • Recognising that compliance to training has been difficult to establish, including the rates of The First Three Minutes, BLS and ALS reports into DPC.

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
WH presented several quality improvement initiatives to demonstrate that an active quality improvement program had been established. All Code Blues are routinely reviewed following each episode using the Response Blue Record. Recognising that there is a prompt box to support the recognition of the Not for Resus (NFR), consider adding a box to identify if the patient has an Advanced Care Plan (ACP). This also provides another layer for compliance monitoring for Action 5.17 (The health service organisation has processes to ensure that current advance care plans are in place). Recognising that this process should be captured on the NFR form may not be evident at the time of signing the NFR form.
Suggestion(s) for Improvement
• Consider Code Blue as part of the DPC audit schedule; this to include notification of significant contacts / relatives that a Code Blue has occurred. • Consider adding status if the patient has an ACP into the prompt box to inform the calling of a Code Blue.

Rating	Applicable HSF IDs
Met	All

ACTION 8.03
Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Comments
Documents reviewed demonstrate a process that supports partnering with consumers in recognising and responding to acute deterioration. This process includes involving patients in care planning and during handover to ensure they are well informed and engaged in shared decision-making to meet their goals of care. Interviews with staff and patients confirmed that patients are actively involved in planning and making decisions about managing acute deterioration. The Assessors observed many examples of shared decision-making during the assessment, supported by interviews with clinicians and patients.

Rating	Applicable HSF IDs
Met	All

ACTION 8.04
The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient
Comments
Vital signs are monitored according to policy using a Human Factor designed observation chart to highlight monitoring parameters. The EMR provides an electronic system incorporating human factor principles, including adjusted escalation processes with ordered modification of vital signs. Observations are undertaken in response to each patient's individual circumstances, and the chart highlights potential clinical deterioration and the need for escalation / intervention. The EMR is an excellent initiative as this system provides instant reception of changes to vital sign parameters. Regular auditing demonstrated good compliance with the completion of these documents. Staff training on using these charts, both hard copies and electronic, commences at orientation.

Rating	Applicable HSF IDs
Met	All

ACTION 8.05
The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d. Determine the required level of observation e. Document and communicate observed or reported changes in mental state
Comments
Policies and procedures support staff in identifying acute deterioration in mental state, including the risk of delirium. Assessment and care planning documentation reviewed by the Assessors also supported that assessment drives the establishment of individualised and appropriate management plans for patients with acute mental deterioration and / or delirium. It is evident that a lot of work has been completed to meet the requirements of Advisory AS 19/01. Recognising and responding to acute deterioration standards: recognising deterioration in a person's mental state.

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
Suggestion(s) for Improvement
DPC considers the current monitoring arrangement for Mental Health Training to include other mental health-specific training other than cognitive impairment.

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
EMR system, and where a hard copy record is kept, is designed to capture agreed vital signs parameters. Specialities are able to adjust the parameters, as required, to support the identification and management of acute physiological and mental status, pain and / or distress and concerns raised by staff, patients, carers, and families through clinical documentation audits. The incident management system and clinical review, inclusive of MET Calls systems, further strengthen the monitoring of escalation of care.

Rating	Applicable HSF IDs
Met	All

ACTION 8.07	
The health service organisation has processes for patients, carers or families to directly escalate care	
Comments	
Processes are in place for patients, carers, or families to escalate care directly. The "Call for Help" program is a noteworthy program with patient information of this process on admission with prompts to the process in the WH "Your Healthcare Journey" book and posters on the patient bedside board. All calls are monitored, and categories are used for themes and trends. The DPC actively monitors the process.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.08	
The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance	
Comments	
The policy for escalation of care is clear and provides direction for staff to escalate care and respond to a clinical emergency, supported by the WH Emergency Response Team. Staff could describe this process, and the Assessors were provided with documentation to support the evaluation of these processes.	
Rating	**Applicable HSF IDs**
Met	All

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 WH's policy. Reports provided to the Assessment team 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. Staff interviewed across sites could describe when and how they would escalate care. Assessors were present when care was escalated and witnessed a timely response.	
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	
WH provides access to clinicians with ALS skills and competency with onsite trainers. All staff that attend Code Blue responses have ALS training. Staff are trained in the use of the Emergency trolley as a first response with simulation training being rolled out to support clinicians to know what to do in the first three minutes.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.12	
The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated	
Comments	
Interviews with clinicians confirmed the process for timely referral to mental health services to ensure that these referrals can meet the needs of patients whose mental state has acutely deteriorated. Staff were able to articulate the referral process for these patients. The requirements of Advisory AS 19/01 Recognising and responding to acute deterioration standards: recognising deterioration in a person's mental state have been met.	
Rating	**Applicable HSF IDs**
Met	All

ACTION 8.13	
The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration	
Comments	
Policies and procedures are in place for the timely referral to specialist care for patients who physically deteriorate. Staff were able to explain these processes to members of the Assessment Team, and the effectiveness of escalation of care processes is monitored through the DPC.	
Rating	**Applicable HSF IDs**
Met	All

Recommendations from Previous Assessment

NIL

NS2.1 Short Notice Final Assessment

Final Assessment Report

Western Health

Footscray, VIC

Organisation Code: 210024
Health Service Organisation ID: F7070026
Assessment Date: 14 March 2024

Accreditation Cycle: 1

Contents

Introduction

The Australian Council on Healthcare Standards
The Australian Council on Healthcare Standards (ACHS) is Australia's leading healthcare assessment and accreditation provider. ACHS is an independent, not-for-profit organisation dedicated to improving quality and inspiring excellence in health care. We accredit organisations according to either government standards, or our own established standards.

ACHS is approved to accredit the following standards

- National Safety and Quality Health Service (NSQHS) Standards including the Multi-Purpose Services Aged Care Module (MPS Module)
- National Safety and Quality Digital Mental Health (NSQDMH) Standards
- National Safety and Quality Primary and Community Healthcare (NSQPCH) Standards
- National Clinical Trials Governance Framework
- Royal Australian College of General Practitioners (RACGP) Standards for general practices (5th edition) and the RACGP Standards for point-of-care testing (5th edition)
- National Standards for Mental Health Services (NSMHS)
- Rainbow Tick Standards
- EQuIP Standards

Currently there are more than 1,600 healthcare organisations, including their associates, that undertake ACHS assessment and quality improvement programs. ACHS are proud to accredit the majority of all public and private hospitals in Australia.

With representation from governments, consumers and peak health bodies from throughout Australia, ACHS works with healthcare professionals, consumers, government and industry stakeholders to implement healthcare accreditation programs.

ACHS offers a variety of services including accreditation, education and training, data and benchmarking and consulting. We take a partnership approach to continuous improvement, tailored to the needs of individual services and health systems, using our expertise in accreditation, standards development and education.

Australian Commission on Safety and Quality in Health Care
The Australian Commission on Safety and Quality in Health Care (Commission) leads and coordinates national improvements in healthcare safety and quality. It works in partnership with patients, carers, clinicians, the Australian, state and territory health systems, the private sector, managers and healthcare organisations to achieve a safe, high-quality and sustainable health system.

Key functions of the Commission include developing national safety and quality standards, developing clinical care standards to improve the implementation of evidence-based health care, coordinating work in specific areas to improve outcomes for patients, and providing information, publications and resources about safety and quality.

The Commission works in four priority areas:

1. Safe delivery of health care
2. Partnering with consumers
3. Partnering with healthcare professionals
4. Quality, value, and outcomes

The Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme
Under the National Health Reform Act 2011, the Commission is responsible for the formulation of standards relating to health care safety and quality matters. This includes formulating and coordinating the Australian Health Service Safety and Quality Accreditation Scheme (the AHSSQA Scheme), which provides for the national coordination of accreditation processes.

The AHSSQA Scheme sets out the responsibilities of accrediting agencies in relation to implementation of the following safety and quality standards:

- National Safety and Quality Health Service (NSQHS) Standards including the Multi-Purpose Services Aged Care (MPS) Module
- National Safety and Quality Digital Mental Health (NSQDMH) Standards
- National Safety and Quality Primary and Community Healthcare (NSQPCH) Standards, and
- Any other set of standards that may be developed by the Commission from time to time

The National Safety and Quality Health Service (NSQHS) Standards were developed by the Commission in collaboration with the Australian Government, states and territories, the private sector, clinical experts, patients, and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met.

There are eight NSQHS Standards, which cover high-prevalence adverse events, healthcare associated infections, medication safety, comprehensive care, clinical communication, the prevention and management of pressure injuries, the prevention of falls, and responding to clinical deterioration. Importantly, the NSQHS Standards have provided a nationally consistent statement about the standard of care consumers can expect from their health service organisations.

Rating scale definitions

Whenever the NSQHS Standards (2nd ed.) are assessed, actions are to be rated using the rating scale outline below:

Rating	Description
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. If there are no not met actions across the health service organisation, actions rated met with recommendations will be assessed during the next assessment cycle. **Met with recommendations may not be awarded at two consecutive assessments where the recommendation is made about the same service or location and the same action. In this case an action should be rated not met.** In circumstances where one or more actions are rated not met, the actions rated met with recommendations at initial assessment will be reassessed at the final assessment. If the action is not fully met at the final assessment, it can remain met with recommendations and reassessed during the next assessment cycle. If the organisation is fully compliant with the requirements of the action, the action can be rated as met.

Rating	Description
Not met	Part or all of the requirements of the action have not been met.
Not applicable	The action is not relevant in the service context being assessed. The Commission's advisory relating to not applicable actions for the health sector need to be taken into consideration when awarding a not applicable rating and assessors must confirm the action is not relevant in the service context during the assessment visit.

For further information, see Fact sheet 4: Rating scale for assessment

Repeat Assessment

If a health service organisation has 16 or more percent of assessed actions **rated not met and /or met with recommendations**, and /or more than 8 actions from the Clinical Governance Standard not met at initial assessment and is subsequently awarded accreditation, the organisation is required to undertake a further assessment within six months of the assessment being finalised. All actions rated not met or met with recommendations from the initial assessment will be reassessed. The aim of the reassessment is to ensure the organisation has fully embedded the necessary improvements in their safety and quality systems to maintain compliance with the NSQHS Standards. This is a one-off assessment with a remediation period of 60 business days. **All actions must be met when the assessment is finalised for the organisation to retain its accreditation.**
For further information, see Fact Sheet 3: Repeat assessment of health service organisations

Safety and Quality Advice Centre and Resources

The Advice Centre provides support for health service organisations, assessors, and accrediting agencies on NSQHS Standards implementation, the Primary and Community Healthcare Standards, the Digital Mental Health Standards, the National General Practice Accreditation (NGPA) Scheme, the National Pathology Accreditation Scheme, and the National Diagnostic Imaging Accreditation Scheme.
Telephone: 1800 304 056
Email: AdviceCentre@safetyandquality.gov.au
Further information can be found online at the Commission's Advice Centre via https://www.safetyandquality.gov.au/

Authority to act as an Accrediting Agency

I, Dr Karen Luxford, CEO of the Australian Council on Healthcare Standards (ACHS) declare that ACHS has the approval from the Australian Commission on Safety and Quality in Health Care to conduct assessment to the *NS2.1 Short Notice Final Assessment*. This approval is current until 31st December, 2024.

Under this authority, ACHS is authorised to assess health service organisations against the Australian Health Service Safety and Quality Accreditation Scheme.

Conflicts of Interest

I, Dr Karen Luxford, declare that ACHS has complied with Australian Commission on Safety and Quality in Health Care policy on minimising and managing conflicts of interest.

No conflicts of interest were evident as part of this assessment and no Consultants or third parties participated in this assessment.

Conflict of Interest Resolution

Nil.

Dispute Resolution

Nil.

Assessment Team

Assessor Role	Name	Declaration of independence from health service organisation signed
Assessor	Jordan Kelly	Yes
Lead Assessor	Peter Clout	Yes

Assessment Determination

ACHS has reviewed and verified the assessment report for Western Health. The accreditation decision was made on 20/03/2024 and Western Health was notified on 20/03/2024.

Executive Summary

On 14/03/2024, Western Health underwent an NS2.1 Short Notice Final Assessment. Below is a summary of the Health Service Facilities (HSFs) that were reviewed as part of this assessment:

Health Service Facility Name	HSF Identifier	Delivery Type
Bacchus Marsh and Melton Regional Hospital	100039	On Site
Footscray Hospital	100662	On Site
Melton Health and Community Services (MH)	O100168	On Site
Sunbury Day Hospital	101813	On Site
Sunshine Hospital	100672	On Site
Western Health – Community Mental Health	F707002606	On Site
Williamstown Hospital, The	100674	On Site

Summary of Recommendations Subject to the Final Assessment

Facilities(HSF IDs)	Initial Assessment MwR	Initial Assessment NM
Bacchus Marsh and Melton Regional Hospital-100039	1.20	1.24
Footscray Hospital-100662	1.20	1.24
Melton Health and Community Services (MH)-O100168	1.20	1.24
Sunbury Day Hospital-101813	1.20	1.24
Sunshine Hospital-100672	1.20	1.24
Western Health – Community Mental Health-F707002606	1.20	1.24
Williamstown Hospital, The-100674	1.20	1.24

The final assessment was conducted for Western Health on 14/03/2024. The following report outlines the assessment team's findings.

General Discussion

This final assessment was conducted on site by two assessors over a single day. It was clear to assessors that considerable work had occurred to address issues raised with both of the recommendations. Senior staff interviewed reported favourably on the benefits and improvements derived from the recommendations. Relevant policy and system review had occurred in response to both recommendations and the organisation would appear to be well positioned to sustain appropriate practices consistent with the intent of the actions related to credentialling and mandatory training.

Assessor Findings at Final Assessment

Below is a summary of the findings of the assessment team.

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

Initial Assessment Comments	**Initial Assessment Recommendation(s) / Risk Rating & Comment**
It was not evident to Assessors how the foundation training (which incorporates a range of education relevant to the National Standards) was monitored and reported through the governance structure. There was limited visibility of foundation training completion rates at the organisational level. The component of the action the recommendation relates to is (d) monitoring the workforce's participation in training.	**Rating:** Met with Recommendation **Applicable:** Bacchus Marsh and Melton Regional Hospital, Footscray Hospital, Melton Health, and Community Services (MH), Sunbury Day Hospital, Sunshine Hospital, Western Health – Community Mental Health, Williamstown Hospital, The **Recommendation:** Review how foundation training is monitored and implement a process integrated into the clinical governance structure to provide assurance of training completion. **Risk Rating:** Moderate

Final Assessment Comments
The training requirement policy and procedure have been reviewed and updated. Significant work has been done on the reporting output which now enables organisation-wide visibility of training aligned to National Standards. Reporting arrangement ensures that contemporaneous data on compliance with mandatory and foundational training is provided to the Best Care Steering Committee, and the Board Quality and Safety Committee.

Final Assessment Rating	**Applicable**
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

Initial Assessment Comments	Initial Assessment Recommendation(s) / Risk Rating & Comment
Current theatre lists across all sites were reviewed, and a random sample of 14 surgeons and anaesthetists was selected. Checks against the credentialling system identified two exceptions where credentialling had expired and were in a recredentialling process. In the other case, initial credentialling documentation had not been formally endorsed. Upon further review by WH, it was identified that there were 35 non-compliant medical practitioners with a system issue requiring the Head of Department to approve the initiation of the recredentialling process believed to be a contributing factor. Upon identification of the issue, WH undertook an immediate review process with the Chief Medical Officer signing off on interim credentialling for 21 practitioners. The review identified five were already credentialled but not reflected on the system. The Assessors were advised the remaining nine practitioners will not practice until credentialling is approved. A review of significant incidents was undertaken with WH, confirming none linked to the clinicians with expired credentialling. Based on the actions taken and assurance provided, the risk is rated as high.	**Rating:** Not Met **Applicable:** All **Recommendation:** 1. Complete a thorough review process to ensure that all clinicians, where required, are credentialled with a current scope of practice in a timely manner. 2. Review the credentialling system and process to ensure there are mechanisms to identify and escalate non-compliance risk, including periodic reporting and monitoring through the clinical governance structure. **Risk Rating:** High

Final Assessment Comments
Assessors confirmed that significant review of credentialling data has occurred. Obsolete information has been removed so that current records and active data bases relate to current clinicians. The credentialling process has been streamlined with a series of checkpoints and escalation interventions to ensure a smooth workflow related to the recredentialling system. Assessors sighted the electronic system and data base which clearly indicated relevant dates and alerts to ensure integrity of the process. Regular meetings review credentialling status with reports being provided to the MAC, the CEO, and to the Board Quality and Safety Committee. Assessors randomly reviewed selected clinician data to confirm process. Ongoing review of the Cgov system is occurring and Western Health is planning benchmarking activities with similar Victorian Health services which are also using Cgov to drive further improvement. Random auditing practices are also in place.

Final Assessment Rating	Applicable
Met	All

Summary of Accreditation Status

A summary of the Accreditation awarded is outlined in the below table:

Health Service Facility Name	HSF Identifier	Accreditation Status
Bacchus Marsh and Melton Regional Hospital	100039	3 years Accreditation
Footscray Hospital	100662	3 years Accreditation
Sunshine Hospital	100672	3 years Accreditation
Williamstown Hospital, The	100674	3 years Accreditation
Sunbury Day Hospital	101813	3 years Accreditation
Western Health – Community Mental Health	F707002606	3 years Accreditation
Melton Health and Community Services (MH)	O100168	3 years Accreditation