

Private Health Facilities (Standards) Notice

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| Compliance self-assessment tool | Facility Name: [insert facility name] |
| Purpose of tool Licenced hospitals and day hospitals in Queensland must comply with the requirements of all standards made under the *Private Health Facilities (standards) Notice*, which is made under the *Private Health Facilities Act 1999 (Qld)* (the Act).  This is separate from a facility’s obligation to be accredited against the National Safety and Quality Health Service (NSQHS) Standards. Although several of the Queensland standards are covered by the NSQHS, accreditation is not a substitute for compliance with the legal requirements under Queensland law.  This tool is designed to assist private health facilities to provide evidence to demonstrate their compliance with the requirements of the Queensland standards. | |
| Instructions The tool is divided into the ten standards made under the Act. Each standard has multiple criteria that are required to be satisfied for a facility to comply with that standard.  *Step 1*  For each criteria listed under a standard, indicate whether your facility is compliant or not with the requirements of that criteria by placing the appropriate rating in the ‘Compliance Status’ column - a C for compliant, NC for non-compliant, or N/A if a criteria is not applicable to your facility,  *Step 2*  For each criteria with which the facility is compliant, list details of how the criteria is complied with in the ‘Evidence of Compliance’ column. Examples of suitable evidence are provided for some criteria.  NOTE: Relevant NSQHS actions are highlighted next to the name of each standard. Evidence used to demonstrate compliance with these NSQHS action is often also acceptable evidence to meet the Qld standards.  For more examples of evidence go to <https://www.safetyandquality.gov.au/sites/default/files/migrated/National-Safety-and-Quality-Health-Service-Standards-Accreditation-Workbook.pdf> | |

| **Continuous quality improvement standard (version 4) NSQHS Action 1.1, 1.4, 1.7, 1.8, 1.3, 1.10, 1.11, 1.13** | | | |
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|  | Compliance statusC - CompliantNC - Non-compliantN/A - Not applicable | Evidence of compliance | Assessment of evidence(PHRU to complete) |
| 1. The licensee complies with conditions of the licence:  * Prior to receiving certification from a quality assurance entity, a quality policy must be prepared for the facility and implemented by the licensee. |  | Provide date of last accreditation inspection:  Provide date of next accreditation inspection: |  |
| 1. Processes and mechanisms are established to:  * implement any recommendations made by the Chief Health Officer or quality assurance entities as to how the quality of care and services could be improved |  | For example, name of quality improvement program or equivalent; name of benchmarking program hospital participates in such as Chapel Dean, ACHS, QPS or PCOC. |  |
| * monitor, evaluate and implement strategies to reduce continuous risk of adverse clinical events |  |  |  |
| * change and improve systems. |  |  |  |

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| **Credentials and clinical privileges standard (version 5) NSQHS Actions 1.1, 1.6, 1.22, 1.23, 1.24** | | | |
|  | Compliance StatusC - CompliantNC - Non-compliantN/A - Not applicable | Evidence of Compliance | Assessment of evidence(PHRU to complete) |
| 1. A credentials and clinical privileges committee is established. |  | Terms of reference for relevant committee, include version and most recent review date. |  |
| 1. The members of the committee include:  * the Director of Medical Services, or equivalent; * at least one member of the nursing staff; and * suitably qualified peers of the practitioners whose credentials or clinical privileges are to be considered by the committee. |  | Name of credentialing system used e.g. e-Mercury  List of committee members, positions and /or specialties |  |
| 1. The majority of the members of the committee are medical practitioners. |  | As above |  |
| 1. Any member of the committee whose credentials or clinical privileges are being considered by the committee is excluded during such consideration. |  | Terms of reference for relevant committee, include version and most recent review date. |  |
| 1. The functions of the committee include:  * evaluating the credentials of all medical practitioners providing, or seeking to provide health services at the facility, having regard to * advice received from appropriate clinical colleges and/or health professional registration authorities; * Australian Commission on Safety and Quality in Health Care requirements |  | Terms of reference include functions listed, include version and most recent review date. |  |
| * considering applications for the granting of specific clinical privileges requested by medical practitioners or for the extension of existing clinical privileges; * evaluating the particular health services available at the facility including those services required to support the clinical privileges requested or held; * reviewing clinical privileges at least every five years; * making recommendations to the licensee of the facility in relation to the granting or reviewing of clinical privileges. These recommendations must include the scope of activities to be undertaken by the medical practitioner and the duration of clinical privileges; and * monitoring and reviewing, when necessary, the continuing practice of the individual medical practitioner. |  |  |  |
| 1. The licensee only grants clinical privileges to medical practitioners recommended by the committee as clinically competent to provide the health services. |  |  |  |

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| **Ethics standard (version 3)** | | | |
|  | Compliance StatusC - CompliantNC - Non-compliantN/A - Not applicable | Evidence of Compliance | Assessment of evidence(PHRU to complete) |
| 1. All research undertaken at the facility is approved, monitored and reviewed by an ethics committee constituted in accordance with:  * the National Statement on Ethical Conduct in Human Research (2007) published by the National Health and Medical Research Council (NHMRC) (if the research involves humans); and * the Australian Code for the Care and Use of Animals for Scientific Purposes (2013) published by the NHMRC (if the research involves animals) |  | Is research currently conducted at your facility? Yes / No  If yes, provide the name of the ethics committee that reviews human research projects e.g. Bellberry Human Research Ethic Committee  Copy of research policy or equivalent. |  |
| 1. Patient consent meets the requirements of the NHMRC’s National Statement on Ethical Conduct in Human Research. |  | Copy of research consent forms |  |
| 1. Clinical practice at all times reflects the ethical principles of respect for persons, beneficence and justice. |  | e.g. code of conduct, Ethics policy |  |

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| **Infection control standard (version 3) NSQHS Actions 3.1, 3.2, 3.3, 3.4, 3.5, 3.6, 3.7, 3.10, 3.14** | | | |
|  | Compliance StatusC - CompliantNC - Non-compliantN/A - Not applicable | Evidence of Compliance | Assessment of evidence(PHRU to complete) |
| 1. An Infection Control Management Plan for the facility is developed and implemented which:  * states the objectives of the Plan; * identifies, and assesses, all the infection risks specific to the facility which the licensee knows, or ought reasonably to know, exist or might exist; * states the particulars of training for persons who provide services at the facility that involve infection control risks; * states how the licensee proposes to monitor and review the implementation and effectiveness of the Plan. |  | Provide name of infection control management plan document, include version number and date of most recent review of document.  If applicable, provide name of infection control consultant e.g. STEAM, HICMR and date of most recent visit. |  |
| 1. The Infection Control Management Plan contains written policies and associated procedures, having regard to the infection risks identified in the Plan, which are consistent with the *Australian Guidelines for the Prevention and Control of Infection in Healthcare* (2010) published by the National Health and Medical Research Council (NHMRC)and relate to:  * the use of “standard precautions” and “additional precautions” within the meaning of those terms in the NHMRC Guidelines; * isolation protocols and screenings to control infectious organisms within the facility; * the management of patients and health care workers who are known, or suspected, to be infected with contagious or highly transmissible pathogens; |  | Names of relevant associated policies / procedures, including versions and date reviewed. |  |
| * the collection of information relating to infection rates, infection trends and other infection control information; * environmental cleaning; * infection control risks associated with all purchases must be evaluated. |
| 1. A multidisciplinary infection control committee is establishedwhich has the function of monitoring, and annually reviewing, the Infection Control Management Plan. |  | Name of committee that manages this function.  List of committee members, positions and /or specialties  Terms of reference of committee. |  |
| 1. An ongoing infection control education program is conducted at the facility. |  | Details of IC education requirements by staff designation and / or work area.  System for monitoring education programs and attendance by staff. |  |

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| **Information management standard (version 5) NSQHS Actions 1.16, 1.17, 1.18, 4.5, 4.6, 5.12, 5.13, 8.4** | | | |
|  | Compliance StatusC - CompliantNC - Non-compliantN/A - Not applicable | Evidence of Compliance | Assessment of evidence(PHRU to complete) |
| 1. Information management systems meet the needs of patient care delivery and the organisation**.** |  | Provide name of information management system used at facility e.g. Simday, Meditech. |  |
| 1. The health facility’s medical records comply with Australian Standard 2828.1 - 2012 (Health records - Paper-based health records) and/or AS 2828.2(Int)-2012 Health records - Digitized (scanned) health record system requirements. |  | Names of relevant policies / procedures that demonstrate requirements for medical records, include version number and date of most recent review. |  |
| 1. Each patient, including each infant born or treated at the health facility, has a complete **medical record** which includes the following:  * information required for the provision of reports to the Chief Health Officer under section 144 of *the Private Health Facilities Act 1999*; * progress notes which include the patient’s medical history, the nature of the principal condition of the patient and the nature of any other condition, including adverse events, treated during the patient’s stay in the health facility; * the nature of any surgical/diagnostic procedure performed on the patient during an episode of care; * a daily record of all medical and nursing care given in relation to the patient’s medical, physical, psychological and social needs and responses; * detail of all medication; and medication plan * record of informed consent for the performance of any surgical and/or potentially harmful diagnostic procedures and/or treatment regime. |  |  |  |
| 1. The minimum period for the **retention and storage** of medical records is:  * for clinical records – 10 years after the last clinical attendance or last medico-legal action, whichever is later; * for minors’ clinical records and obstetric records – 10 years from the child attaining adulthood (18 years); * for patients with a condition affecting their decision-making capacity (e.g. intellectually disabled relating to traumatic brain injury, dementia, or severe mental illness) – 10 years from the date the patient’s decision-making capacity is no longer limited, or 80 years from the date of birth of the patient. |  | Provide names of policy documents about healthcare record management, including access, storage, security, consent and sharing of patient information, including version numbers and date of most recent review. |  |
| 1. All records of Assisted Reproductive Technology procedures are retained according to National Health and Medical Research Council guidelines. |  | N/A |  |
| 1. The following **registers** are available where relevant: |  |  |  |
| * Admission and Discharge register: * Birth Register * Operating theatre and/or procedure register: |  | Name of system |  |
| * Mental health register:  1. information required under the relevant Mental Health legislation. |  | N/A |  |
| 1. Security of records complies with:  * AS ISO/IEC 27001:2015 Information technology – Security techniques – Information security management systems – Requirements. * AS ISO/IEC 27002:2015 Information technology – Security techniques – Code of practice for information security controls. |  | Provide names of relevant policy documents, including version numbers and date of most recent review. |  |

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| **Management and staffing standard (version 6) NSQHS Actions 1.22, 1.25, 1.26, 1.27, 1.3, 1.5, 1.6, 1.7, 6.1, 8.13** | | | |
|  | Compliance StatusC - CompliantNC - Non-compliantN/A - Not applicable | Evidence of Compliance | Assessment of evidence(PHRU to complete) |
| 1. A copy of the licence is on display for public viewing. |  |  |  |
| 1. An organisational chart showing clearly established lines of responsibility and communication for medical, nursing and ancillary services within each health service and between appropriate health services provided at the facility. |  |  |  |
| 1. Relevant professional guidelines and statutory requirements are documented and regularly updated. |  | Document register of policies/ review schedule. |  |
| 1. Policies and procedures reflect current professional principles and practices for each health service and are consistent with the goals and objectives of the facility. |  | Provide names of some relevant clinical guidelines and outline how maintained. |  |
| 1. Policies reflecting contemporary human resource management practices are developed and implemented. |  | Name of relevant HR policy including version and review date. |  |
| 1. In accordance with the Queensland Health Clinical Services Capability Framework for Public and Licensed Private Health Facilities CSCF), there should be documented processes underpinning the links between health services for the referral and transfer of patients. |  | Name of referral and transfer policies and date of most recent review.  Name of policy outlining escalation of care process and date of most recent review. |  |
| 1. All staff members receive, on appointment, documented and dated job descriptions and appropriate orientation. |  | Policy documents about orientation and training of the clinical workforce.  Employment records that detail the skills and competencies required of the position, as well as the safety and quality roles and responsibilities. |  |
| 1. Processes are in place to recognise and regularly review employee and visiting health practitioners’ qualifications, skills and competence. |  |  |  |
| 1. Professionals providing health services within the facility maintain registration with the relevant health professional registration authority. |  | System used for monitoring AHPRA registration. |  |
| 1. Access is available to continuing education programs, which maintain and augment knowledge and skills of employees and contract staff. |  | Policy document about continuing education of the clinical workforce |  |
| 1. All staffing, equipment and ancillary health services are in accordance with the QueenslandHealthCSCFandCSCF Companion Manual. |  |  |  |
| 1. A risk management plan is developed and implemented. |  | Name of risk management plan document and date of most recent review.  Risk register that includes actions to manage identified risks (clinical risks) |  |

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| **Minimum patient throughput (version 5)** | | | |
|  | Compliance StatusC - CompliantNC - Non-compliantN/A - Not applicable | Evidence of Compliance | Assessment of evidence(PHRU to complete) |
| 1. The minimum number of patients who receive prescribed health services are as follows:  * Cardiac Catheterisation:  1. 500 diagnostic cardiac procedures per year. 2. 200 Percutaneous Cardiac Intervention (PCI) cardiac procedures per year.  * Cardiac Surgery:  1. 200 procedures per year.  * Obstetrics:  1. 240 births per obstetric facility per year. |  | If applicable, include throughput numbers for the 12 month period, prior to date of inspection. |  |
| 1. If the minimum numbers specified above are not met, a formal affiliation exists with an appropriate health service in accordance with the Queensland Health Clinical Services Capability Framework for Public and Licensed Private Health Facilitiesto ensure staff maintain skill levels. |  | If applicable, provide details of formal / documented arrangements in place to maintain skills levels, including name of health service involved, names and numbers of staff involved, frequency of rotation to other sites etc. |  |

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| **Patient care standard (version 6) NSQHS Actions. 1.14, 2.10, 2.2, 2.3, 2.4, 2.6, 2.7, 2.10, 6.1, 6.2, 6.3, 6.4, 6.5** | | | |
|  | Compliance StatusC - CompliantNC - Non-compliantN/A - Not applicable | Evidence of Compliance | Assessment of evidence(PHRU to complete) |
| 1. The process of entry to the facility is facilitated by an effective admission system, which fully informs and prepares the patient for the episode of care. |  | Name of admission procedure and date of most recent review. |  |
| 1. A record is developed by the appropriate health professionals in consultation with the patient and/or carer which covers:  * patient assessment; * the plan for management of the patient’s care; * treatment provided; * regular evaluation of the patient’s condition; and * discharge plan. |  | State outcomes and date of medical record documentation audit. |  |
| 1. Patients have access to a document, which explains their rights and responsibilities. |  | Name and location of document. |  |
| 1. Patients give informed consent to their treatment. |  | Consent policy or similar documents with version and date of review. |  |
| 1. Patients are informed in a culturally appropriate manner about:  * their condition; * any necessary clinical investigations relevant to their condition; * any treatment proposed; and * the likely outcomes and risk of complications. |  | Name of documents that address needs of CALD patients. |  |
| 1. The number, qualifications and experience of nursing, medical and support staff are appropriate having regard to:  * number of patients; * co-morbidity; * other patient risk factors; and * Casemix. |  | Describe staffing allocation process eg, Trendcare / daily team meeting to discuss patient needs/ patient allocation. |  |
| 1. Facilities, equipment and resources comply with theQueensland Health Clinical Services Capability Framework for Public and Licensed Private Health Facilities (CSCF) and CSCF Companion Manual,Australian Standards and appropriate college / professional body guidelines. |  |  |  |
| 1. The process of separation is facilitated by an effective discharge system, which fully informs and prepares the patient for subsequent appropriate care. |  | Discharge policy and procedure, including version and date of review. |  |
| 1. Processes are established for the receipt, documentation, investigation and review of all complaints relevant to the provision of patient care. |  | Complaints policy including version and date of review. |  |
| 1. Patients are informed on the role of the Office of the Health Ombudsman as an independent health complaints agency. |  | Describe where and how this is available to patients. |  |

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| **Physical environment standard (version 6) NSQHS Actions 1.1, 1.33, 3.11, 3.12** | | | |
|  | Compliance StatusC - CompliantNC - Non-compliantN/A - Not applicable | Evidence of Compliance | Assessment of evidence(PHRU to complete) |
| 1. The premises in which the private health facility is operated are self-contained. |  | Reviewed during inspection walk through. |  |
| 1. The private health facility is in rooms used exclusively by the private health facility. |  | Reviewed during inspection walk through. |  |
| 1. Access to the proposed/licensed private health facility:  * Safe guards the health and safety of patients and visitors. |  | Reviewed during inspection walk through. |  |
| 1. All equipment, furnishings and fittings in the facility comply with:  * Queensland Health; and * relevant Australian Standards, National Health and Medical Research Council Guidelines and college/professional body guidelines. |  | Reviewed during inspection walk through. |  |
| 1. All curtains and bed screens consist of, or are treated with, fire retardant and are treated with fire retardant after laundering. |  | Reviewed during inspection walk through. |  |
| 1. In order to reduce the risk of scalding, a system exists to control the outlet temperature of hot water to every bath, shower and hand-basin used by patients and staff. |  | Maintenance schedule and/or procedures |  |
| 1. The generating plant or other equipment capable of providing an emergency power supply to the facility is properly maintained and tested regularly. |  | Maintenance schedule and/or procedures |  |
| 1. Buildings, equipment, apparatus, furniture, fittings, electrical installations and wiring, bedding and other articles used in connection with the provision of health services in the facility are:  * maintained in good repair and operational order; and * kept clean and free from hazards. |  | Reviewed during inspection walk through. |  |
| 1. Regular safety inspections of the facility are carried out and the findings documented, and remedial action taken, where necessary, to ensure the health and safety of patients, visitors and staff. |  | Maintenance schedule and/or procedures  Occupational Health and Safety |  |
| 1. A report, issued by an authorised fire officer within the meaning of the *Fire and Emergency Services Act 1990*, is provided to the Chief Health Officer every 3 years stating that the licensee has complied with the requirements of Part 9A of that Act and with the *Building Fire Safety Regulation 2008*. |  | Date of most recent QFES letter. |  |

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| **Specialty health services standard (version 5)** **NSQHS Actions** **5.4, 5.5, 5.13**  (NOTE: Speciality health services are ALL services described on hospital licence) | | | |
|  | Compliance StatusC - CompliantNC - Non-compliantN/A - Not applicable | Evidence of Compliance | Assessment of evidence(PHRU to complete) |
| 1. Patients at the health facility who receive specialty health services must also have access to the ancillary health services necessary to ensure the health and wellbeing of those patients. |  | Names of all third-party service providers and services they offer.  Eg pharmacy, sleep studies, x-ray |  |
| 1. The provision of specialty health services is in accordance with the QueenslandHealthCSCF and CSCF Companion Manualand appropriate college / professional body guidelines. |  | Self assessment provided/Reviewed during onsite compliance inspection. |  |

| Self-assessment performed by: >*insert name*< | |
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| Designation: >*insert*< | Date: >*insert*< |

### Version Control

| Version | Date | Comments |
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| 2.0 | 11 July 2019 | Draft approved by Director for trial. |
| 2.1 | 20 November 2019 | Revised based on feedback from team. |