DNV GL Business Assurance Australia

GATEWAY DAY HOSPITAL

Accreditation Assessment for compliance to
NSQHS Standards New Hospital (Second Edition)

Team Leader: Rhonda Williams

Date of Assessment: October 9 and 22, 2019

Project Number: PRJN-167421-2019-MSC -AUS

CLIENT INFORMATION

Client:	Gateway Day Hospital	
Client Contact:	Fiona Ferrier	E-mail: fionaferrier@cityfertility.com.au
Position:	National Quality and Safety Manager	Phone: 07 3058 9610

ASSESSMENT DESCRIPTION

Standard	National Safety and Quality Health Service Standards (New Hospital)		
Assessment Type	Initial Assessment ☒	RC ☐	Other:
Duration	Onsite: 2 days		
Assessed Site	Level 18, 1 Macquarie Place Sydney NSW 2000		
Assessment team	Lead Assessor	Rhonda Williams	
	Team member	n/a	
	Observer	n/a	
Assessment plan sent	October 1, 2019		
Organisation type	Hospital with multiple shifts? ☐ (see shift sampling below) Day Procedure Services with multiple shifts? ☐ (see shift sampling below) Day Procedure or other service with single shift only? ☒		
Shift sampling:	Total Number shifts: 1	Shifts sampled: 1	N/ A ☐
Previous accreditation details:			N/ A ☒

CERTIFICATION INFORMATION

Scope of Accreditation: For the provision of IVF and Gynaecology Services

Non-applicable actions requested and approved: 1.2, 1.4, 1.32, 1.33, 2.13, 4.6, 4.12, 5.9, 5.15, 5.16, 5.18, 5.19, 5.20, 5.27, 5.28, 5.32, 5.34, 5.35, 5.36.

Health Facility Registration Details: NSW Ministry of Health Licence: DC0030064 (21/10/19)
Poisons Licence: No. S8 D2093

EA Code: 38	Employee Numbers: 6	Licensed Beds: 3 trolleys, 3 chairs

Changes in Client Information at this Assessment

Client Name/Address	No	Scope	No
Employee Numbers	No	Other	No

Comment

EXECUTIVE SUMMARY

An assessment of **Gateway Day Hospital** Management System was conducted on the above dates by DNV GL in accordance with the requirements outlined in ISO 17021:2015, JAS-ANZ Health Care Services Management Systems Scheme Parts 1 and 2 and the requirements of the Australian Commission on Safety and Quality in Health Care.

Assessment Objectives

The purposes of the assessment were; to verify compliance of the safety and quality system and associated procedures and practices to the requirements of the NSQHS Standards and to ensure that the management has a system in place to identify applicable legal, statutory and contractual obligations.

Summary of Assessment Methodology

Methodology used to conduct the assessment was through sampling of the organisation's records, documented procedures and processes, observed practice and/or interviews with staff using the **PICMoRS** approach. A range of business and patient processes were reviewed as per the assessment plan.

Summary Of Assessment Findings

Management and staff demonstrated a good understanding of their roles and responsibilities. The internal audit program was seen to be effectively planned to provide a platform for improving the systems and processes within the organisation.

There were no not met actions identified during the audit. The remainder of the actions were rated "Met" "Prescribed" or "Not Applicable". This was explained at the Closing meeting. Opportunities for improvement that would further strengthen the system were discussed throughout the assessment and at the closing meeting.

Assessment objectives were met	Yes ☒	No☐
Number of Core NSQHSS actions identified as Not Met	Nil	
Number of Core NSQHSS actions identified as Met with Recommendations	Nil	

Recommendation and Next Assessment Date

Recommended for Interim NSQHS Standards Accreditation	Yes ☒ Pending*☐ No ☐
Date for initial response to Core Not Met Actions	Not Applicable
Date for closeout of Core Not Met Actions	Not Applicable
Recommended date for next assessment	Within the next 12 months

EFFECTIVENESS OF THE SAFETY AND QUALITY MANAGEMENT SYSTEM

Description of the Operations including Changes to the System

Gateway Day Hospital (GDH) is a new private free-standing day hospital conveniently located in the Sydney CBD providing an all inclusive service for people accessing fertility and gynaecology services. Gateway Day Hospital, under the umbrella of City Fertility and City Health Day Hospitals is collocated with the new RTAC licenced and accredited facility, City Fertility Sydney CBD. This is the first licensed day hospital for the group.

GDH consists of two operating theatres, three Stage 1 recovery bays and 3 Stage 2 rooms. The facility has been purpose built and provides a welcoming environment overlooking the Sydney Harbour. At this stage services offered include IVF and gynaecology. There are currently eight accredited clinicians (four fertility/gynaecology specialists and four anaesthetists).

A number of internal services such as human resources and on-boarding are integrated within the City Fertility management system (CFC Work Desk integrated data management system). There is also a National Quality and Safety Manager who provides oversight of the quality management system.

NSW Health licensing has been completed with approval to commence operating as of October 21st, 2019. At this stage approval has been given for the use of one operating theatre as anaesthetic equipment has not been installed for the second theatre.

A significant amount of work has been undertaken to meet the requirements of both licensing and NSQHS Standards accreditation. The involvement and level of commitment displayed by all personnel during the assessment is to be commended. GDH is aware that interim accreditation only is granted at this stage.

General Comment on Effectiveness of the Safety and Quality Management System

A documented quality management system (Safety and Quality Manual QMS001 27/9/19 v18) which adequately reflects the size, nature, role and application of the organisation's core and support business activities was sighted along with processes for continuous business improvement and demonstrated commitment by management and staff in embracing the principles and practice of quality management. The requirements of the NSQHS Standards have been integrated into the Gateway Day Hospital Governance for Safety and Quality in Procedure Centres and Day Hospitals (1.10.2 24/7/19 v1).

The capability and effectiveness of the governance system to ensure compliance with customer, statutory and regulatory requirements and meeting organisational objectives, although in its infancy, was demonstrated.

Policies and procedures to support both business and clinical processes have been documented, with monitoring and review to be managed through the internal audit program, non-conformance reporting and clinical governance processes.

Focus Areas Identified in this Assessment

Nil

Other Areas of Review in this Assessment

Shift handover observed	Yes ☐	No ☐	N/A ☒
Interview with night/afterhours Manager conducted	Yes ☐	No ☐	N/A ☒
Client files reviewed include night shift records	Yes ☐	No ☐	N/A ☒
Interview with Consumer Representative:	Yes ☒	No ☐	

NSQHSS COMPLIANCE SUMMARY

Heading	NSQHS 2nd Ed Clause Number	Rating	Description If NM or MR
1 Clinical Governance Standard			
Governance, leadership and culture	1.1	M	1.1 (f) (g) Prescribed
	1.2	N/A	There are no Aboriginal and Torres Strait Islander patients in any of the surgeons' current patient cohort, if there was to be any, the risk would be the same as the general population as per admission criteria. **OBS:** A report on Aboriginal and Torres Strait Islander admissions is able to be generated through SimDay and this will be reviewed at the next assessment to confirm continuing non-applicable status
Organisational leadership	1.3	M	
	1.4	N/A	There are no Aboriginal and Torres Strait Islander patients in any of the surgeons' current patient cohort, if there was to be any, the risk would be the same as the general population as per admission criteria. **OBS:** Management has approached the local area health service to acknowledge commencement of GDH and to ask for education for staff however as there are unlikely to be any admissions this was declined by the area health service. Acknowledgement of Country is on the front page of the website and staff have completed training
	1.5	M	
Clinical leadership	1.6	M	
Policies and procedures	1.7	M	1.7 (b) (c) Prescribed
Measurement and quality improvement	1.8	Prescribed	
	1.9	Prescribed	
Risk management	1.10	M	1.10 (d) (e) Prescribed
Incident management systems and open disclosure	1.11	M	1.11 (c), (d), (e), (f) (g) Prescribed
	1.12	M	1.12 (b) Prescribed

Heading	NSQHS 2nd Ed Clause Number	Rating	Description If NM or MR
Feedback and complaints management	1.13	M	1.13 (c) Prescribed
	1.14	M	1.14 (b) (d) (e) (g) Prescribed
Diversity and high-risk groups	1.15	Prescribed	
Healthcare records	1.16	M	
	1.17	M	
Healthcare records	1.18	M	
Safety and quality training	1.19	M	
	1.20	M	1.20 (a) (b) Prescribed
	1.21	M	
Performance management	1.22	M	
Credentialing and scope of clinical practice	1.23	M	1.23 (c) Prescribed
	1.24	M	1.24 (b) Prescribed
Safety and quality roles and responsibilities	1.25	M	
	1.26	M	
Evidence-based care	1.27	M	
Variation in clinical practice and health outcomes	1.28	M	1.28 (a) (b) (c) (e) Prescribed
Safe environment	1.29	M	**OBS:** GDH has been advised by NSW Health that legionella testing is not required however GDH will plan to do so.
	1.30	M	
	1.31	M	
	1.32	N/A	Day procedure services only. There are no overnight facilities
	1.33	N/A	There are no Aboriginal and Torres Strait Islander patients in any of the surgeons' current patient cohort, if there was to be any, the risk would be the same as the general population as per admission criteria. **OBS:** A report on Aboriginal and Torres Strait Islander admissions is able to be generated through SimDay and this will be reviewed at the next assessment to confirm continuing non-applicable status. Management has approached the local area health service to

Heading	NSQHS 2nd Ed Clause Number	Rating	Description If NM or MR
			acknowledge commencement of GDH and to ask for education for staff however as there are unlikely to be any admissions this was declined by the area health service. Acknowledgement of Country is on the front page of the website and staff have completed training.
2 Partnering with Consumers Standard			
Integrating clinical governance	2.1	M	
Applying quality improvement systems	2.2	M	
Healthcare rights and informed consent	2.3	M	
	2.4	M	
	2.5	M	
Sharing decisions and planning care	2.6	M	
	2.7	M	
Communication that supports effective partnerships	2.8	Prescribed	
	2.9	M	
	2.10	M	
Partnerships in healthcare governance planning, design, measurement and evaluation	2.11	Prescribed	
	2.12	Prescribed	**OFI:** The consumer representatives could be referred to online consumer advocate orientation information.
	2.13	N/A	There are no Aboriginal and Torres Strait Islander patients in any of the surgeons' current patient cohort, if there was to be any, the risk would be the same as the general population as per admission criteria. **OBS:** A report on Aboriginal and Torres Strait Islander admissions is able to be generated through SimDay and this will be reviewed at the next assessment to confirm continuing non-applicable status. Management has approached the local area health service to acknowledge commencement of GDH and to ask for education for staff however as there are unlikely to be

Heading	NSQHS 2nd Ed Clause Number	Rating	Description If NM or MR
			any admissions this was declined by the area health service. Acknowledgement of Country is on the front page of the website and staff have completed training.
	2.14	Prescribed	
3 Preventing and Controlling Healthcare-Associated Infection Standard			
Integrating clinical governance	3.1	M	
Applying quality improvement systems	3.2	M	
Partnering with consumers	3.3	M	
Surveillance	3.4	Prescribed	
Standard and transmission-based precautions	3.5	M	
	3.6	M	
	3.7	M	
Hand hygiene	3.8	M	3.8 (b) Prescribed
Aseptic technique	3.9	M	3.9 (d) Prescribed
Invasive medical devices	3.10	M	
Clean environment	3.11	M	
	3.12	M	
Workforce immunisation	3.13	M	
Reprocessing of reusable devices	3.14	M	**OFI:** The use of covered containers to transport dirty instruments from theatre to CSSD could be considered as the corridor is also used for walking patients into theatre. Even though there is only one CSSD technician steriliser print-outs could be signed.
Antimicrobial stewardship	3.15	M	**OFI:** The use of covered containers to transport dirty instruments from theatre to CSSD could be considered as the corridor is also used for walking patients into theatre. Even though there is only one CSSD technician steriliser print-outs could be signed.
	3.16	Prescribed	
4 Medication Safety Standard			
Integrating clinical governance	4.1	M	

Heading	NSQHS 2nd Ed Clause Number	Rating	Description If NM or MR
Applying quality improvement systems	4.2	M	
Partnering with consumers	4.3	M	
Medicines scope of clinical practice	4.4	M	
Medication reconciliation	4.5	M	
	4.6	N/A	Medications are not altered during the episode of care.
Adverse drug reactions	4.7	M	
	4.8	M	
	4.9	M	
Medication review	4.10	M	
Information for patients	4.11	M	
Provision of a medicines list	4.12	N/A	Medications are not altered during the episode of care.
Information and decision support tools for medicines	4.13	M	
Safe and secure storage and distribution of medicines	4.14	M	
High-risk medicines	4.15	M	
5 Comprehensive Care Standard			
Integrating clinical governance	5.1	M	
Applying quality improvement systems	5.2	M	
Partnering with consumers	5.3	M	
Designing systems to deliver comprehensive care	5.4	M	
Collaboration and teamwork	5.5	M	
	5.6	M	
Planning for comprehensive care	5.7	M	
	5.8	M	
	5.9	N/A	There are processes in place to accept Advance Care Directives however there is no requirement to support patients to develop them.
Screening of risk	5.10	M	
Clinical assessment	5.11	M	
Developing the comprehensive care plan	5.12	M	
	5.13	M	

Heading	NSQHS 2nd Ed Clause Number	Rating	Description If NM or MR
Using the comprehensive care plan	5.14	M	
Comprehensive care at the end of life	5.15	N/A	The day hospital does not provide care to patients at end of life
	5.16	N/A	The day hospital does not provide care to patients at end of life
	5.17	M	
	5.18	N/A	The day hospital does not provide care to patients at end of life
	5.19	N/A	The day hospital does not provide care to patients at end of life
	5.20	N/A	The day hospital does not provide care to patients at end of life
Preventing and managing pressure injuries	5.21	M	
	5.22	M	
	5.23	M	
Preventing falls and harm from falls	5.24	M	
	5.25	M	
	5.26	M	
Nutrition and hydration	5.27	N/A	Day only procedures
	5.28	N/A	Day only procedures
Preventing delirium and managing cognitive impairment	5.29	M	**OFI:** Where pre-admission processes identify there is no indication of cognitive impairment then the need to complete formal screening on admission could be reviewed.
	5.30	M	
Predicting, preventing and managing self-harm and suicide	5.31	M	
	5.32	N/A	GDH would not admit patients at risk of self-harm or suicide.
Predicting, preventing and managing aggression and violence	5.33	M	
	5.34	N/A	GDH would not admit patients who are at risk of aggression or violence
Minimising restrictive practices: restraint	5.35	N/A	GDH does not use restraint practices during an episode of care.
Minimising restrictive practices: seclusion	5.36	N/A	GDH does not use seclusion.
6 Communicating for Safety Standard			

Heading	NSQHS 2nd Ed Clause Number	Rating	Description If NM or MR
Integrating clinical governance	6.1	M	
Applying quality improvement systems	6.2	M	
Partnering with consumers	6.3	M	
Organisational processes to support effective communication	6.4	M	
Correct identification and procedure matching	6.5	M	
	6.6	M	
Clinical handover	6.7	M	
	6.8	M	
Communicating critical information	6.9	M	
	6.10	M	
Documentation of information	6.11	M	
7 Blood Management Standard			
Integrating clinical governance	7.1	M	The use of blood and blood products is limited to the use of Anti-D Immunoglobulin only. **OFI:** The Safety and Quality Manual needs to reflect Standard 7 is applicable
Applying quality improvement systems	7.2	M	
Partnering with consumers	7.3	M	
Optimising and conserving patients' own blood	7.4	M	
Documenting	7.5	M	
Prescribing and administering blood and blood products	7.6	M	
Reporting adverse events	7.7	M	
	7.8	Prescribed	
Storing, distributing and tracing blood and blood products	7.9	M	
Availability of blood	7.10	M	
8 Recognising and Responding to Acute Deterioration Standard			
Integrating clinical governance	8.1	M	
Applying quality improvement systems	8.2	M	
Partnering with consumers	8.3	M	
Recognising acute deterioration	8.4	M	
	8.5	M	

Heading	NSQHS 2nd Ed Clause Number	Rating	Description If NM or MR
Escalating care	8.6	M	
	8.7	M	
	8.8	M	
	8.9	M	
Responding to deterioration	8.10	M	
	8.11	M	
	8.12	M	**OFI:** Emergency details for referral to mental health services could be included in the acute deterioration policy 1.10.89 (currently documented in DHN 130).
	8.13	M	

This assessment has been conducted utilising the PICMoRS Method.

Process – documentation on policies, procedures and processes throughout the facility have been reviewed for accuracy and currency. Staff interviewed have been asked and were able to show how to access information which is readily available on the City Fertility intranet.
Improvement – improvement strategies will be documented through RiskClear with staff training currently underway. A number of improvements have been identified during the initial set-up (e.g. insufficient ABHR locations) and were identified during the assessment e.g. relocation of disposable gloves in theatre.
Consumer – consumer involvement in review or design of processes and the development of improvement strategies have been discussed with consumer representatives e.g. insufficient information regarding parking with this now easily identifiable on the website.
Monitoring – ongoing monitoring strategies will be evidenced through review of clinical outcomes data, clinical indicators and benchmarking programs (ACHS) and feedback received through patient/carer surveys and consumer representatives.
Reported – evidence of reporting of information will be demonstrated during the next assessment through sampling of minutes of meetings from all areas of the organisation including Board and Medical Advisory Committee.
Systems – integration of safety and quality systems has been evidenced through review of training and education programs and development of policies, as well as discussion with staff.

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. *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*. Met with recommendations may only be awarded at initial assessment if there are no other not met actions.
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 relevant 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.
Not assessed	Actions that are not part of the current assessment process and therefore not reviewed.

ADDITIONAL REQUIREMENTS

Use of Marks and Logos

Not applicable for this assessment

Accreditation and Re-accreditation Only - Verification of Non-Applicable Actions Claimed

The claim for non-applicable actions form was sighted.	Yes ☒	No ☐	N/A ☐
Not applicable actions were accepted as requested.	Yes ☐	No ☒	N/A ☐
Auditor comments on claims for non-applicable actions: Non-applicable actions for 1.2, 1.4, 1.33, 2.13, falls and pressure injury will be reviewed after the first twelve months.			
The following actions have been approved as non-applicable for this organisation: See Scope of Accreditation (page 2)			

Unresolved Issues

Nil recorded

Justification for Use of One Assessor

☒ Size and complexity of the organisation warrants use of single auditor for this audit.

☐ N/A

Progress toward implementation of AS 4187:2014

Gap Analysis completed and level of compliance with AS/NZS 4187:2014 determined?	Yes ☒	No ☐	N/A ☐
Implementation plan, including timeline, established?	Yes ☐	No ☐	N/A ☒
Implementation plan, including timeline, revised?	Yes ☐	No ☐	N/A ☒
Progress on implementation in accordance with plan	Yes ☐	No ☐	N/A ☒
Auditor comments on implementation plan:			

CONCLUSION

The assessment determined that the Management System satisfies the requirements for **Interim Accreditation** to the National Safety and Quality Health Service Standards. A further assessment will be conducted within the first twelve months of operation.

It is considered that **Gateway Day Hospital** has the capability to systematically meet agreed requirements for activities within the current scope of Accreditation and at the location covered on the certificate.

I would like to thank the staff for the assistance given to me during the assessment and for choosing DNV GL to be partners with you in the certification of your quality management system. Our aim is to ensure your QMS remains effective and efficient and can adapt to the changing needs of the organisation to ensure quality outcomes for everyone involved.

I look forward to seeing everyone again at the next scheduled visit.

Disclaimer

Some issues, non-compliances or required improvements within the organisation may not have been identified in this report, due to the sampling size and time available during the audit. The organisation's management is responsible for implementing a surveillance system (based on internal audits) to identify nonconformities/continuous improvement opportunities and to take the necessary controls to ensure the quality management system implemented is effective and meets organisational and regulatory requirements.

Confidentiality Statement

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Report by:	Rhonda Williams RN MScMed		October 26, 2019
	Lead Assessor	**Signature**	**Date**

RESPONSE TIMES

Program	Immediate response	Acknowledgment of NMs (NM Findings Sheet)	Response to NMs (identification of cause, + plan for correction) (NM Findings Sheet)	Close out (NM Findings Sheet)
Critical (Significant Risk)	Correction Critical deficiencies, or those that have an immediate or pending effect on the health or safety of consumers, shall be closely monitored by daily email/phone contact until the immediate threat is mitigated. Action plan to be developed within 2 business days	At audit closing meeting or immediately after	Action plan to be provided to DNV GL within 2 business days for forwarding to relevant regulator and Commission.	Critical deficiencies to be treated as not met actions once immediate threat has been mitigated.
Not Met (NM)	nil	At audit closing meeting or immediately after	Within 10 working days	Within 80 business days
Met with Recommendations	nil	At audit closing meeting or immediately after	Not required	Action in response to the observed deficiency shall be reviewed at the next audit with view to either close-out or escalation
OFI/Observation	nil	not required	not required	Action in response to the observed deficiency shall be reviewed at the next audit with view to either close-out or escalation

AWARDING OF ACCREDITATION

Note: NSQHSS Accreditation or reaccreditation shall not be awarded until all NSQHSS actions have been satisfactorily met. A follow up documentation review or onsite audit will be conducted to verify the closure of any NSQHSS not met actions. This shall be at a date to be arranged but at not less than 80 days from the final day of this audit or prior to the expiry of your current accreditation certificate. Please see Not Met findings sheet accompanying this report for dates of initial client response and final date for addressing the not met actions.