DNV GL Business Assurance Australia

SOUTHSIDE PROCEDURE CENTRE

Initial and Final Assessment for compliance to
NSQHS Standards (Second Edition) for
New Hospitals

Team Leader: Rhonda Williams

Date of Assessment: December 16 and 17, 2020

Project Number: PRJC-556538-2020-MSC-AUS

Client: Southside Procedure Centre	Assessment Dates: December 16-17, 2020
Assessment Report: NSQHS Standards	PRJC-556538-2020-MSC-AUS

CLIENT INFORMATION

Client:	Southside Procedure Centre	
Client Contact:	Fiona Ferrier	Email: fionaferrier@cityfertility.com.au
Position:	National Compliance, Regulatory and Safety Manager	Phone: 07 3058 9610

AUDIT DESCRIPTION

Standard	National Safety and Quality Health Service Standards Second Edition			
Assessment Type	Interim (New Hosp) ☒	Accreditation ☐	Follow-up ☐	Final Assessment ☐
Initial Assessment Date	December 16 and 17, 2020			
Final Assessment Date	February 23, 2021			
Duration	Onsite: 1.5 days			
Assessed Site	Level 2, Sunnybank Private Specialist Centre, 245 McCullough Street Sunnybank QLD 4109			
Assessment team	Lead Assessor	Rhonda Williams		
	Team member	Kelly Duggan		
	Observer	N/A		
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 ☒	

ACCREDITATION INFORMATION

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

Non-applicable actions requested and approved: 1.32, 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, Std 7.

Health Facility Registration Details: Not available at this stage
Poisons Licence: Not available at this stage

EA Code: 38	Employee Numbers: FTE 3, PTE 3	Licensed Beds: 2 trolleys, 3 chairs

Changes in Client Information at this Assessment

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

Comment

Client: Southside Procedure Centre	Assessment Dates: December 16-17, 2020
Assessment Report: NSQHS Standards	PRJC-556538-2020-MSC-AUS

EXECUTIVE SUMMARY

An initial assessment of **Southside Procedure Centre** Management System was conducted on the above dates by DNV GL in accordance with the requirements outlined in Health Care Services (HCS) Scheme Issue 3 2019 and the requirements of the Australian Commission on Safety and Quality in Health Care (Policy November 2019).

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.

The assessment was conducted onsite.

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 six (6) Not Met and one (1) Met with Recommendation actions identified during the audit. The remainder of the actions were rated "Met" 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 NSQHSS actions identified as Not Met	6	1.5, 3.5, 3.9, 3.11, 3.13, 3.14
Number of NSQHSS actions identified as Met with Recommendations	1	1.20 (d)
Actions Outstanding at Final Assessment	Nil	

Recommendation and Next Assessment Date

Recommended for Interim NSQHS Standards Accreditation	Yes ☐ Pending*☒ No ☐
Date for initial response to Not Met Actions	January 5, 2021
Date for closeout of Not Met Actions	March 17, 2021
Recommended date for next assessment	12 months
*Accreditation will not be recommended until all Not Met Actions have been closed out	

EFFECTIVENESS OF THE SAFETY AND QUALITY SYSTEM

Description of the Operations including Changes to the System

Southside Procedure Centre (SPC) is a new purpose built facility providing surgical services for patients undergoing fertility treatment. SPC, under the umbrella of City Fertility and City Health Day Hospitals is co-located with the RTAC licenced and accredited facility, City Fertility Southside. The facility consists of one procedure room, two stage 1 recovery trolleys and three stage 2 recliners, and a sterile storage area. With the exception of an ultrasound transducer, single use equipment only is utilised.

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 Compliance, Regulatory and Safety Manager who provides oversight of the quality management system. There is access to an external infection prevention and control consultant.

There are currently only two permanent peri-operative staff available. Extra staffing is sourced from the nurses working within the fertility clinic or from a nursing agency.

The procedure centre has been operational as an unlicenced facility since January 2019. Until now procedures have been performed under local or conscious sedation only. Patients wishing to have general anaesthesia are admitted through the Sunnybank Private Hospital.

An application for licencing as a day hospital, as well as the QLD Health Clinical Services Capability Framework, has been submitted to QLD Health. Through the licencing process it was identified that the procedure room did not have a HEPA filtration system and on advice from QLD Health licencing is to be restricted to a procedure centre only. This will likely restrict procedures, however, will be determined upon licencing.

The licencing inspection was to have been completed by now, however notification was received last week that installation of the new nurse call bell system has been delayed until mid-January 2021. The delay has been communicated to QLD Health who advised licencing would be delayed until after installation. QLD Health was aware that an accreditation assessment was scheduled and made themselves available for discussion if necessary. A licencing certificate is to be provided to DNV GL following the completion of the inspection.

Installation and functionality of the Nurse Call system has been completed and verified (23/02/2021).

Management is aware that following closure of the Not Met actions identified that Interim Accreditation only will be granted.

General Comment on Effectiveness of the Safety and Quality System

A documented clinical governance and safety and quality framework (1.10.2 Day Hospital and Procedure Centre Governance for Safety, Quality and Risk v2 24/2/2020) has been implemented. Oversight of SPC activities, in accordance with the clinical governance framework, have been outlined within 1.10.1 Clinical Governance – Governing Body v2 30/11/2020. The requirements of the NSQHSS have been integrated into the quality management system infrastructure. An Attestation Statement has been received for 2020/21.

Processes are in place to engage consumer and carer feedback on safety and quality systems.

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, has been demonstrated.

Policies and procedures to support both business and clinical activities have been implemented. Monitoring of internal processes and compliance will be managed through the internal audit, risk and incident management programs (RiskClear).

Actions as required by Advisories AS18/10, AS18/14, AS18/15 and AS19/01 have been fully implemented. Actions related to AS18/11 (implementation of My Health Record) have commenced. Actions related to AS/NZS4187:2014 have been determined applicable to the reprocessing of ultrasound transducers only.

NSQHSS COMPLIANCE SUMMARY

Heading	NSQHS 2nd Ed Clause Number	Rating Initial Assessment	Description If NM or MR	Rating Final Assessment
1 Clinical Governance Standard				
Governance, leadership and culture	1.1	M (a) (b) (c) (d) (e)	1.1 (f) (g) Prescribed	M (a) (b) (c) (d) (e)
	1.2	M	Not applicable status to be reviewed in 12 months when patient data is available.	M
Organisational leadership	1.3	M		M
	1.4	M	Not applicable status to be reviewed in 12 months when patient data is available.	M
	1.5	**NM**	**Staffing numbers for appropriately trained personnel in the peri-operative area do not meet ACORN recommendations which may pose a risk in the event of a surgical emergency or clinical deterioration.**	M
Clinical leadership	1.6	M		M
Policies and procedures	1.7	M (a)	1.7 (b) (c) Prescribed	M (a)
Measurement and quality improvement	1.8	Prescribed		Prescribed
	1.9	Prescribed		Prescribed
Risk management	1.10	M (a) (b) (c) (f)	1.10 (d) (e) Prescribed	M (a) (b) (c) (f)
Incident management systems and open disclosure	1.11	M (a) (b)	1.11 (c) (d) (e) (f) (g) Prescribed	M (a) (b)
	1.12	M (a)	1.12 (b) Prescribed	M (a)
Feedback and complaints management	1.13	M (a) (b)	1.13 (c) Prescribed	M (a) (b)
	1.14	M (a) (c) (f)	1.14 (b) (d) (e) (g) Prescribed	M (a) (c) (f)
Diversity and high-risk groups	1.15	Prescribed		Prescribed
Healthcare records	1.16	M	**OFI:** Ensure audit records are fully completed e.g. date of audit, name of auditor and evidence of records reviewed.	M
	1.17	M		M
Healthcare records	1.18	Prescribed		Prescribed
Safety and quality training	1.19	M		M

Heading	NSQHS 2nd Ed Clause Number	Rating Initial Assessment	Description If NM or MR	Rating Final Assessment
	1.20	**MR**	1.20 (a) (b) Prescribed **d) There was little evidence to demonstrate that workforce participation in training is monitored.**	M (c) (d)
	1.21	M	**OFI:** It may be beneficial to source alternate avenues for Aboriginal and Torres Strait Islander cultural safety training.	M
Performance management	1.22	M		M
Credentialing and scope of clinical practice	1.23	M (a) (b)	1.23 (c) Prescribed **OFI:** Clarify whether clinicians will complete ALS training annually or biennially.	M (a) (b)
	1.24	M (a)	1.24 (b) Prescribed	M (a)
Safety and quality roles and responsibilities	1.25	M	**OFI:** It may be of benefit for SPC to modify the Orientation Checklist to make it more specific to the site e.g. removing difficult intubation and CSSD.	M
	1.26	M		M
Evidence-based care	1.27	M		M
Variation in clinical practice and health outcomes	1.28	M (d) (f)	1.28 (a) (b) (c) (e) Prescribed	M (d) (f)
Safe environment	1.29	M		M
	1.30	M		M
	1.31	M		M
	1.32	N/A	There are no overnight facilities.	N/A
	1.33	M	Not applicable status to be reviewed in 12 months when patient data is available.	M
2 Partnering with Consumers Standard				
Integrating clinical governance	2.1	M		M
Applying quality improvement systems	2.2	M		M
Healthcare rights and informed consent	2.3	M		M
	2.4	M		M
	2.5	M		M
Sharing decisions and planning care	2.6	M		M
	2.7	M		M
Communication that supports effective partnerships	2.8	Prescribed		Prescribed
	2.9	M		M
	2.10	M		M

Heading	NSQHS 2nd Ed Clause Number	Rating Initial Assessment	Description If NM or MR	Rating Final Assessment
Partnerships in healthcare governance planning, design, measurement and evaluation	2.11	Prescribed		Prescribed
	2.12	Prescribed		Prescribed
	2.13	M	Not applicable status to be reviewed in 12 months when patient data is available.	M
	2.14	Prescribed		Prescribed
3 Preventing and Controlling Healthcare-Associated Infection Standard				
Integrating clinical governance	3.1	M	**OFI:** It may be of benefit to review infection prevention and control policies to better reflect local practices.	M
Applying quality improvement systems	3.2	M		M
Partnering with consumers	3.3	M		M
Surveillance	3.4	Prescribed		Prescribed
Standard and transmission-based precautions	**3.5**	**NM**	**SPC was unable to demonstrate that all staff working in the perioperative area have undertaken standard and transmission based precautions/infection control training.**	M
	3.6	M		M
	3.7	M		M
Hand hygiene	3.8	M (a)	3.8 (b) Prescribed **OFI:** Consider accessing the audit tools from Hand Hygiene Australia and register for the appropriate Gold Standard training in order to train other staff and record hand hygiene surveillance appropriately.	M (a)
Aseptic technique	**3.9**	**NM (a) (b) (c)**	3.9 (d) Prescribed **Training and competency in aseptic technique/invasive devices was not able to be demonstrated for all staff working in the perioperative area.**	M (a) (b) (c)
Invasive medical devices	3.10	M		M
Clean environment	**3.11**	**NM**	**There did not appear to be a cleaning contract that included referenced cleaning guidelines for the cleaner to follow. The cleaner was unable to articulate any training had been completed with regard to health care facility cleaning requirements and the cleaning checklist was limited.**	M
	3.12	M	**OFI:** Request compliance with AS4146 and evidence of routine pathology results be included in the contract from the linen company.	M

Heading	NSQHS 2nd Ed Clause Number	Rating Initial Assessment	Description If NM or MR	Rating Final Assessment
Workforce immunisation	**3.13**	**NM**	**SPC was unable to demonstrate that the immunisation program has been implemented, in line with jurisdictional requirements, for all staff working in the peri-operative area.**	M
Reprocessing of reusable devices	**3.14**	**NM**	**a) Although full compliance to AS/NZS4187 is not required sterile stock is stored onsite. There does not appear to be an effective way to control and regulate temperature and humidity within the sterile stock room which can affect the integrity of the stock e.g. temperature was recorded at 27°C with 67% humidity. These parameters were reaching or passing the upper limits recommended on the packaging.** **b) There did not appear to be a formal link to the incident management system when temperature/humidity ranges were outside recommended parameters.**	M
Antimicrobial stewardship	3.15	M	**Observation:** The AMS formulary did not reflect the minutes of the recent MAC meeting however this was rectified during the assessment and email approval by MAC members was sighted.	M
	3.16	Prescribed		Prescribed
4 Medication Safety Standard				
Integrating clinical governance	4.1	M		M
Applying quality improvement systems	4.2	M		M
Partnering with consumers	4.3	M		M
Medicines scope of clinical practice	4.4	M		M
Medication reconciliation	4.5	M		M
	4.6	N/A	Medications are not altered during the episode of care.	N/A
Adverse drug reactions	4.7	M		M
	4.8	M		M
	4.9	M		M
Medication review	4.10	M	**OFI:** Even though an order for Penthrox from the doctor is documented on the admission sheet it would be also advisable to have the doctor sign the Medication Chart as he is the prescriber.	M
Information for patients	4.11	M	**OFI:** If patients are to be provided pre-procedure medication then information sheets will need to be developed.	M
Provision of a medicines list	4.12	N/A	Medications are not altered during the episode of care.	N/A

Heading	NSQHS 2nd Ed Clause Number	Rating Initial Assessment	Description If NM or MR	Rating Final Assessment
Information and decision support tools for medicines	4.13	M		M
Safe and secure storage and distribution of medicines	4.14	M		M
High-risk medicines	4.15	M	**OFI:** The development of a signature register would assist with monitoring of staff signing out S4 and S8 medicines, particularly as staff numbers increase.	M
5 Comprehensive Care Standard				
Integrating clinical governance	5.1	M		M
Applying quality improvement systems	5.2	M		M
Partnering with consumers	5.3	M		M
Designing systems to deliver comprehensive care	5.4	M		M
Collaboration and teamwork	5.5	M		M
	5.6	M		M
Planning for comprehensive care	5.7	M		M
	5.8	M		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.	N/A
Screening of risk	5.10	M		M
Clinical assessment	5.11	M		M
Developing the comprehensive care plan	5.12	M		M
	5.13	M		M
Using the comprehensive care plan	5.14	M		M
Comprehensive care at the end of life	5.15	N/A	SPC does not provide care to patients at end of life.	N/A
	5.16	N/A	SPC does not provide care to patients at end of life.	N/A
	5.17	M		M
	5.18	N/A	SPC does not provide care to patients at end of life.	N/A
	5.19	N/A	SPC does not provide care to patients at end of life.	N/A
	5.20	N/A	SPC does not provide care to patients at end of life.	N/A
Preventing and managing pressure injuries	5.21	M	Not applicable status to be reviewed in 12 months when patient outcome data is available.	M
	5.22	M	Not applicable status to be reviewed in 12 months when patient outcome data is available.	M

Heading	NSQHS 2nd Ed Clause Number	Rating Initial Assessment	Description If NM or MR	Rating Final Assessment
	5.23	M	Not applicable status to be reviewed in 12 months when patient outcome data is available.	M
Preventing falls and harm from falls	5.24	M	Not applicable status to be reviewed in 12 months when patient outcome data is available.	M
	5.25	M	Not applicable status to be reviewed in 12 months when patient outcome data is available.	M
	5.26	M	Not applicable status to be reviewed in 12 months when patient outcome data is available.	M
Nutrition and hydration	5.27	N/A	Day only procedures	N/A
	5.28	N/A	Day only procedures	N/A
Preventing delirium and managing cognitive impairment	5.29	M		M
	5.30	M		M
Predicting, preventing and managing self-harm and suicide	5.31	M		M
	5.32	N/A	Patients at risk of self-harm or suicide would not be admitted.	N/A
Predicting, preventing and managing aggression and violence	5.33	M	**OFI:** It may be advantageous for the counsellors to provide in-service on managing aggressive patients	M
	5.34	N/A	Patients at risk of becoming aggressive or violent would not be admitted	N/A
Minimising restrictive practices: restraint	5.35	N/A	Restraint practices are not used.	N/A
Minimising restrictive practices: seclusion	5.36	N/A	Seclusion is not used.	N/A
6 Communicating for Safety Standard				
Integrating clinical governance	6.1	M		M
Applying quality improvement systems	6.2	M		M
Partnering with consumers	6.3	M		M
Organisational processes to support effective communication	6.4	M		M
Correct identification and procedure matching	6.5	M		M
	6.6	M		M
Clinical handover	6.7	M		M
	6.8	M		M

Heading	NSQHS 2nd Ed Clause Number	Rating Initial Assessment	Description If NM or MR	Rating Final Assessment
Communicating critical information	6.9	M		M
	6.10	M		M
Documentation of information	6.11	M		M
7 Blood Management Standard				
Integrating clinical governance	7.1	N/A	There are no blood or blood products stored or used within SPC.	N/A
Applying quality improvement systems	7.2	N/A	There are no blood or blood products stored or used within SPC.	N/A
Partnering with consumers	7.3	N/A	There are no blood or blood products stored or used within SPC.	N/A
Optimising and conserving patients' own blood	7.4	N/A	There are no blood or blood products stored or used within SPC.	N/A
Documenting	7.5	N/A	There are no blood or blood products stored or used within SPC.	N/A
Prescribing and administering blood and blood products	7.6	N/A	There are no blood or blood products stored or used within SPC.	N/A
Reporting adverse events	7.7	N/A	There are no blood or blood products stored or used within SPC.	N/A
	7.8	N/A	There are no blood or blood products stored or used within SPC.	N/A
Storing, distributing and tracing blood and blood products	7.9	N/A	There are no blood or blood products stored or used within SPC.	N/A
Availability of blood	7.10	N/A	There are no blood or blood products stored or used within SPC.	N/A
8 Recognising and Responding to Acute Deterioration Standard				
Integrating clinical governance	8.1	M		M
Applying quality improvement systems	8.2	M		M
Partnering with consumers	8.3	M		M
Recognising acute deterioration	8.4	M		M
	8.5	M		M
Escalating care	8.6	M		M
	8.7	M		M
	8.8	M		M
	8.9	M		M

Heading	NSQHS 2nd Ed Clause Number	Rating Initial Assessment	Description If NM or MR	Rating Final Assessment
Responding to deterioration	8.10	M	**OFI:** Medical emergency could be included on the Orientation Checklist for all staff.	M
	8.11	M		M
	8.12	M		M
	8.13	M		M

PICMoRS Methodology

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 observed were able to access information, be it hard copy or electronic. The goal is to maintain all documentation electronically.

Improvement – improvement strategies and how to determine the effectiveness of changes has been discussed. A review of the processes for pre-procedure medication has recently resulted in a change of practice that is yet to be tested for its effectiveness.

Consumer – consumer involvement in review or design of processes and the development of improvement strategies to date has been restricted to one-on-one discussions with a few patients with no specific feedback received. Consumers will participate in the design of the website prior to its introduction.

Monitoring – ongoing monitoring strategies have been determined through the use of clinical indicator data that will be reported to the Medical Advisory Committee.

Reporting – evidence of reporting of information has been demonstrated at this stage through sampling of Medical Advisory Committee meeting minutes (4/2/2020 and 4/11/2020). RiskClear has also been introduced as a further means of reporting information such as internal audits, incidents, complaints and patient feedback.

Systems – integration of safety and quality systems has been evidenced through review of training and education programs and the development of policies that meet the needs of the facility.

High Risk Scenarios

High risk scenarios have been reviewed, particularly the actions to be followed in the event of an emergency be it a medical or surgical event. Resources particularly were discussed with all personnel. The acknowledgement that there is a lack of sufficient and appropriately trained staff has resulted in the issuing of a Not Met action.

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

Unresolved Issues

Nil recorded

Justification for Use of One Auditor

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

☒ N/A

Progress toward implementation of AS/NZS 4187:2014 (as amended)

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:

Single use items only are utilised in the procedure room. There is no method for sterilising available onsite.

The only RMD available is limited to a transvaginal ultrasound transducer. Disinfection methods have been implemented and were observed.

A sterile storage area is available and issues identified with temperature and humidity have been declared a Not Met action.

CONCLUSION

The assessment determined that except for the not met actions identified in this report, the Management System satisfies the requirements for Interim Accreditation to the National Safety and Quality Health Service Standards. Accreditation to the NSQHS Standards is therefore **conditional** on successful closure of all not met actions within 60 days of the final day of this assessment (March 17, 2021).

It is considered that **Southside Procedure Centre** 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 the team during the audit and for choosing DNV GL to be partners with you in the accreditation of your safety and quality system. Our aim is to ensure your safety and quality 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

DNV GL, its employees, assessors and contractors, shall keep all information relating to your organisation collected during this audit confidential, and shall not disclose any such information to any third party, except that as required by legislation or relevant accreditation bodies.
DNV GL, its employees, assessors and contractors and accreditation bodies have signed confidentiality agreements and will only receive confidential information as per the requirement of the standards being audited.
Please note that all our assessors are under instruction to destroy all audit evidence held on portable electronic devices once the report is concluded.

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Report by:	Rhonda Williams RN MScMed		December 19, 2020
	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 business days	Within 60 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 60 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.

FINAL ASSESSMENT

Not met actions identified at the initial assessment were followed up in a desk top review and detailed below.

Heading	NSQHS 2nd Ed Clause Number	Corrective action	Rating Final Assessment
Organisational leadership	1.5	Approval to employ experienced perioperative nurses has been completed (2 new staff – MG, TW). Nursing agency will continue to support additional requirements	M
Safety and quality training	MR 1.20d	DON has received training on how to run reports on staff training status – learner report status verified (KB)	M
Standard and transmission-based precautions	3.5	All perioperative staff have completed infection control training (Steam Consulting on-line training modules). Competency assessments have been completed.	M
Aseptic technique	3.9	Perioperative staff have completed on-line training, assessments and quiz (Aseptic Technique and Invasive Devices Quiz).	M
Clean environment	3.11	Cleaner has signed an agreement that includes daily, weekly, monthly schedules that reference NHMRC Infection Control Guidelines. The cleaner has completed Steam Consulting on-line infection control module.	M
Workforce immunisation	3.13	City Fertility National HR Manager has added immunisation to Pre-employment Check for peri-operative staff. Immunisation status to be provided at pre-employment and noted on employment register for individual staff member (KP)	M
Reprocessing of reusable devices	3.14	Dirty utility and sterile stock rooms have been swapped. Two additional air conditioning vents added. Heat reflective film applied to window. Clever logger – temp/humidity installed in sterile stock room.	M

RECOMMENDATION

Recommendation for accreditation is made.

Final Report by:	Rhonda Williams RN MScMed		March 1, 2021
	Lead Assessor	**Signature**	**Date**