DNV Business Assurance Australia

BRISBANE PROCEDURE CENTRE

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

Team Leader: Rhonda Williams

Date of Assessment: April 7 and 8, 2021

Project Number: PRJC-225666-2021-AST-AUS

CLIENT INFORMATION

Client:	Brisbane 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	April 7 and 8, 2021			
Final Assessment Date	April 7 and 8, 2021			
Duration	Onsite: 2 days			
Assessed Site	42 Doggett Street, Newstead QLD 4006			
Assessment team	Lead Assessor	Rhonda Williams		
	Team member	Amanda Ginger (8th April only)		
	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: 1.2, 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, 5.29b, 5.32, 5.34, 5.35, 5.36, Std 7.

Health Facility Registration Details: QLD Health Licence QDH0611/20 expiry 30/9/2021
Poisons Licence: included in licence

EA Code: 38	Employee Numbers: 6	Licensed Beds: 3 Stage 1 bays

Changes in Client Information at this Assessment

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

Comment

Client: Brisbane Procedure Centre	Assessment Dates: April 7-8, 2021
Assessment Report: NSQHS Standards	PRJC-225666-2021-AST-AUS

EXECUTIVE SUMMARY

An initial assessment of **Brisbane Procedure Centre** Management System was conducted on the above dates by DNV 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 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 NSQHSS actions identified as Not Met	Nil	
Number of NSQHSS actions identified as Met with Recommendations	Nil	
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	N/A		
Date for closeout of Not Met Actions	N/A		
Recommended date for next assessment	Within 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

Brisbane Procedure Centre (BPC) is a new purpose built facility providing surgical services for patients undergoing fertility treatment. BPC, under the umbrella of City Fertility and City Health Day Hospitals, is co-located with the RTAC licenced and accredited facility, City Fertility Brisbane. The facility consists of one theatre, one embryo transfer room, three stage 1 recovery trolleys and three stage 2 recliners, and a sterile storage area. With the exception of a reusable 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.

QLD Health licensing has been completed and the first procedure was undertaken on March 25th. BPC is licensed to perform oocyte collection, embryo transfer, hysteroscopy, termination of pregnancy and cervical procedures only. To date procedures have been performed under IV sedation and conscious sedation (Penthrox) only.

There are currently four permanent peri-operative staff available. Extra staffing is sourced from a nursing agency. There is also the ability to share some staff resources with Southside Procedure Centre, another City Health licensed facility located in Sunnybank QLD.

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. BPC is aware that interim accreditation only is granted at this stage and a further assessment is to be undertaken within twelve months at which time Not Applicable actions requested will also be reviewed.

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 BPC activities, in accordance with the clinical governance framework, have been outlined within 1.10.1 Clinical Governance – Governing Body v2 30/11/2020. The Medical Advisory Committee (combined Brisbane and Southside Procedure Centres) reports to the City Fertility/City Health Chief Executive Committee. The requirements of the NSQHSS have been integrated into the quality management system infrastructure (Safety and Quality Manual QMS001 v19 10/11/2020). An Attestation Statement (that incorporates all City Health facilities) has been received for 2020/21.

Processes are in place to engage consumer and carer feedback on safety and quality systems currently being managed through one on one interviews or feedback surveys. As processes are generally similar across all City Health facilities consumer feedback has been used from other facilities to drive improvements for the group. A consumer representative for Brisbane has only just been appointed with formal orientation to be completed next week.

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).

With patients' permission, processes (to determine compliance with the NSQHS Standards) were observed from admission to discharge for patients undergoing procedures on April 8th.

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	N/A	Patient cohort expected to be minimal with risks the same as the general population.	N/A
Organisational leadership	1.3	M		M
	1.4	N/A	Patient cohort expected to be minimal with risks the same as the general population.	N/A
	1.5	M		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		M
	1.17	M		M
Healthcare records	1.18	Prescribed		Prescribed
Safety and quality training	1.19	M		M
	1.20	M	1.20 (a) (b) Prescribed	M (c) (d)
	1.21	M		M
Performance management	1.22	M		M

Heading	NSQHS 2nd Ed Clause Number	Rating Initial Assessment	Description If NM or MR	Rating Final Assessment
Credentialing and scope of clinical practice	1.23	M (a) (b)	1.23 (c) Prescribed **OFI:** The process for introduction of new procedures (4.6) could be strengthened. As the MAC is combined for both Brisbane and Southside Procedure Centres it may be beneficial to have these included as two distinct agenda items.	M (a) (b)
	1.24	M (a)	1.24 (b) Prescribed **OFI:** If laparoscopies are not included as part of licensing it could be removed from the Credentialing Application Form.	M (a)
Safety and quality roles and responsibilities	1.25	M		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	N/A	Patient cohort expected to be minimal. There is acknowledgement within meetings and within patient information.	N/A
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	**OFI:** The procedure for the way patients/carers are involved in the decision making process could be strengthened within the policy (1.10.6).	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	N/A	Patient cohort expected to be minimal.	N/A
	2.14	Prescribed		Prescribed
3 Preventing and Controlling Healthcare-Associated Infection Standard				
Integrating clinical governance	3.1	M		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	M		M
	3.6	M		M
	3.7	M		M
Hand hygiene	3.8	M (a)	3.8 (b) Prescribed	M (a)
Aseptic technique	3.9	M (a) (b) (c)	3.9 (d) Prescribed	M (a) (b) (c)
Invasive medical devices	3.10	M	**OFI:** Include anaesthetists in the invasive devices audit (for insertion of IV cannula).	M
Clean environment	3.11	M	**OFI:** Add a cleaning schedule completion audit to the audit calendar (currently managed through the cleaning company).	M
	3.12	M		M
Workforce immunisation	3.13	M	**OFI:** Consider an ongoing immunisation program for staff (currently managed externally).	M
Reprocessing of reusable devices	3.14	M		M
Antimicrobial stewardship	3.15	M	**OFI:** Consider adding indication for antibiotic prescribing in the recovery register as they are not routinely administered.	M
	3.16	Prescribed		Prescribed
4 Medication Safety Standard				
Integrating clinical governance	4.1	M	**OFI:** It would be beneficial if each of the procedure centres have their own specific medication policies (currently overarching) as there are different requirements in each State.	M

Heading	NSQHS 2nd Ed Clause Number	Rating Initial Assessment	Description If NM or MR	Rating Final Assessment
			The process for determining how the patient is to receive a pre-medication could be included in the medication policy.	
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		M
Information for patients	4.11	M		M
Provision of a medicines list	4.12	N/A	Medications are not altered during the episode of care.	N/A
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		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

Heading	NSQHS 2nd Ed Clause Number	Rating Initial Assessment	Description If NM or MR	Rating Final Assessment
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	BPC does not provide care to patients at end of life.	N/A
	5.16	N/A	BPC does not provide care to patients at end of life.	N/A
	5.17	M		M
	5.18	N/A	BPC does not provide care to patients at end of life.	N/A
	5.19	N/A	BPC does not provide care to patients at end of life.	N/A
	5.20	N/A	BPC 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
	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(a) N/A (b)	Antipsychotics and other psychoactive medicines are not used	M (a) N/A(b)
	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		M
	5.34	N/A	Patients at risk of becoming aggressive or violent would not be admitted	N/A

Heading	NSQHS 2nd Ed Clause Number	Rating Initial Assessment	Description If NM or MR	Rating Final Assessment
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	**OFI:** ISOBAR could be included in the Clinical Handover Policy (currently on the Alert Form).	M
	6.8	M		M
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 BPC.	N/A
Applying quality improvement systems	7.2	N/A	There are no blood or blood products stored or used within BPC.	N/A
Partnering with consumers	7.3	N/A	There are no blood or blood products stored or used within BPC.	N/A
Optimising and conserving patients' own blood	7.4	N/A	There are no blood or blood products stored or used within BPC.	N/A
Documenting	7.5	N/A	There are no blood or blood products stored or used within BPC.	N/A
Prescribing and administering blood and blood products	7.6	N/A	There are no blood or blood products stored or used within BPC.	N/A
Reporting adverse events	7.7	N/A	There are no blood or blood products stored or used within BPC.	N/A
	7.8	N/A	There are no blood or blood products stored or used within BPC.	N/A

Heading	NSQHS 2nd Ed Clause Number	Rating Initial Assessment	Description If NM or MR	Rating Final Assessment
Storing, distributing and tracing blood and blood products	7.9	N/A	There are no blood or blood products stored or used within BPC.	N/A
Availability of blood	7.10	N/A	There are no blood or blood products stored or used within BPC.	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	**OFI:** How to escalate care posters (e.g. REACH) could be included in the patient folder.	M
	8.8	M		M
	8.9	M		M
Responding to deterioration	8.10	M		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. Patients are provided with a feedback tool to discuss the admission process in order to implement changes in these early days.

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. During the assessment a consumer had just agreed to be a representative for the facility and will commence reviewing information and particularly the website which is new.

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

Reporting – evidence of reporting of information has been demonstrated at this stage through sampling of Medical Advisory Committee meeting minutes (22/2/2021). 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 discussed with staff, particularly the actions to be followed in the event of an emergency be it a medical or surgical event. Staff were able to provide video evidence of training in the evacuation of a patient in the event of an emergency. It is expected that training in other medical emergencies specific to fertility treatment such as Ovarian Hyperstimulation Syndrome and the signs to look for in the patient will be provided as well.

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 February 2021)

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.

CONCLUSION

The assessment determined that the Management System satisfies the requirements for Interim Accreditation to the National Safety and Quality Health Service Standards.

It is considered that **Brisbane 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 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 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 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		April 10, 2021
	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 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.