

POLICY TITLE: QUALITY MANAGEMENT & IMPROVEMENT

Sunshine Coast University Private Hospital recognises that the principal responsibility for a patient's care lies with that patient's doctor. Following consultation with doctors and clinical employees, and through reference to current industry best practice standards, we have developed this policy as a minimum standard to ensure that optimal care is given to the patient. Facility management and relevant employees must comply with this policy and ensure that these minimum standards are integrated into the Hospital's clinical systems and Employee's individual practice.

Key Words:	Quality; Systems; Processes; Improvement; Accreditation
POLICY STATEMENT:	<p>Sunshine Coast University Private Hospital (SCUPH) is committed to a systematic evaluation of services / care provided by the hospital and to ensure that improvement is constantly sought to maintain and exceed levels of excellence through the Hospital Quality Management System (QMS), Mission Statement and the Ramsay Way Values.</p> <p>The QMS shall comply with the procedure requirements of ISO 9001:2008 to:</p> <ol style="list-style-type: none"> Provide a customer defined high quality service, which will be achieved through regular customer consultation via customer surveys and ongoing feedback mechanisms including meetings of clinicians. Provide an avenue for identifying, resolving and preventing activities or incidents that form a barrier to the ability to deliver a high quality service with a dynamic reporting mechanism (Riskman). Through regular internal auditing to validate the effectiveness of the QMS and use the results of audits as a basis for performance improvement. Achieve and maintain a standard of management and service delivery that meets the requirements of the International Standard ISO 9001:2008. Verification will be obtained by certification to the Standard by an appropriately accredited external auditing body. Use of information provided by key national and international bodies to ensure Sunshine Coast University Private Hospital maintains current legislative, regulation standards and best practice compliance.
POLICY PURPOSE:	<p>The quality approach is defined by the quality management system which complies with ISO9001:2008 and incorporates the core standards for safety and quality in healthcare. Optimal standards of patient care and service delivery will be achieved and maintained through:</p> <ul style="list-style-type: none"> Compliance with Australian Standards, Department of Health Policies, Legislation and Accreditation Guidelines Development of a multi-disciplinary approach to Quality Management Identification and realisation of opportunities for improvement Achievement of the most effective and efficient utilisation of resources for our patients and shareholders Upholding the integrity of the organization Promotion of employee development Benchmarking via ACHS Clinical Indicator submissions and other external bodies Benchmarking via RHC Clinical Indicator submissions

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POLICY REFERS TO:	<ul style="list-style-type: none"> • All employees of Sunshine Coast University Private Hospital • Casual & Agency employees engaged to work at SCUPH • Employed Medical Officers • Medical Practitioners accredited to work at SCUPH
EXPECTED OUTCOME:	<ul style="list-style-type: none"> • The Hospital will have a structured focus on Quality within the organisation based on ISO 9001:2008, Core Standards for Safety & Quality in Healthcare & the National Safety and Quality Health Service (NSQHS) Standards • All departments will adopt a customer focused approach to quality improvements through application of the 'plan-do-check-act' (PDCA) cycle principles of quality improvement • The Executive will be accountable for annual review of performance improvement in the organisation and the Quality Management System (Management Review)
DEFINITIONS:	<p>Quality Management System: the organisational structures, processes, procedures and resources required to implement quality management.</p> <p>Non-conformance: is any outcome that is not the implied or expected outcome of QMS, for example: clinical incident, complaint.</p>
PROCEDURE / GUIDELINES:	<p>Sunshine Coast University Private Hospital (SCUPH) is committed to providing excellence in the quality of care and services we provide to our customers. The hospital achieves this by the continuous evaluation of its key processes. The evaluation is designed to ensure that all departments /units and services set and attain standards of excellence in relation to employees, procedures and equipment within the constraints of available resources. The culture at Sunshine Coast University Private Hospital will reflect "The Ramsay Way" which underpins the Quality Management System and service delivery</p> <p>Quality improvement activities form part of departmental business plans or are entered into the Quality Improvement Register. All activities are reviewed by the Heads of Department Committee and the Executive Committee reviews as required.</p> <p>Data is obtained from multiple sources and used to evaluate processes involved in the provision of care and services.</p> <ul style="list-style-type: none"> • <i>Non-clinical sources include</i> regular financial reviews, cost benefit analysis, service utilisation reviews, employee performance reviews, and minutes of meetings, education reviews, safety audits and incidents. • <i>Clinical and patient related sources include</i> - patient records, case reviews, patient care plans and incident reports, reports from infection control, patient satisfaction surveys and clinical indicators. <p>Responsibility</p> <p>Overall responsibility of the services provided is governed by the Chief Executive Officer and Ramsay Health Care Board of Directors. The Medical Advisory Committee is responsible for the promotion, co-ordination and review of medical quality activities as per Ramsay Facility Rules.</p> <p>Hospital Executive is responsible for establishing the strategic direction and communicating this to employees. In collaboration between the Executive, Quality & Risk Manager and Department Manager, an annual Quality Plan will be developed.</p>

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The Quality Management System (including the Quality Management & Improvement Policy) is audited at regular intervals to monitor its effectiveness and this occurs through the internal audit process. Recommendations from these reviews are reviewed by the Executive Committee and any other relevant committees as required.

The Quality Program is overseen by the *Quality and Risk Manager (QRM)* and reports to the Chief Executive Officer and Director of Clinical Services. The QRM acts as a resource on quality activities and facilitates the implementation and evaluation of the Quality Management & Improvement program for all hospital departments

Department Managers hold overall responsibility for the Quality Program within their department and is responsible for developing and implementing a Quality Plan in their own department, as well as initiating a multi-disciplinary team approach to problem solving

The hospital committee structure has been developed in order to promote a multidisciplinary approach to quality improvement. Each committee has specific responsibilities to ensure all aspects of the health care team are monitored.

When planning for a sustainable quality improvement, the hospital promotes the use of the Plan, Do Check Act Cycle for all improvements as this process has been proven to assist in implementing effective and sustainable improvements

Objectives of the Quality Policy

- Develop and implement a strategic direction for quality improvement activities throughout the hospital which continually improves our customer satisfaction, standards of care and delivery of service;
- The Quality Management & Improvement Policy be reviewed annually by the Executive Committee and be communicated to employees via Memorandum (*Policy Update* Memorandum), QRM monthly report, Head of Department meeting and departmental meetings. An electronic copy will be available on the hospital *Intranet* with a hard copy available at department level. The original authorised version shall be maintained in the Executive office.
- To achieve continuous certification to an international Quality Management System Standard by a recognised JAS-ANZ accredited certifying body;
- Empower all departments/units to develop an approach to quality activities which are customer focussed utilising the organisational processes provided;
- Identify those positions responsible for initiating each specific quality action with a set time frame;
- Review and evaluate outcomes achieved through Quality Activities undertaken throughout the hospital during a twelve month period;
- Ensure co-ordination and integration of quality activities throughout hospital departments/units using a team approach within a customer focussed quality service environment;

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Model for a Successful Quality Improvement

Development Stage – ‘PLAN’

- Define policy/procedure to be reviewed or initiated, or issue to be improved
- Collect baseline information and associated existing policy/procedure, literature search, other RHC hospitals and always review available best practice guidelines
- Complete Corrective / Preventive Action form. Alert QRM.
- Liaise with key stakeholders
- Brainstorm/plan corrective actions
- Build an outcome measure system to evaluate effectiveness if change is required
- Prepare for pilot study or trial as required
- Present revised or instigated policy/procedure/quality improvement at Department / relevant

Revision Stage – ‘ACT’

- Evaluate effectiveness of change/improvement
- Adopt Improvement
- Revise any associated policy/procedures required
- Reward and recognise employee participation
- Communicate changes
- Update policy/procedure as needed for systems, clinical or technology changes
- Complete Improvement Register

Implementation Stage – ‘DO’

- Assign a person responsible to oversee pilot
- Pilot tool or new activity / process
- Survey key stakeholders for feedback
- Keep track of recommended improvements and update documentation
- Provide feedback & progress to key stakeholders

Measurement Stage – ‘CHECK’

- Measure and present outcomes
- QRM to assist & verify results as required/requested
- Post results for all employees to review
- Determine any problems

Sunshine Coast University Private Hospital management requires all employees to be committed to:

- Ensuring all aspects of the services and service delivery offered will be focused on the identified needs of all our customers.
- Promoting and maintaining "best practice" in all individual professional roles.
- Individual responsibility for identifying professional development requirements.
- Commitment to the health and safety policies
- Sharing the responsibility for promoting and improving the QMS.
- Individual responsibility for providing a timely and effective response to non-conformance as per the Ramsay Risk Management policy.

REFERENCES:	<ul style="list-style-type: none"> AS/ANZS ISO 9001- Quality Management Systems - Requirements AS/NZS: 4360:2004 – Risk Management HB 228: 2001: Guidelines for Managing Risk in the Healthcare Sector. HB 90.8 – 2000 Healthcare Services –Guide to ISO 9001:2000 Australian Standard AS2828 – 2012, Paper Based Health Care Records Australian Standard 4801:2001, Section 4.5.3. OHS Management Systems – Specification with guidance for use Queensland Health Standards 2000 – Information Management Standards
RELATED POLICY:	<ul style="list-style-type: none"> Non-Conformance, Reporting & Management (Ref 0006) Management of Preventative and Corrective Actions (Ref 0007) Internal Auditing Program (Ref 0009) SCUPH Quality Manual
STANDARDS:	<ul style="list-style-type: none"> Australian Commission on Safety & Quality in Healthcare (2011) National Safety & Quality Health Service Standards (NSQHSS 1) ISO 9001: 2008 Quality Management System
Authorisation / Ratification:	<p>_____</p> <p>Kimberley Pierce Chief Executive Officer</p>

DOCUMENT HISTORY

<i>Prepared By</i>	<i>Quality & Risk Coordinator</i>	<i>August 2013</i>
<i>Reviewed By (stakeholders)</i>	<i>Chief Executive Officer Director of Clinical Services Assistant Director of Clinical Services</i>	<i>August 2013</i>
<i>Approved By</i>	<i>Executive Committee</i>	<i>September 2013</i>
<i>Endorsed By</i>	<i>Chief Executive Officer</i>	<i>September 2013</i>
Date Implemented	<i>November 2013</i>	
Next Review Due	<i>November 2014</i>	
<i>Document Control</i>	<i>Quality & Risk Coordinator</i>	
<i>Version 1</i>	<i>Initial Release</i>	<i>November 2013</i>

POLICY VALIDITY STATEMENT

This policy is due for review by the date shown above, after which it may become invalid. Policy users should ensure that they are consulting the currently valid version of the document

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POLICY TITLE: CONTROL OF DOCUMENTS

Sunshine Coast University Private Hospital recognises that the principal responsibility for a patient's care lies with that patient's doctor. Following consultation with doctors and clinical employees, and through reference to current industry best practice standards, we have developed this policy as a minimum standard to ensure that optimal care is given to the patient. Facility management and relevant employees must comply with this policy and ensure that these minimum standards are integrated into the Hospital's clinical systems and Employee's individual practice.

Key Words:	Document; Processes; Control
POLICY STATEMENT:	Documents that are used to define, direct and control delivery of our health care service shall be controlled to ensure that they are necessary, accurate, up to date and easily accessible to those employees that require them to undertake tasks. This policy applies to all documents used within the hospital, inclusive of labels
POLICY REFERS TO:	<ul style="list-style-type: none"> All employees of Sunshine Coast University Private Hospital Casual and Agency employees engaged to work at Sunshine Coast University Private Hospital Employed Medical Officers Medical Practitioners accredited to work at Sunshine Coast University Private Hospital
EXPECTED OUTCOME:	<ul style="list-style-type: none"> Variation and/or duplication are eliminated with document control and standardisation. Required forms, policies and other documents are legible, readily available and easily accessible to the appropriate hospital employees. Medical Record forms are compliant with Australian Standards. The organisation and documents comply with relevant legislative requirements. All controlled documents used at Sunshine Coast University Private Hospital will be developed, reviewed and monitored to ensure that information is current and accurate. All internally generated documents comply with the minimum requirements as specified within in this policy for document and version control.
DEFINITIONS:	<p>Forms – These are any internally generated document that are routinely used by employees or other users within the hospital (such as medical staff, patients etc), that assist in the delivery of the health care service. These forms include, but are not limited to; Medical Record forms, that are required to adhere to Australian Standards; daily checklists (e.g. Housekeeping); Clinical Pathways; order forms etc. Once forms have been written on they become records of a task having been completed (see below). Forms, as with documents, MUST be controlled as they too have the ability to affect the delivery of health care. Forms also can be revised or reviewed from time to time.</p> <p>Records – These are important documents used within the hospital as evidence that certain activities have been performed and therefore records also need to be controlled. The key difference between records and documents is that records are usually written on and once this has occurred they cannot be altered or revised, BUT documents can be updated or revised from time to time.</p>

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DOH-DL 14/15-006 RTI Document 6

Document Register – a register of all forms utilised by Sunshine Coast Private Hospital and provides the history & version of such documents.

Documents – are any policies or procedures, work instructions, job descriptions, orientation manuals, duty statements or patient information brochures that are generated internally and used by the hospital or its' employees to guide or direct their delivery of health care. These documents **MUST** be controlled. Documents can be revised or reviewed as necessary.

Control - This means that all documents / forms are approved prior to release with approval authority & date visible. These key documents / forms are updated when necessary & undergo re-approval, are legible and accurate and are available at the point of use to assist employees and other users of the documents and forms, to undertake their duties to ensure the delivery of health care. A central register of these key documents/forms will be maintained by the Policy & Document Control Committee, to ensure control is achieved & the latest version of the document is easily identifiable.

Policy

Policies are documented statements that direct employees as to their responsibilities in relation to the activities of the business. They provide guidance, clarity and consistency for decision making within the organisation. Policies are underpinned by Ramsay values and are developed based upon statutory and organisational requirements and based on the available current best practice

Procedure – a set of written instructions conveying the recommended steps for correctly performing a particular procedure.

Guideline – a set of standards, criteria, or specifications to be followed in performing a certain task.

Competency – Structured and defined criteria required to complete a task that enables a staff member to demonstrate an ability to safely perform a procedure.

Work Instruction / Task Sheet – a set of specific instructions for completing a particular non-clinical task with or without time frames.

Safe Operating Procedures (SOP) – A set of written instructions that addresses the workplace health and safety issues in performing a specific procedure or task.

External Documents – These are documents that are designed and issued by organisations external to the hospital, but are used by the hospital or its' employees to guide them in their duties. These may include but are not limited to; service manuals for equipment, patient information brochures, Government approved forms or documents, legislative changes and Ramsay Corporate policies. These documents must also be controlled and introduced for use in the hospital only after approval by the Executive or CEO

Collectively: policy, procedure, guidelines & SOPs will be known as policy documents.

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**PROCEDURE /
GUIDELINES:**

Ramsay Health Care (RHC) corporate documents provide minimum standards of practice: hospital documents align with corporate process whilst providing additional direction. RHC corporate documents can be identified by the corporate logo and RHC policy number, RHC will document control corporate documents.

Externally created documents:

A central register of documents/forms will be maintained by the Quality & Risk Co-ordinator to ensure control is achieved & the latest version of the document is easily identifiable.

Note:

Documents / records created by Ramsay Health Care will have document control process managed by relevant department:

National Safety Team, Safe Operating procedure:

Document control will be managed by National safety team

Where the original RHC document is altered to meet requirements of SCUPH then this becomes an internal document managed in accordance with this policy.

Internally created Documents

SCUPH Document Register

For ease of use SCUPH documents are organised in the SCUPH policy manual format. All relevant documents will be collated in the SCUPH document index located on SCUPH intranet. SCUPH Index is organised into:

- Policies (all policy documents)
- Forms
- Patient information brochures

Quality & Risk Co-ordinator is responsible for maintaining the SCUPH document register.

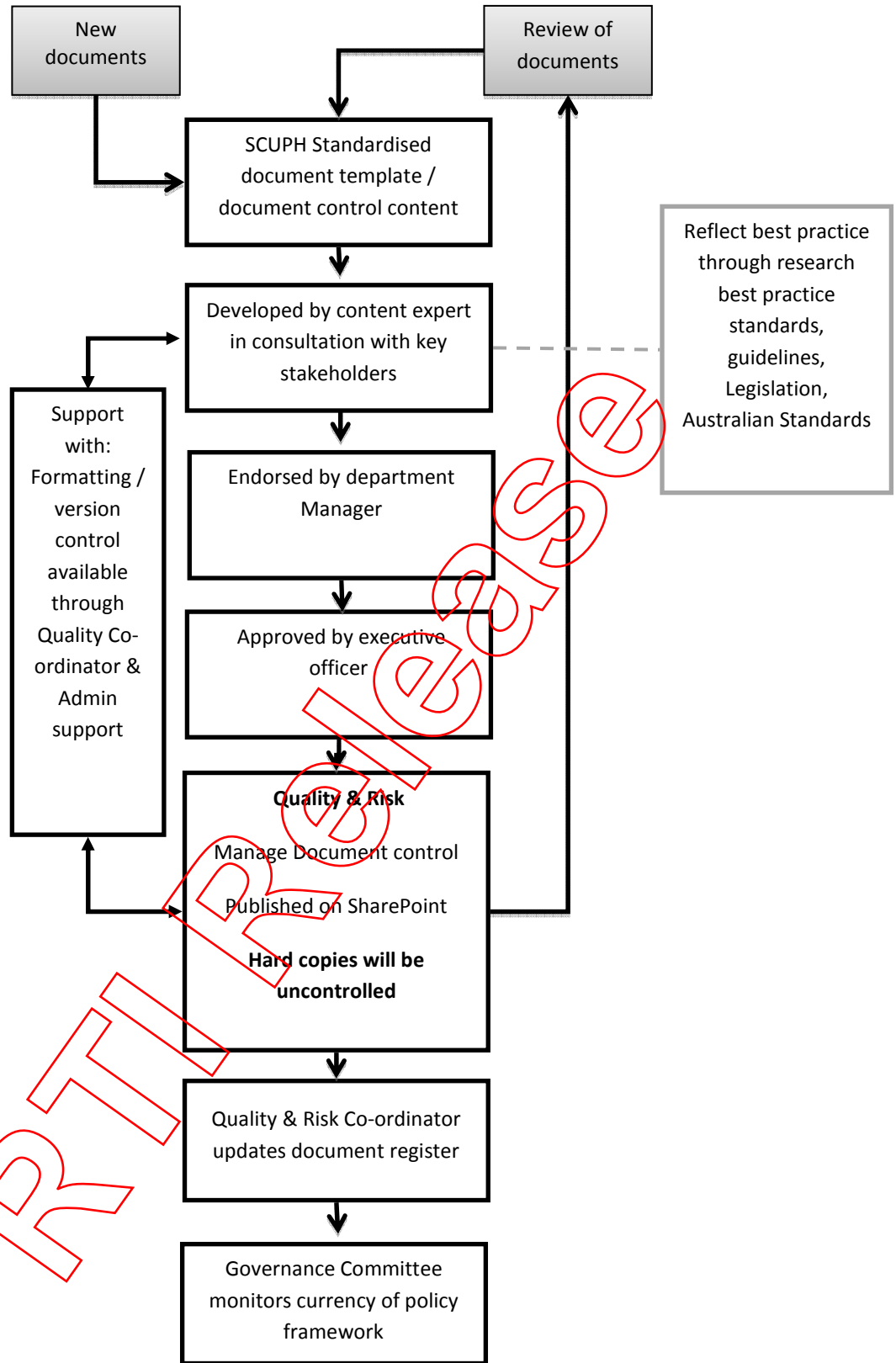
SCUPH documents will be available as an electronic resource on SCUPH intranet page (share point). Employees will be orientated to accessing policy documents on orientation.

As a risk contingency for failure of intranet access: All policy documents will be maintained in a hard copy manual located in the Quality & Risk office and Executive Office. The After Hours Manager will hold a copy of policy documents on a USB, it is the role of the Quality & Risk Co-ordinator to maintain currency of the hard copy manual and the soft copy on AHM USB.

An exception to this process is CSSD where hard copy policy documents will be available in the CSSD department. The CSSD manager is responsible for the currency of the hard copy documents (local and HICMR)

PROCEDURE / GUIDELINES:

Development of SCUPH documents



New documents

To avoid creating duplicate documents consider the scope of current SCUPH & RHC documents.

Prior to development of new Policy, guideline or SOP seek approval from department lead and liaise with Quality and Risk Co-ordinator.

Standardised templates & formatting

- *Policy documents:* SCUPH standardised templates will be utilised for all policy documents. Form F0001, F0002, F0003, F0004, F0005.
- Policy documents will be written in: Calibri, font 11, line spacing 1.15
- *All Other documents:* All internally created documents will detail, as a minimum requirement:

<p>Document History: Document Author (role) & date Approved by (role) & date Date Implemented Next review Document Control contact Version control</p>

Patient Information: Support with formatting is available through marketing department.

Content expert

Nominated Content Expert is responsible for the development of document.
 All documents are to be evidence based with references used being current and appropriate to topic.
 The use of abbreviations is to be avoided and if used, spell the word/s in full followed by the acceptable abbreviation e.g. Quality Improvement (QI), blood pressure (BP).
 All documents must be clearly watermarked as DRAFT, before being forwarded to Department lead.
 Where applicable content must be referenced using APA Style.

Stakeholder consultation

Stakeholder consultation in development and review of documents is essential to ensure that the documents are workable in practice. Effective stakeholder consultation will support the implementation of the new / updated document.
 Representation of all appropriate stakeholders will be consulted in development of documents. Stakeholders (position titles) consulted will be documented within the policy document history.

Policy documents: As appropriate to the policy document consumer consultation should be sought in the development / review of policy document.

Patient Information: Consumer consultation is mandatory for all internally created patient information, this can be facilitated through SCUPH Consumer Advisory Group or formation of consumer focus group.

Department Manager & Executive approval

All documents require endorsement of the department manager and approval of the reporting Executive member.

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Specialty	Department Manager: to endorse document	Executive officer: to approve document
Governance: Quality	Quality & Risk Coordinator	Director Clinical Services
Governance: Learning & Development	Learning & Development Manager	Director Clinical Services
Governance: Health Information Management	Health Information Services Manager	Commercial Manager
Clinical: General	Assistance Director Clinical Services	Director Clinical Services
Clinical: Perioperative Services	Assistant Director of Nursing Perioperative Services	Director Clinical Services
Clinical: ICU	Nursing Unit Manager ICU	Director Clinical Services
Commercial Services: Catering Services	Catering Manager	Commercial Manager
Commercial Services: Facilities Management (Maintenance / Security)	Facilities Manager	Commercial Manager
Commercial Services: Environmental Services	Environmental Services Manager	Commercial Manager
Commercial Services: Administration	Contracts & Patient Administration Manager	Commercial Manager
Work Health & Safety	Occupational Health & Safety Coordinator	Commercial Manager
Infection Prevention & Control	Infection Prevention & Control Coordinator	Director Clinical Services

Version Control

Content expert is responsible for identifying version control on the document in development.

Draft documents will be identified as Version 0.1 with amendments recognised as 0.2, 0.3 etc until *Final Draft* version is complete.

Version 1.0 is the initial release of the ratified document.

Version numbering for authorised and published documents always begins with 1.0, and the number will only be modified after the first minor amendment to become 1.1.

Each major revision would result in the number to the left of the point incrementing by 1 and the number to the right of the dot point returning to zero i.e. 2.0.

Example:

- o The approved and issued document is released as Version 1.0
- o Subsequent minor revisions will be Version 1.1
- o Major revision will be recorded as 2.0 or 3.0 etc

Document Review

All documents will be periodically reviewed.

Role of Executive Officer to nominate appropriate review period in accordance with table below:

Criteria	Review period
Documents addressing high-risk areas (as identified in SCUPH Risk Register). Documents relating directly to the Quality Manual. Policy detailing medication prescription and Nurse Initiated Medications	1 year or more frequently if required.
Documents referring to Legislation or Standards. Policy addressing medium or low risk area (as identified in SCUPH Risk Register).	3 years or more frequently if required.
None of the above criteria apply.	5 years or more frequently if required.

All current documents will be published on the intranet via SharePoint.

SharePoint will trigger review requirements of policy documents to Quality & Risk Co-ordinator who will liaise with Department Manager and content expert to facilitate review.

Document Control Register

The Quality & Risk Co-ordinator will maintain centralised document registers on which all documents and forms in use at SCUPH are registered. This will include internal and external documents.

The Document Register includes the following aspects:

- Document name
- Document control number (where applicable)
- Version number
- Location
- Owner
- Approval/Authorising position
- Date approved/implemented
- Date last reviewed
- Next review date/obsolete

Review dates for all documents will be monitored via the relevant Document Control Register.

• Quality & Risk Co-ordinator role

- Support with development of documents
- Apply reference number to documents as per table below
- Publication of documents on SCUPH intranet.
- Ensuring records management of documents in accordance with *Control of Records Policy (Ref 0002)*.
- Ensure all documents will have appropriate document control as per this policy
- Maintain *Document Register* of all SCUPH documents, forms, policies and relevant RHC policy.

Document Indexing	
Specialty	Reference number (Forms will be prefixed with 'F')
Governance: Quality	001 – 0999
Governance: Learning & Development	1000 – 1499
Governance: Health Information Management	1500 – 1999
Clinical: General; Medical; Surgical; Oncology; Paediatrics; Infection prevention; Allied Health	2000 – 3899
Clinical: Perioperative services	4000 – 4999
Clinical: Intensive Care Unit	5000 – 5499
Commercial Services: Catering services	8500 – 8999
Commercial Services: Facilities Management (maintenance / security)	7000 - 7999
Commercial Services: Environmental Services	6500 – 6999
Commercial Services: Financial Services & Administration	8000 - 8499
Work Health & Safety	6000 – 6499

Governance
Governance committee will monitor compliance with review and currency of documentation.

Archiving Controlled Documents

- The Quality and Risk Co-ordinator is responsible for archiving previous versions of all policies, procedures and obsolete forms and other types of controlled documents. This will be performed electronically if possible and retained for a period of 7 years for policies & procedures and 10 years for medical records or as per legislative requirements. All archived controlled documents will be watermarked "Obsolete" and the month/year of archiving.
- Non-Medical records, e.g. Minutes, Education records, Checklists, etc. are retained for twelve (12) months by the EA to the Chief Executive Officer.

REFERENCES:

- Greenslopes Private Hospital (March 2013) Policies - Creating or Amending Documents
- Ramsay Health Care (2012) Clinical Governance Unit – Policy development policy
- ISO 9001: 2008 Quality Management System (4.2.3)

RELATED FORMS:

- Policy template F0001
- Guideline template F0002 (CSSD F0005)
- SOP template F0003, F0004
- Medical Record Forms Management Policy

**STANDARDS:
LEGISLATION:**

- Australian Commission on Safety & Quality in Healthcare (2011) National Safety & Quality Health Service Standards (NSQHSS 1)
- ISO 9001: 2008 Quality Management System (4.2.3)

Authorisation / Ratification:

_____ Chief Executive Officer
Kimberley Pierce

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DOCUMENT HISTORY

<i>Prepared By</i>	<i>Quality & Risk Coordinator</i>	<i>August 2013</i>
<i>Reviewed By (stakeholders)</i>	<i>Chief Executive Officer Director of Clinical Services Assistant Director of Clinical Services</i>	<i>August 2013</i>
<i>Approved By</i>	<i>Executive Committee</i>	<i>September 2013</i>
<i>Endorsed By</i>	<i>Chief Executive Officer</i>	<i>September 2013</i>
<i>Date Implemented</i>	<i>November 2013</i>	
<i>Next Review Due</i>	<i>November 2016</i>	
<i>Document Control</i>	<i>Quality & Risk Coordinator</i>	
<i>Version 1</i>	<i>Initial Release</i>	<i>November 2013</i>

POLICY VALIDITY STATEMENT
This policy is due for review by the date shown above, after which it may become invalid. Policy users should ensure that they are consulting the currently valid version of the document

RTI Released

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POLICY TITLE: CONTROL OF RECORDS

Sunshine Coast University Private Hospital recognises that the principal responsibility for a patient's care lies with that patient's doctor. Following consultation with doctors and clinical employees, and through reference to current industry best practice standards, we have developed this policy as a minimum standard to ensure that optimal care is given to the patient. Facility management and relevant employees must comply with this policy and ensure that these minimum standards are integrated into the Hospital's clinical systems and Employee's individual practice.

Key Words:	Records; Retention; Storage
POLICY STATEMENT:	<p>Records and documents created, received or used by Sunshine Coast University Private Hospital employees in the normal course of business are the property of the Hospital, unless otherwise agreed. This includes reports compiled by external consultants.</p> <p>The Hospital's records constitute corporate memory, and as such are a vital asset for ongoing operations, and for providing evidence of business activities and transactions.</p> <p>Therefore, records are to be:</p> <ul style="list-style-type: none"> • managed in a consistent and structured manner; • managed in accordance with legislative guidelines and procedures; • stored in a secure manner; and disposed of, or permanently archived, in line with hospital policy.
POLICY REFERS TO:	<ul style="list-style-type: none"> • All employees of Sunshine Coast University Private Hospital • Casual and Agency employees engaged to work at Sunshine Coast University Private Hospital • Employed Medical Officers • Medical Practitioners accredited to work at Sunshine Coast University Private Hospital
EXPECTED OUTCOME:	<ul style="list-style-type: none"> • Records are maintained to provide evidence of patient care outcomes, conformance with requirements and outcomes of the safety and quality systems. • Storage of records is appropriate to protect their integrity and confidentiality for the required retention period.
DEFINITIONS:	<p>Records – Are important documents used within the hospital as evidence that certain activities have been performed and therefore records also need to be controlled. The key difference between records and documents is that records are usually written on and once this has occurred they cannot be altered or revised</p> <p>Control - Documents are approved prior to release – with approval authority & date visible. Documents / forms are updated when necessary & undergo re-approval, are legible and accurate and are available at the point of use to assist employees and other users of the documents/forms to undertake their duties in the delivery of health care. A central register of these key documents/forms will be maintained by Quality & Risk Coordinator to ensure control is achieved & the latest version of the document is available for use.</p>

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PROCEDURE / GUIDELINES:

General Records

- Records are stored in a manner that preserves their physical integrity, legibility and useability until the retention time has expired. Records provide evidence of compliance to procedures and these are to be made available to internal auditors, third party assessors for certification purposes, including compliance assessments and by regulatory bodies for auditing, where it has been agreed.
- The preferred method of record destruction shall be shredding unless specified differently by the Chief Executive Officer or regulatory authority.
- Confidential records are stored securely to prevent unauthorised access.
- Electronic records on all computers are backed up daily by the server with CD/DVD copies locked on site.
- Integrity of electronic records is maintained through the use of anti-virus software which is set to download updates automatically.

Medical Records

Refer to Medical Records Policies available via SharePoint

Back-up procedure:

Backups of information systems occur daily and are managed by RHC MIS are the responsibility of RHC Management Information Systems - refer RHC IT Policy 9.10 *Backup Policy Framework*.

<http://vwidc95/sites/corporate/ITServices/Policies%20and%20Procedures/Backup%20Policy%20Framework.pdf>

and Backup Procedure - *MIS PR003 Backup Procedure*

Record retention and archiving:

refer Medical Records policies:

- *Retention & Disposal of clinical records*
- *Storage & Culling of medical records*
- *Control of Documents (Ref 0002)*

Record Type	Master Copy Format	Storage Location & Responsible Officer	Retention Period
Policies and Procedures	Electronic	SharePoint QRC	Indefinitely
Minutes of Meetings	Electronic	SharePoint Executive Assistant	
Internal Audit Records	Electronic	SharePointQRC	
Employee Health	Hard Copy / electronic	File Path IC Co-ordinator	30 years
Rosters	Hard Copy	Executive Office Executive	7 years
Education Records	Electronic & Hard Copy	Executive Office Learning & Development Manager	7 years
Riskman Database Entries	Electronic	Ramsay Corporate	30 years
Employee Return to Work/Rehabilitation case Notes	Hard Copy	R&RTWC Office RTW Co-ordinator	10 years
HR/ Personnel Records	Hard Copy	Executive Office Executive	7 years post termination.
VMO / Credentialing	Hard copy	Executive Office Executive	8 years

	Medical Records	Hard copy	Medical Records Health Information Manager	Adults: 10yr Child: 28yr
	Medico-legal & other correspondence	Hard copy	Executive Office Executive	7yrs post last entry
	Operating Theatre register	Electronic & Hard Copy	Front Office Manager Medical Records	Indefinitely
	Drug registers	Hard copy	Executive Office Executive	2yrs after last entry
	External survey reports & service agreements	Hard Copy	Executive Office Executive	Hard copy 7y Electronic – Indefinitely
		Electronic		
	Financial Records	Hard Copy	Executive Office Commercial Manager	8 years
		Electronic		
	Purchasing Records	Hard copy Electronic	SAP Supply Officer	7 years
	Safety Documents and Registers	Hard copy	H&S Office WH&S Manager	7 years
	Safety Data Sheets	Hard copy	WH&S Office WH&S Manager	5 years
	Maintenance Records	Electronic	TFMS Maintenance Manager	3 years
REFERENCES:	<ul style="list-style-type: none"> AS/ANZS ISO 9001- Quality Management Systems - Requirements HB 90.8 – 2000 Healthcare Services –Guide to ISO 9001:2000 Australian Standard AS2828 – 2012, Paper Based Health Care Records Australian Standard AS4801:2001, Section 4.5.3. OHS Management Systems – Specification with guidance for use Queensland Health Standards 2000 – Information Management Standards 			
RELATED / POLICY:	<ul style="list-style-type: none"> Control of Documents (Ref 0002) Internal Audit Program (Ref 0009) Medical Records Policies/Procedures: via SharePoint <ul style="list-style-type: none"> Standard, Format & Characteristics Creating an additional volume Retrieval of patient medical record Retention & Destruction Tracking of patient medical records RHC IT policies: <ul style="list-style-type: none"> http://vwidc95/sites/corporate/ITServices/Pages/PoliciesandForms.aspx IT Security policy http://vwidc95/sites/corporate/ITServices/Policies%20and%20Procedures/IT%20Security%20Policy.pdf 			
STANDARDS:	<ul style="list-style-type: none"> AS/ANZS ISO 9001- Quality Management Systems - Requirements HB 90.8 – 2000 Healthcare Services –Guide to ISO 9001:2000 Australian Standard AS2828 – 2012, Paper Based Health Care Records Australian Standard AS4801:2001, Section 4.5.3. OHS Management Systems – Specification with guidance for use Queensland Health Standards 2000 – Information Management Standards 			
Authorisation / Ratification:	<hr/> Kimberley Pierce			Chief Executive Officer

Manual Title: Governance / Quality	Page 3 of 4	Facility Policy Number: 0005
Policy Title: Control of Records	Version 1	

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DOH-DL 14/15-006 Document 17

DOCUMENT HISTORY

<i>Prepared By</i>	<i>Quality & Risk Coordinator</i>	<i>August 2013</i>
<i>Reviewed By (stakeholders)</i>	<i>Chief Executive Officer Director of Clinical Services Assistant Director of Clinical Services</i>	<i>August 2013</i>
<i>Approved By</i>	<i>Executive Committee</i>	<i>September 2013</i>
<i>Endorsed By</i>	<i>Chief Executive Officer</i>	<i>September 2013</i>
<i>Date Implemented</i>	<i>November 2013</i>	
<i>Next Review Due</i>	<i>November 2016</i>	
<i>Document Control</i>	<i>Quality & Risk Coordinator</i>	
<i>Version 1</i>	<i>Initial Release</i>	<i>November 2013</i>

POLICY VALIDITY STATEMENT

This policy is due for review by the date shown above, after which it may become invalid. Policy users should ensure that they are consulting the currently valid version of the document

RTI Released

Manual Title: Governance / Quality	Page 4 of 4	Facility Policy Number: 0005
Policy Title: Control of Records	Version 1	

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DOH-DL 14/15-006

RTI Document 18

POLICY TITLE: CONTROL OF NON CONFORMANCES, CORRECTIVE AND PREVENTIVE ACTION

Sunshine Coast University Private Hospital recognises that the principal responsibility for a patient's care lies with that patient's doctor. Following consultation with doctors and clinical employees, and through reference to current industry best practice standards, we have developed this policy as a minimum standard to ensure that optimal care is given to the patient. Facility management and relevant employees must comply with this policy and ensure that these minimum standards are integrated into the Hospital's clinical systems and Employee's individual practice.

Key Words:	Continual improvement; Non-conformance; Corrective; Preventive; Risk
POLICY STATEMENT:	<p>Sunshine Coast University Private Hospital (SCUPH) will participate in the development & maintenance of a robust risk management program for the identification, analysis, and management of potential non-conformances.</p> <p>Non-conformances relating to health, safety or property are documented via Riskman Incident Reporting System. Non-conformances relate to equipment repairs are logged on online Maintenance Program (AssetPlus). All non-conformances are managed so as to prevent their recurrence.</p> <p>Records of actions taken and the subsequent review are to be maintained as per the Policies (Control of Documents, Control of Records, Internal Audit program)</p>
POLICY REFERS TO:	<ul style="list-style-type: none"> • All employees of Sunshine Coast University Private Hospital • Casual and Agency employees engaged to work at SCUPH • Medical Practitioners accredited to work at SCUPH
EXPECTED OUTCOME:	<ul style="list-style-type: none"> • Effective management of non-conformances facilitates the process of continuous quality improvement and effective risk management. • To ensure timely recording and resolution of non-conformances, corrective and preventive actions and that the outcome of these actions is effective. • To ensure staff are aware of their responsibilities in the Quality Management System (QMS) cycle and are proactive in identification and elimination of possible causes of customer complaints and non-conformity.
DEFINITIONS:	<p>Non-Conformance – Any outcome or measure that does not meet the stated expectations of the health service product or the QMS. Expectations may be implied or stated.</p> <p>Preventive Action – is concerned with analysing the system using the available data and information to identify causes for potential problems and thus eliminating possible causes of nonconformity or patient/customer complaints.</p> <p>Corrective Action – is generally initiated by the occurrence of a nonconformity, patient/customer complaint, or similar event. Corrective action is taken to ensure that the cause of a problem is identified and action taken to prevent recurrence of the problem.</p> <p>Continual Improvement – is a set of activities that an organisation carries out in order to enhance its ability to meet requirements. This can be achieved by carrying out audits, self-assessment, management reviews and benchmarking projects</p>

Manual Title: Governance: Quality	Facility Policy Number: 0006
Policy Title: Control of Non-conformances, Corrective & Preventive Actions	Page 1 of 3 Version 1

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**PROCEDURE /
GUIDELINES:**

Non-conformance may include but are not limited to:

- Clinical Incident,
- Safety Incident,
- Complaints,
- Outcome of audit,
- Outcome of external review.

Non-conformances such as identified hazards or incidents and complaints will be treated as incidents/events and be entered into Riskman.

Non-conformances raised/identified through quality activities, internal audits and committee meetings, external reviews are to be forwarded to the Quality & Risk Co-ordinator.

Employees may document the details of non-conformances or process improvements on the *Corrective & Preventive Action Process Improvement Form* located on the SCUPH Intranet and forward to their department manager

The relevant Department Manager is provided the *Corrective & Preventive Action Process Improvement form* to add their preventive/corrective actions and allocate a risk rating as per the Ramsay Risk Rating Code. The department manager is responsible for analysis of the problem to determine the cause of the non-conformance

Responsibility for managing non-conformances and subsequent re-verification including review of the effectiveness of the action taken will that of the Department Manager recorded on the *Corrective & Preventive Action Register* as the responsible person. A copy of the completed and in-progress actions / improvements will be reported to relevant Committee, Heads of Department Committee (monthly) and Quality Improvement Committee.

Intent of review is to assess system that may have contributed to non-conformance and develop relevant preventative / corrective actions to prevent re-occurrence.

The *Corrective & Preventive Action Form* is to be forwarded to the Quality and Risk Co-ordinator who will document the non-conformance on the *Corrective & preventive Action Register* and allocate a register number for tracking. The register located on SCUPH intranet site.

In management of non-conformance senior manager is to ensure adherence to relevant policy specific to non-conformance, for example: Corporate *Clinical Governance Unit, Clinical Incident Guidelines*.

Where review of non-conformance identifies performance management concerns these are to be reported to appropriate line manager for action.

Except in extraordinary circumstances, it is expected that non-conformances will be closed out within a risk assessed timeframe.

Manual Title: Governance: Quality		Facility Policy Number: 0006
Policy Title: Control of Non-conformances, Corrective & Preventive Actions	Page 2 of 3	Version 1

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	<p>As a guide:</p> <p>Extreme risk (RRR 1) : items will be required to be addressed immediately</p> <p>High risk (RRR 2): items will be closed within 2 months</p> <p>Medium/Low risk (RRR3 or 4): items will be closed within a 6 month timeframe.</p> <p>Long term corrective actions will remain open on the register as projects progress. All open items will continue to be reviewed on a monthly basis.</p> <p>Management of non-conformance and effectiveness of preventative / corrective actions will be measured as part of the ongoing audit system.</p> <p>Verification of completion of corrective actions will be undertaken by an allocated trained internal auditor with review for compliance and tracking through meeting minutes as appropriate</p>
REFERENCES:	<ul style="list-style-type: none"> AS/NZS ISO 9001:2008 Quality Management Systems – Requirements Greenslopes Private Hospital (2012) Non-Conformance Management & Reporting Nambour Selangor Private Hospital (2012) Control of Non-conformance HB 90.8 – 2000 Healthcare Services – Guide to ISO 9001:2000
RELATED POLICY:	Internal Audit Program (Ref 0009)
RELATED FORMS	<ul style="list-style-type: none"> Corrective & Preventive Action Register The Corrective & Preventive Action Form Ramsay Risk Rating Matrix
LEGISLATION / STANDARDS:	<ul style="list-style-type: none"> AS/NZS ISO 9001:2008 Quality Management Systems – Requirements NSQHS Standard 1
Authorisation / Ratification:	<p>_____ Chief Executive Officer</p> <p>Kimberley Pierce</p>

DOCUMENT HISTORY

<i>Prepared By</i>	<i>Quality & Risk Coordinator</i>	<i>August 2013</i>
<i>Reviewed By (stakeholders)</i>	<i>Chief Executive Officer Director of Clinical Services Assistant Director of Clinical Services</i>	<i>August 2013</i>
<i>Approved By</i>	<i>Executive Committee</i>	<i>September 2013</i>
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<i>Version 1</i>	<i>Initial Release</i>	<i>November 2013</i>

POLICY VALIDITY STATEMENT

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Manual Title: Governance: Quality		Facility Policy Number: 0006
Policy Title: Control of Non-conformances, Corrective & Preventive Actions	Page 3 of 3	Version 1

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Document 21

DOH-DL 14/15-006

POLICY TITLE: INTERNAL AUDIT PROGRAM

Sunshine Coast University Private Hospital recognises that the principal responsibility for a patient's care lies with that patient's doctor. Following consultation with doctors and clinical employees, and through reference to current industry best practice standards, we have developed this policy as a minimum standard to ensure that optimal care is given to the patient. Facility management and relevant employees must comply with this policy and ensure that these minimum standards are integrated into the Hospital's clinical systems and Employee's individual practice.

Key Words:	Audit; compliance; non-conformance
POLICY STATEMENT:	<p>Sunshine Coast University Private Hospital is committed to a systematic evaluation of services / care provided by the hospital and to ensure that improvement is constantly sought to maintain and exceed levels of excellence through the Hospital Quality Management System (QMS), Values and the Ramsay Way Values</p> <p>The audit program at Sunshine Coast University Private Hospital will concurrently verify compliance with the National Safety & Quality in Health Service (NSQHS) Standards.</p>
POLICY REFERS TO:	<ul style="list-style-type: none"> All employees of Sunshine Coast University Private Hospital Casual and Agency employees engaged to work at SCUPH Medical Practitioners accredited to work at SCUPH
EXPECTED OUTCOME:	<ul style="list-style-type: none"> Sunshine Coast University Private Hospital exhibits a Quality Management System that is effective in assisting the organisation achieve its goals. Sunshine Coast University Private Hospital has an effective Internal Audit program that assists in reducing variations in processes and identifies opportunities for improvement. demonstrates compliance with ISO 9001:2008 Quality management systems, National Safety & Quality Health Service Standards, requirements of Queensland Private Health Regulatory unit and Work Health & Safety Act & Regulation (QLD) 2011
DEFINITIONS:	Internal auditor: Employee who has completed Internal Auditor Training Program
PROCEDURE / GUIDELINES:	<p>The Internal Audit program evaluates the Quality Management System as a whole, to ensure it is effective in assisting in the achievement of predetermined organisational goals.</p> <p>An internal audit process is a proactive risk management tool and can be seen as just another way of ensuring continual organisational improvement. Internal audits are important verification tools for the Quality Management System (QMS) of Sunshine Coast University Private Hospital (SCUPH).</p> <p>The purpose of the policy is to delineate the minimal auditing processes and detail the responsibilities that are required to ensure that the QMS meets the quality requirements of ISO 9001:2008.</p> <p>SCUPH Internal Audit Program (including support audit tools & check sheets) is accessible on SCUPH intranet (via SharePoint).</p>

Manual Title: Governance / Quality	Page 1 of 5	Facility Policy Number: 0009
Policy Title: Internal Audit Program	Version: 1	

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The role of the Quality and Risk Co-ordinator is to develop, maintain and monitor the SCUPH Internal Audit Program.

Audit Program will be reviewed annually to ensure that the scope of the program is meeting the requirements of the Quality Management System and incorporates organisational high risk areas.

Audit program consists of four phases:

- Routine Check Schedule
- Departmental Audit Schedule
- Internal Audit schedule
- Governance.

Routine Check Schedule

At a departmental level detail requirements, rationale, nominated officer and frequency for completion of routine checks with any identified variance/s to be rectified without delay.

Departmental Audit Schedule

Routine and systemic review of activity to meet requirements of the National Safety & Quality Health Service Standards and jurisdictional requirements.

Audits are undertaken by nominated employee who is require to possess the relevant skills and content knowledge but does **not** have to have undertaken Internal auditor training.

Audit results are to be reviewed at department level, and appropriate quality improvement activities to be implemented.

Summary of departmental audits to be tabled at relevant organisational committees. This process will be managed by Quality & Risk Co-ordinator.

Internal audit schedule

Internal audits will be undertaken by trained auditors who have completed Internal Auditor Training Program.

Undertaking internal audit:

Refer also flow chart (page 5)

- Auditors will not audit their own work, but may audit their organisational department
- Audit will be conducted in a professional, impartial and non-threatening way
- Auditors will liaise with relevant manager of organisational unit prior to undertaking review to arrange an agreed day for the audit to be undertaken
- Will review relevant documentation, discuss with workers and consumers and observe actions of workers
- Discuss findings with relevant manager

	<p>On completion of Internal audit,</p> <ul style="list-style-type: none"> • SCUPH internal audit report will be completed • The auditor will report on variance from planned activity (non-conformance) on the <i>Corrective & Preventive Action Form</i> • Internal audit report will be circulated to appropriate managers and tabled at relevant organisational committees • Preventative or corrective actions will be entered into SCUPH Corrective & preventive Action Register and be managed in accordance with SCUPH Policy <i>Control of Non-conformance, Corrective & Preventive Actions (Ref 0006)</i>. <p>Governance schedule</p> <p>Details the reporting to organisational committees to provide comprehensive organisational review and meet requirements of the National Safety & Quality Health Service Standards, Work Health & Safety Guidelines.</p> <p>Audit tools</p> <p>Audit tools are developed by appropriate key stakeholders and based available as an electronic resource on SCUPH intranet page (SharePoint). Tools will be periodically reviewed (as required and minimum 3rd yearly). SharePoint will trigger review requirements to Quality & Risk Co-ordinator to facilitate review.</p>
REFERENCES:	<ul style="list-style-type: none"> • AS/NZS ISO 9001:2008 – Quality management systems – Requirements. Standards Australia International Ltd, Sydney. • HB90.8 – 2000. Healthcare Services, Guide to ISO 9001. Standards Australia International Ltd, Sydney. • St Andrew's Ipswich & Hillcrest Rockhampton Private Hospital Internal Audit Policy
RELATED FORMS:	<ul style="list-style-type: none"> • SCUPH Audit schedule and associated tools. • The Corrective & Preventive Action Form • Ramsay Risk Rating Matrix • Internal/Quality Audit Report • Corrective / Preventive / Improvement Register • Internal Audit Flowchart
RELATED POLICIES:	<ul style="list-style-type: none"> • Quality Management & Improvement (Ref 0001) • Control of Documents (Ref 0002) • Control of Records (Ref 0005) • Control of Non-conformances, Corrective & Preventive (Ref 0006) • RHC Risk Management Framework
LEGISLATION/ STANDARDS:	<ul style="list-style-type: none"> • ISO 9001:2008 Quality management systems • National Safety & Quality Health Service Standards • Queensland Private Health Regulatory Unit. • Work Health & Safety Act & Regulation (QLD) 2011
Authorisation / Ratification:	<p>_____ Chief Executive Officer</p> <p>Kimberley Pierce</p>

Manual Title: Governance / Quality	Page 3 of 5	Facility Policy Number: 0009
Policy Title: Internal Audit Program	Version: 1	

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DOH-DL 14/15-006 **RHI Document 24**

DOCUMENT HISTORY

<i>Prepared By</i>	<i>Quality & Risk Coordinator</i>	<i>August 2013</i>
<i>Reviewed By (stakeholders)</i>	<i>Chief Executive Officer Director of Clinical Services Assistant Director of Clinical Services</i>	<i>August 2013</i>
<i>Approved By</i>	<i>Executive Committee</i>	<i>September 2013</i>
<i>Endorsed By</i>	<i>Chief Executive Officer</i>	<i>September 2013</i>
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<i>Version 1</i>	<i>Initial Release</i>	<i>November 2013</i>

POLICY VALIDITY STATEMENT

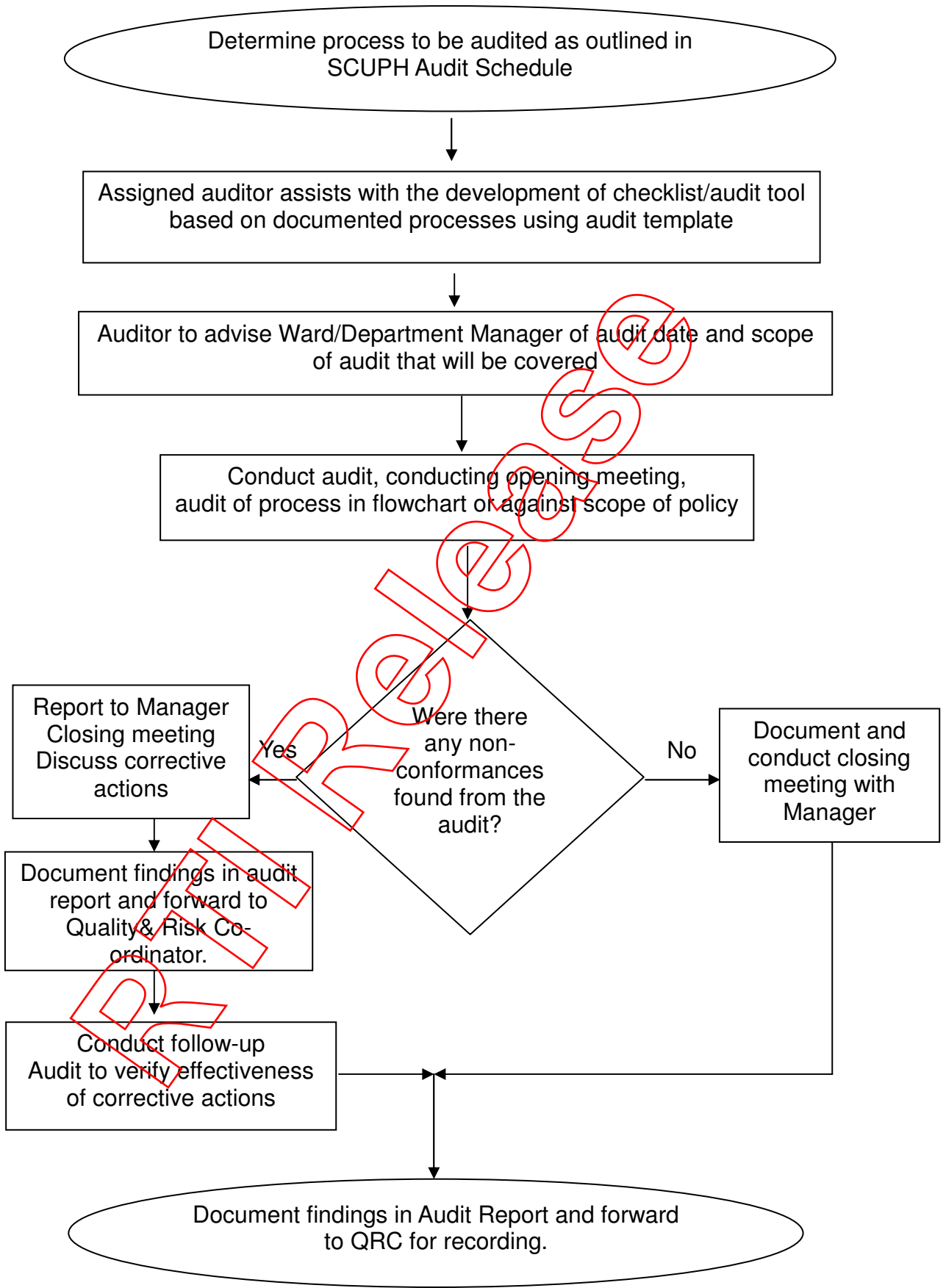
This policy is due for review by the date shown above, after which it may become invalid. Policy users should ensure that they are consulting the currently valid version of the document

RTI Release

Manual Title: Governance / Quality	Page 4 of 5	Facility Policy Number: 0009
Policy Title: Internal Audit Program		Version: 1
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Internal Audit Flowchart



Sunshine Coast Hospital and Health Service

Ramsay Health Care Australia Pty Limited

Deed of Variation - Services Agreement

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Date 3 October 2013

Parties

Sunshine Coast Hospital and Health Service ABN 21 667 257 934 of Nambour
General Hospital, Hospital Road, Nambour, Queensland (SCHHS)

Ramsay Health Care Australia Pty Limited ACN 003 184 889 of Level 9, 154 Pacific
Highway, St Leonards, New South Wales (Operator)

Background

- A QH and the Operator entered into the Services Agreement under which QH engaged the Operator to provide the Contracted Services at the Facility.
 - B By transfer notice dated 18 June 2012, the Services Agreement was transferred from QH to the SCHHS. As a result of the transfer notice, the SCHHS replaced QH as party to the Services Agreement.
 - C The SCHHS and the Operator now wish to vary certain aspects of the Services Agreement on the terms and conditions of this document.
-

Agreed terms

- 1 Effect of this document
 - 1.1 **Document is supplemental**

This document is supplemental to and constitutes a variation of the Services Agreement, and the Services Agreement will be construed and take effect from the Effective Date as varied by this document.
 - 1.2 **Full force and effect**

Except as set out in this document, the Services Agreement remains in full force and effect on its terms.
 - 1.3 **Inconsistency**

To the extent that any provision of this document and any provision of the Services Agreement are inconsistent or conflicting, the inconsistent or conflicting provision of this document takes precedence over and will be and constitute an amendment of the Services Agreement, but only to the extent that such provision is inconsistent or conflicting with the Services Agreement.

2 Definitions

In this document:

(a) capitalised terms used but not defined in this document have the same meaning given in the Services Agreement, unless the context otherwise permits; and

(b) these terms have the following meanings:

Business Day	A day which is not a Saturday, Sunday or bank or public holiday in Brisbane.
Effective Date	The date this document is last executed by the parties.
Services Agreement	The Services Agreement between the parties dated 4 April 2011.
QH	The State of Queensland through the Department of Health ABN 66 329 169 412.

3 Amendments

The parties agree that on and from the Effective Date the Services Agreement is amended as set out in this clause 3.

3.1 References to QH

Except where the context requires for historical or factual purposes, all references to QH in the Services Agreement are taken to be references to SCHHS.

3.2 Schedule 1 (Management), Part 1 (Specification), section 5.3(b)(1)

Section 5.3(b)(1) of Part 1 of Schedule 1 to the Services Agreement is deleted and replaced with the following:

"send copies of the Public Patient Record (either electronically or in hard copy, whichever format is requested by SCHHS) to SCHHS no later than 5.00pm on the next Business Day after the request is made, provided that if SCHHS requires the Public Patient Record urgently the Operator shall provide the Public Patient Record to SCHHS as soon as practicable; and"

3.3 Schedule 1 (Management), Part 1 (Specification) section 6.3, Table 1(a)

Table 1(a) in section 6.3 of Part 1 of Schedule 1 to the Services Agreement is deleted and replaced with the new Table 1(a) set out in schedule 1.

3.4 Schedule 1 (Management), Part 1 (Specification), section 6.3, Table 1(b)

Table 1(b) in section 6.3 of Part 1 of Schedule 1 to the Services Agreement is deleted and replaced with the following:

Table 1(b): Baseline Average WAU Per Referral

Service Stream	Average WAU per referral
General Medicine	1.13
Gastroenterology	0.52
General Surgery	1.15
ENT	0.47
Orthopaedics	1.89
Plastic Surgery	0.67
Urology	1.06
Angiography	1.20

3.5 Schedule 1 (Management), Part 1 (Specification), Attachment B
Attachment B to Part 1 of Schedule 1 to the Services Agreement is deleted and replaced with the new Attachment B in schedule 2.

3.6 Schedule 2 (Performance Standards), Part 1 Specification, Table 4

Table 4 in section 2.2 of Part 1 of Schedule 2 to the Services Agreement is deleted and replaced with the following:

Table 4: Activity Limited (In WAUs) by Service Stream

Service Stream	2013/14		2014/15		2015/16		2016/17		2017/18	
	Lower	Upper	Lower	Upper	Lower	Upper	Lower	Upper	Lower	Upper
General Medicine										
Gastroenterology										
General Surgery										
ENT										
Orthopaedics										
Plastic Surgery										
Urology										
Angiography										

4 General

4.1 Legal costs

Except as expressly stated otherwise in this document, each party must pay its own legal and other costs and expenses of negotiating, preparing, executing and performing its obligations under this document.

4.2 Amendment

This document may only be varied or replaced by a document executed by the parties.

4.3 Waiver and exercise of rights

- (a) A single or partial exercise or waiver by a party of a right relating to this document does not prevent any other exercise of that right or the exercise of any other right.
- (b) A party is not liable for any loss, cost or expense of any other party caused or contributed to by the waiver, exercise, attempted exercise, failure to exercise or delay in the exercise of a right.

4.4 Rights cumulative

Except as expressly stated otherwise in this document, the rights of a party under this document are cumulative and are in addition to any other rights of that party.

4.5 Consents

Except as expressly stated otherwise in this document, a party may conditionally or unconditionally give or withhold any consent to be given under this document and is not obliged to give its reasons for doing so.

4.6 Further steps

Each party must promptly do whatever any other party reasonably requires of it to give effect to this document and to perform its obligations under it.

4.7 Governing law and jurisdiction

- (a) This document is governed by and is to be construed in accordance with the laws applicable in Queensland.
- (b) Each party irrevocably and unconditionally submits to the non-exclusive jurisdiction of the courts exercising jurisdiction in Queensland and any courts which have jurisdiction to hear appeals from any of those courts and waives any right to object to any proceedings being brought in those courts.

4.8 Assignment

- (a) A party must not assign or deal with any right under this document without the prior written consent of the other parties.
- (b) Any purported dealing in breach of this clause is of no effect.

4.9 Liability

An obligation of two or more persons binds them separately and together.

4.10 Counterparts

This document may consist of a number of counterparts and, if so, the counterparts taken together constitute one document.

4.11 Entire understanding

- (a) This document contains the entire understanding between the parties as to the subject matter of this document.
- (b) All previous negotiations, understandings, representations, warranties, memoranda or commitments concerning the subject matter of this document are merged in and superseded by this document and are of no effect. No party is liable to any other party in respect of those matters.
- (c) No oral explanation or information provided by any party to another:
 - (i) affects the meaning or interpretation of this document; or
 - (ii) constitutes any collateral agreement, warranty or understanding between any of the parties.

4.12 Relationship of parties

This document is not intended to create a partnership, joint venture or agency relationship between the parties.

4.13 Construction

Unless expressed to the contrary, in this document:

- (a) words in the singular include the plural and vice versa;
- (b) any gender includes the other genders;
- (c) if a word or phrase is defined its other grammatical forms have corresponding meanings;
- (d) 'includes' means includes without limitation;
- (e) no rule of construction will apply to a clause to the disadvantage of a party merely because that party put forward the clause or would otherwise benefit from it;
- (f) a reference to:
 - (i) a person includes a partnership, joint venture, unincorporated association, corporation and a government or statutory body or authority;
 - (ii) a person includes the person's legal personal representatives, successors, assigns and persons substituted by novation;
 - (iii) any legislation includes subordinate legislation under it and includes that legislation and subordinate legislation as modified or replaced;

- (iv) an obligation includes a warranty or representation and a reference to a failure to comply with an obligation includes a breach of warranty or representation;
 - (v) a right includes a benefit, remedy, discretion or power;
 - (vi) time is to local time in Brisbane;
 - (vii) '\$' or 'dollars' is a reference to Australian currency;
 - (viii) this or any other document includes the document as novated, varied or replaced and despite any change in the identity of the parties;
 - (ix) writing includes any mode of representing or reproducing words in tangible and permanently visible form, and includes fax transmissions;
 - (x) this document includes all schedules and annexures to it; and
 - (xi) a clause, schedule or annexure is a reference to a clause, schedule or annexure, as the case may be, of this document;
- (g) if the date on or by which any act must be done under this document is not a Business Day, the act must be done on or by the next Business Day; and
- (h) where time is to be calculated by reference to a day or event, that day or the day of that event is excluded.

4.14 Headings

Headings do not affect the interpretation of this document.

4.15 Deed

This document is a deed. Factors which might suggest otherwise are to be disregarded.

Schedule 1

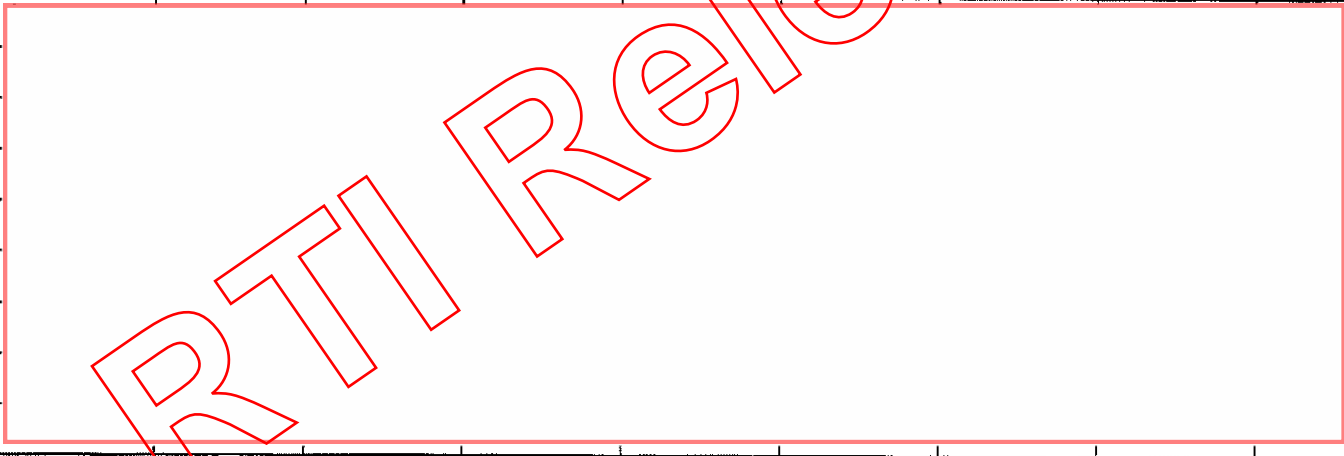
New Table 1(a): Baseline Monthly Referral Percentages

Service Stream	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total
General Medicine	<div style="font-size: 4em; color: red; opacity: 0.3; transform: rotate(-15deg); pointer-events: none;">RTI Release</div>												100.0%
Gastroenterology													100.0%
General Surgery													100.0%
ENT													100.0%
Orthopaedics													100.0%
Plastic Surgery													100.0%
Urology													100.0%
Angiography													100.0%

Schedule 2

New Attachment B: Initial Activity Forecast

Monthly Referral Targets by Service Stream

Service Stream	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	Jun 2014	Total
General Medicine									
Gastroenterology									
General Surgery									
ENT									
Orthopaedics									
Plastic Surgery									
Urology									
Angiography									

Monthly Referral Limits by Service Stream

Service Stream	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	Jun 2014	Total
General Medicine	<div style="font-size: 48px; color: red; opacity: 0.5; transform: rotate(-30deg); pointer-events: none;"> RTI Release </div>								
Gastroenterology									
General Surgery									
ENT									
Orthopaedics									
Plastic Surgery									
Urology									
Angiography									

Quarterly Percentages

Quarter	Percentage
October – December	<div style="font-size: 48px; color: red; opacity: 0.5; transform: rotate(-30deg); pointer-events: none;"> RTI Release </div>
January – March	
April – June	

Execution

Executed as a deed.

Executed by the **Sunshine Coast
Hospital and Health Service** by its
chief executive in the presence of:

[Redacted Signature Box]

Kevin Hegarty, Chief Executive

12/9/2013

[Redacted Signature Box]

Witness

GINA MEAGURES

Name of Witness (print)

Executed by **Ramsay Health Care
Australia Pty Limited**

[Redacted Signature Box]

Company Secretary/Director

[Redacted Signature Box]

Director

[Redacted Signature Box]

Name of Company Secretary/Director
(print)

[Redacted Signature Box]

Name of Director (print)

3/10/2013

RTI REQUEST

RFI Release

People caring for people



Your impressions

Your impressions are important to us, and we would love to hear what you think about your stay here. Use this card to jot down your thoughts and hand it to a member of staff or give it to reception on discharge.

Ward (optional)

.....

SUNSHINE COAST
UNIVERSITY PRIVATE HOSPITAL

Yes No N/A

My admission was handled smoothly

Comment:

My room was clean and pleasant

Comment:

My meals were nutritious and appetising

Comment:

Nursing staff were attentive to my needs

Comment:

Visitors were made comfortable and welcome by staff

Comment:

Staff listened to and acted on my requests

Comment:

My stay in hospital met my expectations

Comment:

Allied Health services were attentive to my needs

Comment:

Volunteers were attentive to my needs

Comment:

Please tell us

How can we improve?

.....

Follow up

Would you like a hospital representative to phone you?

If YES, please include your name and best daytime contact telephone number below.

Name Telephone number

Sunshine Coast University Private Hospital

Quality Manual ISO 9001:2008

ATTACHMENTS

Committee Terms of Reference

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DOH-DL 14/15-006

RJI Document 41



The Ramsay Vision

Ramsay Health Care is committed to being a leading provider of health care services by delivering high quality outcomes for patients and ensuring long term profitability.

The Ramsay Way

We are caring, progressive, enjoy our work and use a positive spirit to succeed

We take pride in our achievements and actively seek new ways of doing things better

We value integrity, credibility and respect for the individual

We build constructive relationships to achieve positive outcomes for all

We believe that success comes through recognizing and encouraging the value of people and teams

We aim to grow our business while maintaining sustainable levels of profitability, providing a basis for stakeholder loyalty

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DOH-DL 14/15-006

RHI Document 42

COMMITTEE SCHEDULE (2013) ALL COMMITTEES SHALL MEET BEFORE THE END OF 2013

Committee	Chair	Secretariat	Frequency	Nov	Dec
SCUPH Executive (inc emergency planning)	CEO	Executive Assistant	Monthly		
Medical Advisory Committee	Elected MAC Chair	Executive Assistant	Quarterly		
Credentialing	VMO	Executive Assistant	Quarterly		
Clinical Review Committee Medical	VMO	Q&R Admin	6 monthly		
Clinical Review Committee Surgery & Anaesthesia	VMO	Q&R Admin	6 monthly		
Consumer & Community Advisory Committee	DCS	Q&R Admin	Quarterly		
Quality Improvement Committee	CEO	Q&R admin	Monthly		
Information Management	CM	Executive Assistant	Quarterly		
WH&S Committee	Elected HSR / employee rep	Q&R Admin	Quarterly		
HR Committee	HR Coordinator	Q&R Admin	Quarterly		
Infection Prevention & Control	IC Coordinator	Q&R Admin	Quarterly		
Pharmacy & Therapeutics (incl antimicrobial stewardship)	Pharmacist	Q&R Admin	Quarterly		
Theatre Management Committee	Perioperative Services Manager	Q&R Admin	Monthly		
Heads of Department meeting	CEO	Executive Assistant	Monthly		
Clinical Leadership Meeting	DCS	Executive Assistant	Monthly		
Departmental meetings	HOD	Nominee	Monthly		

RTI RELEASED

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COMMITTEE SCHEDULE 2014

Committee	Chair	Secretariat	Frequency	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
SCUPH Executive (inc emergency planning)	CEO	Executive Assistant	Monthly												
Medical Advisory Committee	Elected MAC Chair	Executive Assistant	Quarterly												
Credentialing	VMO	Executive Assistant	Quarterly												
Clinical Review Committee Medical	VMO	Q&R Admin	6 monthly												
Clinical Review Committee Surgery & Anaesthesia	VMO	Q&R Admin	6 monthly												
Consumer & Community Advisory Committee	DCS	Q&R Admin	Quarterly												
Quality Improvement Committee	CEO	Q&R admin	Monthly												
Information Management	CM	Executive Assistant	Quarterly												
WH&S Committee	Elected HSR / employee rep	Q&R Admin	Quarterly												
HR Committee	HR Co-ordinator	Q&R Admin	Quarterly												
Infection Prevention & Control	IC Co-ordinator	Q&R Admin	Quarterly												
Pharmacy & Therapeutics (incl antimicrobial stewardship)	Pharmacist	Q&R Admin	Quarterly												
Theatre Management Committee	Perioperative Services Manager	Q&R Admin	Monthly												
Heads of Department meeting	CEO	Executive Assistant	Monthly												
Clinical Leadership Meeting	DCS	Executive Assistant	Monthly												
Departmental meetings	HOD	Nominee	Monthly												

DOH-DL 14/15-006

HOSPITAL COMMITTEES

OBJECTIVE

To promote efficient and effective hospital operations.

POLICY

All formal committees must have documented Terms of References, and where relevant, key performance indicators (KPIs).

Terms of References are reviewed annually and maintained by the Quality and Safety Coordinator .

Committees must be evaluated annually to ensure they are effective and must produce measured outcomes of their activities (see "Committee Evaluation Form").

All policies, procedures /Guidelines & SOP's must be ratified by an appropriate committee.

Minutes must be recorded, dated, and signed for all committees, working parties and departmental meetings.

PROCEDURE

Minute Taking

Minutes are taken at all formal committee meetings by a designated Committee Secretary.

Minutes are recorded in the format described in form "Hospital Committee Meeting Template".

All Meeting Agendas are to be circulated to members at least 1 week prior to the meeting and are to be written as in the format described in form "Committee Agenda Template".

All Meeting Agendas must include the following as standing agenda items

- Policy Updates and
- New Legislation/Codes of Practice.

All Minutes need to be signed and dated by the respective Chairperson, and the original copy kept in the Executive Board Room. The integrity of these Minutes is maintained by the appropriate Executive Secretary. A copy of any tabled documents, presentations and attachments should be attached with the minutes.

Minutes format numbering is to be recorded by the Meeting Number e.g. Meeting Number 20, Item Number 6 is recorded as 20.6.

Action steps must be recorded at each meeting with responsibilities assigned and target dates for completion.

All minutes are to be available online apart from the Medical Advisory Committee, Ethics Committee, and Executive Management Committee.

Responsibilities of Committee Members

Chairperson

- Confirm Terms of Reference (TOR) for new committees. Annually review TOR and perform an annual committee evaluation (with assistance from the QI Department).
- Formulate an agenda in conjunction with the minute secretary.
- Chair the meeting ensuring:
 - smooth functioning of the meeting;
 - appropriate time management of meetings;
 - agreed actions are summarised and clarified; and
 - The discussions are relevant to the TOR.

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- Contact members who do not attend regularly and recommend replacement where appropriate.

Minute Secretary

- Formulate an agenda in conjunction with the Chairperson and circulate to members at least one week prior to the next meeting.
- Use the Agenda Template as per form “Committee Agenda Template”.
- Book venue and catering as required in conjunction with the Executive Secretary if required.
- Take the minutes, clearly identify what actions are required, the person responsible and timeframes (use the Minute template as per form “Committee Agenda Template”).
- Process and distribute minutes within 7 working days following meeting.
- Retain the ‘original’ copy of the minutes and take these to the next meeting for the Chairperson to sign.
- Forward signed ‘original’ to the appropriate Executive Secretary. Minute records being forwarded for inclusion in the hospital’s ‘original’ records must contain any tabled documents or copies of presentations.
- Committee Minute Secretary to be nominated for all formal hospital committees with the exception of liaison meetings as per the Summary of Committee Structure.

Members

- Maintain confidentiality of all minutes and all issues discussed.
- Disseminate relevant information back to individual units.
- Identify actions required and expected timeframes.
- Attend all meetings on time.
- Come prepared for meetings; do not only bring problems but also possible solutions.
- Be seen to support the decision of the group.
- Any member who does not attend three consecutive meetings without good reason will be replaced.

Departmental Meetings

- Regular departmental meetings provide an opportunity to involve all staff in the management and performance of the department.
- Departmental Meetings are to be held a minimum of once per month.
- Agendas are to be written prior to all meetings and displayed in a prominent place e.g. staff notice board. Clinical departments are to utilise the Agenda template as found in form “Clinical Department Agenda Template” and non-clinical areas are to utilise the template as per form “Non-Clinical Department Agenda”.
- All members of the department should be invited i.e. environmental service representatives, relevant allied health professionals.
- All issues are to be briefly documented as per the departmental meeting template in form “Meeting Action Sheet” and actions are to be clearly identified – what is to be done, by whom and when.
- Minutes of the meeting are to be distributed or placed in a prominent place for all team members to view.
- All “actions” from the previous meeting are to be reviewed at the following meeting to ensure that appropriate outcomes have been achieved.
- All members use the meeting to improve the functioning of the department – not just bring problems.
- Departmental Key Performance Indicators, satisfaction surveys, complaints, reports on audits and business improvement progress opportunities are to be tabled at each meeting and were relevant discussed.
- A copy of the Departmental Meeting minutes is to be sent to the department manager e.g. Ward meeting minutes will be sent to the relevant Assistant Director of Nursing Services.

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Working Groups

A working group is formed to address a specific project or issue. This may be department focused or across various specialities. Working groups may also be formed under specific hospital committees.

- Maximum members for a working group are 8.
- A team leader should be nominated to coordinate the progress and provide regular reports to the appropriate personnel.
- At the commencement of the group, clear objectives need to be developed. A Gantt chart may be used to identify each of the steps and the timeframes.
- A nominated person is to collate minutes and working documents for accreditation purposes.
- All issues are to be briefly documented and actions are to be clearly identified i.e. what is done, by whom and when.
- Minutes are to be distributed to all committee members and a copy should also be forwarded to the Administrative Assistant, Quality and Safety for saving onto the I drive.
- All "actions" from the previous meeting are reviewed at the following meeting to ensure that appropriate outcomes have been achieved.

Terms of Reference

- All Terms of Reference clearly indicate what data, clinical incidents, clinical indicators and adverse events a committee is responsible for.
- Terms of Reference are coordinated by the Quality and Safety Unit.
- An electronic copy of each Committees TOR is kept on the I Drive.
- All Terms of Reference are reviewed on an annual basis.

Role of the Quality & Safety Unit

- Maintain Terms of Reference
- Annual evaluation of all committees.

Forms

- Hospital Committee Meeting Template
- Committee Agenda Template
- Departmental Meeting Template
- Clinical Department Agenda Template
- Committee Evaluation Forms
- Non – Clinical Departmental Meeting Agenda Template
- Meeting Action Sheet

Competencies: Nil

Contact: Quality & Safety Coordinator

Developed: August 2013

Approved by: Director of Clinical Services
Quality Improvement Committee

Authorised by: Chief Executive Officer

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TEMPLATE SAMPLE:

AGENDA OF MEETING
XX COMMITTEE
TBA
9.00AM XX ROOM
MEETING NUMBER 1

- 1 Present
- 2 Apologies
- 3 Confirmation of Previous Minutes
- 4 Review of Actions from Previous Minutes
Refer Action Sheet
- 5 Quality & Risk
- 6 Work Health and Safety
- 7 Financial / Budget Performance
- 8 Learning & Development
- 9 New Business
 - 9.1 Audits
 - 9.2 Capex
- 10 Next Meeting TBA @ in the xx Room

Item #	Discussion	Action	By Whom	Date	Status
48/08	10.6.3 Health Funds	xx to....	xx		In progress

NB:

Once an item has been completed this can be removed from the table of actions for the agenda copy.

TEMPLATE SAMPLE:

MINUTES OF MEETING
XX MEETING
TBA
MEETING NUMBER 1

To: -

xx Chief Executive Officer
xx Chief Executive Officer
xx Director of Clinical services
xx Assistant Director Perioperative Services

Minutes taken by xx

- 1 Present
- 2 Apologies
- 3 Confirmation of Previous Minutes
- 4 Review of Actions from Previous Minutes
Refer Action Sheet
- 5 Quality & Risk
- 6 Work Health and Safety
- 7 Financial / Budget Performance
- 8 Learning & Development
- 9 New Business
 - 9.1 Audits
 - 9.2 Capex
- 10 Next Meeting TBA @ in the xx Room

Item #	Discussion	Action	By Whom	Date	Status
48/08	10.6.3 Health Funds	xx to....	xx	date	In progress
1/09	1.5.2 Budget Performance	xx to....	xx	date	In progress
2/09	1.6.1 Audits	Everyone to.....	xx		In progress

SIGNATURE

CHAIRPERSON

DATE

NB: Once an item has been completed this can be removed from the table of actions for the minutes copy.

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SAMPLE :

5-MINUTE COMMITTEE EVALUATION (MEMBERS)

To be completed by all committee members

Committee Name: _____

Please rate your agreement with the following statements by circling the number on the scale provided. The higher the number the more satisfied you are.

Strongly Disagree	Disagree	Agree	Strongly Agree
1	2	3	4
⊗			⊗

Please provide comments for each of the statements below:

I fully understand the purpose of this meeting:	1	2	3	4
The committee is effective and results in improvement in the hospital:	1	2	3	4
The membership is appropriate for the committee:	1	2	3	4
The agenda reflects the purpose of the meeting:	1	2	3	4
The minutes clearly outline the proceedings of the meeting and show who is responsible for any actions required:	1	2	3	4
The frequency and the length of the meeting are appropriate for the agenda:	1	2	3	4
All participants have the opportunity to contribute to the meeting:	1	2	3	4
How many meetings have you attended this year?				
What suggestions do you have that would help improve the meeting:				
Name:	Date:	Signature:		

Thank you for completing this evaluation form!

SAMPLE :

5-MINUTE COMMITTEE EVALUATION (CHAIRPERSON)

To be completed by all committee Chairperson

Committee Name: _____

How many times has this committee been cancelled over the past year?		
Do all the members participate in this committee?		
Please briefly note the major improvements or outcomes that this meeting has achieved over the past year:		
Name:	Date:	Signature:

Thank you for completing this evaluation form!

EXECUTIVE MANAGEMENT COMMITTEE

PURPOSE	The Hospital Executive Management Committee is responsible for financial, staff, operational, clinical and strategic management. Ensuring that the organization and its risks are effectively and efficiently governed and managed.	
FUNCTIONS	<p>To maintain and promote an organisational culture of openness, transparency and accountability. Continuous improvement, excellence.</p> <p>To ensure the organisation's strategic and operational plans are developed annually and reviewed regularly</p> <p>To review operational performance of Departments, including staffing issues. Oversight management of Queensland Health Contractual requirements.</p> <p>To review the Budget Plan, Marketing Plan and Financial Management Strategies</p> <p>To ensure compliance facility wide with all statutory requirements</p> <p>To disseminate information and recommendations from hospital committees, Executive or Ramsay Health Care</p> <p>To ensure that the delivery of treatment, care and service are maintained at an optimal level of quality and efficiency and ensure the Continuation of performance improvement activities.</p> <p>To ensure Safety, OH&S / Fire Safety and Infection Control issues and any other Risk Management issues are reviewed and improvements implemented</p> <p>To review Adverse events – (Risk Rated 1 and 2) and any other significant event as necessary</p> <p>To ensure that the facilities educational needs are met.</p> <p>Maintain a customer focus and ensure that customer feedback is actioned and reviewed appropriately</p> <p>To ensure management responsibility under ISO 9001:2008 and National Safety & Quality Health Service Core Standards.</p> <p>To assess opportunities for improvement and the need for changes to the quality management system and service development.</p> <p>Ensure service developments align with Clinical Service Capability Framework (CSCF).</p>	
REPORTING STRUCTURE & PROCESS	Reports to the State Manager Queensland via the CEO	
SUB COMMITTEES	Nil	
CHAIR	Chief Executive Officer	
DEPUTY CHAIR	N/A	
MEMBERSHIP	3	
QUORUM	3	
SECRETARY	Executive Assistant	
FREQUENCY OF MEETINGS	Monthly	
FORMULATED	September 2013	
LAST REVISED	N/A	
PERFORMANCE INDICATORS	RESPONSIBILITY	FREQUENCY
Significant outcomes from all committees are reported by the relevant Executive representative to the Executive Management Committee.	CEO/DCS/CM	Weekly
Operational/Financial performance presented weekly	CM	Weekly
The function and outcomes of the Executive committee is reviewed annually and a written annual report summarising outcomes and future directions of the committee is prepared as part of the annual hospital committee review process.	CM	January
Overall Hospital Risk Register is reviewed.	CEO	March
Organisational wide Strategic/Operational Plans exist and are aligned with the directions of Ramsay Health Care.	CEO	May
Prepare an annual financial and operational budget.	CM	May
Hospital wide contracts are reviewed annually.	CM	November

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Third party contracts are reviewed annually.	CM	November
Hospital Committee Structure is reviewed.	CEO	Annually
The committee is responsible for monitoring the compliance with ISO standards on Leadership.	DCS	Annually
All Hospital Policies are ratified by the Executive team.	CEO	Three year cycle
All patient, Dr and staff satisfaction surveys are tabled at the Executive Management Committee.	DCS	Ongoing
Review & Endorse progress against the Hospital Wide Safety Plan	DCS	Biannually

RTI Release

HEADS OF DEPARTMENT

PURPOSE	<p>To provide a means of communication between the Hospital Executive and the departmental heads of the hospital.</p> <p>To support the Executive management committee to monitor the organisational environment and performance in order to identify potential problems or opportunities associated with the achievement of organisational objectives.</p>
FUNCTIONS	<p>To drive an organisational culture of openness, transparency and accountability</p> <p>To foster and maintain an effective interaction between all departments in the Hospital</p> <p>To report on the hospital financial position and mitigate risks</p> <p>To advise the Hospital Executive of any problems which have the capacity to affect the Hospital's image within the community.</p> <p>To provide an open forum for the presentation of ideas, reports and submissions.</p> <p>To provide a forum for the formulation and review of departmental budgets</p> <p>Oversight management of accreditation process against</p> <ul style="list-style-type: none"> ○ Private Health Regulatory Unit ○ ISO 9001 ○ National Safety & Quality Health Service Standards <p>To implement necessary changes to ensure the hospital is on track for accreditation and prepared for each phase of the cycle.</p> <p>Oversight implementation of policy & guidelines</p> <p>Review audit findings as indicated by internal audit schedule</p> <p>Review identification and management of risk relevant to committee scope</p> <p>Review consumer feedback (satisfaction surveys, complaints and compliments, external survey) for quality improvement opportunities</p> <p>To ensure business plans are working documents by reviewing outcomes related to these on a three monthly basis (portfolio holders to liaise with department managers)</p>
REPORTING STRUCTURE & PROCESS	Reports to the Executive Committee
SUB COMMITTEES	Nil
CHAIR	Chief Executive Officer
DEPUTY CHAIR	Director of Clinical Services
MEMBERSHIP	<p>Chief Executive Officer (Chair)</p> <p>Director of Clinical Services</p> <p>Commercial Manager</p> <p>Perioperative Services Manager</p> <p>ADCS</p> <p>ICU NUM</p> <p>Learning & Development Manager</p> <p>Quality & Risk Coordinator</p> <p>HR Coordinator</p> <p>Environmental Service Manager</p> <p>Catering Manager</p> <p>Administration Manager</p> <p>Stores Manager</p> <p>Facilities Manager</p> <p>Chief Biomedical Engineer</p> <p>Allied Health Manager</p> <p>Pharmacy Manager</p>
QUORUM	<p>A quorum will comprise of half the members plus 1.</p> <p>A quorum must include the Chair or nominated Chair.</p>
SECRETARY	Executive Assistant
FREQUENCY OF MEETINGS	Monthly
FORMULATED	September 2013
LAST REVISED	N/A

MEETING PROTOCOLS	<p>Meeting will be held monthly: dates of the meeting will be set and distributed minimum six months in advance</p> <p>The agenda and pre reading for the next meeting are to be circulated no less than five days prior to the meeting</p> <p>The committee shall not proceed to discuss new business until it has considered and dealt with the accuracy of the minutes for the immediately preceding meeting. Consideration of previous minutes is limited to their accuracy.</p> <p>If the committee resolves that the minutes of a preceding meeting are accurate, the chairperson shall sign a copy of them. The chairperson's signature is evidence of their accuracy.</p> <p>Minutes of meeting will be distributed to committee members seven days post meeting.</p> <p>Communication strategy: minutes tabled at monthly Executive management committee</p>
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PERFORMANCE INDICATORS	RESPONSIBILITY	FREQUENCY
Cost Centre exception reports	Monthly	HoDs
Key Risk reports	Monthly	HoDs
Quality Management Reports	Monthly	HoDs
Hospital Financials	Monthly	CM
Dept Audit reports	Quarterly	HoDs

RTI Release

MEDICAL ADVISORY COMMITTEE

PURPOSE	<p>The Medical Advisory Committee (MAC) is an advisory committee to the CEO. The roles of the MAC are:</p> <ul style="list-style-type: none"> To be the formal organisational structure through which the views of the Accredited Practitioners of the Facility are formulated and communicated To provide a means whereby Accredited Practitioners can participate in the policy-making and planning processes of the Facility.
FUNCTIONS	<p>To plan and manage a continuing education program for members of the Medical Council or junior medical staff where appropriate.</p> <p>To advise the CEO on the clinical organisation of the Facility:</p> <ul style="list-style-type: none"> To assist in identifying health needs of the community and to advise the CEO on services that may be required to meet those needs To participate in the planning and implementation of quality programs To endeavour to ensure that the level of patient care provided by the Facility is optimised given local resource To ensure that a process for review of clinical outcomes and patient management is established and executed according to these Facility Rules To review the recommendations of the Credentials Committee and advise in relation to: applications for Accreditation and re-Accreditation of Health Professionals in accordance with the Facility Rules and the Scope of Clinical Practice of applicants recommended for Accreditation or re-Accreditation To review the recommendations of the Credentials Committee and advise in relation to: the Scope of Clinical Practice of Accredited Practitioners whose Scope of Clinical Practice has been subject to review Applications for the introduction of New Clinical Services, Procedures and Other Interventions and in each case make recommendations to the CEO <p>To establish a Clinical Review Committee in accordance with Rule 197 Facility Rules.</p> <p>Each Clinical Department shall provide a report or minutes of its meetings to the MAC on a regular basis.</p>
REPORTING STRUCTURE & PROCESS	Reports to the CEO
SUB COMMITTEES	Credentialing Committee and Clinical Review Committee
CHAIR	Elected medical representative
DEPUTY CHAIR	Elected member
MEMBERSHIP	<p>Chief Executive Officer (non-voting) Director of Clinical Services (non-voting) Chair of MAC & Deputy chair of MAC (collectively known as Medical Executive) Gynaecology specialist ENT specialist Urology specialist General Medical Specialist Gastroenterologist Cardiologist Orthopaedic specialist Intensive care specialist Anaesthetics Pathologist Radiologist General Surgery Specialist General Practitioners (2)</p> <p>A MAC may co-opt the services of any other person (including persons who are not Accredited Practitioners) whether for a specific time or generally, as it sees fit. A person co-opted to assist a MAC has no voting rights.</p>

QUORUM	A quorum will comprise of half the members plus 1 A quorum must include the CEO, Chair or Deputy Chair	
SECRETARY	Executive Assistant	
FREQUENCY OF MEETINGS	Quarterly	
FORMULATED	September 2013	
LAST REVISED	N/A	
MEETING PROTOCOLS	<p>Ordinary meetings of the MAC must be held not less than four (4) times per year at a time and place determined by the chairperson of the MAC in consultation with the CEO, provided that at least fourteen (14) days' notice must be given of every ordinary meeting.</p> <p>A special meeting of the MAC may be called by the chairperson of the MAC at any time subject to the approval of the CEO. The members of the MAC must be given at least seven (7) days' notice of a special meeting or such shorter period as may be necessary in the circumstances and consented to by the members of the MAC.</p> <p>The MAC shall not proceed to discuss new business until it has considered and dealt with the accuracy of the minutes for the immediately preceding meeting. Consideration of previous minutes is limited to their accuracy.</p> <p>If a meeting of the MAC resolves that the minutes of a preceding meeting are accurate, the chairperson shall sign a copy of them. The chairperson's signature is evidence of their accuracy.</p> <p>The chairperson of the MAC shall have a deliberative vote and, where there is an equality of votes, a casting vote.</p> <p>The CEO or delegate shall record minutes of all meetings of the MAC. Those minutes shall be distributed to the members of the MAC prior to their next meeting.</p> <p>The MAC shall not proceed to discuss new business until it has considered and dealt with the accuracy of the minutes for the immediately preceding meeting.</p>	
RESPONSIBILITY OF MEMBERS	<p>Members of the MAC other than the CEO and Director of Clinical Services are entitled to vote at its meetings.</p> <p>All questions shall be decided by a show of hands. The chairperson shall conduct a secret ballot where at least one of the members of the MAC requests it.</p> <p>No member of a MAC is entitled to represent that individually or collectively they represent Ramsay Health Care or the Facility, other than with the written permission of the CEO. The marks, logos and symbols of Ramsay Health Care and its Facilities may only be used for purposes authorised by the CEO.</p>	
REFERENCE	Ramsay Health Care Group (2011) Facility Rules	
PERFORMANCE INDICATORS	RESPONSIBILITY	FREQUENCY
Medical policies are reviewed and ratified by the Medical Advisory Committee	DCS	Ongoing
Significant outcomes from Hospital Committees are tabled	CEO	Monthly
Recommendations from the Clinical Review committee are tabled	CEO	Bi -Monthly
The function and outcomes of the Medical Advisory Committee are reviewed annually and a written report summarising outcomes and future direction of the committee is provided to the executive.	CEO	January

CREDENTIALING COMMITTEE

PURPOSE	<p>To ensure that all accredited practitioners at Sunshine Coast University Private Hospital are competent, work within their scope of clinical practice and provide high quality care consistent with the terms and conditions set out in the Ramsay Health Care Facility Rules.</p> <p>The credentialing committee is an advisory committee to the MAC.</p>
FUNCTIONS	<p>The role of the Credentials Committee shall be to:</p> <ul style="list-style-type: none"> • Advise the CEO through the MAC on the application of Ramsay Health Care’s policies for verification of credentials of applicants for Accreditation or re-Accreditation or when considering a request for a review of Scope of Clinical Practice of an Accredited Practitioner: • Develop criteria for and plan and monitor the effectiveness of a programme for the delineation of Scope of Clinical Practice of Medical Practitioners and Dentists, where required by the Board • Consider, in relation to every application referred to it for Accreditation or for review of an Accredited Practitioner’s Scope of Clinical Practice: <ul style="list-style-type: none"> ○ the Credentials, qualifications, experience, professional standing and other relevant professional attributes of each Health Professional for the purposes of forming a view about their competence, performance, Current Fitness, character of and confidence held in the applicant and professional suitability; and ○ the needs and capabilities of the Facility; ○ and make recommendations to the MAC on Accreditation or re-Accreditation and the appropriate Scope of Clinical Practice for each applicant; • Consider applications by Accredited Practitioners for review of their authorised Scope of Clinical Practice and make recommendations to the MAC: • Where so requested in accordance with the Facility Rules to review the current Scope of Clinical Practice of an Accredited Practitioner and, following due consideration and taking into account the Credentials, qualifications, experience, competence, professional performance, Current Fitness, professional suitability of and confidence held in the Accredited Practitioner and the needs and capabilities of the Facility, make recommendations concerning amendment or revocation of the Accredited Practitioner’s Scope of Clinical Practice and/or Accreditation to the Facility.
REPORTING STRUCTURE & PROCESS	Reports to the MAC
SUB COMMITTEES	Nil
CHAIR	MAC Chair
DEPUTY CHAIR	MAC nominated representative
MEMBERSHIP	<p>Chief Executive Officer (non-voting) Director of Clinical Services (non-voting) Chair of MAC & Deputy chair of MAC (collectively known as Medical Executive) Gynaecology specialist ENT specialist Urology Specialist General Medical Specialist Gastroenterologist Cardiologist Orthopaedic specialist Intensive care specialist Anaesthetics Pathologist Radiologist</p>

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	General Surgery Specialist Urologist	
	The chairperson of the Credentials Committee shall be elected for an annual term from the Accredited Practitioner members of the committee.	
QUORUM	A quorum will comprise of half the members plus 1 A quorum must include the CEO, DCS, Chair or Deputy Chair	
SECRETARY	Executive Assistant	
FREQUENCY OF MEETINGS	Quarterly	
FORMULATED	September 2013	
LAST REVISED	N/A	
MEETING PROTOCOLS	<p>Ordinary meetings of the committee must be held not less than four (4) times per year at a time and place determined by the chairperson in consultation with the CEO, provided that at least fourteen (14) days' notice must be given of every ordinary meeting.</p> <p>The chairperson may call a special meeting of the committee at any time subject to the approval of the CEO. The members must be given at least seven (7) days' notice of a special meeting or such shorter period as may be necessary in the circumstances and consented to by the members of the MAC.</p> <p>The committee shall not proceed to discuss new business until it has considered and dealt with the accuracy of the minutes for the immediately preceding meeting. Consideration of previous minutes is limited to their accuracy.</p> <p>If a meeting of the committee resolves that the minutes of a preceding meeting are accurate, the chairperson shall sign a copy of them. The chairperson's signature is evidence of their accuracy.</p>	
RESPONSIBILITY OF MEMBERS	<p>Each committee member is to be aware of their obligations to act fairly and without bias and to avoid conflicts of interest.</p> <p>When considering accreditation of members of the committee that member is to be excluded from committee.</p> <p>All questions shall be decided by a show of hands. The chairperson shall conduct a secret ballot where at least one of the members of the committee requests it.</p> <p>The CEO or delegate shall record minutes of all meetings of the committee. Those minutes shall be distributed to the members of the committee prior to their next meeting.</p>	
REFERENCE	Ramsay Health Care Group (2011) Facility Rules	
PERFORMANCE INDICATORS	RESPONSIBILITY	FREQUENCY
New clinical applications are tabled	CEO	Monthly
Recommendations on appointment are made to the Medical Advisory Committee	CEO	Monthly
Review all clinical appointments on a cyclical basis	CEO	5 Yearly
The function and outcomes of the Credential and Clinical Privileges Committee is reviewed annually and a written report summarising outcomes and future directions of the committee is provided to Executive	CEO	January

CLINICAL REVIEW COMMITTEE

PURPOSE	To provide a forum for clinical review process of mortality and morbidity, identifying areas of clinical risk, related to speciality thus endeavouring to ensure best, safe, clinical practice – outcomes.
FUNCTIONS	<p>The Clinical Review Committee shall:</p> <ul style="list-style-type: none"> • Be responsible for clinical leadership of safety and quality within the speciality area and at the Facility • Provide a multidisciplinary forum for clinical review • Provide leadership and direction for quality improvement activities from the review of data and trends in: <ul style="list-style-type: none"> ○ Morbidity and mortality reports ○ Clinical indicators ○ Clinical incident management ○ Clinical Audit ○ Consumer feedback • Advise MAC, Hospital Executive and Quality and Risk Manager of actions that need to be taken to assure and improve effective clinical review and quality improvement activities and programs at the Facility. • Monitor the clinical review and quality improvement activities of the speciality area and advise the MAC and Quality & Safety Committee of their adequacy for service improvement and compliance with applicable statutory requirements
REPORTING STRUCTURE & PROCESS	Reports to the MAC
SUB COMMITTEES	Nil
CHAIR	Elected representative
DEPUTY CHAIR	Elected representative
MEMBERSHIP	<p>The MAC decided that there will be a Medical and Surgical Clinical Review Committee with MAC specialty members co opted as required.</p> <p>One Medical Specialist One Surgical Specialist CEO DCS ADCS Perioperative Services Manager</p> <p>The chairperson of the Clinical Review Committee shall be elected for an annual term by the members of the committee from the Accredited Practitioner members of the committee.</p>
QUORUM	<p>A quorum will comprise of half the members plus 1.</p> <p>A quorum must include representation from medical & nursing professions</p>
SECRETARY	Quality & Risk Admin
FREQUENCY OF MEETINGS	6 monthly
FORMULATED	September 2013
LAST REVISED	N/A
MEETING PROTOCOLS	<p>Meetings will be held as required by specialist area. Minimum requirement is for 6 monthly meetings.</p> <p>At least fourteen (14) days' notice must be given of every ordinary meeting.</p> <p>The agenda and pre reading for the next meeting are to be circulated no less than five days prior to the meeting.</p> <p>No business shall be considered at a meeting of the Clinical Review Committee until the minutes of the previous meeting have been confirmed or otherwise disposed of.</p>

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	<p>Minutes of a meeting shall be confirmed by resolution and signed by the chairperson at the next meeting and minutes so confirmed and signed shall be taken as evidence of proceedings thereat.</p> <p>Minutes shall be submitted to the MAC, Hospital Executive, Safety & Quality Committee and also distributed to all those entitled to attend meetings seven days post meeting.</p>	
RESPONSIBILITY OF MEMBERS	<p>Be aware of their roles & responsibilities.</p> <p>Be active participants in the committee.</p> <p>Bring to the Committee relevant expertise and experience and not act in a way that represents their specific personal interests.</p> <p>In situations where conflict of interest or the appearance thereof arises in the course of the work of the committee, the individual involved will declare its existence.</p> <p>Discussions will involve all committee members: aim for decision making by way of consensus.</p>	
REFERENCE	Ramsay Health Care Group (2011) Facility Rules	
PERFORMANCE INDICATORS	RESPONSIBILITY	FREQUENCY
The function and outcomes of the Clinical Review Committee is reviewed annually and a written annual report summarising outcomes and future directions of the committee is provided to the Executive Management Committee	DCS	January
Hospital wide Clinical Indicator data is tabled	DCS	February, May, August, November
Adverse clinical trends and incidents related to clinical practice are reviewed by the Committee	DCS	February, May, August, November
Review reports from all Clinical Departments on clinical review and quality improvement activities undertaken	DCS	February, May, August, November
The committee is responsible for monitoring the compliance with ISO standards on Clinical Review	Quality & Risk Manager	Annually

RTI REQUEST

CONSUMER AND COMMUNITY ADVISORY COMMITTEE

PURPOSE	<p>The Consumer and Community Advisory Committee (CCAC) consists of local consumers and community members.</p> <p>CCAC provides advice from a consumer perspective about key aspects of the operation of Sunshine Coast University Private Hospital (SCUPH) and on relevant issues to facilitate patient centred care.</p> <p>Consumer partnership in service planning/designing care:</p> <ul style="list-style-type: none"> • provide advice and feedback on the facilities, equipment and hospital environment • provide advice and feedback on the Strategic Plan • provide advice and feedback on Marketing Strategies • review information distributed to patients and or relatives/carers • monitor community sentiment so that SCUPH can respond in a positive proactive manner • promote and enhance consumer and community participation <p>Consumer partnership in service measurement and evaluation:</p> <ul style="list-style-type: none"> • provide information and advice from a consumer perspective • provide advice and feedback on, and participate in patient and carer satisfaction
FUNCTIONS	<p>Consumer partnership in service planning/designing care:</p> <ul style="list-style-type: none"> • provide advice and feedback on the facilities, equipment and hospital environment • provide advice and feedback on the Strategic Plan • provide advice and feedback on Marketing Strategies • review information distributed to patients and or relatives/carers • monitor community sentiment so that SCUPH can respond in a positive proactive manner • promote and enhance consumer and community participation <p>Consumer partnership in service measurement and evaluation:</p> <ul style="list-style-type: none"> • provide information and advice from a consumer perspective • provide advice and feedback on, and participate in patient and carer satisfaction
REPORTING STRUCTURE & PROCESS	CCAC reports to the Hospital Executive via the Director of Clinical Services.
SUB COMMITTEES	Nil
CHAIR	Director of Clinical Services
DEPUTY CHAIR	Marketing Manager
MEMBERSHIP	<p>Membership is to reflect the actual/potential patient community serviced by SCUPH. The following representation is most desirable:</p> <ul style="list-style-type: none"> • Ex-patients – at least one under 50-years and one over 50-years (2-3) • Ex-Service Organisation (1) • Community representatives, e.g., from local community organisation or neighbouring school (2) • Hospital Executive members (2) • SCUPH Marketing Manager <p>Other staff members may attend by invitation. All members will have voting rights.</p>

	<p>Term of membership Each member is appointed for a two (2) year term, <i>and</i> is eligible to stand for re-appointment. <i>A review of the membership will take place each time a two (2) year term expires.</i> Membership of CCAC is not to exceed ten (10) members.</p> <p>Chairperson A CCAC member is to be elected Chairperson at the first meeting of the year. The Chairperson may be elected for subsequent terms at the discretion of CCAC.</p> <p>Selection Process The members of CCAC will be selected by a panel comprising:</p> <ul style="list-style-type: none"> • Director of Clinical Services • Quality & Risk Coordinator • Representative of CCAC. <p>Expressions of interest will be sought via advertising in the local press and/or the SCUPH website.</p> <p>Members will be selected according to the following set of selection criteria:</p> <p>Individuals</p> <ul style="list-style-type: none"> • Commitment to improving the patient experience and the safety and quality of care and services • Direct or indirect experience of the services at SCUPH or other Ramsay Health Care (RHC) QLD hospitals • Ability to attend meetings and participate fully in the work of CCAC • Ability to work in a team • Enthusiasm and commitment <p>Representatives</p> <ul style="list-style-type: none"> • Commitment to improving the patient experience and the safety and quality of care and services • Ability to represent a broad constituency • Commitment to report back to their organisation and consult on relevant matters • Direct or indirect experience of the services at SCUPH or other RHC QLD hospitals • Ability to attend meetings and participate fully in the work of CCAC • Ability to work in a team • Enthusiasm and commitment
QUORUM	Four (4) members present shall constitute a quorum one of whom will be from the Hospital Executive.
SECRETARY	Quality & Risk Admin
FREQUENCY OF MEETINGS	Quarterly
FORMULATED	September 2013
LAST REVISED	N/A
MEETING PROTOCOLS	<p>CCAC will meet quarterly. Adhoc meetings may be called as necessary. Minutes will be maintained and provided to the Director of Clinical Services SCUPH and CCAC members. Recommendations for action will be forwarded to the Director of Clinical Services SCUPH who will forward these as appropriate to the relevant Hospital Committee or department manager.</p> <p>The Chairperson will provide an annual report to the Hospital Executive.</p> <p>The Marketing Department will assist with the presentation of feedback from CCAC to the local community via the local newspapers.</p>

	<p>Support provided by SCUPH for CCAC will be as follows:</p> <ul style="list-style-type: none"> • provision of venue and secretarial support for minute taking and distribution (including photocopying and postage) • light refreshments will be provided at each meeting. <p>All information gathered for the purpose of evaluating and improving the quality of care and services by SCUPH is considered confidential and is to be used only for that purpose.</p> <p>The Hospital's approach to consumer participation and outcomes achieved will be reviewed annually by CCAC and the Hospital Executive.</p>	
RESPONSIBILITY OF MEMBERS	<p>Members experience or expertise in their designated position is recognised and acknowledged. Members will be expected to read material between meetings and be available for other meetings as appropriate.</p> <p>Orientation sessions will be held for new members.</p>	
REFERENCE	Hollywood Private Hospital	
PERFORMANCE INDICATORS	RESPONSIBILITY	FREQUENCY
The committee reviews patient information and provides advice as to format and suitability	Members	Quarterly
The committee provides advice on the equipment and services of the facility from a consumer perspective	Members	Quarterly
The committee provides feedback as to the facilities relationship with community service providers	Members	Quarterly
The committee provides advice and feedback re marketing programs	Members	Quarterly

RTI RELEASES

INFORMATION MANAGEMENT COMMITTEE

PURPOSE	To promote the effective management of information at Sunshine Coast University Private Hospital.		
FUNCTIONS	<p>To make recommendations concerning the strategic direction for Information Systems</p> <p>To monitor standards and methods of data collection to promote accuracy and efficiency.</p> <p>To monitor and action any issues relating to information systems that are impeding operational efficiency.</p> <p>To discuss and implement policy and procedure changes with a view to improving the use of information systems and the information provided.</p> <p>To ratify policies relating to information management.</p> <p>To monitor compliance with ACHS standards for Information Management.</p> <p>All significant risks relevant to the Committee's areas of responsibility are identified and reported to the Executive Management Committee on a timely basis.</p>		
REPORTING STRUCTURE & PROCESS	Provides regular feedback to the Executive Management Committee		
SUB COMMITTEES	Nil		
CHAIR	CM		
DEPUTY CHAIR	Information Services State Manager (Qld)		
MEMBERSHIP	<p>CM</p> <p>Information Services State Manager (Qld)</p> <p>Regional Health Information Services Manager</p> <p>Administration Manager</p> <p>Director of Clinical Services</p> <p>Quality and Risk Coordinator</p> <p>Assistant Director of Clinical Services</p> <p>Nurse Unit Manager representative</p>		
QUORUM	5 people		
SECRETARY	Executive Secretary		
FREQUENCY OF MEETINGS	Quarterly		
FORMULATED	September 2013		
LAST REVISED	N/A		
PERFORMANCE INDICATORS	RESPONSIBILITY	FREQUENCY	
The committee monitors the development and implementation of new information systems.	Information Systems State Manager/CM	Monthly	
The committee reports on data collection errors	Administration Manager	Monthly	
The committee develops and monitors training for information systems	HR & Learning & Development Manager	Monthly	
The committee is responsible for monitoring the compliance with standards related to Information Management.	CM/ Q&RC	Annually	
The function and outcomes of the Information Management committee is reviewed annually and a written annual report summarising outcomes and future directions of the committee is provided to Executive.	CM	January	

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FORMS MANAGEMENT SUB-COMMITTEE

PURPOSE	To ensure that all hospital patient records forms are document controlled, accessible electronically in one centralised repository and reviewed regularly.		
FUNCTIONS	<p>Maintain document control of all hospital forms.</p> <p>Coordinate the review of all hospital forms every 3 years and/or drive the continual review process of hospital forms.</p> <p>Ensure that relevant staff are involved in the development and/or review of hospital forms.</p> <p>Monitor the trialling of all new forms.</p> <p>Ensure that hospital forms are modified where changes in practice have occurred.</p> <p>Coordinate, if required, staff education relating to newly released hospital documents/forms and processes.</p> <p>Address any issues that may arise due to the implementation of new hospital forms.</p> <p>Address any issues arising from forms production with printers and in-house processes.</p> <p>Evaluate the effectiveness of the review and process implemented for hospital forms.</p>		
REPORTING STRUCTURE & PROCESS	Provides regular feedback to the Quality Improvement Committee.		
SUB COMMITTEES	Nil – working parties only		
CHAIR	Administration Services Manager		
DEPUTY CHAIR	Regional HIMS		
MEMBERSHIP	Quality and Risk Coordinator Allied Health Manager Stores Supply Manager Administrative Services Manager Nurse Unit Manager representative Assistant Director of Clinical Services Regional HIMS		
QUORUM	5 people		
SECRETARY	Quality & Risk Admin		
FREQUENCY OF MEETINGS	Monthly		
FORMULATED	September 2013		
LAST REVISED	N/A		
PERFORMANCE INDICATORS	RESPONSIBILITY	FREQUENCY	
The progress and outcomes of working parties (when applicable) are reviewed.	Working Party Representative(s)	Monthly	
New hospital forms are posted on ward bulletin boards and tabled at appropriate clinical meetings.	ASM / Committee	Ongoing	
The function and outcomes of the Committee are reviewed annually and presented to Hospital Executive and the Quality Improvement Committee.	ASM/RHIMS	January	
A summary of progress is presented to the Quality Improvement Committee.	ASM/RHIMS	March, June, September, December	
A three-year plan of forms to be reviewed is formulated and updated yearly.	RHIMS/ASM	November	

QUALITY IMPROVEMENT COMMITTEE

PURPOSE	<p>To actively promote best practice to minimise preventable harm to patients and consumers through sustaining the quality and safety of health care delivery</p> <p>To support the Executive management committee to monitor clinical performance and risk the, to identify potential problems or opportunities associated with the achievement of organisational objectives.</p>
FUNCTIONS	<p>To drive an organisational culture of openness, transparency and accountability. Provide leadership of safety and quality at the Facility.</p> <p>Development & implementation of the Sunshine Coast University Private Hospital Safety & Quality plan.</p> <p>Coordination of quality activity of different governance committees hospital departments.</p> <p>Work in coordination with specialty Clinical Review committees in the development, monitoring and reporting measures of quality patient care including, but not limited to: clinical indicators, clinical reviews and internal audits, patient mortality and morbidity, patient incidents, complaints and compliments, patient satisfaction and analysis of trends through the ongoing review of data.</p> <p>Support the Clinical Standards Committee</p> <p>Maintain compliance and systemic monitoring against National Safety & Quality Health Service Standards.</p> <p>Management / oversight of quality performance reporting:, including but not limited to:</p> <ul style="list-style-type: none"> • Queensland Health Quality and clinical performance indicator's • Health Quality and Complaints Commission Annual Quality Activity Return (AQAR). • Third party providers <p>Clinical Risk oversight.</p> <ul style="list-style-type: none"> • Development and implementation of preventative and corrective actions from the review of performance or review of system.
REPORTING STRUCTURE & PROCESS	Reports to the Hospital Executive Committee
SUB COMMITTEES	Nil
CHAIR	Chief Executive Officer
DEPUTY CHAIR	Director of Clinical Services
MEMBERSHIP	<p>CEO (Chair)</p> <p>DCS</p> <p>MAC Chair</p> <p>ADCS</p> <p>Perioperative Services Manager</p> <p>Quality and Risk Coordinator</p> <p>NUM Surgical - representative</p> <p>NUM Medical – representative</p> <p>Workplace Safety Manager</p>
QUORUM	A quorum will comprise of half the members plus 1
SECRETARY	Quality & Risk Admin
FREQUENCY OF MEETINGS	Monthly
FORMULATED	September 2013
LAST REVISED	N/A
MEETING PROTOCOLS	<p>The agenda and pre reading for the next meeting are to be circulated no less than five days prior to the meeting</p> <p>The committee shall not proceed to discuss new business until it has considered and dealt with the accuracy of the minutes for the immediately preceding meeting. Consideration of previous minutes is limited to their accuracy.</p>

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If the committee resolves that the minutes of a preceding meeting are accurate, the chairperson shall sign a copy of them. The chairperson's signature is evidence of their accuracy.

Minutes of meeting will be distributed to committee members seven days post meeting.

The Committee may in the process of their deliberations make use of sub-groups. These sub-groups and their nominees will be authorised by the Committee or the District Manager. All sub-groups will have terms of reference determined by the Committee.

Communication strategy: minutes tabled at monthly Executive management committee

PERFORMANCE INDICATORS	RESPONSIBILITY	FREQUENCY
All clinical audits are submitted to the Q&S meeting and compliance against the standards is reviewed	Q&R Coordinator	Monthly
Action lists are provided by all relevant departments on audits that are not compliant	Working Party Representative	Monthly/PRN
New policies and amendments are posted electronically, locally and tabled at appropriate clinical meetings	DCS	January
QH KPIs are reviewed	Q&S Unit	Quarterly
A list of all reviewed policies is submitted to the committee	Clinical Standards Chair	Quarterly
All planned Quality activities are submitted to the Q&SC prior to commencement for ratification	DCS/CM	Monthly
RCAs are undertaken for all level 1 sentinel events	DCS	PRN

RTI Release

CLINICAL STANDARDS COMMITTEE

PURPOSE	To ensure a coordinated approach to the delivery of care for patients attending Sunshine Coast University Private Hospital and to monitor the adherence to professional standards and legislative requirements.		
FUNCTIONS	<p>To ensure that Clinical areas are aligned with hospital strategic directions.</p> <p>To review all clinical incidents trends and adverse outcome data that are not specifically reviewed by other committees.</p> <p>To ensure that policies and procedures that relate to clinical areas are evidence based, meet legislative and professional requirements and are appropriate for SCUPH and timeframe.</p> <p>To facilitate the measurement of outcomes and analysis of data ensuring care and services are based on objective data.</p> <p>To advise with regard to the delivery of patient care in the hospital with the aim of ensuring it is maintained at the optimal level of quality and efficiency and that care is provided in an ethical and professional manner.</p> <p>To monitor performance against the ISO 9001/QMS standards included in the Clinical function.</p> <p>All significant risks relevant to the Committee's areas of responsibility are identified and reported to the Executive Management Committee on a timely basis.</p>		
REPORTING STRUCTURE & PROCESS	Provides regular feedback to the Executive Management Committee & Leadership Committee		
SUB COMMITTEES	Clinical Practice & Standards Sub-Committee		
CHAIR	Director of Clinical Services		
DEPUTY CHAIR	Chair of Clinical Standards & Practice Sub-Committee		
MEMBERSHIP	Director of Clinical Services (Chair) Assistant Director of Clinical Services Perioperative Services Manager Quality and Risk Coordinator Allied Health Manager Learning & Development Manager Nurse Unit Manager – Surgical X2 Nurse Unit Manager – Medical X2 Nurse Unit Manager – ICU Nurse Unit Manager – CCL Nurse Unit Manager – OT/PACU		
QUORUM	10 members		
SECRETARY	Executive Secretary (to Director of Clinical Services)		
FREQUENCY OF MEETINGS	Monthly		
FORMULATED	September 2013		
LAST REVISED	N/A		
PERFORMANCE INDICATORS	RESPONSIBILITY	FREQUENCY	
A report outlining the % of staff members who have successfully completed mandatory clinical competencies reported to the committee	Learning & Development manager	Monthly	
An evaluation of Code Blues and Medical Emergency Team outcomes is reported to the committee.	Nurse Unit Manager (ICU)	Monthly	
Significant clinical event trends are reviewed by the committee.	Quality and Risk Coordinator	Monthly	
A summary report of the trends of clinical adverse events is presented monthly.	Quality and Risk Coordinator	Monthly	
Clinical policies are ratified from Clinical Standards & Practice Committee.	ADCS	Monthly	
Review audit results of compliance with key clinical policies, long audits and trends.	Quality and Risk coordinator	Monthly	
The committee monitors performance against ISO 9001 standards.	Quality and Risk Coordinator	Annually	
The function and outcomes of the Clinical Standards	DCS	January	

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Committee is reviewed annually and a written report summarising outcomes and future directions of the Committee is provided to Executive.		
All summary reports of the trends of clinical complaints are presented.	Quality and Risk Coordinator	February, May, August, Nov
A summary report of discharge and LOS trends is reported to the committee.	Quality and Risk Coordinator	Feb, May, Aug, Nov
A summary report of admissions trends is reported to the committee.	Administration Manager	March, June, Sept, Dec
A summary report of carepath variance is reported to the committee.	Assistant Director Clinical Services	April, July, October

RTI Release

CLINICAL POLICY COMMITTEE

PURPOSE	To ensure that all clinical policies and procedures are reviewed in a systematic process, reflect best practice, relevant legislative requirements and professional standards, are evidence based and provide appropriate guidance to staff and promote patient safety.	
FUNCTIONS	<p>The Clinical Policy Committee:</p> <p>Ensures that relevant staff are involved in the development and review of clinical policies and procedures.</p> <p>Drives the continual review process of clinical policies and procedures.</p> <p>Ensure that clinical policies and procedures are modified where changes in practice have occurred.</p> <p>Coordinates if required, staff education relating to newly released clinical policies and procedures.</p> <p>Addresses any issues that may arise due to the implementation of new clinical policies and procedures.</p> <p>Evaluates the effectiveness of implemented clinical policies and procedures.</p> <p>Alert clinical staff of significant changes to policies</p>	
REPORTING STRUCTURE & PROCESS	<p>Provides regular feedback to the Director of Nursing Services through the Assistant Director of Nursing Services member.</p> <p>Provides feedback to the Nurse Unit Managers through Nurse Unit Manager's Meetings.</p>	
SUB COMMITTEES	Nil – working parties only	
CHAIR	Assistant Director of Clinical Services	
DEPUTY CHAIR	Quality & Risk Coordinator	
MEMBERSHIP	<p>Assistant Director of Clinical Services</p> <p>Quality & Risk Coordinator</p> <p>Clinical Educator representative</p> <p>Nurse Unit Manager (ICU)</p> <p>Nurse Unit Manager (Surgical rep)</p> <p>Nurse Unit Manager (Medical rep)</p> <p>Ad hoc relevant staff members as required</p>	
QUORUM	4 people	
SECRETARY	Quality & Safety Administrative Assistant	
FREQUENCY OF MEETINGS	Monthly	
FORMULATED	September 2013	
LAST REVISED	N/A	
PERFORMANCE INDICATORS	RESPONSIBILITY	FREQUENCY
A summary of progress is presented to the Clinical Standards Committee and NUM Meetings.	Q&R Coordinator	Monthly
The progress and outcomes of working parties (when applicable) are reviewed.	Working Party Representative	Monthly / PRN
New policies and amendments are posted electronically, locally and tabled at appropriate clinical meetings.	Q&R Coordinator	January
The function and outcomes of the Committee are reviewed annually and presented to the Clinical Standards Committee.	Q&R Coordinator	October
A three-year plan of policies to be reviewed is formulated and updated yearly. Annually 14 sections will be reviewed.	Q&R Coordinator	November

CLINICAL PATHWAY SUB COMMITTEE

PURPOSE	To ensure that Clinical pathways and patient Care paths are developed and reviewed according to SCUPH policy. Specifically that clinical pathway & care paths align with SCUPH clinical policies, funding requirements, medical standing orders, accepted practice and available clinical evidence.	
FUNCTIONS	<p>Prioritise Clinical pathway development.</p> <p>Ensure that appropriate members of the multidisciplinary team have input to review and development of Clinical pathways</p> <p>Review and approve the content of pathway reviewed or developed.</p> <p>Ensure that pathways align with policies, standing orders and funding requirements.</p> <p>Ensure appropriate document control of pathways and patient pathways.</p>	
REPORTING STRUCTURE & PROCESS	Provides feedback to the Nurse Unit Managers through Nurse Unit Manager's Meetings.	
SUB COMMITTEES	Nil – Working Parties only	
CHAIR	DCS	
DEPUTY CHAIR	ADCS	
MEMBERSHIP	<p>Director of Clinical Services</p> <p>Assistant Director of Clinical Services</p> <p>Quality and Risk Coordinator</p> <p>Nurse Unit Manager x 2</p> <p>Allied Health Manager</p> <p>Learning & Development Manager</p> <p>Other staff as required for specific activities</p>	
QUORUM	5 members	
SECRETARY	Exec Secretary	
FREQUENCY OF MEETINGS	Monthly	
FORMULATED	September 2013	
LAST REVISED	N/A	
PERFORMANCE INDICATORS	RESPONSIBILITY	FREQUENCY
Regular reports are generated for Hospital Executive and Nurse Unit Manager Committee re: activities undertaken and Carepath variances.	NUM/Learning & Development manager	Monthly
All Carepaths are reviewed regularly.	DCS/ADCS	Annually
The function and outcomes of the Clinical Pathway Sub-Committee is reviewed annually and a written annual report summarising outcomes and future directions of the committee is provided to Executive.	Q&R Co-ord	January
New pathways are developed in line with identified priorities.	NUM/Learning & Development manager	As developed
Patient pathways are reviewed and developed linked to Carepaths.	NUM/Learning & Development manager	As developed
Pathways have multidisciplinary input and align with hospital policies and VMO standing orders.	NUM/Learning & Development manager	As developed
LOS of pathways reflect funding agreements.	DCS/ADCS	As developed and reviewed
Documents and forms reviewed and developed are controlled as per SCUPH policy.	NUM/Learning & Development manager	As developed and reviewed

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TRANSFUSION COMMITTEE

PURPOSE	To promote a safe and effective transfusion practice within the hospital.	
FUNCTIONS	<p>To make recommendations concerning the proper use of blood, and blood products.</p> <p>To advise and assist with quality improvement programs to ensure appropriate transfusion practice, including assisting with medical and nursing education programs in transfusion medicine.</p> <p>To advise on appropriate procedures for patient and blood sample identification and documentation of all blood/blood products transfused.</p> <p>To review transfusion reactions and make recommendations to improve transfusion practices.</p> <p>To consider legal aspects of transfusion practice such as documentation, product liability, and informed consent.</p>	
REPORTING STRUCTURE & PROCESS	<p>Provide feedback to the Operating Theatre & Anaesthetic Committee via the DCS.</p> <p>Provide feedback to the Nurse Unit Management Committee via the DCS</p>	
SUB COMMITTEES	Nil	
CHAIR	Assistant Director of Clinical Services	
DEPUTY CHAIR	Quality & Risk Co-ordinator	
MEMBERSHIP	<p>Director of Clinical Services</p> <p>Sullivan Nicolaides Pathology, Haematologist</p> <p>Sullivan Nicolaides Pathology, Chief Scientist, Blood Bank</p> <p>Medical Representative from MAC</p> <p>Intensive Care NUM</p> <p>Day Oncology Lead RN</p> <p>Theatre NUM</p> <p>Quality and Risk Coordinator</p>	
QUORUM	50% + 1	
SECRETARY	Executive Secretary	
FREQUENCY OF MEETINGS	Quarterly	
FORMULATED	September 2013	
LAST REVISED	N/A	
PERFORMANCE INDICATORS	RESPONSIBILITY	FREQUENCY
The following Clinical indicator data is tabled and reviewed quarterly: Transfusion statistics; and Audit results – use and wastage of blood components, clinical and laboratory indications for transfusion.	SNP	Quarterly
Incident / Adverse events related to transfusion are reviewed by the Committee.	Quality and Risk Co-ordinator	Quarterly
Policies related to Transfusion and the use of blood and blood products are reviewed and ratified by the Committee.	Quality and Risk Co-ordinator	Quarterly
The function and outcomes of the Transfusion Committee meeting is reviewed annually and a written annual report summarising outcomes and future directions of the meeting is provided to Executive.	SNP/DCS	January

WORK HEALTH & SAFETY COMMITTEE

PURPOSE	To promote a safe environment for workers, patients and visitors.	
FUNCTIONS	<p>To act in an advisory capacity to the Hospital Executive.</p> <p>To create and maintain an active interest in health and safety and assist in reducing injuries, illnesses and adverse occurrences to employees, patients, visitors, contractors and members of the general public.</p> <p>To advise on development of training and education and promotion of health and safety at Sunshine Coast University Private Hospital.</p> <p>To facilitate cooperation between the employer and workers in instigating, developing and carrying out measures designed to ensure the health and safety legislation.</p> <p>To formulate, monitor, review and disseminate, standards, policies and procedures in relation to workplace health and safety.</p> <p>To monitor trends and review significant work related injuries, illnesses and adverse occurrences.</p> <p>To assist and advise third parties and sub-contractors as appropriate.</p> <p>To maintain and disseminate records of meetings.</p> <p>All significant risks relevant to the Committee's areas of responsibility are identified and reported to the Executive Management Committee on a timely basis.</p> <p>To monitor the ongoing progress in relation to H&S for all accreditation and licensing requirements</p>	
REPORTING STRUCTURE & PROCESS	Provides regular feedback to the Executive Management Committee	
SUB COMMITTEES	Nil	
CHAIR	Nominated Employee representative (HSR)	
DEPUTY CHAIR	Workplace Health and Safety Manager	
MEMBERSHIP	Commercial Manager (executive rep) Work Health & Safety Manager / FSA Quality and Risk Coordinator Health & Safety Representatives (HSR's) Elected Employee work streams x 6	
QUORUM	8 members	
SECRETARY	Quality & Risk Admin	
FREQUENCY OF MEETINGS	Monthly	
FORMULATED	September 2013	
LAST REVISED	N/A	
PERFORMANCE INDICATORS	RESPONSIBILITY	FREQUENCY
Risk Analysis is undertaken in all areas and findings reviewed by the committee.	WH&S Co-ordinator	Monthly
De-identified trends of staff/visitor incidents are reviewed by the Committee	WH&S Manager	Monthly
The Committee review H&S policies and makes recommendations to Executive.	WH&S Manager	Monthly
Evacuation Drill activities are reported to the Committee.	F&S Coordinator	Annually
The committee is responsible for monitoring the compliance with ISO standards on Health & Safety.	Quality & Risk Co-ordinator	Annually
The committee ratifies an annual Safety Plan (FAWSIMP) of activities for Health & Safety.	WH&S Manager	Annually
A summary of progress to Safety Plan (FAWSIMP) is presented.	WH&S Manager	Quarterly

HUMAN RESOURCE COMMITTEE

PURPOSE	To advise on the development, evaluation and revision of human resource practices, policies and procedures.		
FUNCTIONS	<p>To review and monitor recruitment, selection, appointment and probation processes throughout the hospital.</p> <p>To make recommendations on priority areas for staff training and development and evaluate the outcomes of training programs.</p> <p>To monitor and review industrial relations policies and practices to ensure they comply with statutory requirements.</p> <p>To advise on Corporate Wellness initiatives and to facilitate the development of policies and procedures to support these initiatives where necessary.</p> <p>To monitor the efficient utilisation of Human Resources through the development and implementation of performance measures.</p> <p>To initiate and contribute to activities designed to position the Hospital as an employer of choice.</p> <p>To ensure local initiatives are aligned with Corporate HR directions.</p> <p>All significant risks relevant to the Committee's areas of responsibility are identified and reported to the Executive Management Committee on a timely basis.</p> <p>Review resignations and exit interview data.</p>		
REPORTING STRUCTURE & PROCESS	Provides regular feedback to the Executive Management Committee		
SUB COMMITTEES	Staff Competency Sub Committee		
CHAIR	HR Coordinator		
DEPUTY CHAIR	Director of Clinical Services		
MEMBERSHIP	<p>Director of Clinical Services</p> <p>Assistant Director of Clinical Services</p> <p>HR Co-ordinator</p> <p>Return To Work Coordinator (HR Assistant)</p> <p>Learning & Development Manager</p> <p>Environmental Services Manager</p> <p>Administrative Services Manager</p>		
QUORUM	5 members		
SECRETARY	Quality & Risk admin assistant		
FREQUENCY OF MEETINGS	Quarterly		
FORMULATED	September 2013		
LAST REVISED	N/A		
PERFORMANCE INDICATORS	RESPONSIBILITY	FREQUENCY	
Updates on industrial relations issues are reported and discussed.	HR Manager	Bi-Monthly	
Organisational HR indicators are presented monthly.	HR Manager	Bi-Monthly	
The committee reviews HRM policies and makes recommendations to Executive.	HR Manager	Ongoing	
Staff completion of compulsory competencies is monitored by committee.	HR Manager	Quarterly	
Evaluation of orientation and formal training program is reviewed by the Committee.	Learning & Development Manager	Quarterly	
Staff feedback from surveys and exit interviews is reviewed regularly.	HR Manager	Quarterly	

INFECTION PREVENTION & CONTROL COMMITTEE

PURPOSE	To ensure a safe microbiological environment for patients, staff and visitors, by means of an effective program for the surveillance, prevention and control of infection.	
FUNCTIONS	<p>To develop and regularly review Infection Control policies and procedures including: Policies and procedures that impact on Infection Control Standards such as sterilisation, food hygiene, waste management, cleaning services and clinical care. Policies and procedures to prevent and control nosocomial infection and occupationally acquired infectious disease.</p> <p>To review reports and initiate investigation as required. Reports include: Nosocomial infection rates and trends. Specific surveillance studies.</p> <p>To develop and review quality activities and education programs relevant to Infection Control.</p> <p>To advise on Infection Control issues related to policy, hospital redevelopment and changes or enhancements to services.</p> <p>To monitor and evaluate staff health program.</p> <p>To assess need for investigation into infection control issues.</p> <p>To develop , review and evaluate the influenza /pandemic flu plan</p> <p>All significant risks relevant to the Committee's areas of responsibility are identified and reported to the Executive Management Committee on a timely basis.</p>	
REPORTING STRUCTURE & PROCESS	Provides regular feedback to the Executive Management Committee	
SUB COMMITTEES	Nil	
CHAIR	Infection Control Coordinator	
DEPUTY CHAIR	Quality & Risk Coordinator	
MEMBERSHIP	Director of Clinical Services Assistant Director of Clinical Services Infection Prevention & Control Co-ordinator Infection Diseases Physician/Consultant Microbiologist (SNP) Quality and Risk Coordinator CSSD Manager Nurse Unit Manager (Medical) Pharmacy Manager Environmental Services Manager	
QUORUM	8 Members	
SECRETARY	Quality & Risk Admin	
FREQUENCY OF MEETINGS	Quarterly	
FORMULATED	September 2013	
LAST REVISED	N/A	
PERFORMANCE INDICATORS	RESPONSIBILITY	FREQUENCY
A summary report including significant organism data, surgical site infections, hospital-acquired bacteraemia is tabled.	Infection Control Coordinator	Monthly
The committee is responsible for monitoring the compliance with National Accreditation standards on Infection Control.	Quality and Risk Coordinator	Annually
The function and outcomes of the Infection Prevention & Control Committee is reviewed annually and a written annual report summarising outcomes and future directions of the committee is provided to Executive.	DCS	January
Staff health program reviewed and recommendations tabled.	Infection Control Coordinator	April
Departmental audit results reviewed and recommendations made.	Infection Control Coordinator	May, November

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Annual ratification of Infection Control Unit Business Plan by the Committee.	Quality and Risk Coordinator	September
External audits e.g.: HICMR and action plan	Infection Control Coordinator	Annual audit
Communication with Clinical staff- 1 page summary from meeting	Infection Control Coordinator	Monthly

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PRODUCT REVIEW COMMITTEE

PURPOSE	To review new and existing products to ensure cost benefits, evidence based practice, quality care and optimum outcomes are achieved for all hospital products.	
FUNCTIONS	<p>To provide advice to the Executive Management Committee on purchase of hospital products.</p> <p>To minimise the number of similar or duplicate products available for use throughout the Hospital.</p> <p>To examine cost savings through the use of different products and/or changes in clinical practice.</p> <p>To approve all product trials at Sunshine Coast University Private Hospital.</p> <p>To maintain a Product Trial Register Folder.</p> <p>To undertake post implementation reviews on product suitability and cost savings</p> <p>To monitor all TGA recalls.</p> <p>To review all product complaints.</p>	
REPORTING STRUCTURE & PROCESS	Provides regular feedback to the Executive Management Committee	
SUB COMMITTEES	Nil	
CHAIR	Commercial Manager	
DEPUTY CHAIR	Perioperative Services Manager	
MEMBERSHIP	Commercial Manager Assistant Director of Clinical Services Perioperative Services Manager Stores Manager Work Health & Safety Coordinator Biomedical Engineer Nurse Unit Manager x 2 Clinical Educator Infection Control Coordinator	
QUORUM	6 members	
SECRETARY	Executive Secretary (CM)	
FREQUENCY OF MEETINGS	Monthly	
FORMULATED	September 2013	
LAST REVISED	N/A	
PERFORMANCE INDICATORS	RESPONSIBILITY	FREQUENCY
Present a report of all product trials in SCUHP.	Stores Manager	Monthly
A summary of recalled products/equipment to be presented to the Committee.	Stores Manager	Monthly
All incident reports relating to Equipment problems/failures to be presented monthly.	WH&S Manager	Monthly
To look at equipment for replacement on ongoing basis for feedback from committee prior to CAPEX allocation	BME Representative	Annually
The committee is responsible for monitoring the compliance with Equip standards on Supply Management.	Quality and Risk Manager	Annually
The function and outcomes of the Product Review Committee is reviewed annually and a written annual report summarising outcomes and future directions of the committee is provided to Executive.	ADCS	January

PHARMACY & THERAPEUTICS COMMITTEE

PURPOSE	To monitor and advise on prescribing, dispensing and administration of medications within the hospital.		
FUNCTIONS	<p>To review appropriate clinical indicators related to medication administration including:</p> <ul style="list-style-type: none"> Patient complaints ISO Indicators Medication errors Medication audit results <p>To advise on changes to policies to improve the safety, efficacy and efficiency of medication administration.</p> <p>To monitor and improve customer service across all clinical units</p> <p>Medication Safety Trends</p>		
REPORTING STRUCTURE & PROCESS	Provides regular feedback to the Executive Management Committee and the Medical Advisory Committee		
SUB COMMITTEES	Nil		
CHAIR	Pharmacy Manager		
DEPUTY CHAIR	Assistant Director of Clinical Services		
MEMBERSHIP	<ul style="list-style-type: none"> Director of Clinical Services Pharmacy Manager Assistant Director of Clinical Services Quality and Risk Coordinator Nurse Unit Manager medical Nurse Unit Manager surgical Workplace Health & Safety Coordinator Learning & Development Manager 		
QUORUM	6 people		
SECRETARY	Quality & Risk Admin		
FREQUENCY OF MEETINGS	Quarterly		
FORMULATED	September 2013		
LAST REVISED	N/A		
PERFORMANCE INDICATORS	RESPONSIBILITY	FREQUENCY	
The following Clinical indicator data is tabled and reviewed monthly: Patient complaints. ISO Indicators. Medication errors. Medication audit results.	DOCS	Monthly	
Incident / Adverse events related to medication incidents are reviewed by the committee.	Quality & Risk Co-ordinator	Monthly	
Policies related to Pharmacy and medications are reviewed and ratified by the Committee.	Quality & Risk Co-ordinator	Ongoing	
The committee is responsible for monitoring the compliance with ISO standards on Pharmacy.	Quality & Risk Co-ordinator	Annually	
The function and outcomes of the Pharmacy committee is reviewed annually and a written annual report summarising outcomes and future directions of the Committee is provided to Executive.	RHC Director Pharmacy	January	
Track Authority scripts compliance and cost of.	Director of Pharmacy	Monthly	
Monitor compliance to National Medication Safety Standard	Quality & Risk Co-ordinator	Monthly	

SUNSHINE COAST RADIOLOGY MEETING

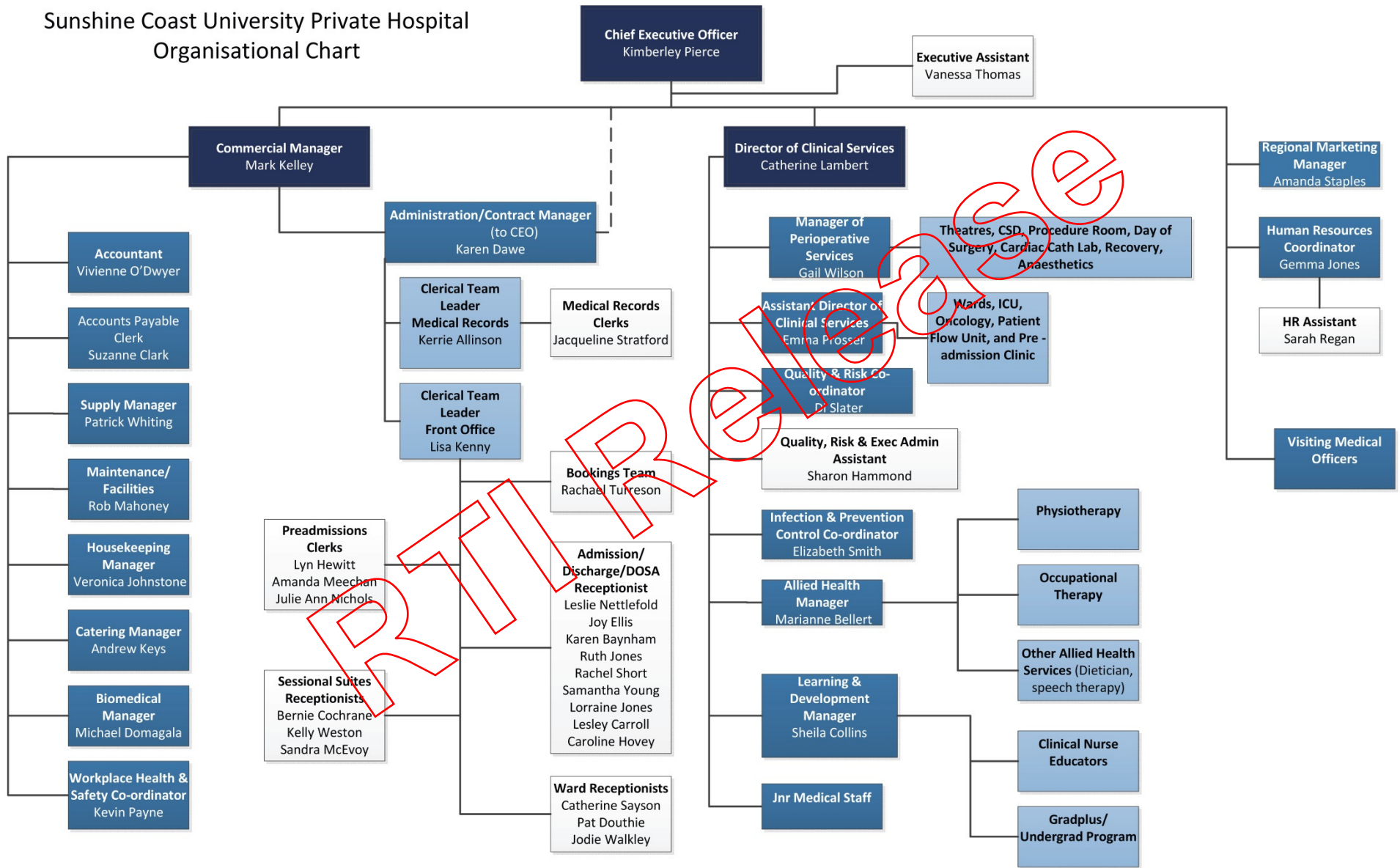
PURPOSE	To discuss and address issues relating to service provision and to service levels are consistent with those agreed. To further develop service provision to ensure that it meets the standards required in the changing clinical requirements.	
FUNCTIONS	To review and monitor service contractual arrangements. To monitor KPIs. To monitor incidents, complaints and compliments. To resolve operational issues affecting both parties. To liaise with external bodies in relation to issues affecting both parties	
REPORTING STRUCTURE & PROCESS	Provides regular feedback to the Executive Management Committee. Both parties should submit to the agenda items to the Executive Secretary at least 10 days prior to the meeting. Both parties should submit a report covering KPIs, incidents, complaints/compliments and operational issues to the Executive Secretary at least 10 days prior to the meeting.	
SUB COMMITTEES	Nil	
CHAIR	Chief Executive Officer	
DEPUTY CHAIR	Commercial Manager	
MEMBERSHIP	Chief Executive Officer / delegate 1 x SCR Managing Partner 1 x SCR Representatives Commercial Manager Director of Clinical Services	
QUORUM	5 members (2 of which must be S&N representation)	
SECRETARY	Executive Secretary (CM)	
FREQUENCY OF MEETINGS	Bi-Monthly	
FORMULATED	September 2013	
LAST REVISED	N/A	
PERFORMANCE INDICATORS	RESPONSIBILITY	FREQUENCY
Patient complaints/compliments are tabled and reviewed bi-monthly.	DCS / SCR	Bi-Monthly
Incident/Adverse events related to Qld X-Ray services are reviewed by the committee.	DCS / SCR	Bi-Monthly
Services Agreement KPIs are presented and monitored.	SCR/CM	Bi-Monthly
The function and outcomes of the SCR Liaison meeting is reviewed annually and a written annual report summarising outcomes and future directions of the meeting is provided to Executive.	CM	January

SULLIVAN & NICOLAIDES PATHOLOGY MEETING

PURPOSE	<p>To discuss and address issues relating to service provision and to service levels are consistent with those agreed.</p> <p>To further develop service provision to ensure that it meets the standards required in the changing clinical requirements.</p> <p>To discuss arrangements that relate to access and operational issues to being on site of the facility</p>		
FUNCTIONS	<p>To review and monitor service contractual arrangements.</p> <p>To monitor KPIs.</p> <p>To monitor incidents, complaints and compliments.</p> <p>To resolve operational issues effecting both parties.</p>		
REPORTING STRUCTURE & PROCESS	<p>Provides regular feedback to the Executive Management Committee.</p> <p>Both parties should submit to the agenda items to the Executive Secretary at least 10 days prior to the meeting.</p> <p>Table the review of activity statistics, KPI's relating to performance of services</p>		
SUB COMMITTEES	Nil		
CHAIR	CEO		
DEPUTY CHAIR	CM		
MEMBERSHIP	<p>Chief Executive Officer / delegate</p> <p>1 x SNP Managing Partner</p> <p>1 x SNP Representative</p> <p>Commercial Manager</p> <p>Director of Clinical Services</p>		
QUORUM	4 members (2 of which must be SNP representation)		
SECRETARY	Executive Secretary (CM)		
FREQUENCY OF MEETINGS	Bi-Monthly		
FORMULATED	September 2013		
LAST REVISED	N/A		
PERFORMANCE INDICATORS	RESPONSIBILITY	FREQUENCY	
Patient complaints/compliments are tabled and reviewed bi-monthly.	DCS /SNP	Bi-Monthly	
Incident/Adverse events related to S&N services are reviewed by the committee.	DCS /SNP	Bi-Monthly	
Services Agreement KPIs are presented and monitored.	DCS/SNP	Bi-Monthly	
The function and outcomes of the S&N Liaison meeting is reviewed annually and a written annual report summarising outcomes and future directions of the meeting is provided to Executive.	CM	January	

APPENDIX A: ORGANISATIONAL CHART

Sunshine Coast University Private Hospital Organisational Chart

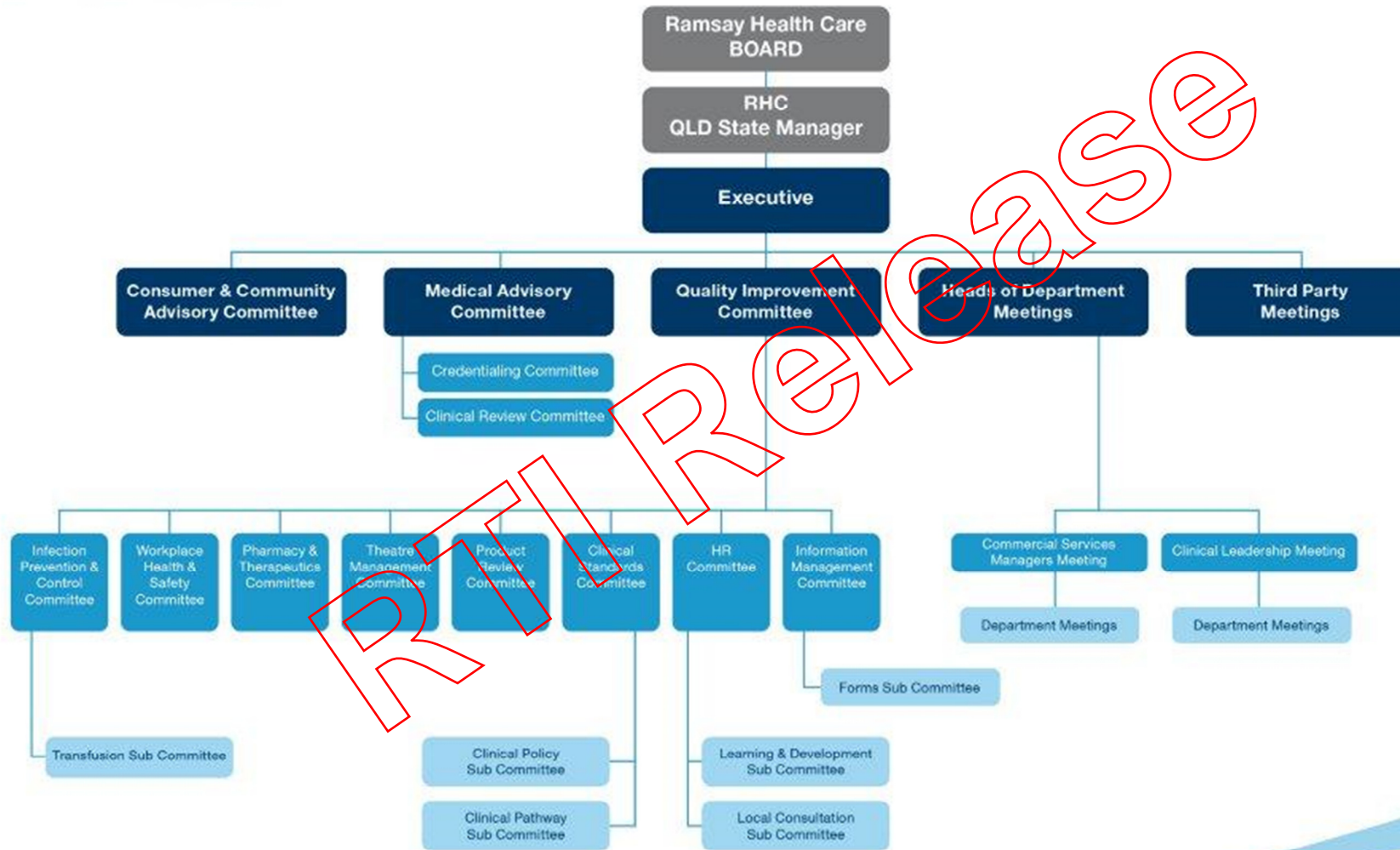


5 September 2013

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APPENDIX B: COMMITTEE STRUCTURE

Sunshine Coast University Private Hospital
Committee Structure - August 2013



SUNSHINE COAST
 UNIVERSITY PRIVATE HOSPITAL

RTI Release

Agreement

Services Agreement

The State of Queensland through the Department of Health

Ramsay Health Care Australia Pty Limited

RTI Release

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Management

Performance Standards

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Signing page

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Services Agreement

Date ► 4 April 2011

Between the parties

**The State of Queensland through the Director-General
Department of Health**

of State Health Building, 147-163 Charlotte Street, Brisbane, QLD
(QH)

Ramsay Health Care Australia Pty Limited

ACN 003 184 889 of Level 9, 154 Pacific Highway, St Leonards,
NSW

(the Operator)

Recitals

- 1 QH is, subject to the provisions of this Agreement and the other Private Hospital Contracts, proposing to develop the SCUH on the Kawana Site.
 - 2 QH invited certain private hospital operators to provide binding bids for the design, construction, finance, Commissioning, operation and maintenance of a private hospital providing health facilities and other related health services at the Private Hospital Site which forms part of the Kawana Site, initially on a stand alone basis and proposed to be collocated with the SCUH in the future.
 - 3 The Operator has been selected to design, construct, finance, commission, operate and maintain the Facility.
 - 4 Prior to and during the proposed development of the SCUH, QH requires the Operator to provide certain Contracted Services for Public Patients at the Facility.
 - 5 QH wishes to engage the Operator, and the Operator has agreed to provide, the Contracted Services at the Facility on the terms and conditions of this Agreement.
-

The parties agree as follows:

1 Definitions and interpretation

1.1 Definitions

The meanings of the terms used in this Agreement are set out below.

Term	Meaning
Accreditation	certification from a quality assurance entity (within the meaning of the Private Health Facilities Act) that the Facility operates under a quality assurance system (within the meaning of the Private Health Facilities Act).
Activity Forecast	has the meaning given to it in the Rules of Interpretation.
Agreed Platform	has the meaning given to it in the Rules of Interpretation.
Agreement	this agreement between QH and the Operator and includes all Schedules and Attachments.
Audit Recommendations	the recommendations of the independent auditor issued in draft under clause 7.4(j)(2) and finalised under clause 7.4(m).
Authorisations	<ol style="list-style-type: none">any consent, registration, filing, agreement, notarisation, certificate, licence, approval, permit, authority or exemption from, by or with a Government Entity (pursuant to any Law); orany consent or authorisation regarded as given by a Government Entity due to the expiration of the period specified by a statute within which the Government Entity should have acted if it wished to proscribe or limit anything already lodged, registered or notified under that statute, and includes, in respect of the Operator, the Authorisations referred to in clause 2.1 of the Lease.
Availability KPI	a KPI set out in Table 9 of Part 1 of Schedule 3.
Business Day	any day on which banks are open for business on the Sunshine Coast and Brisbane excluding Saturdays and Sundays and public holidays.

Term	Meaning
Claim	<p>includes any claim, proceeding, cause of action, action, demand or suit (including by way of contribution or indemnity):</p> <ol style="list-style-type: none"> 1 in contract; 2 otherwise at law or in equity including: <ul style="list-style-type: none"> • by statute; • in tort for negligence or otherwise, including negligent misrepresentation; or • for quantum meruit or restitution, including restitution based on unjust enrichment, <p>under, arising out of, or in connection with this Agreement or any Private Hospital Contract.</p>
Collocation Agreement	the collocation agreement dated 4 April 2011 between QH and the Operator.
Compensable Patient	a patient who would be entitled to receive free public hospital services but for the fact that the patient (or his or her estate) is entitled to receive or has received a compensation payment in respect of the relevant injury, illness or disease.
Commencement Date	<p>the later of:</p> <ol style="list-style-type: none"> 1 the date of commencement of the Lease; and 2 2 December 2013.
Confidential Information	<p>in respect of a party, information that:</p> <ol style="list-style-type: none"> 1 is by its nature confidential; 2 is designated by the disclosing party as confidential; or 3 the other party knows or ought to know is confidential, <p>and, without limitation, includes the terms of this Agreement.</p>
Contamination	a solid, liquid, gas, odour, heat, sound, vibration, radiation, pollutant or substance of any kind which makes or may make the environment unsafe, unfit or harmful for habitation, use or occupation by any person or animal or is such that any part of the environment does not satisfy the contamination criteria or standards published or adopted by the Queensland Environment Protection Agency from time to time.
Contracted Services	hospital services provided or to be provided by the Operator to a Public Patient at the Facility, being clinical services listed in Part 1 of Schedule 2 which the Operator is engaged to provide for that Public Patient under clause 4.1(c), facilities management services as specified in section 4.1 of Part 1 of Schedule 2 and associated

Term	Meaning
	administrative and record-keeping services.
Contract Manager	a person appointed under clause 19.1(a).
Contract Material	all Material created or developed by or made available by the Operator to QH during or as a result of the Operator providing the Contracted Services.
Corporations Act	the <i>Corporations Act 2001</i> (Cth).
Corporations Regulations	the <i>Corporations Regulations 2001</i> (Cth).
Cure Event	has the meaning given to it in clause 9.2.
Cure Period	subject to clause 9.5, the 20 Business Day periods referred to in clauses 6.4 and 7.6 and the periods set out in the table in clause 9.3.
Direct Admission Patient	<ol style="list-style-type: none"> 1 an acute (non-elective) patient who is referred or who is to be referred to the Facility by QH for admission on the day of referral; or 2 a public inpatient at a QH Facility who QH wishes to transfer to the Facility, <p>but, for the avoidance of doubt, a Direct Admission Patient does not become a Public Patient for the purpose of this Agreement unless and until QH issues a Referral Order to the Operator in respect of that Direct Admission Patient.</p>
Dispute	has the meaning given to it in clause 10.
Dispute Representative	a person appointed by either QH or the Operator under clause 10.5.
Dispute Resolution Committee	a committee comprising senior representatives of each party, established in accordance with clause 10.3.
Dispute Resolution Procedures	the procedures established to hear and resolve Disputes under clause 10.

Term	Meaning
District	<p>depending on the context:</p> <ol style="list-style-type: none"> 1 the administrative unit within QH known as the QH Sunshine Coast Health Service District; or 2 the geographic area constituting the QH Sunshine Coast Health Service District.
Extended Force Majeure	has the meaning given to it in clause 12.3(d).
Facility	has the meaning given to it in the Lease.
Financial Year	<ol style="list-style-type: none"> 1 each period of 12 months commencing on 1 July and ending on the following 30 June; and 2 if, as contemplated by clause 3.1(b), the expiry date of this Agreement is not 30 June (in either 2018 or 2019), the period of less than 12 months commencing on 1 July and ending on the expiry date.
Force Majeure	<p>any event or circumstance or combination of events and circumstances which is beyond the control of the party affected, which occurs without the fault or negligence of the affected party or any of its Personnel or subcontractors, including:</p> <ol style="list-style-type: none"> 1 natural disaster, fire, explosion, storm, lightning, flood (except to the extent that the cause of the default or delay is due to the Operator not constructing the Facility to meet the Specifications (as defined in the Collocation Agreement) regarding flooding), earthquake, hurricane, cyclone or other act of God; 2 riots, civil commotion, sabotage, terrorism, blockade, act of a public enemy, war (declared or undeclared) or revolution; 3 radioactive Contamination or toxic or dangerous chemical Contamination; 4 strikes, lockouts, industrial disputes, labour disputes, work bans, secondary boycotts, blockades or picketing, or similar stoppage of work, which are not specific to the Private Hospital Site or the Operator or its Personnel; or 5 the declaration of a 'disaster situation' as that term is defined in the <i>Disaster Management Act 2003</i> (Qld), <p>which:</p> <ol style="list-style-type: none"> 6 causes or results in default or delay in the performance by the affected party of any of its obligations under this Agreement; and 7 is not an event or circumstance the risk or responsibility of which is by this Agreement or any Private Hospital Contract assumed by the affected party; and 8 could not reasonably have been prevented, overcome or remedied by the exercise by the affected party of a standard of care and diligence consistent with that of a prudent and

Term	Meaning
	<p>competent person undertaking the affected obligation, but not including:</p> <ul style="list-style-type: none"> 9 wet or inclement weather not being a flood, hurricane, storm or cyclone; 10 staff or contractor or supply shortages; 11 an Insolvency Event in relation to the Operator or its Personnel; 12 strikes, lockouts, industrial disputes, labour disputes, work bans, secondary boycotts, blockades or picketing, which are specific to the Private Hospital Site or the Operator or its Personnel; 13 malicious damage; or 14 change in Law.
Force Majeure Notice	a notice given in accordance with clause 12.1(a).
Government Entity	any government or any governmental, semi governmental, administrative, fiscal or judicial body, department, commission, authority (including statutory authority) tribunal, agency or entity and includes a government entity described in section 21 of the <i>Public Service Act 2008</i> (Qld), the Local Authority, the State of Queensland and the Commonwealth.
Implementation Date	the date nominated by the independent auditor (issued in draft under clause 7.4(k) and finalised under clause 7.4(m)) as the date by which the Audit Recommendations should be substantially implemented.
Implementation Notice	a notice given in accordance with clause 7.6.
Insolvency Event	<p>in relation to the Operator (or a Material Subcontractor or other relevant entity as applicable) (Relevant Entity) means each of the following events:</p> <ul style="list-style-type: none"> 1 a liquidator, provisional liquidator, trustee in bankruptcy, administrator, manager, receiver, receiver and manager or similar officer is appointed in respect of the Relevant Entity or any of its assets; 2 an order is made or a resolution is passed for the purpose of appointing a person referred to in paragraph 1 or for winding up the Relevant Entity or for implementing a scheme of arrangement for the Relevant Entity or for placing it under official management; 3 a moratorium of any debts of the Relevant Entity or an official assignment or a composition or an arrangement formal or informal with its creditors or any similar proceeding or arrangement by which its assets are submitted to the control of its creditors is proposed, ordered or declared;

Term	Meaning
	<ol style="list-style-type: none"> 4 the Relevant Entity suspends payments of its debts generally without the prior consent of QH; 5 the Relevant Entity ceases to carry on business; 6 the Relevant Entity becomes, is declared or is deemed insolvent within the meaning of any applicable Law or is unable or admits in writing its inability to pay its debts as these fall due; 7 the Relevant Entity transfers or parts with the whole or any substantial part of its undertakings and assets otherwise than in the ordinary course of business; 8 execution is levied against the assets of the Relevant Entity; 9 a mortgagee enters into possession of any of the assets of the Relevant Entity; or 10 any other event analogous to any of the above occurs in respect of the Relevant Entity, which has a substantially similar effect.
Integrated Management System	has the meaning given to it in the Rules of Interpretation.
Intellectual Property Rights	all present and future industrial and intellectual property rights and interests throughout the world, whether registered or unregistered, including copyright, trade marks, designs, patents, circuit layouts, confidential information, trade secrets, know-how and any right to apply for registration of or any application of these rights.
Kawana Site	the freehold land at the corner of Kawana Way and Lake Kawana Boulevard at Birtinya (Kawana) owned by QH comprising approximately 20 hectares of land, survey plan reference Lot 5, SP 229840.
KPI Failure	has the meaning given to it in the Rules of Interpretation.
KPIs	has the meaning given to it in the Rules of Interpretation.
Law	<ol style="list-style-type: none"> 1 Legislation; 2 those principles of law established by decisions of the courts; 3 lawful requirements of Government Entities (pursuant to any Law); and 4 Authorisations (including conditions and requirements in respect of those Authorisations).
Lease	the lease dated after the date of this Agreement between QH and the Operator.

Term	Meaning
Legislation	<ol style="list-style-type: none"> 1 any act of parliament; 2 any subordinate legislation, rules, standards, orders, regulations or by-laws, or policy; and 3 guidelines of the Commonwealth, the State of Queensland or the Local Authority with which the Operator is legally required to comply.
Local Authority	Sunshine Coast Regional Council.
Loss	any cost, loss, expense, fees, payments, damage, fine, penalty or other liabilities of any kind whatsoever whether direct, indirect, consequential (including economic loss), present or future, fixed or unascertained, actual or contingent.
Lower Limit	has the meaning given to it in the Rules of Interpretation.
Material	all documents, reports, records, manuals, software, processes, data and other materials in whatever form.
Material Subcontract	<p>means:</p> <ol style="list-style-type: none"> 1 any agreement under which the Operator engages a third party to provide the whole or any significant part of the Contracted Services; and 2 each subcontract for the following services (to the extent the relevant service is not provided by the Operator directly): <ul style="list-style-type: none"> • the pathology provider for the Facility; and • the diagnostic imaging provider for the Facility.
Material Subcontractor	a person engaged by the Operator under a Material Subcontract.
Minimum Requirements	the requirements and standards set out in Part 1 of each Schedule.
Moral Rights	rights of integrity of authorship, rights of attribution of authorship, rights not to have authorship falsely attributed, and rights of a similar nature conferred by statute that exist, or may come to exist, anywhere in the world including all rights described in Part IX of the <i>Copyright Act 1968</i> (Cth).
NPPs	the National Privacy Principles under the Privacy Act.
Objectives	the objectives for this Agreement as specified in clause 2.

Term	Meaning
Operator Default	an event of a kind specified in clause 9.3(a).
Operator's Submission	those parts of the final submissions of the Operator in respect of the RFBB which are contained in Part 2 of each Schedule.
Performance Standards	the standards set out in Part 1 of Schedule 2.
Personnel	the officers, employees, contractors or agents of a party.
Privacy Act	the <i>Privacy Act 1988</i> (Cth).
Private Health Facilities Act	the <i>Private Health Facilities Act 1999</i> (Qld).
Private Hospital Contracts	<ol style="list-style-type: none"> 1 this Agreement; 2 the Collocation Agreement; 3 the Site Management Deed; 4 the Lease; 5 any collocation agreement, lease or other agreement entered into in relation to the Expansion Zone, any Expansion Proposal or any Integration Proposal as contemplated under the Site Management Deed; and 6 any other document which the parties agree (whether under or pursuant to a Private Hospital Contract or otherwise) comprises a Private Hospital Contract.
Private Hospital Site	has the meaning given to it in the Site Management Deed.
Private Patient	patient of the Facility other than a Public Patient.
Public Patient	a person designated as a public patient in a Referral Order (who may be a Compensable Patient).
Public Patient Record	has the meaning given to it in the Rules of Interpretation.
QH Facility	<ol style="list-style-type: none"> 1 a public hospital operated by QH inside or outside the District (including the SCUH once it is operational); and 2 solely in reference to a facility into which QH may nominate for the purpose of accepting a transfer of a Public Patient from the

Term	Meaning
	Facility, a private hospital with which QH has a contract to provide services to public patients, including The Noosa Hospital.
QH Background Material	all Material that is created by or for or used by QH and is provided by or on behalf of QH to the Operator for the purpose of the Operator providing the Contracted Services.
QH Default	has the meaning given to it in clause 9.4.
Rectification Plan	has the meaning given to it in the Rules of Interpretation.
Referral Default	<ol style="list-style-type: none"> 1 a series of Referral Failures in relation to Direct Admission Patients; or 2 a series of Referral Failures in relation to patients who are not Direct Admission Patients and which affect a material proportion of patients who are not Direct Admission Patients, which, taken together, has materially compromised the Operator's ability to meet the standards of safety, quality and timeliness required under this Agreement.
Referral Failure	<p>an occasion on which:</p> <ol style="list-style-type: none"> 1 QH arranges or authorises the presentation of a patient at the Facility where the Operator has not accepted a Referral Order in relation to that patient; 2 the Operator accepts a Referral Order in relation to a Direct Admission Patient and, within 6 hours of the arrival of the Direct Admission Patient at the Facility, the Operator determines that the Direct Admission Patient is not appropriate for treatment at the Facility, in circumstances where it is reasonably likely that the patient's clinical needs would have been correctly determined by QH if QH had undertaken proper triage and/or pre-admission assessment of the patient before referring the patient to the Operator; or 3 the Operator accepts a Referral Order in relation to a patient who is not a Direct Admission Patient and before admission the Operator determines that the patient is not appropriate for treatment at the Facility, in circumstances where it is reasonably likely that the patient's clinical needs would have been correctly determined by QH if QH had undertaken proper triage and/or pre-admission assessment of the patient before referring the patient to the Operator.
Referral Order	an electronic order form prepared in accordance with clause 7.1 and provided by QH to the Operator via the Agreed Platform for the purpose of instructing the Operator to provide hospital services to a Public Patient referred to the Operator through that Service

Term	Meaning
	Initiation Pathway.
Related Corporation	a related body corporate within the meaning of section 9 of the Corporations Act.
RFBB	QH's request for binding bids for the design, construction, financing, operation and maintenance of a private hospital and the provision of the Contracted Services at the Private Hospital Site dated 16 July 2010.
Rules of Interpretation	the rules for interpreting the Schedules.
SCUH	the Sunshine Coast University Hospital currently proposed to be developed on the SCUH Site adjoining or in the vicinity of the Private Hospital Site.
SCUH Site	the site proposed by QH for the SCUH within the Kawana Site.
Service Initiation Pathway	the method by which QH may request the Operator to provide hospital services to a Public Patient as described in clause 7.1(b) to 7.1(g) (inclusive).
Services Review Committee	the committee established under clause 19.4.
Service Stream	has the meaning given to it in the Rules of Interpretation.
Site Management Deed	the agreement between QH and the Operator in respect of matters relevant to the development and management of the Kawana Site, including in respect of the Proposed Development of the Kawana Site, co-ordination and integration issues with the Proposed Development and management of the Facility, dated 4 April 2011.
Tax	any tax, levy, charge, impost, fee, deduction, compulsory loan or withholding, which is assessed, levied, imposed or collected by any Government Entity and includes any interest, fine, penalty, charge, fee or any other amount imposed on, or in respect of any of the above.
Term	the term of this Agreement determined in accordance with clause 3.1.

Term	Meaning
Termination Payment	has the meaning given to it in the Site Management Deed.
Upper Limit	has the meaning given to it in the Rules of Interpretation.
WAU	a weighted activity unit, which is a single standardised unit of measure of activity used by QH, which provides a common unit of comparison to measure activity consistently and is reviewed periodically.

1.2 Rules of Interpretation

The Rules of Interpretation form part of each Schedule.

1.3 Interpretation

In this Agreement unless the contrary intention appears:

- (a) a reference to this Agreement includes any Schedule or Attachment to it;
- (b) a reference to this Agreement includes any variation or replacement of any of them;
- (c) a reference to a statute, ordinance, code or other Law includes regulations and other instruments under it and consolidations, amendments, re-enactments or replacements of any of them;
- (d) the singular includes the plural and vice versa;
- (e) the word 'person' includes a firm, a body corporate, partnership, joint venture, an unincorporated association or a Government Entity;
- (f) a reference to a person includes a reference to the person's executors, administrators, successors, substitutes (including, without limitation, persons taking by novation) and assignees and, in particular, a reference to QH or the District includes a reference to a department or agency of the State of Queensland which takes over all or the relevant part of the role of QH or the District as at the date of this Agreement;
- (g) an agreement, representation or warranty in favour of two or more persons is for the benefit of them jointly and severally;
- (h) an agreement, representation or warranty on the part of two or more persons binds them jointly and severally;
- (i) a reference to an accounting term is to be interpreted in accordance with accounting standards under the Corporations Act, schedule 5 to the Corporations Regulations and, if not inconsistent with those accounting standards and that schedule, generally accepted principles and practices in Australia consistently applied by a body corporate or as between bodies corporate and over time;
- (j) a reference to any thing is a reference to the whole and each part of it and a reference to a group of persons is a reference to all of them collectively, to any two or more of them collectively and to each of them individually;

- (k) headings and marginal notes have been inserted for guidance only and shall not be deemed to form any part of the substance of this Agreement;
- (l) references to clauses and sections shall be references to clauses and sections of this Agreement and references to clauses include sub-clauses of this Agreement;
- (m) a reference to a 'day' is a reference to a calendar day (and includes, without limitation, weekends and public holidays);
- (n) any covenant or agreement by the Operator not to do any act or thing is deemed to include an obligation not to permit that act or thing to be done;
- (o) other parts of speech and grammatical forms of a word or phrase defined in this Agreement have a corresponding meaning;
- (p) no provision of this Agreement will be construed adversely to a party solely on the ground that the party was responsible for the preparation of this Agreement or that provision;
- (q) the expressions 'includes', 'including' and 'include' have the meaning as if followed by 'without limitation'; and
- (r) references to a party shall, in relation to information provided by or on behalf of the party, indemnities and releases given in favour of the party and exclusions of warranties and representations, and exclusions of liability for Claims or Losses that arise in relation to this Agreement, extend to Personnel of that party and in the case of QH, the State or any Government Entity of the State involved in or connected with the entry into the Private Hospital Contracts, when any such party is acting in a capacity relating to this Agreement and not in any alternative capacity (including in respect of Authorisations).

2 Objectives of this Agreement

The objectives of QH and the Operator in entering into this Agreement are:

- (a) to facilitate the achievement of the overall project objectives set out in clause 3 of the Site Management Deed;
- (b) to ensure that the Operator provides the Contracted Services to the required standards of safety, quality and timeliness set out in this Agreement, including:
 - (1) achievement of clinical outcomes for Public Patients which are at least equivalent to the target clinical outcomes for relevant public hospitals; and
 - (2) provision of equitable access to the Contracted Services for Public Patients, including:
 - (A) that Public Patients are treated in the most appropriate clinical setting to optimise health outcomes;
 - (B) provision of a 24 hours a day, 7 days a week, referral service for acutely sick patients or patients with complicated healthcare requirements;
- (c) to ensure that QH obtains the Contracted Services at a fair and reasonable cost to QH, in a manner which achieves a value for money solution for QH; and
- (d) to achieve these objectives through a culture of mutual respect and cooperation, and in an environment that fosters innovation, continuous improvement, cost efficiency, transparency and open, honest and timely communication.

3 Term

3.1 Term and expiry

- (a) Subject to clauses 3.1(b) and 14, this Agreement commences on the date it is signed and expires on 30 June 2018. However, each party acknowledges that:
- (1) QH may not, and will not, give a Referral Order to the Operator before:
 - (A) in the case of a Direct Admission Patient, the Commencement Date; and
 - (B) otherwise, the date which is 30 days prior to the Commencement Date (and, for Referral Orders received before the Commencement Date, the Operator will have 60 days after receipt of the Referral Order to commence the inpatient episode of care); and
 - (2) the Operator must not admit or treat a Public Patient before the Commencement Date;
 - (3) clauses 4.1, 5, 7 and 9.7, and the parties' obligations under the Schedules (other than section 2.2 of Part 1 of Schedule 4) commence on the Commencement Date.
- (b) Without limiting clause 3.3, the expiry date of this Agreement may be changed to a date which is later than 30 June 2018 pursuant to clause 5.2 of the Site Management Deed or clause 26.3(a) of the Collocation Agreement.

3.2 Arrangements for later expiry

- (a) If, as contemplated by clause 3.1(b), the expiry date of this Agreement is changed to a date which is later than 30 June 2018, the parties will negotiate in good faith to agree the upper and lower activity limits, for each Service Stream and in aggregate for all Service Streams, which will apply for the period of operation after 1 July 2018 and (if applicable) in the 2017/2018 Financial Year.
- (b) Unless the parties otherwise agree:
- (1) the 'ramp down' profile shown for the 2017/2018 Financial Year in section 2 of Part 2 of Schedule 2 will apply for the final 12 months of operation of this Agreement, whether or not the 12 month period coincides with a Financial Year; and
 - (2) the 'full operations' profile shown for the 2016/2017 Financial Year in section 2 of Part 2 of Schedule 2 will apply until the date which is 12 months before the revised expiry date of this Agreement.
- (c) If it is necessary to calculate upper and lower activity limits for a part-Financial Year, QH will perform this calculation in good faith having regard to the proportionate spread of activity across the most recently ended Financial Year.
- (d) Section 6.3 of Part 1 of Schedule 1 applies to the period of operation after 1 July 2018 and (if applicable) in the 2017/2018 Financial Year as though paragraphs (a) and (b)(4) of that section instead referred to the activity limits agreed or determined under this clause 3.2.
- (e) In the 2018/2019 and 2019/2020 Financial Year(s) (as applicable), section 3.4 of Part 1 of Schedule 4 will apply on the basis that the following amounts are set out in Table 14:

2018/2019	2019/2020
[Redacted]	[Redacted]

3.3 Consideration of possible extension

- (a) At least 2 years before the scheduled expiry of this Agreement, QH must use its reasonable endeavours to consult with the Operator in relation to the projected demand for public hospital services in the District in the period after such expiry, and the manner in which QH proposes to meet such demand.
- (b) At any time during the Term, the Operator may give QH a written proposal for an extension of the term of this Agreement.
- (c) If QH receives a proposal under clause 3.3(b), QH will:
 - (1) assess the proposal having regard to the Objectives, including the extent to which:
 - (A) the provision of the Contracted Services by the Operator has achieved the Objectives prior to the receipt of the proposal; and
 - (B) the proposal offers a value for money solution to QH compared to direct provision of such services through facilities operated by QH; and
 - (2) use its reasonable endeavours to consult with the Operator about the proposal in a timely manner.
- (d) If (in its absolute discretion) QH accepts a proposal to extend the term of this Agreement, the parties must act in good faith to agree any amendments to this Agreement, including the Schedules, that are required to accommodate the extension.

4 Engagement

4.1 Contracted Services

- (a) QH engages the Operator to provide the Contracted Services to Public Patients at the Facility during the Term.
- (b) The Operator accepts the engagement referred to in clause 4.1(a) and agrees to provide the Contracted Services to Public Patients at the Facility during the Term in accordance with this Agreement.
- (c) In respect of an individual Public Patient, the Operator's engagement:
 - (1) commences only if and when the Public Patient has completed a Service Initiation Pathway in respect of the provision of treatment at the Facility;
 - (2) relates only to those clinical services:
 - (A) specified in the Referral Order for the relevant Public Patient; and
 - (B) which are otherwise clinically necessary for the appropriate treatment of the relevant Public Patient while the Public Patient is admitted or awaiting admission to the Facility; and
 - (3) ends when the Public Patient:

- (A) is discharged or transferred in accordance with section 6 of Part 1 of Schedule 2;
- (B) advises the Operator (or advises QH which advises the Operator) that the Public Patient does not wish to proceed with the relevant treatment, or has elected to be treated elsewhere (including as a Private Patient at the Facility);
- (C) cannot be contacted after the Operator has attempted to contact the Public Patient on four separate occasions using the contact details set out in the Referral Order; or
- (D) dies.

4.2 Private Patients

QH acknowledges that the Operator will also provide hospital services to Private Patients at the Facility during the Term.

4.3 Nature of relationship

- (a) Each party acknowledges that:
 - (1) the relationship between QH and the Operator is that of a principal (in the case of QH) and independent contractor (in the case of the Operator);
 - (2) the Operator retains full responsibility for its acts and omissions under this Agreement;
 - (3) nothing in this Agreement renders or deems either party to be a partner, joint venturer or agent of the other party; and
 - (4) except as expressly provided in this Agreement, nothing in this Agreement deems either party to be the agent or legal representative of the other party, or creates any fiduciary relationship between the parties.
- (b) The Operator:
 - (1) is not authorised, and
 - (2) must not hold itself out as being authorised,

to exercise any responsibilities for or on behalf of QH other than as provided by this Agreement.

4.4 Changes to health care funding components

- (a) If, during the Term, the cost components used to calculate the price per WAU under the funding model applied to public health facilities in Queensland are changed, the parties must procure their Contract Managers to meet and discuss in good faith adjustments to the fees payable by QH to the Operator, on the basis that:

- (b) If the parties do not agree within 20 Business Days after the date of the change, either party may refer the matter for resolution in accordance with clause 10.

4.5 Changes to health care funding model

- (a) If, during the Term there is a material change to the funding model applied to public health facilities in Queensland with the result that it is no longer possible to quantify activity in WAUs, or to refer to a price per WAU under the funding model applied to public health facilities in Queensland, the parties must discuss alternative fee structures in good faith having regard to the Objectives.
- (b) If the parties are unable to agree upon an alternative fee structure under clause 4.5(a) within 60 Business Days of the material change to the funding model, the parties agree that for the purpose of calculating the Service Fee the parties will:

(1)

(2)

4.6 Consideration of possible additional volume or service streams

- (a) At least 3 months before finalising its activity targets for a Financial Year, QH must use its reasonable endeavours to consult with the Operator in relation to the projected demand for public hospital services in the District in the Financial Year, and the manner in which QH proposes to meet such demand.
- (b) At any time during the Term, the Operator may give QH a written proposal for QH to acquire:
- (1) more activity from the Operator in one or more Service Streams; and/or
 - (2) hospital services in a modality other than the Service Streams,
- for some or all of the remaining Financial Years of the Term, on the basis that such additional activity or services will form part of the Contracted Services under this Agreement. Any such proposal must specify a proposed upper and lower activity limit for the relevant Service Streams or modalities.
- (c) If QH receives a proposal under clause 4.6(b), QH will:
- (1) assess the proposal having regard to the Objectives, including the extent to which:
 - (A) the provision of the Contracted Services by the Operator has achieved the Objectives prior to the receipt of the proposal; and
 - (B) the proposal offers a value for money solution to QH compared to direct provision of such services through facilities operated by QH;
 - (2) use its reasonable endeavours to consult with the Operator about the proposal in a timely manner; and
 - (3) if QH is in receipt of such a proposal within 2 months before finalising its activity targets for a Financial Year, consider in good faith whether to accept the proposal in respect of the relevant Financial Year having regard to the Objectives.
- (d) If (in its absolute discretion) QH accepts a proposal under clause 4.6(c)(3):
- (1) any additional modality is treated as an additional Service Stream under this Agreement including the Schedules;

- (2) the upper and lower limits for the relevant Service Streams apply in accordance with the proposal;
- (3) consequential adjustments are made to the aggregate upper and lower limits across all Service Streams;
- (4) QH must issue its activity target for the relevant Financial Year based on the changes referred to in clauses 4.6(d)(1) to 4.6(d)(3); and
- (5) the parties must act in good faith to agree any other amendments to this Agreement, including the Schedules, that are required to accommodate the proposal.

5 Requirements for Contracted Services

5.1 Minimum Requirements and Operator's Submission

- (a) The Operator must provide the Contracted Services in accordance with:
 - (1) the Minimum Requirements; and
 - (2) the Operator's Submission.
- (b) If the Minimum Requirements and the Operator's Submission prescribe different standards in relation to the same matter, the higher standard prevails.

5.2 Accreditation

The Operator must:

- (a) actively work towards achieving Accreditation as soon as is practicable after the Commencement Date;
- (b) achieve Accreditation within 12 months after the Commencement Date; and
- (c) maintain that Accreditation for the Term of this Agreement.

5.3 Consultants and subcontractors

- (a) If the Operator engages subcontractors (including consultants) to undertake any of its obligations under this Agreement, the Operator must ensure that such persons are professionally qualified to undertake the tasks, which will be required of them, including holding all Authorisations to perform those tasks.



5.4 Material Subcontractors

- (a) The Operator may only engage a person as a Material Subcontractor if the person is approved in writing by QH before the person's engagement takes effect, such approval not to be unreasonably withheld and which must be provided or rejected within 20 Business Days from the date on which details of

the relevant Material Subcontractor are provided to QH, or such other longer period as agreed by the parties. QH will:

- (A) without limitation, not be acting unreasonably if it withholds its approval because the proposed Material Subcontractor does not meet the requirements of clause 5.4(b); and
 - (B) be deemed to have approved in writing the person's engagement if QH does not approve or reject the engagement within the 20 Business Day period.
- (b) Any Material Subcontractor must:
- (1) be capable of performing and have sufficient financial capability to perform all of the obligations of the Operator that are (or are to be) subcontracted to that Material Subcontractor to the standard required by this Agreement; and
 - (2) have experience, demonstrated recent good performance and a good reputation in the provision of services similar to the Contracted Services that are to be subcontracted and (if relevant) be licensed to carry out the Contracted Services.
- (c) The Operator must diligently pursue its rights under each Material Subcontract to which it is a party.
- (d) If any Material Subcontract is terminated:
- (1) the Operator must notify QH immediately upon the Operator becoming aware of such termination; and
 - (2) the Operator must, select and appoint a new Material Subcontractor subject to and in accordance with the provisions of this clause 5.4 (unless the services are to be provided by the Operator itself).

5.5 Removal of a Material Subcontractor

If:

- (a) a Material Subcontractor does not satisfy or ceases to satisfy the criteria referred to in clause 5.4(b); or
- (b) an Insolvency Event occurs in relation to a Material Subcontractor,

then QH may at any time require the Operator to remove or procure the removal of the Material Subcontractor and to appoint or procure the appointment of a new Material Subcontractor (unless the services are to be provided by the Operator itself),

5.6 Insurance

The Operator must maintain insurances as required by the Lease and use all reasonable endeavours to ensure that Material Subcontractors maintain medical malpractice insurance on the terms required by the Lease.

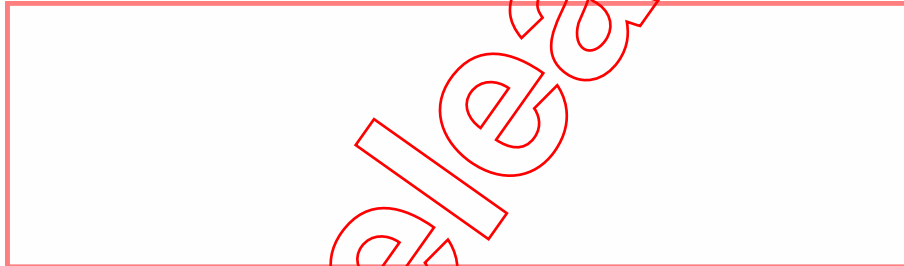
6 Fees and payment

6.1 Accounts

- (a) The Operator must issue to QH an account for the fees payable by QH to the Operator under Part 1 of Schedule 4 at the times required under that Part.
- (b) Accounts issued under clause 6.1(a) must contain any information specified in Part 1 of Schedule 4.
- (c) The Operator must issue an annual financial report in accordance with section 5 of Part 1 of Schedule 4.

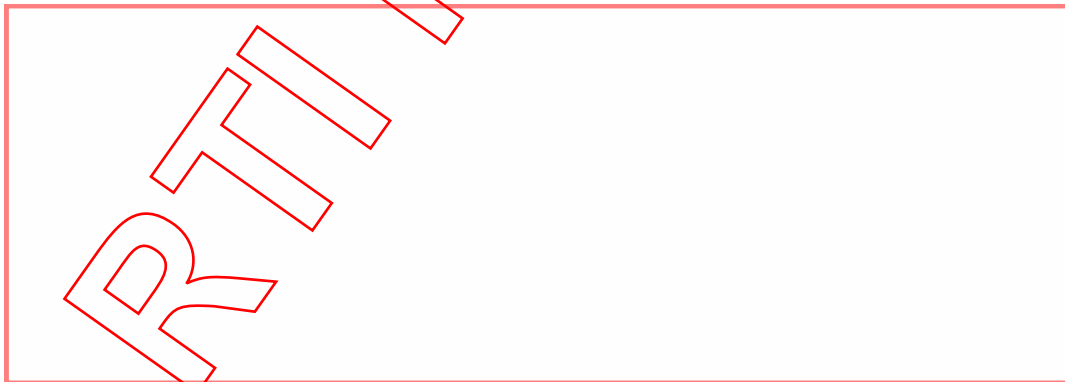
6.2 Payment

- (a) Subject to clause 6.2(b), QH must pay any account issued by the Operator within 30 days (or, for accounts issued under section 2.2(h) of Part 1 of Schedule 4, 10 Business Days) after receiving an account in the form required under Part 1 of Schedule 4.
- (b) If there is a dispute in respect of any part of an account submitted by the Operator, QH must:



6.3 Correction of overpayment

- (a) If the Operator overcharges QH in any month, in addition to any other rights under this Agreement, QH may:



6.4 Demand by Operator

If QH fails to make payment to the Operator on or before the due date for payment of the account under clause 6.2(a) (excluding any amount which is subject to a dispute), the Operator may issue a formal demand to QH requiring QH to make payment within a further 20 Business Days of receipt of the demand.

7 QH obligations

7.1 QH obligations

During the Term, QH will:

- (a) provide access to QH's referral and discharge service, which will be available 24 hours a day, 7 days a week, for the referral of Public Patients to the Facility and discharge or transfer of Public Patients from the Facility;
- (b) ensure all Public Patients referred to the Facility have undergone (as applicable):
 - (1) triage;
 - (2) assessment of suitability for admission to the Facility;
 - (3) preadmission assessment;
- (c) manage the elective surgery waiting list in the District;
- (d) provide the Operator all the clinical notes held by QH in relation to the Public Patient's current proposed inpatient episode and may also provide additional clinical notes where relevant for the purposes of providing the proposed treatment at the Facility;
- (e) subject to clause 7.2, provide the Operator with evidence of Public Patient consent to be referred to the Facility by QH and consent to the collection, use and disclosure of the Public Patient's personal information (as that term is defined in the Privacy Act) to and by the Operator as required to enable the Operator to provide the Contracted Services in compliance with the NPPs;
- (f) complete a referral order (including information set out in Attachment A to Part 1 of Schedule 2) for each Public Patient referred to the Facility for treatment and issue this information to the Operator via the Agreed Platform;
- (g) provide transport to the Facility for Public Patients requiring direct admission; and
- (h) if QH is required to nominate a QH Facility to accept a transfer of the Public Patient under section 6.5(a)(2), 6.6(c) or 6.6(d) of Part 1 of Schedule 2, make that nomination within the timeframes specified in those sections.

7.2 Process for obtaining consents

- (a) If a patient presents to the Facility without first presenting to a facility operated by QH and QH issues a Referral Order enabling that patient to be treated as a Public Patient at the Facility, the Operator will obtain any necessary consents (including privacy consents) using a form agreed between QH and the Operator for this purpose.
- (b) If, in respect of a Direct Admission Patient referred to the Facility, it is not practicable for QH to obtain necessary consents before the Operator commences to provide treatment because of an incapacity of the Direct Admission Patient, the Operator will obtain any necessary consents (including privacy consents) using a form agreed between QH and the Operator for this purpose as quickly as is practicable after commencing treatment, in accordance with usual clinical practice in this situation.
- (c) The parties intend that clause 7.1(e) will be applied having regard to usual clinical practice, including in relation to assisted and substituted decision making.

7.3 Improvement Notice

- (a) If the Operator considers that a Referral Default has occurred, the Operator may issue to QH a notice (**Improvement Notice**) requiring the Services Review Committee to meet to consider the claimed Referral Default.
- (b) Subject to Privacy Laws, an Improvement Notice must identify the patient the Operator considers have been affected by a Referral Failure (**Affected Patients**).
- (c) The parties must convene a meeting of the Services Review Committee as soon as is practicable after QH receives the Improvement Notice (and in any case within 5 Business Days after QH receives the Improvement Notice), for the purpose of discussing possible improvements to QH's systems for referring patients to the Operator.
- (d) QH must diligently implement any improvements agreed in writing by the members of the Services Review Committee.

7.4 Audit

- (a) If, within the period of 30 Business Days after the date on which the Services Review Committee first met under clause 7.3(c), the Operator considers that a further Referral Default has occurred, the Operator may issue to QH a notice (**Audit Notice**) requiring an audit to be undertaken of QH's systems for referring patients to the Operator.
- (b) Subject to Privacy Laws, an Audit Notice must identify the additional patients the Operator considers have been affected by a Referral Failure since the Improvement Notice was issued under clause 7.3(a) (also **Affected Patients**).
- (c) Within 10 Business Days after QH receives the Audit Notice, the parties shall meet to attempt to agree on an independent auditor to undertake the audit of QH's systems for referring patients to the Operator. If within a further 5 Business Days the parties are unable to agree on an independent auditor to undertake the audit, the auditor shall be nominated by the President for the time being of the Australian College of Health Service Management Queensland Branch. The independent auditor must have the qualifications and experience set out in clause 7.4(d).
- (d) An independent auditor must:
 - (1) have reasonable and appropriate qualifications and substantial practical experience in hospital admission processes;
 - (2) declare he or she has no interest or duty which conflicts or may conflict with his or her functions as an independent auditor, except for any interest or duty he or she has fully disclosed (and which has been accepted by both parties) before his or her appointment;
 - (3) not be a person a reasonable person would consider likely to have a bias for or against either party; and
 - (4) undertake to each party to keep confidential all matters coming to the independent auditor's knowledge by reason of his or her appointment, the performance of his or her duties and the exercise of his or her powers.
- (e) The Operator must give the independent auditor:
 - (1) a copy of the Referral Order (if any) and the Operator's clinical notes in respect of each Affected Patient;
 - (2) information about the basis on which the Operator considers that the Referral Failures claimed by the Operator, taken together constitute

Referral Defaults, including information about the impact on the Operator's ability to meet the standards of safety, quality and timeliness required under this Agreement; and

- (3) such other information as the independent auditor may reasonably request,

including by making Personnel of the Operator available to answer questions. Provided that the Operator assigns a unique identifier to each Affected Patient for the purpose of the audit, the Operator may de-identify such records before giving them to the independent auditor.

- (f) QH must give the independent auditor such information as the independent auditor may request about the process undertaken by QH (including copies of any applicable policies, procedures and forms):
- (1) for referring patients to the Operator; and
 - (2) generally in relation to admission of patients to QH Facilities, including by making Personnel of QH available to answer questions.
- (g) The independent auditor appointed under clause 7.4(c) shall review the material provided under clauses 7.4(e) and 7.4(f) and determine whether:
- (1) each Affected Patient claimed by the Operator to have been the subject of a Referral Failure was in fact the subject of a Referral Failure; and
 - (2) taken together, the Referral Failures (if any) accepted by the independent auditor under clause 7.4(g)(1):
 - (A) constitute a Referral Default; and
 - (B) indicate material deficiencies in QH's systems for referring patients to the Operator.
- (h) The independent auditor shall advise the parties in writing of his or her findings under clause 7.4(g) within 30 Business Days of his or her appointment (or such later date as the parties agree). If the independent auditor finds that there was a Referral Default but no material deficiencies in QH's systems for referring patients to the Operator, [REDACTED]
- (i) If the independent auditor makes a negative finding under clause 7.4(g)(2), the Operator:
- (1) [REDACTED]
 - (2) may not issue another Audit Notice within 6 months of the date on which the independent auditor advised the parties of his or her findings.
- (j) If the independent auditor makes a positive finding under clause 7.4(g)(2), QH:
- (1) [REDACTED]
 - (2) must (within 2 Business Days after receiving the independent auditor's findings) instruct the independent auditor to make written recommendations to QH as to the steps QH should take so that QH's systems for referring patients to the Operator meet the standard of admission practices that could reasonably be expected of a public hospital in Queensland (**Audit Recommendations**).
- (k) The independent auditor shall advise the parties in writing of his or her draft Audit Recommendations under clause 7.4(j)(2) within 20 Business Days of receiving the instruction from QH. The draft Audit Recommendations must

include a date by which the independent auditor reasonably considers the Audit Recommendations should be substantially implemented (**Implementation Date**), having regard to the nature of the Audit Recommendations and the time likely to be required for implementation.

- (l) QH and the Operator are entitled to make written submissions to the independent auditor about his or her draft Audit Recommendations (including the draft Implementation Date) but such submissions must be provided to the independent auditor and the other party within 5 Business Days after the independent auditor gives the parties his or her draft Audit Recommendations. The independent auditor must consider any submissions by QH or the Operator before finalising his or her Audit Recommendations, including as to the Implementation Date.
- (m) The independent auditor shall advise the parties in writing of his or her final Audit Recommendations under clause 7.4(j)(2), including the final Implementation Date, within 10 Business Days of the date referred to in clause 7.4(l).

7.5 Follow-up audit

- (a) QH must diligently implement the Audit Recommendations, including by using its best endeavours to ensure that the Audit Recommendations are substantially implemented by the Implementation Date.
- (b) If the Operator considers that QH has not substantially implemented the Audit Recommendations by the Implementation Date, the Operator may issue to QH a notice (**Follow-up Audit Notice**) requiring a follow-up audit to be undertaken to determine whether QH has substantially implemented the Audit Recommendations by the Implementation Date.
- (c) If the independent auditor who undertook the audit under clause 7.4 (**Original Auditor**) is available, unless the parties otherwise agree, the parties must appoint the Original Auditor as the independent auditor to determine whether QH has substantially implemented the Audit Recommendations by the Implementation Date.
- (d) If clause 7.5(c) does not apply, within 10 Business Days after QH receives the Follow-up Audit Notice, the parties shall meet to attempt to agree on an independent auditor to determine whether QH has substantially implemented the Audit Recommendations by the Implementation Date. If within a further 5 Business Days the parties are unable to agree on an independent auditor to make the determination, the auditor shall be nominated by the President for the time being of the Australian College of Health Service Management Queensland Branch. The independent auditor must have the qualifications and experience set out in clause 7.4(d).
- (e) The parties must give the independent auditor a copy of the Audit Recommendations, including details of the Implementation Date.
- (f) The Operator must give the independent auditor:
 - (1) information about the basis on which the Operator considers that QH has not substantially implemented the Audit Recommendations by the Implementation Date; and
 - (2) such other information as the independent auditor may reasonably request,including by making Personnel of the Operator available to answer questions.
- (g) QH must give the independent auditor such information as the independent auditor may request about the steps undertaken by QH to implement the Audit

Recommendations, including by making Personnel of QH available to answer questions.

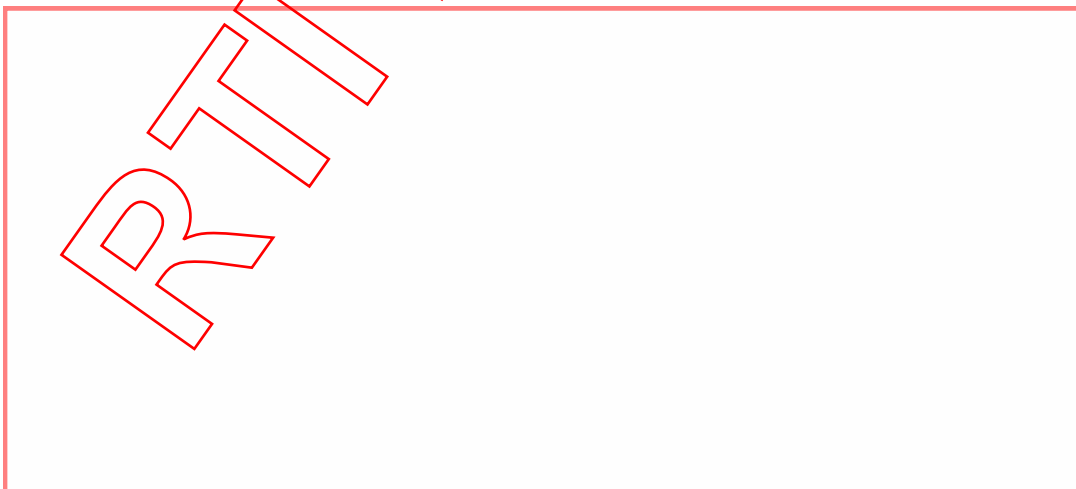
- (h) The independent auditor appointed under clause 7.5(c) or 7.5(d) shall review the material provided under clauses 7.5(e), 7.5(f) and 7.5(g) and determine whether QH substantially implemented the Audit Recommendations by the Implementation Date.
- (i) The independent auditor shall advise the parties in writing of his or her findings under clause 7.5(h) within 20 Business Days of his or her appointment (or such later date as the parties agree).
- (j) If the independent auditor determines that QH has substantially implemented the Audit Recommendations by the Implementation Date, the Operator:
 - (1)
 - (2) may not issue another Audit Notice within 12 months of the date on which the independent auditor advised the parties of his or her findings.
- (k) If the independent auditor determines that QH has not substantially implemented the Audit Recommendations by the Implementation Date,

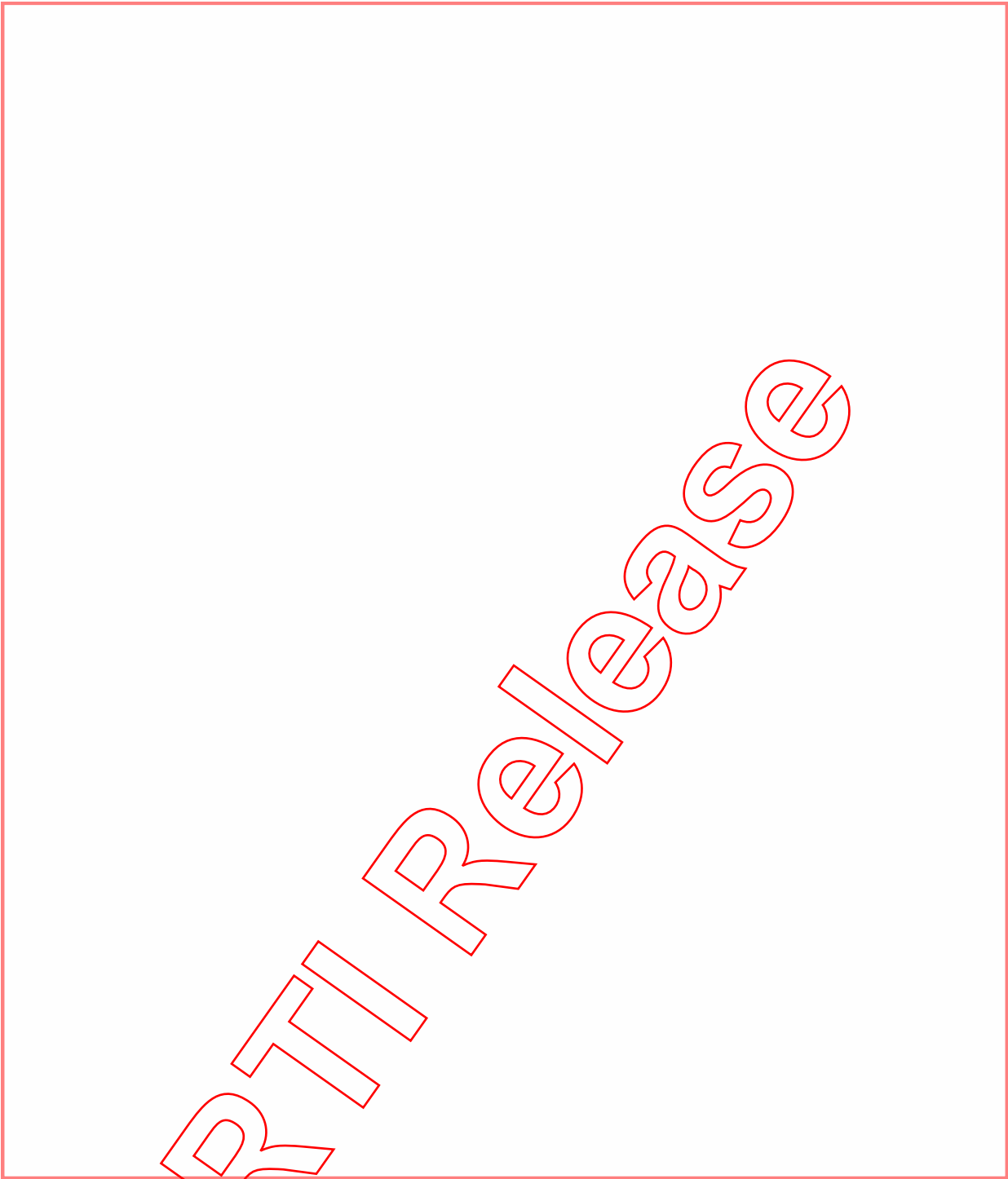
7.6 Implementation Notice

If the independent auditor determines that QH has not substantially implemented the Audit Recommendations by the Implementation Date, within 10 Business Days after receipt of the independent auditor's findings, the Operator may issue to QH a notice (**Implementation Notice**) requiring QH to substantially implement the Audit Recommendations within 20 Business Days after the date on which QH receives the Implementation Notice.

8 Indemnity

8.1 QH indemnified against the Operator's actions



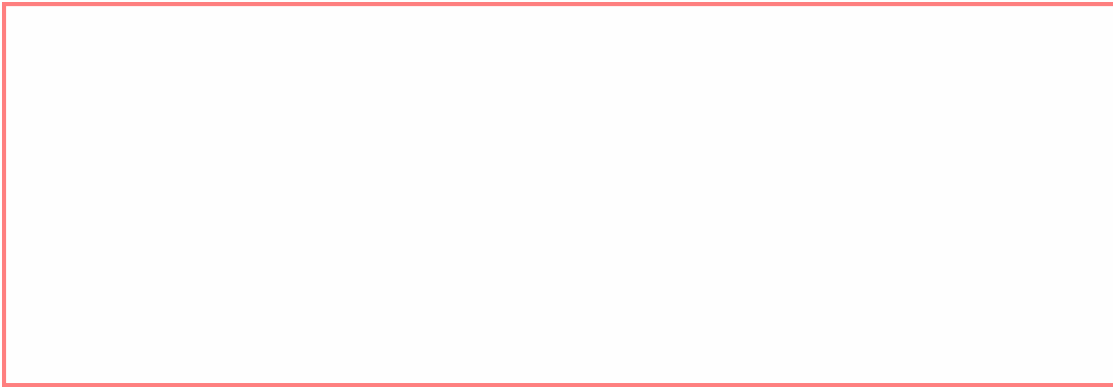


9 Performance management

9.1 **Prevention Events**

Subject to clause 14.1, if:

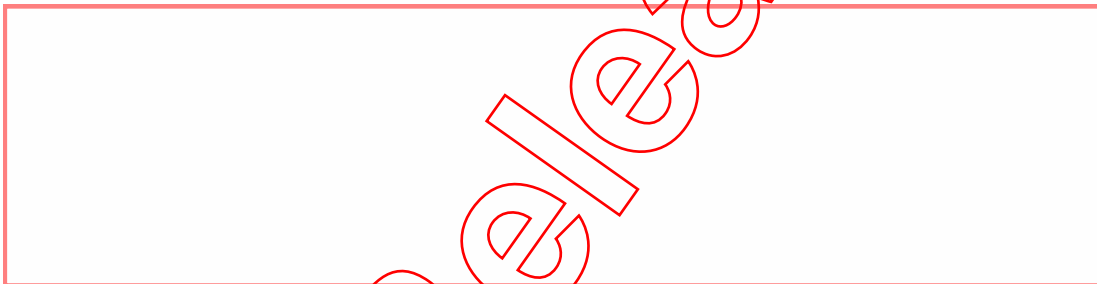
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(each a **Prevention Event**) QH may issue to the Operator a notice requiring the Operator to submit to QH a prevention plan within 5 Business Days, which is to the reasonable satisfaction of QH (acting reasonably), containing full details of all steps which the Operator is taking, or proposes to take to mitigate the effects of the Prevention Event and prevent the reoccurrence of the Prevention Event (**Prevention Plan**), and comply with and diligently pursue the Prevention Plan.

9.2 Cure Events

Subject to clause 14.1, if:

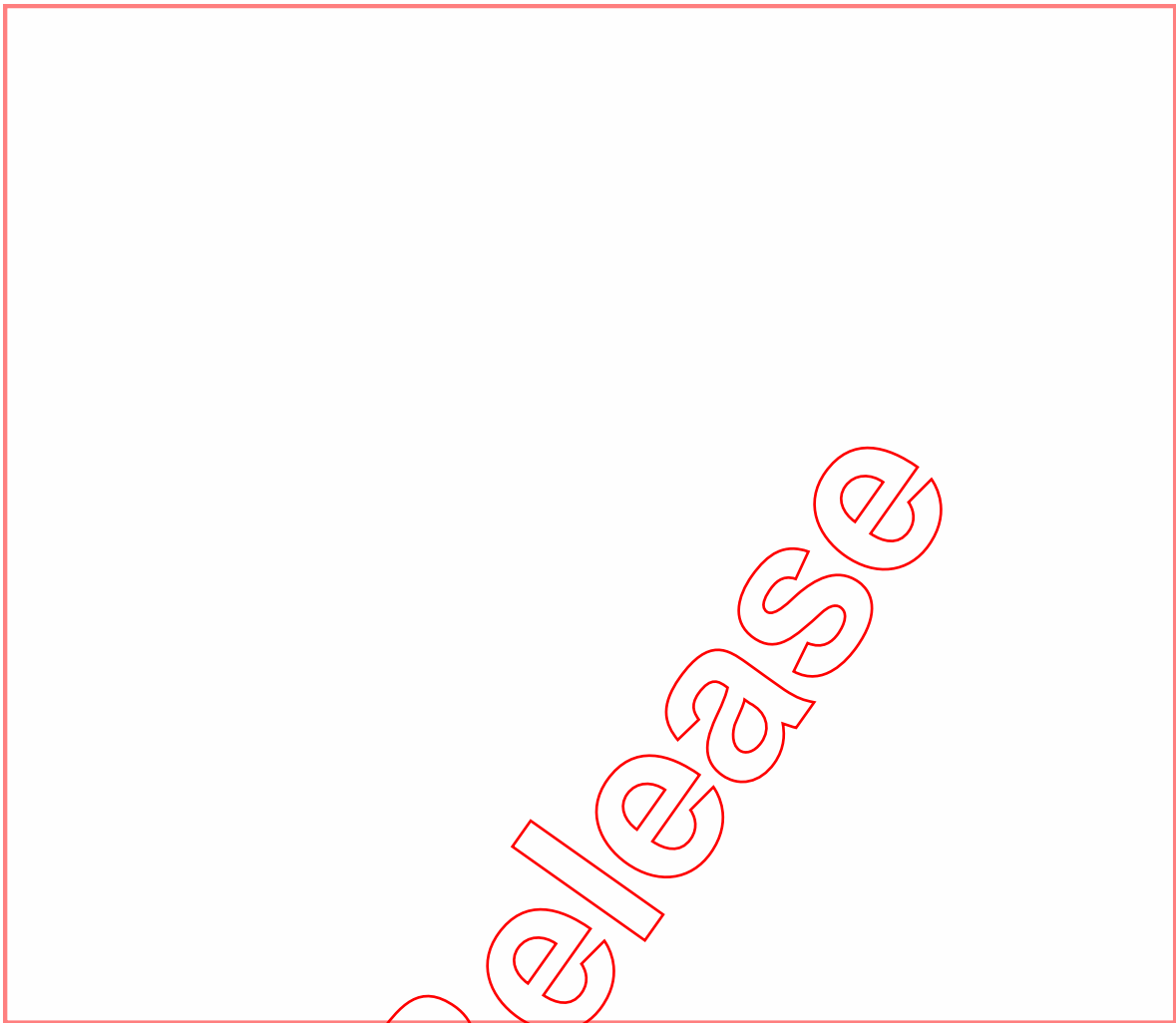


(each a **Cure Event**) QH may issue to the Operator a notice requiring the Operator to submit to QH a cure plan within 5 Business Days, which is to the reasonable satisfaction of QH (acting reasonably) containing full details of all steps which the Operator is taking, or proposes to take to cure the Cure Event and any temporary measures to be undertaken during the period that the cure of the Cure Event is being pursued (a **Cure Plan**) and comply with and diligently pursue the Cure Plan.

9.3 Operator Default

(a) Subject to clause 9.3(b), an Operator Default will occur if any of the following occurs:





9.4 QH Default

- (a) Subject to clause 9.4(b), each party acknowledges that a QH Default will occur if:
- (1) QH fails to pay an amount of money within 20 Business Days after receipt of a demand under clause 6.4;
 - (2) QH fails to substantially implement the Audit Recommendations within 20 Business Days after receiving an Implementation Notice; or
 - (3) an Extended Force Majeure occurs under clause 12.3(d) in relation to QH.
- (b) The events and circumstances set out in clause 9.4(a)(2) will not constitute a QH Default to the extent that such events or circumstances constitute a Force Majeure Event in respect of which QH is entitled to rely on clause 12.

9.5 Extension of Cure Period

If a Cure Period applies to an Operator Default or QH Default, QH or the Operator (as the case may be) may in their absolute discretion:

- (a) in the case of QH, approve a longer Cure Period to apply in relation to compliance with a Prevention Plan or Cure Plan at the time the Prevention Plan or Cure Plan is submitted to QH; or

- (b) extend that Cure Period,

in each case by written notice to the other party, in which case the relevant event in clause 9.3 or 9.4 will not be an Operator Default or a QH Default, unless and until that party fails to take the required steps in relation to that event under clause 9.3 or 9.4 within the extended Cure Period.

9.6 Audit rights

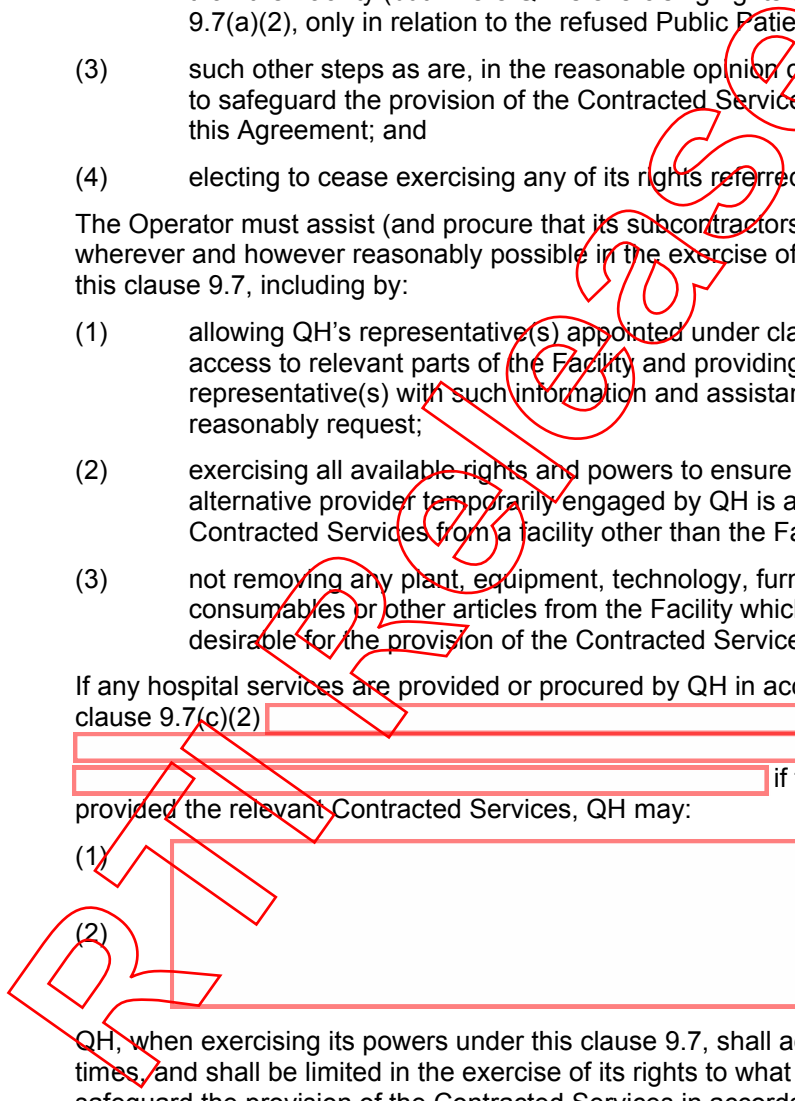
- (a) The Operator must keep proper books of account and all other financial and activity records that would be expected of a prudent and competent person undertaking similar obligations as the Operator pursuant to the Private Hospital Contracts.
- (b) The Operator must have its financial statements audited annually.
- (c) Subject to compliance with the Privacy Act, QH may during the Term and for a period of 12 months following the end of the Term, providing 5 Business Days prior written notice has been given, audit such of the books and records of the Operator in respect of the provision of the Contracted Services and the Pre-payments to be made under section 2.2 of Part 1 of Schedule 4 as is necessary to:
- (1) verify the basis for any claim made by the Operator for payments from QH;
 - (2) verify the accuracy of any account provided to QH by the Operator under this Agreement;
 - (3) assess the extent to which the Operator is complying with the Performance Standards and the KPIs (including where critical incidents or repetitive material non-compliances with the Performance Standards are identified); or
 - (4) if QH has reasonable grounds to consider that an Operator Default has occurred or is likely to occur, ascertain whether this is the case.
- (d) The Operator must make the books and records referred to in clause 9.6(a) available to QH, as is reasonably necessary to enable QH to conduct an audit under clause 9.6(c), including by printing or copying records kept electronically in order to enable QH to review such records.
- (e) The Operator must ensure that all data used in the performance management of the Contracted Services, and performance assessment against the KPIs, is collected and retained, and is made available to QH if reasonably requested by QH for the purposes of audit under clause 9.6(c).
- (f) Subject to the provision of 10 Business Days' notice to the Operator, QH is entitled to:
- (1) subject to clause 9.6(j) undertake its own inspections and examination of any aspect of the Operator's Integrated Management System or the Facility; and
 - (2) participate as an observer on audits undertaken by the Operator, including on its various subcontractors
- in respect of the provision of the Contracted Services as is necessary to:
- (3) verify the basis for any claim made by the Operator for payments from QH;
 - (4) verify the accuracy of any account provided to QH by the Operator under this Agreement;

- (5) assess the extent to which the Operator is complying with the Performance Standards and the KPIs (including where critical incidents or repetitive material non-compliances with the Performance Standards are identified); or
- (6) if QH has reasonable grounds to consider that an Operator Default has occurred or is likely to occur, ascertain whether this is the case.
- (g) The Operator must provide QH with at least 10 Business Days' notice of each scheduled audit.
- (h) Where QH undertakes its own inspections pursuant to clause 9.6(c) and such inspections identify material non-conformances with the Minimum Requirements, [REDACTED]
[REDACTED]
- (i) The Operator shall cooperate and shall procure that any sub-contractor co-operates with QH including providing QH with all information and documentation which QH reasonably requires in connection with its rights under this clause 9.6.
- (j) Unless an audit pursuant to clause 9.6(f) identifies a material breach or breaches of this Agreement:
- (1) [REDACTED] and
- (2) no further audits can be carried out by QH under that clause until the expiration of 12 months from the last audit.
- (k) If an audit pursuant to clause 9.6(f) identifies a material breach of this Agreement:
- (1) QH may conduct further audits in accordance with clause 9.6(f) during that 12 month period until no further material breaches are identified; and
- (2) [REDACTED]

9.7 Step in rights

- (a) Without limiting clause 14.1, if:
- (1) an Operator Default occurs, or
- (2) both of the following apply:
- (A) there is Prevention Event or Cure Event in respect of which the Operator has not yet implemented a Prevention Plan or Cure Plan; and
- (B) the Operator refuses one or more referrals which satisfy section 3.2 of Part 1 of Schedule 2, because of the circumstances giving rise to the Prevention Event or Cure Event,
- then:
- (3) QH will be entitled to, but is not obliged to; and
- (4) the Operator must use all reasonable endeavours to enable QH to, take the steps permitted under this clause 9.7 without prior notice to the Operator for the purpose of curing the Operator Default or procuring the timely provision of hospital services to the refused Public Patients.
- (b) The exercise by QH of its rights under this clause 9.7 will in no way affect any other rights of QH under this Agreement.

- (c) The steps which QH is entitled to take pursuant to this clause 9.7 are:
 - (1) appointing a representative or representatives (not being a competitor of the Operator, an employee of such a competitor or a contractor, agent or adviser to such a competitor who a reasonable person would consider is not independent of that competitor) to attend the Facility and observe the Operator's operations in relation to the affected aspects of the Contracted Services, for the purposes of reporting back to QH and offering advice to the Operator (which the Operator must consider in good faith);
 - (2) itself providing, or procuring the provision by others of, the whole or part of the clinical services capacity the Operator is required to provide under section 2 of Part 1 of Schedule 2 from a facility other than the Facility (but where QH is exercising rights under clause 9.7(a)(2), only in relation to the refused Public Patients);
 - (3) such other steps as are, in the reasonable opinion of QH, necessary to safeguard the provision of the Contracted Services as required by this Agreement; and
 - (4) electing to cease exercising any of its rights referred to above.
- (d) The Operator must assist (and procure that its subcontractors assist) QH wherever and however reasonably possible in the exercise of QH's rights under this clause 9.7, including by:
 - (1) allowing QH's representative(s) appointed under clause 9.7(c)(1) access to relevant parts of the Facility and providing the representative(s) with such information and assistance as they may reasonably request;
 - (2) exercising all available rights and powers to ensure that QH or an alternative provider temporarily engaged by QH is able to provide the Contracted Services from a facility other than the Facility; and
 - (3) not removing any plant, equipment, technology, furniture, fittings, consumables or other articles from the Facility which are necessary or desirable for the provision of the Contracted Services.
- (e) If any hospital services are provided or procured by QH in accordance with clause 9.7(c)(2) [redacted] if the Operator had provided the relevant Contracted Services, QH may:
 - (1) [redacted]
 - (2) [redacted]
- (f) QH, when exercising its powers under this clause 9.7, shall act reasonably at all times, and shall be limited in the exercise of its rights to what is necessary to safeguard the provision of the Contracted Services in accordance with this Agreement.
- (g) QH will cease to exercise the rights under this clause 9.7 as soon as the situation referred to in clause 9.7(a) is cured, prevented or remedied, or QH ceases to pursue a cure, prevention or remedy of that situation (whichever occurs first).
- (h) Subject to clause 9.7(f), the Operator must as directed by QH when QH ceases to exercise its rights under this clause recommence the performance of its obligations under this Agreement.



- (i) The Operator indemnifies QH against, all losses, liabilities, costs and expenses arising from any failure of the Operator to perform its obligations under this clause 9.7.
- (j) At or prior to the expiration of 3 months from the date of an exercise by QH of the step in rights under this clause 9.7, if QH has not ceased to exercise its rights under this clause 9.7 pursuant to clause 9.7(g), QH must either:
 - (1) give the Operator written notice that (without waiving any of its other rights pursuant to this Agreement) QH has elected not to exercise its rights under clause 14.1; or
 - (2) exercise its rights under clause 14.1.

9.8 Undertakings

The Operator must:

- (a) on becoming aware, give QH prompt written notice of the occurrence of:
 - (1) any Operator Default or event or circumstance which may, if uncorrected, give rise to an Operator Default; or
 - (2) any event which will have a material adverse effect on the Operator's business, assets or financial condition, or the Operator's ability to perform its obligations under this Agreement; and
- (b) within 5 Business Days of receipt, provide QH with copies of any correspondence received from a Public Patient which relates to a serious complaint about the provision of the Contracted Services by the Operator provided that the consent of the Public Patient has first been obtained.

9.9 Effective cure of Event of Default

If an Event of Default occurs and is cured or remedied prior to any exercise of any rights under clause 14.1 then the party not in default shall not exercise any termination rights hereunder.

9.10 Interaction between KPIs and this clause 9

The parties acknowledge that:

- (a) a failure by the Operator to satisfy the requirements of section 3.2 (Accepting referrals) or 3.6 (Timing of admissions) of Part 1 of Schedule 2; or
- (b) a KPI Failure by the Operator,

does not, of itself, constitute a breach of this Agreement for the purposes of clauses 9.1(a) and 9.2(a).

10 Dispute Resolution

10.1 Dispute

If a dispute arises out of or relates to this Agreement (including any dispute as to the meaning, performance, validity, subject matter, breach or termination of the Agreement) (**Dispute**) any Court proceedings shall not be commenced by or against QH or the Operator relating to the Dispute unless QH or the Operator as the case may be has complied with this clause 10.

10.2 Meeting of parties

If any Dispute arises between the parties under this Agreement, the Services Review Committee shall meet as soon as possible at a mutually convenient location to attempt to resolve the Dispute in good faith.

10.3 Establishment of Dispute Resolution Committee

QH and the Operator will establish the Dispute Resolution Committee as a forum for representatives of the parties to meet and attempt to resolve any Disputes arising between the parties in an informed and good faith manner.

10.4 Hearing of Disputes

If parties are unable to resolve a Dispute under clause 10.2 within 20 Business Days of the Services Review Committee's initial meeting, either party may immediately refer such Dispute to the Dispute Resolution Committee in writing.

10.5 Appointments

- (a) The Dispute Resolution Committee shall comprise of four members, two appointed by each of QH and the Operator.
- (b) Each of QH and the Operator shall nominate two persons to be its Dispute Representatives on the Dispute Resolution Committee and alternative representatives to represent that party when any of those nominees cannot act.
- (c) Each Dispute Representative shall be empowered to make decisions on behalf of, and to bind contractually, the party appointing such Dispute Representative in all matters raised for determination by the Dispute Resolution Committee.

10.6 Quorum

- (a) The quorum of any meeting of the Dispute Resolution Committee shall be at least one Dispute Representative of each of QH and the Operator.
- (b) If a quorum is not present within 45 minutes after the time appointed for commencement of the meeting of the Dispute Resolution Committee, that meeting shall be adjourned to the same time 2 Business Days after that meeting at the same place or at such other time, day or place as representatives of both the Operator and QH may agree.

10.7 Voting

- (a) At any meeting of the Dispute Resolution Committee voting on any issue requiring decisions shall be by unanimous resolution of Dispute Representatives, each Dispute Representative having one vote.
- (b) If there is not a unanimous vote of Dispute Representatives, at a meeting of the Dispute Resolution Committee, then the matter shall be referred to the next succeeding meeting of the Dispute Resolution Committee (which must be held as soon as possible but in any event no later than 2 Business Days after the initial meeting) and if at the succeeding meeting the matter is again not decided then such matter shall be resolved in accordance with clause 11.

10.8 Resolutions

If a variation is required to the Agreement to implement a resolution of the Dispute Resolution Committee, the Operator must promptly document this variation to the

Agreement for execution by both parties and provide QH with a copy of the varied Agreement.

10.9 Termination of appointments

QH and the Operator shall each be entitled to terminate the appointment of their respective Dispute Representatives and to appoint replacements.

10.10 Appointments in writing

All appointments of members to the Dispute Resolution Committee by a party and any termination thereof shall be notified in writing to the other members of the Dispute Resolution Committee at least 2 Business Days prior to such appointment or termination taking effect.

10.11 Notices

Notices convening meetings of the Dispute Resolution Committee may be given by any Dispute Representative and shall specify the nature of business to be transacted, and unless otherwise agreed by members of the Dispute Resolution Committee, no business other than that specified in the notice shall be transacted at such meeting.

10.12 Location of meeting

Meetings of the Dispute Resolution Committee shall be held at venues to be nominated by the secretary of the Dispute Resolution Committee in Brisbane or the Sunshine Coast unless otherwise agreed by the members of the Dispute Resolution Committee.

10.13 Summoning of meetings

- (a) The Dispute Resolution Committee shall meet to hear and attempt to resolve a Dispute:
 - (1) within 5 Business Days of such Dispute being referred to it under clause 10.4, and
 - (2) when any Dispute Representative summons a meeting of the Dispute Resolution Committee by giving not less than 15 Business Day's notice in writing to the other members of the Dispute Resolution Committee.
- (b) A meeting of the Dispute Resolution Committee may be held on less notice if agreed to in writing by the representatives of each of QH and the Operator or if the notice requirements are waived by unanimous resolution of the Dispute Resolution Committee.

10.14 Secretary

- (a) The parties shall procure that one Dispute Representative is appointed as the secretary of the Dispute Resolution Committee and shall perform such duties as are specified by the Dispute Resolution Committee and shall arrange for minutes of each meeting to be kept.
- (b) A copy of the minutes of each meeting of the Dispute Resolution Committee shall be given to each of the members of the Dispute Resolution Committee within 10 Business Days of each meeting and each member of the Dispute Resolution Committee shall as soon as possible either:
 - (1) ratify the minutes as a true and correct record of the meetings; or

- (2) identify (in writing) the aspect of the minutes with which they disagree.

11 Expert Determination

11.1 Referral to expert

- (a) If the Dispute Resolution Committee is unable to resolve a Dispute in accordance with clause 10.7 then either party may within 10 Business Days of the second meeting of the Dispute Resolution Committee under clause 10.7 refer the matter to an independent expert by providing 10 Business Days' written notice to the other party of its intention to refer the dispute to an independent expert if the Dispute relates to a matter:
 - (1) which this Agreement expressly provides be resolved by an independent expert; or
 - (2) which the parties otherwise agree should be resolved by an independent expert.
- (b) An independent expert must:
 - (1) have reasonable and appropriate qualifications and at least 5 years' commercial and practical experience in the area of the dispute;
 - (2) declare he or she has no interest or duty which conflicts or may conflict with his or her functions as an independent expert, except for any interest or duty he or she has fully disclosed (and which has been accepted by both parties) before his or her appointment;
 - (3) not be an employee or former employee of the Operator;
 - (4) not be, or have been within 3 years prior to appointment, an employee of QH; and
 - (5) undertake to each party to keep confidential all matters coming to the independent expert's knowledge by reason of his or her appointment, the performance of his or her duties and the exercise of his or her powers.

11.2 Independent expert

Within 10 Business Days of a party electing to refer a dispute to an independent expert under clause 11.1, the parties shall meet to attempt to agree on an independent expert to determine the matter in dispute. If within a further 5 Business Days the parties are unable to agree on an independent expert to make the determination, the expert shall be nominated by the President for the time being of the Queensland Chapter of the Institute of Arbitrators & Mediators Australia.

11.3 Independent expert's determination

- (a) The independent expert appointed under clause 11.1(b) shall, subject to the provisions of this clause 11.3, determine and notify the parties of the rules to apply to its determination and make the determination based upon the information made available to him by the parties and shall notify the parties in writing of that determination within 20 Business Days of his appointment (or such later date as the parties agree). The independent expert shall act as an expert and not an arbitrator.
- (b) Either party shall be entitled to make written submissions to the independent expert but such submissions must be provided to the independent expert and

the other party no later than the expiry of the 5 Business Days after the independent expert's appointment.

- (c) Either party shall be entitled to submit a response to the other party's written submissions, but such response must be provided to the expert and the other party no later than 5 Business Days after receipt of submissions.
- (d) If the independent expert decides that further information is required the expert may call for further submissions, documents or information from either or both parties and/or may call a conference between the parties.
- (e) The independent expert may conduct a conference as the expert sees fit but shall give the parties reasonable notice of the matters to be addressed at it.
- (f) At the conference, the parties may be legally represented.
- (g) The conference shall be held in private.
- (h) The independent expert's determination will be final and binding on the parties except in the cause of manifest error, in which cause either party may give a notice of dissatisfaction within 10 Business Days of the issue of the written determination, and that party may again refer the matter to an independent expert in accordance with this clause 11.

11.4 Costs of the independent expert

The cost of the independent expert's determination shall be borne equally by each of the parties to the Dispute.

11.5 Determination may be enforceable

A determination made by an independent expert under this clause 11 may, by leave of a court, be enforced in the same manner as a judgment or order of the court, and where leave is so given, judgment may be entered in the terms of the determination.

12 Force Majeure

12.1 Force Majeure Notice

- (a) If a party alleges and/or wishes to claim that a Force Majeure has occurred the party must give to the other party prompt written notice of the Force Majeure once it becomes aware of the same and the obligations affected together with full particulars of all relevant matters including:
 - (1) details of the Force Majeure;
 - (2) details of the obligations affected;
 - (3) details of the action taken and proposed to be taken to avoid or minimise the consequences of the Force Majeure;
 - (4) an estimate of the time during which the party will be unable to carry out its obligations due to the Force Majeure; and
 - (5) in the case of the Operator, an estimate of the costs the Operator will incur to remedy the situation.
- (b) After giving a Force Majeure Notice, a party must continue to provide to the other party all relevant information pertaining to the Force Majeure and take proper and reasonable steps to avoid or minimise the consequences of the Force Majeure.

12.2 Meeting, application of provisions

The parties shall meet within 5 Business Days of service of a Force Majeure Notice to determine:

- (a) what obligations will be affected by the Force Majeure; and
- (b) the estimated length of time for which the Force Majeure will continue.

The party affected by the Force Majeure shall use its best endeavours to remedy or alleviate the Force Majeure promptly, to the extent to which it is able to do so.

12.3 Consequences of Force Majeure

- (a) If a Force Majeure occurs, the obligations under this Agreement which are affected by the Force Majeure shall be suspended but only to the extent and for so long as such obligations are affected by the Force Majeure and a reasonable period thereafter as may be necessary to recommence.
- (b) If a Force Majeure Notice is issued, no party shall be in default of its obligations under this Agreement in so far as the failure or delay in the observation of performance of those obligations by that party is caused by the Force Majeure specified in the Force Majeure Notice.
- (c) Upon a party becoming able to recommence performing its obligations which were suspended under this clause 12.3, the party must immediately take steps to recommence the performance of those obligations as soon as practicable and notify the other party that the Force Majeure has ceased.
- (d) If a Force Majeure occurs which causes a party's obligations to be suspended for 6 months or longer (**Extended Force Majeure**), an Operator Default or QH Default will be deemed to have occurred and where the affected party was the Operator, clauses 9.7 and 14.1 apply.

13 Confidentiality

13.1 General restriction

Subject to clauses 13.2 and 13.3, neither party will, at any time, without the consent of the other party divulge or suffer or permit its employees, contractors, consultants or agents to divulge to any person, any Confidential Information of the other party.

13.2 Exceptions

The restrictions imposed by clause 13.1 shall not apply to the disclosure of any information:

- (a) which is now or hereafter comes into the public domain (other than as a result of a breach of this clause 13);
- (b) which is required by Law to be disclosed provided, to the extent practicable, prior notice of intended disclosure is given to the other party;
- (c) which, in the reasonable opinion of the Operator, is required to be disclosed to any prospective lender to the Operator or any prospective financier of the Facility provided they assume an obligation of confidentiality in favour of QH on terms similar to this clause 13;

- (d) which is required by law to be disclosed to any stock exchange or to shareholders of the Operator provided, to the extent practicable, prior notice of intended disclosure is given to the other party;
- (e) which, in the reasonable opinion of the Operator, is necessary to be disclosed to providers and suppliers of goods, services and equipment to the Facility provided they assume an obligation of confidentiality in favour of QH on terms similar to this clause 13; or
- (f) which is disclosed by a party to:
 - (1) its legal advisers or auditors; or
 - (2) any of its officers or employees who require the information to enable them to properly carry out their duties,provided they assume an obligation of confidentiality in favour of QH on terms similar to this clause 13.

13.3 Disclosure by QH

The Operator acknowledges that QH may disclose on a confidential basis any Private Hospital Contract or any information in relation to this Agreement or any Private Hospital Contracts (including the commercial bases of the Private Hospital Contracts or any information relating to the negotiations concerning the same or any information which may have come to QH's knowledge in the course of such negotiations or otherwise concerning the operations, dealings, transactions, contracts, commercial or financial arrangements or affairs of the Operator) to Queensland Government Ministers or Departments or Government Entities with an audit responsibility as part of its duty and responsibilities to advise on its activities and developments.

14 Termination

14.1 Termination for default

Subject to clause 9.9, if at any time:

- (a) an Operator Default occurs; or
- (b) a QH Default occurs under clause 9.4(a)(1) or 9.4(a)(2),

QH or the Operator (as the case may be) may terminate this Agreement immediately by giving written notice to the other party.

14.2 Termination due to termination of other Private Hospital Contracts

If:

- (a) the Collocation Agreement is terminated prior to the commencement of the Lease; or
- (b) at any time if the Lease or Site Management Deed is terminated (which will, in either case, have the result that the other terminates automatically),

this Agreement terminates with effect from the date of termination of the Collocation Agreement, the Lease or the Site Management Deed (as the case may be).

14.3 Other rights

The rights of QH and the Operator under clause 14.1 are without prejudice to:

- (a) any other rights available to the relevant party under this Agreement including, without limitation, under clause 9.7; and
- (b) any other legal and equitable remedies available to the relevant party including, without limitation, that party's right to claim and recover damages, suing for specific performance, injunctive relief or such other orders as the party considers appropriate.

14.4 Consequences of termination

If this Agreement is terminated or terminates by effluxion of time:

- (a) each party:
 - (1) subject to clause 14.4(a)(2), must promptly return to the other all Confidential Information of the other party in its possession, power or control (other than Public Patient Records in respect of which the Operator may retain the original provided that QH has received a complete copy under section 5.3(b) of Part 1 of Schedule 1); and
 - (2) may retain copies of Confidential Information or reproduce it after the termination of this Agreement if required by Law or a bona fide document retention policy to retain or reproduce any such Confidential Information; and
- (b) the Operator must (except where this Agreement terminates by effluxion of time, in which case section 11 of Part 1 of Schedule 1 will apply):
 - (1) to the extent reasonable, co-operate with QH or its nominee for a period of not less than 3 months from the date of termination to assist QH or its nominee to transition the Contracted Services:
 - (A) if the Lease is also terminated, to the new operator of the Facility; or
 - (B) otherwise, to a facility nominated by QH;
 - (2) at QH's request, use its reasonable endeavours to forthwith assign or novate all or any Material Subcontracts to QH or its nominee; and
 - (3) at the option of the relevant employee use its reasonable endeavours to, facilitate the transfer to the employment of QH or its nominee of all employees that QH considers are necessary to allow the Facility to operate as a going concern (and all appropriate adjustments in respect of accrued employee entitlements will be made between the parties at the time of transfer of employment),

and must execute and deliver all documents or agreements which are reasonably required to allow or assist QH to exercise its rights under this clause 14.4(b).





15 Representations, warranties and acknowledgements

15.1 Operator's representations and warranties

The Operator hereby represents and warrants to QH that:

- (a) the Operator is duly incorporated and has the power to own its own property and assets and to carry on its business;
- (b) the execution, delivery and performance of this Agreement does not violate its Constitution;
- (c) the Operator has the power, and has taken all corporate and other action required, to enter into this Agreement and to authorise the execution and delivery thereof and the performance of its obligations thereunder;
- (d) the Agreement constitutes a valid and legally binding obligation of the Operator in accordance with its terms;
- (e) the execution, delivery and performance of this Agreement does not violate any existing law or regulation or any document or Agreement to which the Operator is a party or which is binding upon it or any of its assets;
- (f) it is not in default of its material obligations under any Private Hospital Contract;
- (g) it is not the trustee or responsible entity of any trust, nor does it hold any property subject to or impressed by any trust, except to the extent disclosed to, and agreed by QH in writing;
- (h) to the best of the Operator's knowledge, the information provided by the Operator to QH in connection with the Private Hospital Contracts, which has not subsequently been superseded by further information supplied by or on behalf of the Operator to QH, is true, accurate and complete in all material respects and not misleading in any material respect (including by omission of information);
- (i) no Insolvency Event has occurred in respect of the Operator;
- (j) it has not granted or has not entered into any agreement to grant or create any security interest over its interests in any Private Hospital Contracts, other than as permitted by the Private Hospital Contracts;
- (k) no litigation, arbitration, criminal or administrative proceedings are current, pending or, to the knowledge of the Operator, threatened which would or could have a material adverse effect on the Operator's ability to perform its obligations under the terms of this Agreement; and
- (l) no representation or warranty provided by the Operator under this clause 15.1 contains or shall contain any untrue statement of material facts or omits or shall omit to state a material fact necessary to make such representation or warranty not misleading in light of the circumstances in which it was made and to the best of the Operator's knowledge, no other representation or warranty by the Operator contained in this Agreement contains or shall contain any untrue statement of material fact or omits or shall omit to state a material fact necessary to make such representation and warranty not misleading in light of the circumstances under which it was made.

15.2 QH's representations and warranties

QH represents and warrants to the Operator that:

- (a) QH has the power, authority and legal right to execute and deliver and perform its obligations under this Agreement;
- (b) the Agreement constitutes a valid and legally binding obligation of QH in accordance with its terms;
- (c) the execution, delivery and performance of this Agreement does not violate any existing law or regulation or any document or Agreement to which QH is a party which is binding upon it or any of its assets;
- (d) other than representations and warranties specifically incorporated into the Private Hospital Contracts, the Side Deed and the Independent Certifier's Deed, it does not rely upon any representation, information, data, document or material made available, or provided to it, by or on behalf of the Operator in entering into this Agreement;
- (e) QH has the power, and has taken all necessary action, to enter into this Agreement and to authorise the execution and delivery thereof and the performance of its obligations thereunder; and
- (f) no representation or warranty by QH herein contains or shall contain any untrue statement of material fact or omits or shall omit to state a material fact necessary to make such representation and warranty not misleading in light of the circumstances under which it was made.

16 Expenses

- (a) Each party shall bear its own costs associated with the preparation and execution of this Agreement and any subsequent consent, agreement, approval or waiver hereunder or amendment thereto.
- (b) The Operator will pay stamp duties assessed on this Agreement (if any).

17 Assignment and Change In Control

17.1 Prohibition on assignment and Change in Control

The Operator shall not, without the consent in writing of QH, or other than in accordance with the provisions of the Lease:

- (a) assign or otherwise dispose of its interests in the Facility, the Private Hospital Site or this Agreement; or
- (b) effect a Change in Control (as defined in the Lease).

17.2 QH may assign to successor entity

- (a) If administrative responsibility for:
 - (1) prior to the opening of SCUH, Nambour General Hospital; or
 - (2) after the opening of SCUH, SCUH,is proposed to be transferred from QH to a government-owned body corporate which is capable of entering into contracts in its own name, QH may transfer its

rights and obligations under this Agreement to that successor entity with effect from the date of transfer of administrative responsibility, and must give the Operator notice in writing of such transfer including the name and address of the successor entity.

- (b) If QH gives the Operator a notice under clause 17.2(a), references in this Agreement (including the Schedules) to QH and the District shall be read as references to the successor entity.
- (c) For clause 17.2(a), a body corporate is government owned if it is ultimately owned by the State of Queensland.

18 Intellectual property

18.1 Background Material

- (a) The Operator acknowledges and agrees that QH remains the owner or licensee of all Intellectual Property Rights in QH Background Material.
- (b) QH grants to the Operator a non-exclusive, non-transferable, royalty-free licence for the Term to exercise the Intellectual Property Rights in QH Background Material (including the right to sub-licence those Intellectual Property Rights for the Term) solely for the purpose of the Operator meeting its obligations and exercising its rights under this Agreement.

18.2 Contract Material

- (a) Subject to clause 18.3(a), the parties acknowledge that all Intellectual Property Rights in the Contract Material are owned by the Operator or will vest on creation, in the Operator.
- (b) The Operator grants to QH a non-exclusive, non-transferable (except to the extent permitted under clause 17.2), royalty-free licence to exercise the Intellectual Property Rights in the Contract Material for the purpose of QH using the Contract Material for purposes contemplated under this Agreement.

18.3 Public Patient Records

- (a) To the extent that any Intellectual Property Rights are created by or on behalf of the Operator in a Public Patient Record, the Operator hereby grants QH a perpetual, non-exclusive, transferable, royalty free licence to exercise the Intellectual Property Rights in a Public Patient Record.
- (b) Each party must do all things and execute all documents necessary to confirm or give effect to the assignment in this clause 18.3.
- (c) To the extent permitted by law, nothing in this clause prevents the Operator from retaining a Public Patient Record or using it for lawful purposes, provided that QH has received a complete copy under section 5.3(b) of Part 1 of Schedule 1.

18.4 Warranty

Subject to compliance by QH with clause 18.1, the Operator warrants that:

- (a) in performing the Contracted Services and the creation, development and supply of Contract Material, the Operator does not and will not infringe the Intellectual Property Rights or Moral Rights of any person;

- (b) the Contract Material and the exercise of its rights in the Contract Material by or on behalf of QH in accordance with this Agreement does not and will not infringe the Intellectual Property Rights or Moral Rights of any person; and
- (c) it has all rights necessary to grant the licence under this clause 18.

19 Contract Manager and Services Review Committee

19.1 Appointment

- (a) Within 20 Business Days of the date of this Agreement:
 - (1) QH shall appoint QH's Contract Manager; and
 - (2) the Operator shall appoint the Operator's Contract Manager in accordance with the selection criteria notified to QH which shall be at least equivalent to that set out in Part 2 of Schedule 1.
- (b) In the event that the Operator wishes to make a change to the appointment referred to in clause 19.1(a)(2), the Operator must notify QH and provide a replacement who satisfies the selection criteria set out in Part 2 of Schedule 1 and arrange a suitable induction and handover for that replacement.

19.2 Names

Each party shall notify the other in writing of the name of such person, and any change in the identity of the person holding the office within 5 Business Days of the appointment or change, as the case may be.

19.3 Role of Contract Managers

The role of the Operator's Contract Manager and QH's Contract Manager will be to manage and administer the terms of this Agreement to enable the expeditious and economical discharge of the obligations of each of the parties, including:

- (a) working together to develop the Activity Forecast for each Financial Year in accordance with section 6 of Part 1 of Schedule 1;
- (b) discussing and reviewing the provision of the Contracted Services by the Operator to ensure that the Contracted Services are being provided to the required standards of safety, quality and timeliness set out in this Agreement;
- (c) reviewing and agreeing the annual reconciliation of activity; and
- (d) early and clear identification and discussion of potential issues and differences between the parties and attempting to resolve such issues and differences in order to avoid disputes.

19.4 Services Review Committee

- (a) QH and the Operator will establish a committee (the **Services Review Committee**) comprising at least the Contract Managers and a senior representative of each party, or agreed by QH and the Operator from time to time.
- (b) From the date of this Agreement, the Services Review Committee must meet at such times as QH and the Operator agree and at least once each month (or such other period as agreed by QH and the Operator), to discuss any matters arising out of or in connection with this Agreement, including:

- (1) any matters relating to, and to provide an update on, the provision of the Contracted Services; and
- (2) relating to any dispute between the parties.
- (c) The Services Review Committee must conduct its meetings in such a manner and in accordance with such procedures as its members may from time to time agree, provided that at least one representative from each of QH and the Operator must be present in order for there to be a quorum.
- (d) The Services Review Committee will not have any legal responsibility to either QH or the Operator and will not have any power to require either QH or the Operator to act or refrain from acting in any way.
- (e) The decisions of the Services Review Committee do not affect the rights or obligations of either QH or the Operator under any of the Private Hospital Contracts.
- (f) Members of the Services Review Committee may arrange for such other persons as they require from time to time to attend meetings of the Services Review Committee as observers.
- (g) The Operator must, if directed to do so by QH, provide to members of the Services Review Committee:
 - (1) an agenda at least 5 Business Days in advance of each meeting; and
 - (2) minutes of each meeting within 2 Business Days after such meeting.

20 General

20.1 Notices

Every notice or other communication of any nature whatsoever required to be served, given or made under this Agreement:

- (a) shall be in writing in order to be valid;
- (b) shall be deemed to have been duly served, given or made in relation to a party if it is:
 - (1) delivered, in the case of the Operator, to the address of the Operator set out below (or at such other address as may be notified in writing by the Operator to QH from time to time for the purpose of this clause);
 - (2) delivered, in the case of QH, to the address of QH set out below (or at such other address as may be notified in writing by QH to the Operator from time to time for the purpose of this clause);
 - (3) posted by prepaid post to such address;
 - (4) sent, in the case of the Operator, by facsimile to the facsimile number of the Operator as set out below (or such other facsimile number as may be notified in writing by the Operator to QH from time to time for the purpose of this clause); or
 - (5) sent, in the case of QH, to the facsimile number of QH set out below (or such other facsimile number as may be notified in writing by QH to the Operator from time to time for the purpose of this clause);
- (c) shall be sufficient if executed by the party giving, serving or making the same or on its behalf by any attorney, director, secretary, other duly authorised officer or solicitor of such party; and

- (d) shall be deemed to be received, given, served or made:
 - (1) (in the case of prepaid post) on the fifth day after the date of posting;
 - (2) (in the case of facsimile) on receipt of a transmission report confirming successful transmission at the conclusion of the transmission; and
 - (3) (in the case of delivery by hand) on delivery.

20.2 Addresses for notices

The addresses of the parties for the provision of notices under this Agreement are:

- (a) if to QH:

- (b) if to the Operator:

20.3 Variations

No modification, variation or amendment of this Agreement shall be of any force unless such modification, variation or amendment is in writing and executed by each party.

20.4 Waiver

A failure to exercise or enforce or a delay in exercising or enforcing or the partial exercise or enforcement of any right, remedy, power, or privilege hereunder by a party shall not in any way preclude or operate as a waiver of any further exercise or enforcement thereof for the exercise or enforcement of any other right, remedy, power or privilege hereunder or provided by law.

20.5 Severability of provisions

Any provisions of this Agreement which are illegal, void or unenforceable shall be ineffective to the extent only of such illegality, voidness or unenforceability without invalidating any of the remaining provisions of this Agreement.

20.6 Counterparts

This Agreement may be executed in a number of counterparts and all such counterparts taken together shall be deemed to constitute one and the same Agreement.

20.7 Australian Currency

All prices and sums of money referred to in, and payments required to be made under, this Agreement shall be in Dollars.

20.8 Communications

Every communication between QH and the Operator shall be in the English language.

20.9 Relationship

Nothing in this Agreement shall be construed or interpreted as constituting the relationship of QH and the Operator as that of partners, principal and agent, fiduciaries or joint venturers.

20.10 Co-operation

Without detracting from either party's obligations under this Agreement, the Operator and QH shall co-operate with each other in order to achieve the objectives of this Agreement and the performance by each of the parties of its respective obligations hereunder.

20.11 Governing law

- (a) This Agreement shall be construed in accordance with and governed by the laws of Queensland.
- (b) Each party irrevocably and unconditionally submits to the non-exclusive jurisdiction of the courts of Queensland and courts of appeal therefrom. Each party waives any right it has to object to an action being brought in those courts including, without limitation, by claiming that the action has been brought in an inconvenient forum or that those courts do not have jurisdiction.

20.12 Discontinuance of bodies or associations

Reference to any authority, institute, association or body whether statutory or otherwise shall in the event of any such authority, institute, association or body ceasing to exist or being reconstituted, renamed or replaced, or the powers or functions thereof being transferred to any other organisation, be deemed to refer respectively to the organisation established or constituted in lieu of or as replacement for or which serves substantially the same purposes or subject of such authority, institute, association or body.

20.13 Approvals not to affect the Operator's obligations

The giving of any approval or the making of any direction or appointment or the exercise of any authority or discretion or the exercise, giving or making of any other matter or thing of any nature hereunder by QH shall not, except where this Agreement expressly provides to the contrary, relieve the Operator from its obligations under this Agreement.

20.14 QH's position as an authority

Nothing in this Agreement shall in any way restrict or otherwise affect the unfettered discretions of QH as to the use of its powers as a Government Entity.

20.15 Whole agreement

The provisions of this Agreement and the Private Hospital Contracts cover and comprise the whole of the agreements between the parties and it is expressly agreed and declared that no further or other covenants or provisions shall be deemed to be implied herein or to arise between the parties.

20.16 Non-merger

None of the terms or conditions of this Agreement nor any act, matter or thing done under or by virtue of or in connection with this Agreement shall operate as a merger of any of the rights and remedies of the parties in or under this Agreement all of which shall continue in full force and effect until the respective rights and obligations of the parties under this Agreement have been fully performed and satisfied.

20.17 Survival

The rights and obligations of the parties under this clause 20.17 and clauses 6, 8, 9.6, 10, 11, 13, 14, 15, 16, 17, 21 and 22 together with the rights and obligations of the parties set out in this Agreement that are expressed to apply after this Agreement ends, survive the expiry, or early termination, of this Agreement.

20.18 Moratorium

Unless application is mandatory by Law, no statute, ordinance, proclamation, order, regulation or moratorium present or future shall apply to this Agreement so as to abrogate, extinguish, impair, diminish, fetter, delay or otherwise prejudicially affect any rights, powers, remedies or discretions given or accruing to QH or the Operator under this Agreement.

20.19 No Agency

The Operator shall not in connection with this Agreement directly or indirectly hold out nor permit to be held out to any person any statement, act, agreement, matter or thing indicating that the development under this Agreement is being carried on or managed or supervised by QH nor shall the Operator act as or represent itself to be the servant or agent of QH.

20.20 Operator as Trustee

If the Operator at any time upon or subsequent to entering into this Agreement or entering into or incurring the obligations contained in this Agreement is acting in the capacity of trustee of any trust (**Trust**) then whether or not QH may have notice of the Trust the Operator covenants with QH as follows:

- (a) This Agreement extends to all rights of indemnity which the Operator now or subsequently may have against the Trust and the trust fund;
- (b) The Operator has full and complete power and authority pursuant to the Trust to enter into this Agreement and the provisions of the Trust do not purport to exclude or take away the right of indemnity of the Operator against the Trust or the trust fund, and the Operator will not release that right of indemnity or commit any breach of trust or be a party to any other action which might prejudice that right of indemnity;
- (c) Notwithstanding anything in any agreement of trust or settlement or other document, the Operator will be and at all times remain personally liable to QH for the due performance, fulfilment and observation of the obligations in this Agreement;
- (d) During the currency of this Agreement the Operator will not without the consent in writing of QH, cause, permit or suffer to happen any of the following events:
 - (1) the removal, replacement or retirement of the Operator as sole trustee of the Trust;

- (2) any alteration to or variation of the terms of the Trust which affects the rights of QH to an indemnity against the Trust;
- (3) any advancement or distribution of capital of the Trust; and
- (4) any re-settlement of the trust property.

The Operator further covenants with QH that it will be a Cure Event under this Agreement if the Operator is guilty of any breach of trust in respect of the Trust or ceases to be the sole trustee of the Trust or otherwise suffers removal, replacement or retirement as trustee of the Trust.

20.21 Further Assurances

Each party must do all things and execute all further documents necessary to give full effect to this Agreement.

20.22 Interest

If any moneys due and owing by a party under this Agreement remain unpaid after the date upon which they should have been paid, then interest at the Stipulated Rate in the Lease calculated daily, will be payable on the moneys owing from, but excluding, the date upon which they should have been paid, to and including the date upon which the moneys are paid.

20.23 Consents

- (a) Any provision in this Agreement requiring the consent or approval of a party may, unless this Agreement expressly provides otherwise, be given or withheld in that party's discretion.
- (b) Without limiting clause 20.23(a), QH may in giving or withholding any approval or consent or imposing any conditions:
 - (1) act in accordance with relevant government policies;
 - (2) adopt a 'whole of government' approach; and
 - (3) act to protect its reputation.

21 Media Release

- (a) Except in relation to any release which is required by law or listing rules to be disclosed to any stock exchange or to shareholders of the Operator, the Operator during the term of this Agreement, and except in respect of any material listed in Schedule 7 of the Collocation Agreement, shall not issue any publication, document or article for publication concerning the Facility, the District or the Contracted Services in any media or make any public announcement without the prior approval of QH (not to be unreasonably withheld. This clause 21(a) does not apply in respect of any collateral material (including leaflets and brochures) issued by the Operator in the course of its business.
- (b) The Operator shall refer to QH any inquiries concerning the matters referred to in clause 21(a) from any media.
- (c) QH may in its discretion issue any information, document or article for publication concerning any of the matters referred to in clause 21(a) in any media without the prior approval of the Operator but will use reasonable endeavours to give the Operator reasonable prior notice, where that

information, document or article concerns the Facility or the Private Hospital Contracts.

22 Taxes and Goods and Services Tax

22.1 Definitions

In clauses 22.1 to 22.4:

Term	Meaning
GST	“GST”, “taxable supply” and “tax invoice” have the same meanings as in the GST Act.
GST Act	means the <i>A New Tax System (Goods and Services Tax) Act 1999</i> (Cth).

22.2 Payments are exclusive of GST

The consideration payable by a party (**recipient**) to the other party (**supplier**) under a clause of this Agreement for a taxable supply made by the supplier to the recipient is exclusive of any amount attributable to GST (**GST-exclusive consideration**).

22.3 Obligation to pay supplier

- (a) A recipient shall, in respect of any taxable supply made by the supplier to the recipient under this Agreement, pay to the supplier, in addition to the GST-exclusive consideration and at the same time this Agreement requires the GST-exclusive consideration to be paid, an amount which, under the GST Act, is equal to the GST payable on the GST-exclusive consideration.
- (b) A recipient's liability under clause 22.3(a) is not affected by the supplier's entitlement to input tax credits under the GST Act.

22.4 Tax Invoice

A supplier of a taxable supply shall deliver to the recipient a tax invoice for a taxable supply made by the supplier to the recipient.

22.5 Tax

- (a)



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Rules of interpretation

1 Structure

- (a) Part 1 of each Schedule describes the Minimum Requirements.
- (b) Part 2 of each Schedule contains the Operator's Submission describing:
 - (1) the manner in which the Operator shall meet the Minimum Requirements; and
 - (2) the Operator's undertakings for exceeding the Minimum Requirements (if any).

2 Definitions

The meanings of the terms used in the Schedules are set out below.

Terms defined in the Services Agreement and not separately defined in these Rules of Interpretation will have the same meaning when used in the Schedules unless the context otherwise requires.

Term	Meaning
ACAT	aged care assessment team.
ACHS	the Australian Council on Healthcare Standards.
Activity Forecast	for a Financial Year for the Contracted Services: <ul style="list-style-type: none">1 the Referral Target and Referral Limit for each month of that Financial Year for each Service Stream; and2 and Quarterly Percentage for each Quarter of that Financial Year for each Service Stream, developed in accordance with section 6 of Part 1 of Schedule 1.
Activity Report	see section 7.2(a) of Part 1 of Schedule 1.
Additional Services Fee	see section 1.1(b)(2) of Part 1 of Schedule 4.
Agreed Platform	see section 5.2 of Part 1 of Schedule 1.

Term	Meaning
Authorised Medical Personnel	medical practitioners employed or contracted by the Operator to provide the Contracted Services and holding the registrations and other certifications, specialities and privileges specified in section 5.4 of Part 1 of Schedule 2.
Bed Management System	see section 3.1 of Part 1 of Schedule 1.
Builder	has the meaning given to it in the Collocation Agreement.
Builder's Contract Sum	the value of the Building Contract at contract execution less the QH Infrastructure Costs.
Builder's Invoice	an invoice issued in accordance with the Building Contract in respect of a Builder's progress claim following certification of the claim.
Building Contract	has the meaning given to it in the Collocation Agreement.
Chief Health Officer	the chief health officer referred to in section 57B of the <i>Health Services Act</i> .
clause	where the context permits, a clause in the body of the Services Agreement.
CIMIS	<i>Clinical Incident Management Implementation Standard (2009)</i>
Complaints Management Plan	see section 10.2 of Part 1 of Schedule 1.
Complaints Policies	<ol style="list-style-type: none"> 1 the <i>Queensland Health Consumer Complaints Management Policy (2009)</i>; 2 the <i>Queensland Health Consumer Complaints Management Implementation Standard 1 (2007)</i>; and 3 the <i>Queensland Health Consumer Complaints Management Model (2009)</i>, <p>each as amended and updated from time to time.</p>
Cost to Complete	at the relevant time, the expected total cost as determined by the Independent Certifier to complete the Works in accordance with the requirements of the Collocation Agreement less the QH Infrastructure Costs.

Term	Meaning
Credentials and Clinical Privileges	the formal qualifications, registration, training, experience and clinical competence of the Authorised Medical Personnel providing the Contracted Services and the range and scope of clinical responsibility that the Authorised Medical Personnel may exercise at the Facility where such privileges are specific to the individual.
Credentials and Clinical Privileges Committee	the committee having the power to verify credentials and make recommendations to the Operator in relation to the granting or reviewing of clinical privileges rights for and on behalf of the Operator.
CSCF	the <i>Clinical Services Capability Framework for Public and Licensed Private Health Facilities version 3.0</i> .
Dedicated Flexible Acute Beds	see section 3.4(b) of Part 1 of Schedule 1.
Dedicated Medical Acute Beds	see section 3.3(b) of Part 1 of Schedule 1.
Equivalent	of equivalent severity under the Operator's system of classification of the severity of adverse incidents.
Extended Length of Stay	see section 6.3 of Part 1 of Schedule 2.
Food Services Policy	the Queensland Health <i>Queensland Health Food Services Policy</i> (2008) and the associated Queensland Health <i>Queensland Health Food Service Standards</i> , each as amended and updated from time to time.
Funded Infrastructure	has the meaning given to it in Schedule 7 to the Collocation Agreement.
Health and Quality Complaints Commission	the Health and Quality Complaints Commission established under the Quality Act.
Health Services Act	the <i>Health Services Act 1991</i> (Qld).
Incident Management Plan	see section 9.3 of Part 1 of Schedule 1.
Incident Management Policy	the <i>Queensland Health Incident Management Policy</i> (2006), including the <i>Queensland Health Clinical Incident Management Implementation Standard</i> (2009), each as amended and updated from time to time.
Information Management System	see section 5.1 of Part 1 of Schedule 1.

Term	Meaning
Information Standard 44	the Queensland Government Chief Information Office <i>Information Standard 44: (Information Asset Custodianship)</i> (2009) as amended and updated from time to time.
Integrated Management System	see section 1 of Part 1 of Schedule 1.
ISO 9001	Australian/New Zealand Standard AS/NZS ISO 9001:2008 – <i>Quality Management Systems</i> .
KPI Failure	see section 3(a) of Part 1 of Schedule 3.
KPI Report	see section 1.2(c)(2) of Part 1 of Schedule 3.
KPIs	the key performance indicators set out in section 2 of Part 1 of Schedule 3.
Lower Limit	<ol style="list-style-type: none"> 1 for a Financial Year, for each Service Stream, the lower activity limit for the Service Stream for the Financial Year specified in Table 4 or agreed or determined under clause 3.2 or 4.6; and 2 for a Financial Year, for all Service Streams, the aggregate lower activity limit for the Financial Year specified in Table 3 or agreed or determined under clause 3.2 or 4.6.
Management Report	see section 7.1 of Part 1 of Schedule 1.
month	calendar month.
NCR	see section 1.2(c)(1) of Part 1 of Schedule 3.
Performance Monitoring Plan	see section 1(a) of Part 1 of Schedule 3.
Performance Standards	the requirements set out in Part 1 of Schedule 2.
Performance Threshold	for a KPI, the performance threshold for that KPI specified in a Table in Part 1 of Schedule 3.
Prime Data Collection Sheets	<p>means the following data collection sheets:</p> <ol style="list-style-type: none"> 1 PRIME Consumer Feedback State-wide Form (Frontline); 2 PRIME Consumer Feedback State-wide Form;

Term	Meaning
	<ol style="list-style-type: none"> 3 PRIME Consumer Feedback Management Action Form; 4 PRIME Clinical Incident Management Reporting Form; 5 PRIME Clinical Incident Management Action Form, included in Attachment D to Part 1 of Schedule 1.
Privacy Laws	the <i>Privacy Act 1998</i> (Cth).
Public Patient Record	see section 5.3(a) of Part 1 of Schedule 1.
Public Records Act	the <i>Public Records Act 2002</i> (Qld).
QH Infrastructure Costs	has the meaning given to it in Schedule 7 of the Collocation Agreement.
Quality Act	the <i>Health Quality and Complaints Commission Act 2006</i> (Qld).
Quality Assurance System	see section 2.1 of Part 1 of Schedule 1.
Quarter	<ol style="list-style-type: none"> 1 the period commencing on the Commencement Date and ending on 31 December 2013; 2 a calendar quarter within a Financial Year (comprising the period of 3 months commencing on each 1 July, 1 October, 1 January and 1 April); and 3 if, as contemplated by clause 3.1(b), the expiry date of this Agreement is not 30 June, 30 September, 31 December or 31 March (in 2017, 2018 or 2019, as applicable) the period of less than 3 months commencing on 1 July, 1 October, 1 January or 1 April and ending on the expiry date.
Quarterly Lower Limit	<ol style="list-style-type: none"> 1 for a Quarter, for each Service Stream, the Quarterly Percentage of the Lower Limit for the Service Stream for the Financial Year; and 2 for a Quarter, for all Service Streams, the aggregate of the Quarterly Lower Limit for each Service Stream calculated under paragraph 1.
Quarterly Percentage	<p>for a Quarter, for each Service Stream, the percentage of total activity for the relevant Financial Year applicable to that Quarter either:</p> <ol style="list-style-type: none"> 1 set out in Attachment B to Part 1 of Schedule 1; or 2 determined in accordance with section 6.3 of Part 1 of Schedule 1, <p>(as applicable), as adjusted under section 6.5 of Part 1 of Schedule 1.</p>

Term	Meaning
Rectification Plan	see section 3(a) of Part 1 of Schedule 3.
Referral Limit	<p>for a month, for each Service Stream, the maximum number of referrals that the Operator is obliged to accept (pursuant to section 3.2 of Part 1 of Schedule 2) for the Service Stream for the month:</p> <ol style="list-style-type: none"> 1 set out in Attachment B to Part 1 of Schedule 1; or 2 determined in accordance with section 6.3 of Part 1 of Schedule 1, <p>(as applicable), and as adjusted under section 6.5 of Part 1 of Schedule 1.</p>
Referral Target	<p>for a month, for each Service Stream, the number of referrals that QH will target for the Service Stream for the month:</p> <ol style="list-style-type: none"> 1 set out in Attachment B to Part 1 of Schedule 1; or 2 determined in accordance with section 6.3 of Part 1 of Schedule 1, <p>(as applicable), and as adjusted under section 6.4 or 6.5 of Part 1 of Schedule 1.</p>
Right to Information Act	the <i>Right to Information Act 2009</i> (Qld).
Risk Management Plan	see section 4.2(b) of Part 1 of Schedule 1.
Risk Management System	see section 4.1 of Part 1 of Schedule 1.
SAC	severity assessment code, and when followed by a number, refers to the severity assessment code with that number under the Incident Management Policy.
section	where the context permits, a section of these Schedules (and where no Schedule number is specified, a section of the Schedule in which the reference appears).
Sentinel Event	an event treated, at the relevant time, as an event requiring the submission of a 'sentinel event report' to the Chief Health Officer under section 144(1) of the <i>Private Health Facilities Act</i> .
Service Stream	each clinical service stream specified in Table 4.
Services Fee	see section 1.1(b)(1) of Part 1 of Schedule 4.
Target Level	for a KPI, the target level (if any) for that KPI specified in the relevant Table in Part 1 of Schedule 3.

Term	Meaning
Transition Plan	see section 11(a)(1) of Part 1 of Schedule 1.
Upper Limit	<ol style="list-style-type: none"> <li data-bbox="604 398 1369 488">1 for a Financial Year, for each Service Stream, the upper activity limit for the Service Stream for the Financial Year specified in Table 4 or agreed or determined under clause 3.2 or 4.6; and <li data-bbox="604 495 1369 584">2 for a Financial Year, for all Service Streams, the aggregate upper activity limit for the Financial Year specified in Table 3 or agreed or determined under clause 3.2 or 4.6.
Works	has the meaning given to it in the Collocation Agreement.

RTI Released

Schedule 1 Management

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RTI Release

Part 1 - Specification

1 Integrated Management System

The Operator shall develop, implement and maintain during the Term a system for managing the provision of the Contracted Services, which includes at least the following components:

- (a) a Quality Assurance System;
- (b) a Bed Management System;
- (c) a Risk Management System;
- (d) an Information Management System;
- (e) an Incident Management Plan; and
- (f) a Complaints Management Plan,
(an **Integrated Management System**).

2 Quality Assurance System

2.1 Obligation

The Operator shall develop, implement and maintain during the Term, and shall have in place at the commencement of this Agreement, a system for ensuring the quality of the Contracted Services (**Quality Assurance System**) in accordance with this section 2.

2.2 Required features

The Operator's Quality Assurance System shall:

- (a) be at least equivalent to the requirements of ISO 9001 or ACHS requirements for accreditation;
- (b) be reflected in a 'Quality Plan' for the Contracted Services; and
- (c) provide for regular review and audit of the quality systems used in the delivery of the Contracted Services, where material issues, material non-compliances or repetitive non-compliances are identified, and in any case at intervals not exceeding 6 months.

2.3 Certification

- (a) The Operator shall:
 - (1) obtain certification of its Quality Assurance System to ISO 9001 or accreditation with ACHS by an independent assessor within 12 months after the Commencement Date; and
 - (2) thereafter, maintain certification for the Term.

- (b) The assessor must be registered as an assessor on the *IQA National Registration Scheme for Assessors of Quality Systems* or a similar registration scheme approved by QH.
- (c) The Operator shall forward the assessor's *Quality System Assessment Report*, together with the assessor's certification of compliance of the Operator's Quality Assurance System with the ISO 9001 model or ACHS requirements for accreditation, to QH's Contract Manager within 5 Business Days after receipt by the Operator.

2.4 Nominated person

- (a) The Operator shall nominate a suitably qualified person as its representative in all matters pertaining to quality standards, including ensuring that the Quality Assurance System is developed, implemented and maintained as required.
- (b) The nominated person shall be empowered to:
 - (1) liaise with QH's Contract Manager on all matters relating to quality assurance; and
 - (2) respond to any QH concerns regarding quality standards and undertake all necessary actions in a timely manner.

2.5 Reporting and records

- (a) The Operator is responsible for the collection, interpretation and archiving of records generated by its Quality Assurance System.
- (b) Every 6 months the Operator shall submit a report to QH on the status of its compliance with its obligations under this section 2.
- (c) The Operator shall include summaries of the findings of any review and/or audit of the Quality Assurance System in the next occurring Management Report.

2.6 Subcontractors

- (a) Where the Operator proposes to utilise subcontracted services or products for the performance of any material part of the Contracted Services, the Operator shall first advise QH as to the methods by which adequate quality assurance of the subcontracted services or products shall be ensured.
- (b) Where the quality assurance system of a subcontracted party is to be relied upon by the Operator, the Operator shall first submit to QH:
 - (1) the specific details of supplier review, including without limitation scheduled audits; and
 - (2) an independent assessment of the subcontracted party's quality assurance system for compliance with ISO 9001 or ACHS requirements for accreditation.

3 Bed Management System

3.1 Obligation

The Operator shall develop, implement and maintain during the Term, and shall have in place at the commencement of this Agreement, a system for determining, reporting and efficiently utilising the bed capacity of the Facility (**Bed Management System**) in accordance with this section 3.

3.2 Required features

The Operator's Bed Management System shall:

- (a) be updated in real-time;
- (b) be accessible securely by QH;
- (c) indicate forthcoming bed availability for Public Patients from planned discharges, up to 24 hours in advance; and
- (d) specifically identify beds that are available to accept Direct Admission Patients in accordance with sections 3.3 and 3.4

3.3 Dedicated Medical Acute Beds

- (a) At all times during the Term, the Operator shall ensure that beds within the Facility are either:
 - (1) vacant;
 - (2) occupied by a Public Patient who:
 - (A) was a Direct Admission Patient referred in a medical Service Stream; or
 - (B) is referred back to the facility under section 6.6(b)(1) of Part 1 of Schedule 2; or
 - (3) reserved for a Public Patient of the kind referred to in section 3.3(a)(2) in respect of whom the Operator has accepted a referral and who is due to be admitted on the relevant day.
- (b) The Operator's Bed Management System shall separately identify the beds referred to in section 3.3(a) (**Dedicated Medical Acute Beds**).
- (c) The Operator must not allow a Dedicated Medical Acute Bed to be occupied at any time by:
 - (1) a Public Patient other than a Public Patient of the kind referred to in section 3.3(a)(2); or
 - (2) a Private Patient.

3.4 Dedicated Flexible Acute Beds

- (a) At all times during the Term, the Operator shall ensure that beds within the Facility are either:
 - (1) vacant;
 - (2) occupied by a Public Patient who was a Direct Admission Patient (in any Service Stream); or
 - (3) reserved for a Public Patient of the kind referred to in section 3.4(a)(2) in respect of whom the Operator has accepted a referral and who is due to be admitted on the relevant day.
- (b) The Operator's Bed Management System shall separately identify the beds referred to in section 3.4(a) (**Dedicated Flexible Acute Beds**).
- (c) The Operator must not allow a Dedicated Flexible Acute Bed to be occupied at any time by:
 - (1) a Public Patient other than a Public Patient of the kind referred to in section 3.4(a)(2); or
 - (2) a Private Patient.

- (d) For the avoidance of doubt, sections 3.3 and 3.4 have the cumulative effect that there are potentially a total of beds available for the accommodation of Direct Admission Patients referred in medical Service Streams, subject to and in accordance with these sections.

4 Risk Management System

4.1 Obligation

The Operator shall develop, implement and maintain during the Term, and shall have in place at the commencement of this Agreement, a system (**Risk Management System**) for managing risk relating to the Contracted Services in accordance with this section 4.

4.2 Required features

The Operator's Risk Management System shall:

- (a) comply with:
- (1) the CSCF; and
 - (2) the *Continuous Quality Improvement Standard* made under part 3 of the *Private Health Facilities Act*; and
- (b) include the development, updating and implementation of a plan (**Risk Management Plan**) which sets out:
- (1) a description of the approach to risk management that will be applied to the Contracted Services;
 - (2) a description of the implementation strategy for the risk management process;
 - (3) the Operator's approach to risk assessment;
 - (4) the Operator's approach to risk treatment and control; and
 - (5) arrangements in respect of a risk register to be kept in accordance with section 4.3.

4.3 Risk register

The Operator shall:

- (a) establish a risk register to identify risks relating to the Contracted Services, and the manner in which such risks are to be managed;
- (b) review the risk register no less frequently than a prudent hospital operator would review a risk register;
- (c) update the risk register as required; and
- (d) report on any key risks and unresolved risk management issues in the Management Reports.

4.4 Review

The Operator shall:

- (a) review and update the Risk Management Plan at least once during every year of the Term;

- (b) submit the updated Risk Management Plan to QH at least 20 Business Days prior to each anniversary of the Commencement Date; and
- (c) consider any comments QH may have on the updated Risk Management Plan and respond to QH within 20 Business Days of receiving such comments with a written response specifically addressing and closing out each of QH's comments, including updating and re-issuing the Risk Management Plan as required.

5 Information Management System

5.1 Obligation

The Operator shall develop, implement and maintain during the Term, and shall have in place at the commencement of this Agreement, and for 10 years after the Agreement expires or is terminated, a system (**Information Management System**) for recording, safely storing and providing secure access to all data relevant to the provision of the Contracted Services and the operation of the Facility, in accordance with this section 5.

5.2 Agreed Platform

During the Term, the Operator shall

- (a) operate a secure electronic platform which is accessible by QH, through a secure user ID logon and password, and which is capable of enabling QH to access the Operator's real-time Bed Management System; and
 - (b) have the ability to receive Referral Orders electronically (with a dedicated secure email address being satisfactory as a minimum),
- (together, the **Agreed Platform**).

5.3 Public Patient Record

- (a) When a Public Patient completes a Service Initiation Pathway, the Operator shall create an individual record (**Public Patient Record**) for that Public Patient which:
 - (1) facilitates effective patient care management prior to, during and after the patient's stay in the Facility;
 - (2) provides for effective communication between health care providers;
 - (3) enables evaluation of the patient's progress and health outcome; and
 - (4) complies with the Australian Standard 2828 – 1999 (Paper Based Health Care Records),and includes:
 - (5) a copy of the Referral Order for the Public Patient; and
 - (6) the information set out in Attachment A.
- (b) When a Public Patient is transferred or discharged from the Facility, the Operator shall:
 - (1) send paper or electronic copies of the Public Patient Record to QH for appropriate storage; and
 - (2) send notes of the treatment or a summary of the treatment to QH and the Public Patient's general practitioner.

5.4 Compliance

In creating, updating, managing and storing Public Patient Records, the Operator shall (subject to confidentiality obligations and the Privacy Laws) take all actions reasonably required by QH to ensure that QH complies with:

- (a) the *Public Records Act*, and the *Guideline on the Custody and Ownership of Public Records* developed by Queensland State Archives under the *Public Records Act*;
 - (b) the *Right to Information Act*;
 - (c) part 7 of the *Health Services Act*; and
 - (d) Information Standard 44,
- in respect of the Facility.

6 Activity Forecasts

6.1 Acknowledgement

The Operator acknowledges that the purpose of the activity planning process set out in this section 6 is to promote the safe and efficient delivery of the Contracted Services.

6.2 Initial Activity Forecast

The Activity Forecast for the part Financial Year commencing on the Commencement Date and ending on the next occurring 30 June is set out as Attachment B.

6.3 Process for subsequent Financial Years

At least 6 months before the commencement of each Financial Year during the Term (other than as specified in section 6.2), the parties shall work together to develop the Activity Forecast for the Financial Year and finalise that Activity Forecast no later than 3 months before the commencement of the Financial Year as follows:

- (a) **(activity targets)** QH will advise the Operator of QH's activity target (measured in WAUs) for each Service Stream for the Financial Year, which must:
 - (1) be within the activity limits for the relevant Service Stream for the Financial Year set out in Table 4; and
 - (2) in aggregate, be equal to the aggregate activity target for the Financial Year set out in Table 3;
- (b) **(referral targets and limits)** the Operator shall calculate the proposed Referral Target and Referral Limit for each Service Stream for each month of the Financial Year by:
 - (1) determining the total target number of referrals (using an average WAU per referral for the relevant Service Stream to generate this number) required to achieve QH's activity target for the Service Stream for the Financial Year;
 - (2) determining the Operator's preferred profile of referrals in each month of the Financial Year, expressed as a percentage applicable to that month so that the aggregate of the percentages for the months of the Financial Year is equal to 100%;

- (3) calculating the proposed Referral Target for the Service Stream for the month (measured in number of referrals), by applying the percentage for that month referred to in section 6.3(b)(2) to the total target number of referrals referred to in section 6.3(b)(1); and
 - (4) calculating the proposed Referral Limit for the Service Stream for the month (measured in number of referrals), by converting the upper activity limit (the **Upper Limit**) for the Service Stream for the Financial Year set out in Table 4 (expressed in WAUs) to referrals (using the same average WAU per referral used in section 6.3(b)(1)) and applying the percentage for that month referred to in section 6.3(b)(2);
- (c) **(Quarterly Percentages)** the Operator shall determine the Operator's preferred Quarterly Percentage for each Quarter of the Financial Year for each Service Stream;
- (d) **(provision of information to QH)** the Operator shall provide QH with:
- (1) the proposed Referral Target and Referral Limit for each Service Stream for each month of the Financial Year calculated under section 6.3(b), and details of the basis of the calculation, including the average WAU per referral for each Service Stream used to determine the required number of referrals;
 - (2) the proposed Quarterly Percentages; and
 - (3) the rationale behind the Operator's proposed Referral Target, Referral Limit and Quarterly Percentages, including commentary on any reduced availability of clinical services in specific months (eg. due to holidays, conferences or major equipment maintenance) and assumptions about the timing lag between referrals and separations;
- (e) **(review)** QH will review the Operator's proposed Referral Target, Referral Limit and Quarterly Percentages and the Contract Managers will meet and discuss any changes required by QH with the intention of reaching a mutually acceptable Activity Forecast;
- (f) **(escalation)** in the event that the Contract Managers fail to reach agreement on the Activity Forecast within 10 Business Days of the Contract Managers meeting under section 6.3(f) the matter will be referred to the Services Review Committee; and
- (g) **(reversion to baseline)** in the event that the Services Review Committee fails to reach agreement on the Activity Forecast within 20 Business Days of a referral under section 6.3(e):
- (1) the Referral Target and Referral Limit for each Service Stream for each month of the Financial Year will be calculated in a similar manner to that set out in section 6.3(b) but using (in lieu of values proposed by the Operator) either:
 - (i) the baseline monthly referral percentages set out in Table 1(a) and baseline average WAU per referral set out in Table 1(b); or
 - (ii) the monthly referral percentages and average WAU per referral from the Activity Forecast for the previous Financial Year,
 whichever QH determines is most relevant; and
 - (2) the Quarterly Percentages will be (in lieu of the percentages proposed by the Operator) either:
 - (i) the baseline quarterly percentages set out in Table 1(c); or

(ii) the Quarterly Percentages from the Activity Forecast for the previous Financial Year, whichever QH determined is most relevant.

TABLE 1(a): BASELINE MONTHLY REFERRAL PERCENTAGES

Baseline Profile

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
General Medicine												
General Surgery												
Respiratory Medicine												
Orthopaedics												
ENT												
Gastroenterology												
Colorectal Surgery												
Neurosurgery												
Plastics Surgery												
Urology												
Cardiology												
Endocrinology												

TABLE 1(b): BASELINE AVERAGE WAU PER REFERRAL

Service Stream	Average WAU per Referral
General Medicine	1.19
General Surgery	1.11
Respiratory Medicine	1.33
Orthopaedics	1.53
ENT	0.56
Gastroenterology	0.76
Colorectal Surgery	2.83
Neurosurgery	1.45
Plastics Surgery	0.80
Urology	0.96
Cardiology	0.95
Endocrinology	1.39

TABLE 1(c): BASELINE QUARTERLY PERCENTAGES

Month	Percentage
July-September	
October-December	
January-March	
April-June	

6.4 Relevance of Referral Target

- (a) The Referral Target for each Service Stream for each month:
 - (1) cannot exceed the Referral Limit for the Service Stream for the month; and
 - (2) within the Referral Limit, is intended to provide an indication to the Operator of how many referrals QH needs to make to the Operator in that Service Stream during that month in order to achieve the activity target for the Financial Year.
- (b) Except as provided in section 6.5, a change to the Referral Target for a Service Stream during a Financial Year does not affect:
 - (1) the Referral Limit for that Service Stream for any month during that Financial Year;
 - (2) the Upper Limit or Lower Limit for that Service Stream for the Financial Year; or
 - (3) the Upper Limit or Lower Limit for all Service Streams for the Financial Year.
- (c) The Operator acknowledges that if activity in a Service Stream during part of a Financial Year is higher or lower than QH expects (having regard to the Activity Forecast) QH may increase or decrease the Referral Target for the remaining months of the Financial Year, provided always that the Referral Target in any month cannot exceed the Referral Limit for that month.
- (d) QH's Contract Manager will provide an update to the Services Review Committee at each of its meetings as to any changes to the Referral Target for a Service Stream.

6.5 Adjustment during a Financial Year

During a Financial Year, the Activity Forecast will be adjusted as follows:

- (a) if, after the date which is at least 3 months after the start of the Financial Year, the average WAU per referral used in the calculation under section 6.3 for a Service Stream is inaccurate compared to the actual average WAU per referral for the Service Stream for the Financial Year to date, the Activity Forecast for that Service Stream for the remainder of the Financial Year will be:
 - (1) recalculated using the actual average WAU per referral; and
 - (2) adjusted (including by adjusting the Referral Limits) to the extent required to enable the activity target referred to in section 6.3(a) to be achieved by the end of the Financial Year and not materially earlier than that date; and/or
- (b) as agreed in writing by the Services Review Committee.

For the avoidance of doubt, the recalculation and adjustment referred to in section 6.5(a) will only take into account the unexpected variances in the average WAU per referral, and is not intended to allow QH to adjust the Activity Forecast if activity in a Service Stream during part of a Financial Year is otherwise higher or lower than QH expects.

The parties agree that their representatives will act reasonably and in good faith in any discussions relating to possible changes to the Activity Forecast for the purpose of section 6.5(b).

7 Management Reports

7.1 Obligation

The Operator shall submit a written monthly report (**Management Report**) to QH for each month during the Term within 10 Business Days after the last day of the month.

7.2 Content

Subject to section 7.3, the Operator's Management Reports shall include the following in relation to Contracted Services:

- (a) a report (**Activity Report**) containing the information provided for in Attachment C in relation to the Contracted Services provided at the Facility during the relevant month, and which reconciles with the Public Patient Records;
- (b) the KPI Report (including assessment of the Operator's performance against both the Performance Threshold and the Target Level of each KPI), supported by copies of any NCRs and Rectification Plans;
- (c) an Incident Summary, including information about any Sentinel Events, critical incidents and Public Patient complaints during the month;
- (d) quality assurance information as required under section 2.5, including a description of any key risks and unresolved risk management issues during the month;
- (e) the outcomes of any audits referred to in clause 9 of this Agreement; and
- (f) other information as reasonably requested by QH from time to time.

7.3 Frequency of updating

If information specified in section 7.2 also forms part of reporting which the Operator undertakes on a regular basis (not less frequently than every 3 months) under its Quality Assurance System or to the Health and Quality Complaints Commission (**Other Reporting System**), that information shall be included in the Operator's Management Report for the month the information was reported under the Other Reporting System.

8 Copies of reports

The Operator shall give QH's Contract Manager a copy of:

- (a) each report the Operator submits to the Chief Health Officer under section 144(1) of the *Private Health Facilities Act* in respect of the Facility; and
 - (b) any report submitted to the Health Quality and Complaints Commission in respect of a Public Patient referred to and/or treated at the Facility,
- at the same time the relevant report is submitted.

9 Critical incidents

9.1 Sentinel Events

The Operator shall submit a report of any Sentinel Event which occurs at the Facility (whether or not the Sentinel Event involves a Public Patient) to QH's Contract Manager within 2 Business Days after the Sentinel Event occurs.

9.2 Quality Act

The Operator shall comply, and ensure that its Incident Management Plan developed in accordance with section 9.3 complies, with all legislation with respect to the monitoring and reporting of critical incidents occurring within the Facility including:

- (a) the Quality Act;
- (b) the *Health Services Act*; and
- (c) any requirements imposed by the Health and Quality Complaints Commission.

9.3 Incident Management Plan

- (a) Without limiting sections 9.1 and 9.2, the Operator shall develop, implement and maintain during the Term, and shall have in place at the commencement of this Agreement, a plan (**Incident Management Plan**) for managing 'incidents' (as defined in the Incident Management Policy) relating to the Contracted Services in accordance with this section 9.3.
- (b) The Operator's Incident Management Plan shall be developed to standards at least equivalent to that of the Incident Management Policy (as it may be updated from time to time) and shall provide for the development, updating and implementation of the Incident Management Plan and include:
 - (1) a description of the approach to incident management that will be applied to the Contracted Services;
 - (2) a description of the implementation strategy for the incident management process;
 - (3) a process for collection of data, to standards at least equivalent to that of the relevant PRIME Data Collection Sheets;
 - (4) subject to section 9.4, the Operator's system of classification of the severity of adverse incidents; and
 - (5) a requirement that the Operator immediately notify QH's Contract Manager on the occurrence of a SAC1 or SAC2 Equivalent incident.
- (c) If an 'incident' within the meaning of the Incident Management Policy occurs in relation to a Public Patient treated at the Facility, the Operator shall comply with its Incident Management Plan in managing the incident.
- (d) The Incident Management Plan developed by the Operator under this section 9.3 shall require the Operator to:
 - (1) classify applicable clinical incidents according to their severity;
 - (2) report all incidents classified as SAC 1 and SAC 2 Equivalent to the Services Review Committee and QH's Contract Manager, along with a notice stating all actions taken in the management of the incident and any corrective actions required; and
 - (3) develop and implement a Rectification Plan if required in respect of an incident under section 3 of Part 1 of Schedule 3.

- (e) The Operator shall have regard to the Incident Management Policy for the purposes of developing its Incident Management Plan.

9.4 Operator's classification of adverse incidents

The Operator may not materially alter the Operator's system of classification of the severity of adverse incidents, so far as that system applies to Public Patients at the Facility, from the system that applies as at the date of this Agreement, without QH's prior written consent (which will not be withheld if the system maintains equivalence with the classification system under the Incident Management Policy).

10 Management of complaints

10.1 Quality Act

The Operator shall comply, and ensure that its Complaints Management Plan developed in accordance with section 10.2 complies, with all legislation with respect to the management of complaints from Public Patients treated at the Facility including:

- (a) the Quality Act; and
- (b) any requirements imposed by the Health and Quality Complaints Commission.

10.2 Complaints Management Plan

- (a) Without limiting section 10.1, the Operator shall develop, implement and maintain during the Term, and shall have in place at the commencement of this Agreement, a plan (**Complaints Management Plan**) for managing complaints relating to the Contracted Services.
- (b) The Operator's Complaints Management Plan shall be developed to standards at least equivalent to that of the Complaints Policies (as updated from time to time) and shall provide for the development, updating and implementation of the Complaints Management Plan and include:
 - (1) a description of the approach to complaints management that will be applied to the Contracted Services;
 - (2) a description of the implementation strategy for the complaints management process; and
 - (3) a process for collection of data, to standards at least equivalent to that of the relevant PRIME Data Collection Sheets.
- (c) The Operator shall respond to complaints from Public Patients referred to and/or treated at the Facility in accordance with the Complaints Management Plan.
- (d) The Operator shall have regard to the Complaints Policies for the purposes of developing its Complaints Management Plan.

11 Transition of services to the SCUH

- (a) During the 12 months prior to 30 June 2018 or a later date applicable under clause 3.1(b), the Operator and QH shall work together to:

- (1) develop an implementation plan (**Transition Plan**) detailing the planned transition of the Contracted Services to the SCUH; and
 - (2) co-ordinate transition of services from the Facility to the SCUH during the relevant Financial Year(s).
- (b) The Operator acknowledges that QH intends to transition Service Stream by Service Stream rather than provide a fragmented service during the transition period.
- (c) The Transition Plan shall detail the process of service provision from the planning and commencement of transition of the Contracted Services up to full cessation of the Contracted Services.
- (d) The Transition Plan shall include:
- (1) detailed methodology for, and availability of, service requirements (including clinical capability) in order to transition each Service Stream;
 - (2) timeframes for transitioning each Service Stream to QH;
 - (3) logistical and operational details for each Service Stream;
 - (4) change management strategy including in relation to industrial relations issues;
 - (5) communications strategy for staff, patients and the community;
 - (6) workforce transition plan for those staff moving across to QH;
 - (7) risk identification and mitigation plan specifically related to the transition process; and
 - (8) roles and responsibilities of Operator and QH staff in implementing the plan.
- (e) The Operator and QH shall finalise the Transition Plan at least 6 months prior to the commencement of transition of services to SCUH.
- (f) The Operator shall transition the Contracted Services to the SCUH in accordance with the Transition Plan.

RTI
REQUEST

Attachment A – Form of Public Patient Record

Each Public Patient Record shall include, at a minimum, the following in relation to the Contracted Services:

- (a) information required for the provision of reports to the Chief Health Officer under section 144 of the *Private Health Facilities Act*;
- (b) progress notes which include the Public Patient's medical history, the nature of the principal condition of the Public Patient and the nature of any other condition, including adverse events, treated during the Public Patient's stay in the Facility;
- (c) the nature of any surgical/diagnostic procedure performed on the Public Patient during an episode of care;
- (d) a daily record of all medical and nursing care given in relation to the Public Patient's medical, physical, psychological and social needs and responses;
- (e) details of all medication; and
- (f) a record of informed consent for the performance of any surgical and/or potentially harmful diagnostic procedures and/or treatment regimes.

RTI Release

Attachment B – Initial Activity Forecast

Referral Targets

Monthly Referrals by Service Stream

	Nov	Dec	Jan	Feb	Mar	Apr	May	June
General Medicine								
General Surgery								
Respiratory Medicine								
Orthopaedics								
ENT								
Gastroenterology								
Colorectal Surgery								
Neurosurgery								
Plastics Surgery								
Urology								
Cardiology								
Endocrinology								

Referral Limits

Monthly Referrals by Service Stream

	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
General Medicine								
General Surgery								
Respiratory Medicine								
Orthopaedics								
ENT								
Gastroenterology								
Colorectal Surgery								
Neurosurgery								
Plastics Surgery								
Urology								
Cardiology								
Endocrinology								

RTI Release

Quarterly Percentages

Month	Percentage
December	<input type="text"/>
January-March	
April-June	

RTI Release

Attachment C – Form of Activity Report

See attached 8 pages.

RTI Release

Extract File Format : T1HKCPP Medical Records Input Physical file

Field Name	Type	Length	Decimals	Start Position	Justification	Currently Populated	TII Version	Eclipsys Field Description	QLD TII Description	HBCIS SourceTable	Attribute	Comments
HKAACD	A	5		1	L#	Y	5.4.05SP2	Company Code	Company Code	n/a		Identifies the specific health care institution or organisation. Hardcoded in Talons Parameters File.
HKMECD	A	20		6	L#	Y	5.4.05SP2	MRI Encounter Number	Encounter Number	ADM		The unique patient identifier. URNO & sequence number with a prefix at some sites
HKMFCD	A	10		26	L#	Y	5.4.05SP2	MRI Extract Batch	Batch Number	n/a		Required to maintain uniqueness for medical records input data. The Number "1".
HKMMCE	A	12		36	L#	Y	5.4.05SP2	MPI Number	Medical Record Number	ADM		The permanent identifier attached to a patient - UR Number. The patient urno is stripped off the admission no., plus the prefix letter at some sites
HKDUNR	N	3	0	48	R%	Y	5.4.05SP2	Episode Number	Episode Number	ADM		Episode number which identifies how many episodes the patient has had at the facility. HBCIS Admission Sequence Number from the urno plus prefix for some sites
HKF5NR	N	4	0	51	R%	Y	5.4.05SP2	MRI Discharge Fiscal Year	Discharge Fiscal Year	ADM		Discharge Period Financial Year. If patient not discharged at extract run time, then End of Month of requested extract. Calculated from discharge date.
HKF6NR	N	2	0	55	R%	Y	5.4.05SP2	MRI Discharge Fiscal Prd	Discharge Fiscal Period	ADM		Discharge Period Financial Period. If patient not discharged at extract run time, then End of Month of requested extract Calculated from discharge date.
HKD1NR	N	4	0	57	R%	Y	5.4.05SP2	MRI Admit Fiscal Year	Admit Fiscal Year	ADM		Admission Period Financial Year. Calculated from admission date.
HKD2NR	N	2	0	61	R%	Y	5.4.05SP2	MRI Admit Fiscal Period	Admit Fiscal Prd	ADM		Admission Period Financial Period. Calculated from admission date.
HKSLST	A	1		63	L#	Y	5.4.05SP2	MRI Inout Code	Inout Code	n/a		Derived by TALONS. The letter "I" for Inpatient and "O" for Outpatient.
HKRWCD	A	5		64	L#	Y	5.4.05SP2	MRI DRG	DRG	MED-REC	14	The diagnostic related group (ANDRG) associated with the patient upon discharge.
HKTVCD	A	5		69	L#	N	5.4.05SP2	MRI NY DRG	Not Used in QLD	n/a		
HKAFD1	N	8	0	74	R%	Y	5.4.05SP2	MRI Admit Date	Admit Date	ADM	5	The date which the patient was admitted: CCYYMMDD format.
HKAGD1	N	8	0	82	R%	Y	5.4.05SP2	MRI Discharge Date	Discharge Date	ADM		The date which the patient was discharged: CCYYMMDD format. If patient not discharged at extract run time, then End of Month of requested extract (& Billing Status = I)
HKAOD1	N	8	0	90	R%	Y	5.4.05SP2	MRI Extract Date	Extract Date	n/a		Date extract was started
HKOKTX	A	25		98	L#	Y	5.4.05SP2	MRI Phone Number	Phone Number	PATIENT	16	Patient Phone Number
HKAYTE	A	30		123	L#	Y	5.4.05SP2	Person Last Name	Name	PATIENT	1 & 2	Patient name is optional (At Mater if confidential flag on - patient class R - then not brought across)
HKA1TE	A	30		153	L#	Y	5.4.05SP2	Person Address Line 1	Address Line 1	PATIENT	12	Patient address is optional (Mater as above)
HKA2TE	A	30		183	L#	Y	5.4.05SP2	Person Address Line 2	Address Line 2	PATIENT	13	Patient address is optional (Mater as above)
HKA4TE	A	20		213	L#	Y	5.4.05SP2	Person City	City	PATIENT	14	Patient Suburb
HKM2CE	A	4		233	L#	Y	5.4.05SP2	Person State	State	PATIENT	13 & 14	State derived from post code from principle address
HKM3CE	A	10		237	L#	Y	5.4.05SP2	Person Zip Code	Post Code	PATIENT	15	The post code of the city or town in which the patient resides. Derived from principle address within HBCIS.
HKM4CE	A	3		247	L#	N	5.4.05SP2	Person Country	District (Derived)	n/a		The QH District in which the patient resides. Values DERIVED by SITE from list in Appendix D.
HKOPTX	A	20		250	L#	N	5.4.05SP2	Person Maiden Name	Maiden Name			Field within ADT/FMI used for differing purposes between hospitals.
HKEVD1	N	8	0	270	R%	Y	5.4.05SP2	Person Birthdate	Birthdate	PATIENT	3	The patients date of birth: CCYYMMDD format.
HKM5CE	A	12		278	L#	Y	5.4.05SP2	Person Social Security Nb	Medicare and Suffix	PATIENT	30 & 31	Concatenation of the patients Medicare Number and Suffix where populated by the hospital.
HKP1ST	A	1		290	L#	Y	5.4.05SP2	MRI Refresh Flag	Refresh Flag	n/a		Used to determine whether to overlay Encounter Fields with blanks if no values are passed for the corresponding fields. Should always be "Y".
HKMGCD	A	20		291	L#	N	5.4.05SP2	MRI Series Encounter Num	Reserved for later use			
HKRZCD	A	20		311	L#	N	5.4.05SP2	MRI Insurance Plan Code	Insurance Plan Code	n/a		Insurance Schedule for private patients derived by sites
HKR0CD	A	4		331	L#	Y	5.4.05SP2	MRI County	Type of Visit	n/a		Type of visit for EDIS - Delivery Mode for APP2
HKMKCD	A	10		335	L#	Y	5.4.05SP2	MRI Admit Physician	Admit Doctor	ADM	16	First doctor from Treating Doctors List
HKR1CD	A	3		345	L#	Y	5.4.05SP2	MRI Admit Source	Admit Source	ADM	8	HBCIS Admission Source code
HKR2CD	A	3		348	L#	Y	5.4.05SP2	MRI Admit Type	Care Type	ADM	9	Formerly Admit Type for APP2 Insert Session Type as per business rules
HKMNCD	A	10		351	L#	Y	5.4.05SP2	MRI Admit Department	Admit Department	ADM	21	First Unit from Treating Units Transfer list, in local form
HKMOCD	A	4		361	L#	N	5.4.05SP2	MRI Admit Division	Admit Division (Derived)	n/a		DERIVED by SITE from Admit Department (=LIST from HBCIS Clinical Units)
HKMPCD	A	10		365	L#	Y	5.4.05SP2	MRI Admit Service	Admitting Doctors Unit	ADM	21	First Admit Unit from Treating Units Transfer list, in translated form through ward.costcentres file
HKMQCD	A	10		375	L#	Y	5.4.05SP2	MRI Admit Subservice	Admit Ward	ADM	12	First Ward from Ward Transfers List
HKMRCD	A	10		385	L#	N	5.4.05SP2	MRI Admit Diagnosis	Principal Complaint	n/a		Principal complaint for EDIS
HKMSCD	A	10		395	L#	Y	5.4.05SP2	MRI Discharge Department	Discharge Department	ADM	21	Discharge Unit from last of Treating Units Transfer List in local form
HKMTCD	A	10		405	L#	Y	5.4.05SP2	MRI Discharge Floor	Discharge Ward	ADM	12	Discharge Ward code from Ward Transfer List, Last Ward in local form
HKR5CD	A	2		415	L#	Y	5.4.05SP2	MRI Readmit Code	Intention to Readmit	ADM	61	
HKR6CD	A	2		417	L#	N	5.4.05SP2	MRI Clinic Type	Clinic Type	n/a		Clinic Type from Mapping table with APP2 sub specialty code
HKMWCD	A	4		419	L#	Y	5.4.05SP2	MRI Transfer Division	Last Admit Discharge Ward	ADM	12	Discharge Ward code from previous admission episode from Ward Transfer List, Last Ward. If first encounter, comes through blank.
HKMXCD	A	10		423	L#	Y	5.4.05SP2	MRI Transfer Service	Last Admit Discharge Unit	ADM	12	Discharge Unit code from previous admission episode from Ward Transfer List, Last Unit.
HKMYCD	A	10		433	L#	Y	5.4.05SP2	MRI Transfer Subservice	Last Admit DRG	MED-REC	14	DRG of previous episode, for previous admission episode
HKR7CD	A	4		443	L#	Y	5.4.05SP2	MRI Transfer Destination	Hospital Transfer To	ADM	56	Discharge destination to another hospital. Note: HBCIS stores a 5 digit facility code & only 4 characters avail in this field, the last 4 digits come across (not more than 9999 hospitals in Qld therefore not a problem because 0 is dropped off). EDIS transfer destination
HKM0CD	A	10		447	L#	Y	5.4.05SP2	MRI Attending Physician	Attending Doctor	ADM	16	Discharging doctor from last of Treating Doctors Transfer List in local form (Principal Treating Dr in EDIS for XVOP)
HKM1CD	A	4		457	L#	Y	5.4.05SP2	MRI Attending Division	Discharge Division (Derived)	n/a		DERIVED by SITE from Discharge Unit (=LIST from HBCIS Clinical Units)
HKM2CD	A	10		461	L#	Y	5.4.05SP2	MRI Attending Service	Discharge Unit	ADM	21	Discharging Unit from last of Treating Units Transfer List in translated form through ward.costcentres file NB THIS IS THE T2 DEPT CODE
HKM3CD	A	10		471	L#	Y	5.4.05SP2	MRI Attending Subservice	Country	PATIENT	5	Country of birth code.
HKM4CD	A	10		481	L#	Y	5.4.05SP2	MRI Consulting Phys 1	Consent Flags	PATIENT ADM	115 113 112 114 54	Multi value field for patient consent flags. In character position order 1 Workcover Qld 2 Motor Accident Insurance Commission 3 Dept Veterans Affairs 4 Dept of Defence 5 Contact Feedback (from QH) 6. EAM Consent 7. Contracted care
HKM5CD	A	10		491	L#	N	5.4.05SP2	MRI Consulting Phys 2	Not Ready For Care Days	EAM		Value to be inserted and used for calculating time on waiting list
HKM6CD	A	10		501	L#	N	5.4.05SP2	MRI Consulting Phys 3	Theatre Location	Talons		The Suite where the the operation is registered
HKM7CD	A	10		511	L#	Y	5.4.05SP2	MRI Consulting Phys 4	Last Admit Discharge Ward Code	ADM	12	Discharge Ward code from previous admission episode from Ward Transfer List, Last Ward. If first encounter, comes through blank.
HKM8CD	A	10		521	L#	Y	5.4.05SP2	MRI Consulting Phys 5	Principal Surgeon	feeder		This field is derived from the Theatre system, the theatre feeder XVI process must be run before this data will be available with the exclusion of TMS as data can be pulled direct from HBCIS), if no feeder system the field is sent blank. First surgeon of first procedure.
HKM9CD	A	10		531	L#	Y	5.4.05SP2	MRI Referring Physician	Referring Doctor	ADM		Referring Dr Note: sometimes may not be filled in because free text field.
HKNACD	A	10		541	L#	Y	5.4.05SP2	MRI Other Physician 1	2nd Doctor	ADM		Second treating doctor from ward/unit transfers screen (sequential duplicates are removed).
HKNBCD	A	10		551	L#	Y	5.4.05SP2	MRI Other Physician 2	3rd Doctor	ADM		Subsequent treating doctor from ward/unit transfers screen. (sequential duplicates are removed)
HKNCCD	A	10		561	L#	Y	5.4.05SP2	MRI Other Physician 3	4th Doctor	ADM		Subsequent treating doctor from ward/unit transfers screen. (sequential duplicates are removed)
HKNDCD	A	10		571	L#	Y	5.4.05SP2	MRI Other Physician 4	5th Doctor	ADM		Subsequent treating doctor from ward/unit transfers screen. (sequential duplicates are removed)
HKNECD	A	10		581	L#	Y	5.4.05SP2	MRI Other Physician 5	6th Doctor	ADM		Anaesthetist

Field Name	Type	Length	Decimals	Start Position	Justification	Currently Populated	TII Version	Eclipsys Field Description	QLD TII Description	HBCIS SourceTable	Attribute	Comments
HKNFCD	A	2		591	L#	Y	5.4.05SP2	MRI Anesthesia Type	Anaesthesia Type	Feeder		This field is derived from the Theatre system, the theatre feeder XVI process must be run before this data will be available. Note: Anaesthesia now 3 character code and this field is only 2 characters, currently drops the last character.
HKT MST	A	1		593	L#	Y	5.4.05SP2	MRI Surgery Flag	Surgery Flag	Feeder		If operation details are available for this patient, this will be a "Y", otherwise "N". This field is derived from the Theatre system, the theatre feeder XVI process must be run before this data will be available.
HKDVNR	N	5	0	594	R%	Y	5.4.05SP2	MRI Length of Stay	Length of Stay	ADM		Actual LOS is calculated from discharge date minus admission date, less leave days. If this result is less than one then it is corrected to one, then in addition it is less unqualified days if applicable. If the result is then less than zero, it is zero.
HKP3ST	A	1		599	L#	N	5.4.05SP2	MRI Autopsy Performed	Not Used in QLD	n/a		Reserved for autopsy use if ever available.
HKR8CD	A	2		600	L#	Y	5.4.05SP2	MRI Expired Code	EAM Specialty	EAM	2	NMDS Specialty code for use in Surgical Access reporting. For Outpatient encounters, APP2 Specialty Code.
HKDXNR	N	3	0	602	R%	Y	5.4.05SP2	MRI Age	Age	ADM		Age of patient at admission in whole years from birth date to admission date. Age Years calculated by dividing total age in days by 365.25. Can be up to 2 days out.
HKR9CD	A	1		605	L#	Y	5.4.05SP2	MRI Sex	Sex	PATIENT		Patients purported Sex (male, female or indeterminate)
HKSACD	A	3		606	L#	Y	5.4.05SP2	MRI Race	Ethnic Origin	PATIENT	35	
HKSBCD	A	5		609	L#	Y	5.4.05SP2	MRI Religion	Religion	PATIENT	7	
HKSCCD	A	1		614	L#	Y	5.4.05SP2	MRI Marital Status	Marital Status	PATIENT	6	
HKSDCD	A	3		615	L#	Y	5.4.05SP2	MRI Financial Class	Financial Class	n/a		Financial Class Private Insurance
HKDYNR	N	3	0	618	R%	N	5.4.05SP2	MRI Phone Area Code	General Ward SNAP	n/a		DERIVED by SITE (=LOS-Designated SNAP)
HKDZNR	N	3	0	621	R%	Y	5.4.05SP2	MRI Phone Exchange	Funding Source			Funding Source From APP2
HKP4ST	A	1		624	L#	Y	5.4.05SP2	MRI Billing Status	Billing Status	n/a		Derived by TALONS. "F" if Principle Diagnosis is assigned, otherwise "T" if discharged or "I" if still an inpatient at time and date of extract XV being run.
HKSECD	A	1		625	L#	Y	5.4.05SP2	MRI Medical Records Sts	MRI Medical Records Sts	n/a		MRI Medical Records Sts
HKS FCD	A	2		626	L#	Y	5.4.05SP2	MRI Patient Type	Admission Status	ADM	85	For inpatients 1=Emergency,2=Elective,3=Other For APP2 New/Repeat Status codes
HKSGCD	A	2		628	L#	Y	5.4.05SP2	MRI Newborn Flag	Newborn Flag	PATIENT	3	Set to "1" if patient DOB = Admit Date, otherwise =>0. (Note: Not necessarily born in hospital, could have been born at home or elsewhere then admitted. Also missing those born in ambulance 10 mins to midnight then admitted on next day.)
HKD0NR	N	5	0	630	R%	Y	5.4.05SP2	MRI Birthweight Grams	Birthweight Grams	BIRTHS MED-REC	? 12	Where HBCIS Delivery module is interfaced, data is collected from the birth registration details under the mothers admission episode details and linked to the correct baby number. Otherwise this is obtained from MED-REC
HKNPCD	A	12		635	L#	Y	5.4.05SP2	MRI Newborn Mother MR No	Newborn Mother URN			Where the births file data is found, this data is collected from the birth registration details under the mothers admission episode details.
HKSHCD	A	2		647	L#	Y	5.4.05SP2	MRI Discharge Disposition	Discharge Disposition	ADM	27	Discharge Code (inpatient) or Disch Disposition (EMG2, EDIS Separation status). Note only first two characters pass to TII. Remainder truncated off.
HKR7ST	A	1		649	L#	N	5.4.05SP2	MRI Link Key	Staff Type			Mapping Table where indicated default Inpatients A= All For EDIS see business rules
HKSICD	A	2		650	L#	Y	5.4.05SP2	MRI MDC	MDC			Hospital assigned MDC from hospital grouper software.
HKD5NR	N	3	0	652	R%	Y	5.4.05SP2	MRI Trauma Count	Cas Triage Code	Feeder		If linked emergency attendance details are available for this patient, this will be triage into emergency value. The emergency feeder XVI process must be run before this data will be available. (See http://www.csh.com.au/QLd2man.htm#LinkedEmergencyandAdmissionEpisodes)
HKR8ST	A	1		655	L#	Y	5.4.05SP2	MRI Transfer Flag	Transfer flag to another Hosp			If discharge status is 0 or blank then "N" else "Y"
HKNSCD	A	10		656	L#	Y	5.4.05SP2	MRI Principal Diagnosis	Principal diagnosis	MED-REC	2	First of the assigned diagnosis codes
HKSLCD	A	15		666	L#	Y	5.4.05SP2	MRI Principal Procedure	Principal Procedure	MED-REC	3	First of the assigned procedure codes
HKSJCD	A	5		681	L#	Y	5.4.05SP2	MRI Severity Code	Wait List Category	EAM APP2		Where a matching EAM record is found, this is the urgency code from that record. For Outpatient encounters, APP2 Wait List Category.
HKSKCD	A	10		686	L#	Y	5.4.05SP2	MRI Product Line Code	Hospital Transfer From	ADM		Location patient was transferred from, corrected to 4 digits in line with destination to codes. Leading 0 in 5 digit standard QH facility codes is dropped, not a problem because there is not more than 9999 health facilities in Qld.
HKD6NR	N	2	0	696	R%	Y	5.4.05SP2	MRI Age Day	Age Day	PATIENT ADM	3 5	Age of patient at admission in whole days from birth date (att 3 in patient file) and admission date (att 5 in admission file) Age Days is truncated to fit 2 character field. Therefore 102 days old becomes 2 days old.
HKD7NR	N	2	0	698	R%	Y	5.4.05SP2	MRI Age Month	Age Month	PATIENT ADM	3 5	Age of patient at admission in whole months from birth date (att 3 in patient file) and admission date (att 5 in admission file). Calculates 365.25/12
HKAHTM	N	6	0	700	R%	Y	5.4.05SP2	MRI Admit Time	Admit Time	ADM	6	Arrival time from EDIS (non-admitted patients)
HKD8NR	N	5	0	706	R%	Y	5.4.05SP2	MRI Clinic Visits	Clinic Visits	n/a		Has to be "0". Potential to be used in OP Extract. Currently a 0 only needs to be a count for each unique clinic encounter no - fix business rules
HKD9NR	N	5	0	711	R%	Y	5.4.05SP2	MRI ICU Days	ICU Days	ADM	3	The number of ICU ward type days, collated from the unit/ward transfer screen data in the admissions file, and the assigned ward type in the ward.costcentres file. From TALONS department mapping screen.
HKEANR	N	5	0	716	R%	Y	5.4.05SP2	MRI CCU Days	CCU Days	ADM		The number of CCU ward type days, collated from the unit/ward transfer screen data in the admissions file, and the assigned ward type in the ward.costcentres file. From TALONS department mapping screen.
HKEBNR	N	5	0	721	R%	Y	5.4.05SP2	MRI NICU Days	NICU Days	ADM		The number of NICU ward type days, collated from the unit/ward transfer screen data in the admissions file, and the assigned ward type in the ward.costcentres file. From TALONS department mapping screen.
HKECNR	N	5	0	726	R%	Y	5.4.05SP2	MRI Other ICU Days	Other ICU days	ADM		The number of other ICU ward type days (HDU etc), collated from the unit/ward transfer screen data in the admissions file, and the assigned ward type in the ward.costcentres file. From TALONS department mapping screen.
HKEDNR	N	5	0	731	R%	Y	5.4.05SP2	MRI Step Down Days	Step Down Days	ADM		The number of other Step down ICU ward type days, collated from the unit/ward transfer screen data in the admissions file, and the assigned ward type in the ward.costcentres file. From TALONS department mapping screen.
HKEENR	N	5	0	736	R%	Y	5.4.05SP2	MRI Burn Days	Burn Days	ADM		The number of BURN ward type days, collated from the unit/ward transfer screen data in the admissions file, and the assigned ward type in the ward.costcentres file. From TALONS department mapping screen.
HKEFNR	N	5	0	741	R%	Y	5.4.05SP2	MRI Nursery Days	Special Care Nursery Days	ADM		The number of SCN ward type days, collated from the unit/ward transfer screen data in the admissions file, and the assigned ward type in the ward.costcentres file. From TALONS department mapping screen.
HKEGNR	N	5	0	746	R%	Y	5.4.05SP2	MRI Maternity Days	Maternity Ward Days	ADM		The number of ICU ward type days, collated from the unit/ward transfer screen data in the admissions file, and the assigned ward type in the ward.costcentres file. From TALONS department mapping screen.
HKEHNR	N	5	0	751	R%	Y	5.4.05SP2	MRI Routine Days	Routine Days	ADM		The number of normal ward type days, collated from the unit/ward transfer screen data in the admissions file, and the assigned ward type in the ward.costcentres file or where no type is assigned. From TALONS department mapping screen. Default type.
HKEINR	N	5	0	756	R%	Y	5.4.05SP2	MRI Psych Days	Psych Days	ADM		The number of PSYCH ward type days, collated from the unit/ward transfer screen data in the admissions file, and the assigned ward type in the ward.costcentres file. From TALONS department mapping screen.
HKEJNR	N	5	0	761	R%	Y	5.4.05SP2	MRI Rehab Days	Rehab Days	ADM		The number of REHAB ward type days, collated from the unit/ward transfer screen data in the admissions file, and the assigned ward type in the ward.costcentres file. From TALONS department mapping screen.
HKN2CD	A	4		766	L#	Y	5.4.05SP2	MRI Discharge Room	SLA	HQI		Derived from HQI.SLA.SUBURBS file, by combination of suburb and postcode, first applicable SLA is assigned.
HKN3CD	A	1		770	L#	N	5.4.05SP2	MRI Discharge Bed	DRG Type (Derived)	n/a		DERIVED by SITE (M, S, O for Medical, Surgical or Other) Also available within Crystal from corporate reference file.
HKSMCD	A	2		771	L#	Y	5.4.05SP2	MRI Employment Status	Language	PATIENTS	8	Language
HKO FCD	A	10		773	L#	N	5.4.05SP2	MRI Employer	Arrival Method	EMG2		Arrival method to A&E
HKOGCD	A	10		783	L#	Y	5.4.05SP2	MRI Guarantor Employer	Date of Death	PATIENTS	28	Date of death frequently entered from obituary notices or other external sources.
HKKMTX	A	20		793	L#	N	5.4.05SP2	MRI Occupation	Referral Source	EMG2		Referral Source to A&E & APP2
HKPEVL	N	11	4	813	R%	N	5.4.05SP2	MRI Covered Charges	ICU Minutes			Calculated by Talons

Field Name	Type	Length	Decimals	Start Position	Justification	Currently Populated	TII Version	Eclipsys Field Description	QLD TII Description	HBCIS SourceTable	Attribute	Comments
HKELNR	N	3	0	826	R%	Y	5.4.05SP2	MRI Group 1 Procs	PreOp Days	feeder		The number of days between admission and first operation date. If patient is operated on day of admission then it is zero. This field is derived from the Theatre system, the theatre feeder XVI process must be run before this data will be available. If day case then Pre-op days = 0 and Post-op days = 1
HKENNR	N	3	0	829	R%	Y	5.4.05SP2	MRI Group 2 Procs	Post Op Days	feeder		The number of days between discharge date and last operation date. If patient is operated on day of discharge then it is one. This field is derived from the Theatre system, the theatre feeder XVI process must be run before this data will be available.
HKEVNR	N	3	0	832	R%	Y	5.4.05SP2	MRI Group 3 Procs	Leave Whole Days	ADM	1 & 2	Whole Days assigned as "LEV" in Classifications and Leave transfer details (midnight count)
HKEWNR	N	3	0	835	R%	Y	5.4.05SP2	MRI Group 4 Procs	Statistical Beddays	ADM		Discharge date minus admission date. If patient not discharged at time of extract, then end of month of requested extract is assigned.
HKEXNR	N	3	0	838	R%	Y	5.4.05SP2	MRI Group 5 Procs	Sameday Flag	ADM		If admission date = discharge date then "1" otherwise "0"
HKEYNR	N	3	0	841	R%	Y	5.4.05SP2	MRI Group 6 Procs	Elective Status	feeder		Where a matching Electives record is found, this is the Status code from that record. (See http://www.csh.com.au/QLdT2man.htm#Electives System Linking)
HKEZNR	N	3	0	844	R%	Y	5.4.05SP2	MRI Group 7 Procs	Treated from Waiting List = 1	Feeder		Where a matching Electives record is found and an urgency code assigned, this is "1" otherwise "0". (See http://www.csh.com.au/QLdT2man.htm#Electives System Linking)
HKE0NR	N	3	0	847	R%	Y	5.4.05SP2	MRI Group 8 Procs	Private Patient = 1	ADM	2	If any of the patients assigned account classifications is not "P" for public then a "1" otherwise a "0". This includes intermediate patients. - business rules for APP2
HKEMNR	N	3	0	850	R%	Y	5.4.05SP2	MRI Group 1 Sec Procs	Days on Waiting List	Feeder		Where a matching Electives record is found, this is the number of days from the date on list to admit date. Note: If the patient has changed categories, the wait list days count starts again, Talons uses date of most recent category. (See http://www.csh.com.au/QLdT2man.htm#Electives System Linking) Date went on waiting list less admission date. Only accurate up to 999 days as it is a 3 character field. Can be negative if data erroneous or if patient is placed on waiting list and treated during the same inpatient admission.
HKEONR	N	3	0	853	R%	Y	5.4.05SP2	MRI Group 2 Sec Procs	Days Since Last Discharge			Number of days from previous admission episode number discharge date to current episode admit date. If episodes are not correctly sequenced, may cause errors. Will display 999 if >999 days.
HKEPNR	N	3	0	856	R%	Y	5.4.05SP2	MRI Group 3 Sec Procs	MH Employment Status	ADM.MENTAL.HEALTH	3	
HKEQNR	N	3	0	859	R%	Y	5.4.05SP2	MRI Group 4 Sec Procs	MH Pension Status	ADM.MENTAL.HEALTH	4	
HKERNR	N	3	0	862	R%	Y	5.4.05SP2	MRI Group 5 Sec Procs	MH First Admit to Psych	ADM.MENTAL.HEALTH	5	
HKESNR	N	3	0	865	R%	Y	5.4.05SP2	MRI Group 6 Sec Procs	MH Referral Further Care	ADM.MENTAL.HEALTH	6	
HKETNR	N	3	0	868	R%	Y	5.4.05SP2	MRI Group 7 Sec Procs	MH Legal Status	ADM.MENTAL.HEALTH	7	
HKEUNR	N	3	0	871	R%	Y	5.4.05SP2	MRI Group 8 Sec Procs	Planned Sameday	ADM	67	
HKOHCD	A	20		874	L#	Y	5.4.05SP2	MRI Payor Code 1	Payment Class	FIN-STATUS	2	Payment Classification & Payment Class From APP2.
HKOICD	A	20		894	L#	Y	5.4.05SP2	MRI Payor Code 2	Health Fund	FIN-STATUS	3	Insurance Fund.
HKOJCD	A	20		914	L#	N	5.4.05SP2	MRI Payor Code 3	Account Class	n/a		Account Class.
HKOKCD	A	20		934	L#	N	5.4.05SP2	MRI Payor Code 4	Payor Code	n/a		Payor Code - DERIVED by site hospital funding model use
HKOLCD	A	20		954	L#	N	5.4.05SP2	MRI Payor Code 5	Reason For Transfer	n/a		Reason for Transfer from EDIS.
HKOMCD	A	10		974	L#	N	5.4.05SP2	MRI User Alpha 1	User Alpha 1	n/a		Reserved for local derived fields
HKONCD	A	10		984	L#	N	5.4.05SP2	MRI User Alpha 2	User Alpha 2	n/a		Reserved for local derived fields
HKOOCD	A	10		994	L#	N	5.4.05SP2	MRI User Alpha 3	User Alpha 3	n/a		Reserved for local derived fields
HKOPCD	A	10		1004	L#	N	5.4.05SP2	MRI User Alpha 4	User Alpha 4	n/a		Reserved for local derived fields
HKOQCD	A	10		1014	L#	N	5.4.05SP2	MRI User Alpha 5	Carepath	n/a		Carepath from specialised feeder
HKORCD	A	10		1024	L#	N	5.4.05SP2	MRI User Alpha 6	Service Related Group	n/a		DERIVED by SITE to map ARDRG to SRG
HKOSCD	A	10		1034	L#	Y	5.4.05SP2	MRI User Alpha 7	DVA Card Type	ADM	40	"GOLD" or "WHITE" DVA card type.
HKOTCD	A	10		1044	L#	Y	5.4.05SP2	MRI User Alpha 8	User Alpha 8 SNAP Class	n/a		SNAP Class, Derived by TALONS from HBCIS SNAP module data passed through TALONS SNAP Grouper.
HKOUCD	A	10		1054	L#	Y	5.4.05SP2	MRI User Alpha 9	Australian South Sea Islander	REG		"ASSI" for Australian South Sea Islander where "Y" is in attribute 58 of REGISTRATION file.
HKOVCD	A	10		1064	L#	N	5.4.05SP2	MRI User Alpha 10	AR-DRG Table ID	n/a		DERIVED by SITE. ARDRG Table ID
HKOWCD	A	10		1074	L#	N	5.4.05SP2	MRI User Alpha 11	Funding Phase	pAWS		Funding phase from pAWS
HKOXCD	A	10		1084	L#	N	5.4.05SP2	MRI User Alpha 12	User Alpha 12	n/a		Alphabetic field for local site use
HKOYCD	A	10		1094	L#	N	5.4.05SP2	MRI Process MECs Flag	User Alpha 13	n/a		Alphabetic field for local site use
HKOZCD	A	10		1104	L#	N	5.4.05SP2	Capitated Flag	User Alpha 14	n/a		Alphabetic field for local site use
HKSBST	A	1		1114	L#	N	5.4.05SP2	MRI TSI Reserve Key 1	TSI Reserve Key 1	n/a		TSI RESERVED
HKSCST	A	1		1115	L#	N	5.4.05SP2	MRI TSI Reserve Key 2	TSI Reserve Key 2	n/a		TSI RESERVED
HKSDST	A	1		1116	L#	N	5.4.05SP2	MRI TSI Reserve Key 3	TSI Reserve Key 3	n/a		TSI RESERVED
HKSEST	A	1		1117	L#	N	5.4.05SP2	MRI TSI Reserve Key 4	TSI Reserve Key 4	n/a		TSI RESERVED
HKSFST	A	1		1118	L#	Y	5.4.05SP2	MRI TSI Reserve Key 5	TSI Reserve Key 5	n/a		TSI RESERVED
HKNXCD	A	10		1119	L#	Y	5.4.05SP2	MRI User Key 1 Alpha	Snap Care Type	ADM	68	Snap Care Type
HKNYCD	A	10		1129	L#	Y	5.4.05SP2	MRI User Key 2 Alpha	Facility Code			Derived by TALONS from discharge ward, campus code, to facility code. Will get those not discharged because comes from most recent ward. In Outpatient encounters, Facility as per Clinic Code mapping table entry in TALONS. For EDIS equals Facility code portion of Episode ID with 2 leading zero characters.
HKNZCD	A	10		1139	L#	Y	5.4.05SP2	MRI User Key 3 Alpha	Account Class	ADM	2	Account Class at discharge (last on list)
HKN0CD	A	10		1149	L#	Y	5.4.05SP2	MRI User Key 4 Alpha	Admit Account Class	ADM	2	Account Class at admission (first on list)
HKN1CD	A	10		1159	L#	Y	5.4.05SP2	MRI User Key 5 Alpha	P, S or R (Derived from 990)			
HKOOVL	N	11	4	1169	R%	N	5.4.05SP2	MRI User Key 1 Numeric	Designated Unit Beddays	Derived		Derived by Site from Midnight Bedday counts
HKOPVL	N	11	4	1180	R%	Y	5.4.05SP2	MRI User Key 2 Numeric	Unqualified days	Derived		Unqualified Beddays
HKOQVL	N	11	4	1191	R%	Y	5.4.05SP2	MRI User Key 3 Numeric	Qualified Beddays	Derived		Insert Value LOS- (Designated Unit Beddays + Unqualified Beddays)
HKORVL	N	11	4	1202	R%	Y	5.4.05SP2	MRI User Key 4 Numeric	Designated SNAP Days	n/a		Derived by TALONS for any patient with a valid SNAP Class via TALONS SNAP Grouper
HKOSVL	N	11	4	1213	R%	N	5.4.05SP2	MRI User Key 5 Numeric	Non ARDRG Revenue Days	Derived		Derived by sites Designated days plus unqualified beddays
HKAZTE	A	30		1224	L#	N	5.4.05SP2	Person First Name	Not Used in QLD			leave field blank
HKMWCE	A	1		1254	L#	N	5.4.05SP2	Person Middle Initial	Not Used in QLD			leave field blank
HKMXCE	A	10		1255	L#	N	5.4.05SP2	Person Name Suffix	Not Used in QLD			leave field blank
HKA3TE	A	30		1265	L#	N	5.4.05SP2	Person Address Line 3	Not Used in QLD			leave field blank
HKBLBR	N	8	0	1295	R%	Y	5.4.05SP2	Person User Date Fld 1	Not Used in QLD			insert value 0
HKMPCE	A	30		1303	L#	N	5.4.05SP2	Person User Alpha Fld 1	Not Used in QLD			leave field blank
HKMQCE	A	30		1333	L#	N	5.4.05SP2	Person User Alpha Fld 2	Not Used in QLD			leave field blank
HKMRCE	A	30		1363	L#	N	5.4.05SP2	Person User Alpha Fld 3	Not Used in QLD			leave field blank
HKMSCE	A	30		1393	L#	N	5.4.05SP2	Person User Alpha Fld 4	Not Used in QLD			leave field blank

Field Name	Type	Length	Decimals	Start Position	Justification	Currently Populated	TII Version	Eclipsys Field Description	QLD TII Description	HBCIS SourceTable	Attribute	Comments
HKMTCE	A	30		1423	L#	N	5.4.05SP2	Person User Alpha Fld 5	Not Used in QLD			leave field blank
HKM7CE	A	10		1453	L#	N	5.4.05SP2	Person User Alpha Fld 6	Not Used in QLD			leave field blank
HKM8CE	A	10		1463	L#	N	5.4.05SP2	Person User Alpha Fld 7	Not Used in QLD			leave field blank
HKM9CE	A	10		1473	L#	N	5.4.05SP2	Person User Alpha Fld 8	Not Used in QLD			leave field blank
HKNACE	A	10		1483	L#	N	5.4.05SP2	Person User Alpha Fld 9	Not Used in QLD			leave field blank
HKNBCE	A	10		1493	L#	N	5.4.05SP2	Person User Alpha Fld 10	Not Used in QLD			leave field blank
HKBMBR	N	15	4	1503	R%	Y	5.4.05SP2	Person User Numeric Fld 1	Not Used in QLD			insert value 0.0000
HKBNBR	N	15	4	1518	R%	Y	5.4.05SP2	Person User Numeric Fld 2	Not Used in QLD			insert value 0.0000
HKBOBR	N	15	4	1533	R%	Y	5.4.05SP2	Person User Numeric Fld 3	Extract Date & Time	Talons		Date and time Extract record was created CCYYMMDDHHMM
HKBPBR	N	15	4	1548	R%	Y	5.4.05SP2	Person User Numeric Fld 4	Extract table version	Talons		Extract Table Version (Talons use)
HKBQBR	N	15	4	1563	R%	Y	5.4.05SP2	Person User Numeric Fld 5	Mandatory Field Complete Flag	Talons		Mandatory Field Complete Flag (Talons use)
HKEWD1	N	8	0	1578	R%	Y	5.4.05SP2	Person Posting Date	Not Used in QLD			insert value for date of discharge
HKTNST	A	1		1586	L#	Y	5.4.05SP2	MRI Reject Reason	Reject Reason	n/a		use N as default
HKBITM	N	6	0	1587	R%	Y	5.4.05SP2	MRI Discharge Time	Discharge Time	ADM	26	Time RTG from EDIS
HKIQCF	A	5		1593	L#	N	5.4.05SP2	MRI CMG Code	Not Used in QLD			leave field blank
HKVFBR	N	15	4	1598	R%	N	5.4.05SP2	MRI APC Bundled Charges	Not Used in QLD			insert value 0.0000
HKI9CF	A	5		1613	L#	N	5.4.05SP2	MRI APR DRG	Not Used in QLD			leave field blank
HKJECF	A	5		1618	L#	N	5.4.05SP2	MRI Risk of Mortality	Not Used in QLD			leave field blank
HKJFCF	A	5		1623	L#	N	5.4.05SP2	MRI Severity Index	UDG Code			UDG code calculated by talons from discharge disposition and triage code
HKG6D1	N	8	0	1628	R%	N	5.4.05SP2	MRI Encounter Date 1	Referral Date	ADM2	3	Outpatient Referral Date
HKG7D1	N	8	0	1636	R%	N	5.4.05SP2	MRI Encounter Date 2	Initial Categorisation Date	ADM2	13	Initial Outpatient Categorisation Date
HKG8D1	N	8	0	1644	R%	N	5.4.05SP2	MRI Encounter Date 3	To Be Advised			Reserved for later use populate with date of discharge until further advised
HKG9D1	N	8	0	1652	R%	N	5.4.05SP2	MRI Encounter Date 4	To Be Advised			Reserved for later use populate with date of discharge until further advised
HKHAD1	N	8	0	1660	R%	N	5.4.05SP2	MRI Encounter Date 5	To Be Advised			Reserved for later use populate with date of discharge until further advised
HKS RTE	A	30		1668	L#	N	5.4.05SP2	MRI EncExt User Alpha 1	EDIS EF Encounter Number	TALONS		EDIS EF Encounter number as generated by Talons
HKSSTE	A	30		1698	L#	N	5.4.05SP2	MRI EncExt User Alpha 2	CFAU HQI ID	pAWS		HQI Unique ID from pAWS
HKSTTE	A	30		1728	L#	N	5.4.05SP2	MRI EncExt User Alpha 3	CFAU pAWS ID	pAWS		CFAU Unique ID from pAWS
HKSUTE	A	30		1758	L#	N	5.4.05SP2	MRI EncExt User Alpha 4	CFAU Campus TLA	pAWS		Campus TLA from pAWS
HKSVTE	A	30		1788	L#	N	5.4.05SP2	MRI EncExt User Alpha 5	CFAU HBCIS ADMNO	pAWS		HBCIS ADM NO from pAWS
HKSWTE	A	30		1818	L#	N	5.4.05SP2	MRI EncExt User Alpha 6	To Be Advised			Reserved for later use -leave field blank
HKSXTE	A	30		1848	L#	N	5.4.05SP2	MRI EncExt User Alpha 7	To Be Advised			Reserved for later use -leave field blank
HKSYTE	A	30		1878	L#	N	5.4.05SP2	MRI EncExt User Alpha 8	To Be Advised			Reserved for later use -leave field blank
HKSZTE	A	30		1908	L#	N	5.4.05SP2	MRI EncExt User Alpha 9	To Be Advised			Reserved for later use -leave field blank
HKS0TE	A	30		1938	L#	N	5.4.05SP2	MRI EncExt User Alpha 10	To Be Advised			Reserved for later use -leave field blank
HKS1TE	A	30		1968	L#	N	5.4.05SP2	MRI EncExt User Alpha 11	To Be Advised			Reserved for later use -leave field blank
HKS2TE	A	30		1998	L#	N	5.4.05SP2	MRI EncExt User Alpha 12	To Be Advised			Reserved for later use -leave field blank
HKS3TE	A	30		2028	L#	N	5.4.05SP2	MRI EncExt User Alpha 13	To Be Advised			Reserved for later use -leave field blank
HKS4TE	A	30		2058	L#	N	5.4.05SP2	MRI EncExt User Alpha 14	To Be Advised			Reserved for later use -leave field blank
HKS5TE	A	30		2088	L#	N	5.4.05SP2	MRI EncExt User Alpha 15	To Be Advised			Reserved for later use -leave field blank
HKJ1CF	A	10		2118	L#	N	5.4.05SP2	MRI EncExt User Alpha 16	Reason For Transfer			Reason for Transfer from EDIS
HKJ2CF	A	10		2128	L#	N	5.4.05SP2	MRI EncExt User Alpha 17	New Repeat Status	APP2 - APPOINTMENTS	04	New Repeat Status from APP2
HKJ3CF	A	10		2138	L#	N	5.4.05SP2	MRI EncExt User Alpha 18	Clinic Type	APP2	04	Clinic Type from APP2 sub specialty code
HKJ4CF	A	10		2148	L#	N	5.4.05SP2	MRI EncExt User Alpha 19	Clinic Code	APP2/TALONS		Clinic Code from APP2
HKJ5CF	A	10		2158	L#	N	5.4.05SP2	MRI EncExt User Alpha 20	Appointment Status	APP2	08	Status from APP2 / Appointments
HKJ6CF	A	10		2168	L#	N	5.4.05SP2	MRI EncExt User Alpha 21	Funding Source	ADM2	92	Funding Source
HKJ7CF	A	10		2178	L#	N	5.4.05SP2	MRI EncExt User Alpha 22	Language Code Category	PATIENTS	9	Reserved for later use -leave field blank
HKJ8CF	A	10		2188	L#	N	5.4.05SP2	MRI EncExt User Alpha 23	Workers Comp Claim No			Workers Comp Claim Number where recorded for this presentation
HKJ9CF	A	10		2198	L#	N	5.4.05SP2	MRI EncExt User Alpha 24	Inpatient Episode Number	ADM2	1	FOR XVOP EDEF -Episode number which identifies how many episodes the patient has had at the facility. HBCIS Admission Sequence Number from the urno plus prefix for some sites
HKKACF	A	10		2208	L#	N	5.4.05SP2	MRI EncExt User Alpha 25	Split by Payment Type			Split by Payment Type
HKKBCF	A	10		2218	L#	N	5.4.05SP2	MRI EncExt User Alpha 26	Funding Type			Funding Type
HKKCCF	A	10		2228	L#	N	5.4.05SP2	MRI EncExt User Alpha 27	CFAU pAWS Facility Code	pAWS		Facility Code from pAWS
HKKDCF	A	10		2238	L#	N	5.4.05SP2	MRI EncExt User Alpha 28	CFAU Campus TLA	pAWS		Campus TLA from pAWS
HKKECF	A	10		2248	L#	N	5.4.05SP2	MRI EncExt User Alpha 29	CFAU HBCIS ADMNO	pAWS		HBCIS ADM NO from pAWS
HKKFCF	A	10		2258	L#	N	5.4.05SP2	MRI EncExt User Alpha 30	ED Only Flag	pAWS		ED Only flag for ED trolley wards
HKKGCF	A	10		2268	L#	N	5.4.05SP2	MRI EncExt User Alpha 31	CFAU Payment Type	pAWS		CFAU Payment Type
HKKHCF	A	10		2278	L#	N	5.4.05SP2	MRI EncExt User Alpha 32	CFAU Allocated DRG	pAWS		CFAU Allocated DRG
HKKICF	A	10		2288	L#	N	5.4.05SP2	MRI EncExt User Alpha 33	CFAU Group Ref	pAWS		CFAU Grouper version
HKKJCF	A	10		2298	L#	N	5.4.05SP2	MRI EncExt User Alpha 34	CFAU MDC	pAWS		CFAU assigned MDC
HKKKCF	A	10		2308	L#	N	5.4.05SP2	MRI EncExt User Alpha 35	To Be Advised			Reserved for later use -leave field blank
HKKLCF	A	10		2318	L#	N	5.4.05SP2	MRI EncExt User Alpha 36	To Be Advised			Reserved for later use -leave field blank
HKKMCF	A	10		2328	L#	N	5.4.05SP2	MRI EncExt User Alpha 37	To Be Advised			Reserved for later use -leave field blank
HKKNCF	A	10		2338	L#	N	5.4.05SP2	MRI EncExt User Alpha 38	To Be Advised			Reserved for later use -leave field blank
HKKOCF	A	10		2348	L#	N	5.4.05SP2	MRI EncExt User Alpha 39	To Be Advised			Reserved for later use -leave field blank
HKKPCF	A	10		2358	L#	N	5.4.05SP2	MRI EncExt User Alpha 40	To Be Advised			Reserved for later use -leave field blank
HKKQCF	A	10		2368	L#	N	5.4.05SP2	MRI EncExt User Alpha 41	To Be Advised			Reserved for later use -leave field blank
HKKRCF	A	10		2378	L#	N	5.4.05SP2	MRI EncExt User Alpha 42	To Be Advised			Reserved for later use -leave field blank
HKKSCF	A	10		2388	L#	N	5.4.05SP2	MRI EncExt User Alpha 43	AHIMS Payroll number			Reserved for later use -leave field blank
HKKTCF	A	10		2398	L#	N	5.4.05SP2	MRI EncExt User Alpha 44	Pay Level			Reserved for later use -leave field blank

Field Name	Type	Length	Decimals	Start Position	Justification	Currently Populated	TII Version	Eclipsys Field Description	QLD TII Description	HBCIS SourceTable	Attribute	Comments
HKKUCF	A	10		2408	L#	N	5.4.05SP2	MRI EncExt User Alpha 45	AHIMS Departments/Teams..			Reserved for later use -leave field blank
HKS6TE	A	1		2418	L#	N	5.4.05SP2	MRI EncExt User Alpha 46	AHIMS Attendnace Sequence			Reserved for later use -leave field blank
HKS7TE	A	1		2419	L#	N	5.4.05SP2	MRI EncExt User Alpha 47	Conditions on Admission (HBCIS)			This is for HBCIS Code
HKS8TE	A	1		2420	L#	N	5.4.05SP2	MRI EncExt User Alpha 48	To Be Advised			Reserved for later use -leave field blank
HKS9TE	A	1		2421	L#	N	5.4.05SP2	MRI EncExt User Alpha 49	To Be Advised			Reserved for later use -leave field blank
HKTATE	A	1		2422	L#	N	5.4.05SP2	MRI EncExt User Alpha 50	To Be Advised			Reserved for later use -leave field blank
HKQ2V1	N	11	4	2423	R%	N	5.4.05SP2	MRI EncExt Usr Numeric 1	Intensive Care Day DRG	Derived		Derived by site insert value 0.0000
HKQ3V1	N	11	4	2434	R%	N	5.4.05SP2	MRI EncExt Usr Numeric 2	Days Waited Seen	APP2 / TALONS		(Patient Seen Date – Referral Received) – Not Ready for Care Days
HKQ4V1	N	11	4	2445	R%	N	5.4.05SP2	MRI EncExt Usr Numeric 3	Days Waited Referral	APP2 / TALONS		(Referral Received – Referral Initiated by GP) – Not Ready for Care Days
HKQ5V1	N	11	4	2456	R%	N	5.4.05SP2	MRI EncExt Usr Numeric 4	Long Term Beddays	ADM2		Count of Hospital in the Home/Nursing Home Beddays
HKQ6V1	N	11	4	2467	R%	N	5.4.05SP2	MRI EncExt Usr Numeric 5	CFAU DRG Days	pAWS		sum DRG days - DRG leave
HKQ7V1	N	11	4	2478	R%	N	5.4.05SP2	MRI EncExt Usr Numeric 6	CFAU ICU Days	pAWS		sum ICU days - ICU leave
HKQ8V1	N	11	4	2489	R%	N	5.4.05SP2	MRI EncExt Usr Numeric 7	CFAU PICU Days	pAWS		sum PICU days - PICU leave
HKQ9V1	N	11	4	2500	R%	N	5.4.05SP2	MRI EncExt Usr Numeric 8	CFAU NICU Days	pAWS		sum NICU days - NICU leave
HKRAV1	N	11	4	2511	R%	N	5.4.05SP2	MRI EncExt Usr Numeric 9	CFAU CCU Days	pAWS		sum CCU days - CCU leave
HKRBV1	N	11	4	2522	R%	N	5.4.05SP2	MRI EncExt Usr Numeric 10	CFAU SCN Days	pAWS		sum SCN days - SCN leave
HKRCV1	N	11	4	2533	R%	N	5.4.05SP2	MRI EncExt Usr Numeric 11	CFAU AACUTE Days	pAWS		sum AACUTE days - SAACUTE leave
HKRDV1	N	11	4	2544	R%	N	5.4.05SP2	MRI EncExt Usr Numeric 12	CFAU CACUTE Days	pAWS		sum CACUTE days - CACUTE leave
HKREV1	N	11	4	2555	R%	N	5.4.05SP2	MRI EncExt Usr Numeric 13	CFAU AEP Days	pAWS		sum AEP days - AEP leave
HKRFV1	N	11	4	2566	R%	N	5.4.05SP2	MRI EncExt Usr Numeric 14	CFAU SECURE Days	pAWS		sum SECURE days - SECURE leave
HKRGV1	N	11	4	2577	R%	N	5.4.05SP2	MRI EncExt Usr Numeric 15	CFAU SNAP Class Days	pAWS		sum SNAP days - SNAP leave
HKV0BR	N	11	2	2588	R%	N	5.4.05SP2	MRI EncExt Usr Numeric 16	CFAU NA Days	pAWS		sum NA days - NA leave
HKV1BR	N	11	2	2599	R%	N	5.4.05SP2	MRI EncExt Usr Numeric 17	Year Scaling Factor	pAWS		proportion for LOS>365 else = 1
HKV2BR	N	11	2	2610	R%	N	5.4.05SP2	MRI EncExt Usr Numeric 18	CFAU Inpatient Funding	pAWS		CFAU funded \$ for IP episode
HKHBD1	N	8	0	2621	R%	N	5.4.05SP2	MRI EncExt User Date 1	CFAU pAWS Extract date	pAWS		date of pAWS extract
HKHCD1	N	8	0	2629	R%	N	5.4.05SP2	MRI EncExt User Date 2	To Be Advised			Reserved for later use populate with date of discharge until further advised
HKLACF	A	5		2637	L#	N	5.4.05SP2	MRI LTAC DRG	Not Used in QLD			leave field blank
HKO7CF	A	5		2642	L#	N	5.4.05SP2	MRI MS-DRG	Not Used in QLD			leave field blank
HKO8CF	A	5		2647	L#	N	5.4.05SP2	MRI MS-LTCH DRG	Not Used in QLD			leave field blank
HKJ9SA	A	1		2652	L#	N	5.4.05SP2	MRI Present on Admission	Present on Admission			This is for the Eclipsys Code. Insert Y where at least 1 Diagnosis present on admission (with HBCIS prefix of P or A) insert a N where the diagnosis code of C.

RTI REQUEST

Extract File Format : T1H5CPP Procedures Input Physical file

Field Name	Field Description	Queensland Description	Type	Length	Decimals	Start Position	Justification	Currently Populated	TII Version	Comments
H5AACD	Company Code	Company Code	A	5		1	L	Y	5.4.05SP2	Identifies the specific health care institution or organisation. Hardcoded in Talons Parameters File.
H5RQCD	Encounter Number	Encounter Number	A	20		6	L	Y	5.4.05SP2	The unique patient identifier. URNO & sequence number with a prefix at some sites
H5O7CD	Procedure Code (Enctr)	Procedure Code	A	15		26	L	Y	5.4.05SP2	Insert Procedure Code from MED REC ORMIS/TMS2 or EMG2 EDIS
H5AID1	Date Of Service	Date Of Service	N	8	0	41	R	Y	5.4.05SP2	Insert Date Of Procedure from MED REC or ORMIS/TMS or EDIS/EMG2 may also come from Radiology system
H5FCNR	Procedures Input Sequence	Procedures Input Sequence	N	3	0	49	R	Y	5.4.05SP2	Use a counter with leading zeros 001,002 etc
H5P0ST	Reject Reason	Reject Reason	A	1		52	L	Y	5.4.05SP2	Insert Default "N"
H5P2ST	Surgery Flag	Surgery Flag	A	1		53	L	Y	5.4.05SP2	Insert Flag Y when valid operating register record from ORMIS - Case no TMS2 field 1
H5O8CD	Ordering Physician	Discharge Doctor	A	10		54	L	Y	5.4.05SP2	Insert Discharging doctor from last of Treating Doctors Transfer List in local form
H5O9CD	Surgeon	Principal Surgeon	A	10		64	L	N	5.4.05SP2	Insert Principal Surgeon code for procedure
H5V3CE	Assisting Surgeon(1)	Surgeon Assisting	A	10		74	L	N	5.4.05SP2	Insert 1st Assistant Surgeon code for procedure
H5V4CE	Assisting Surgeon(2)	Assistant Surgeon	A	10		84	L	N	5.4.05SP2	Insert 2nd Assistant Surgeon code for procedure
H5V5CE	Surgery Reason	Surgery Type	A	10		94	L	N	5.4.05SP2	Insert Elective or Emergency
H5V6CE	Anaesthesiologist	Anaesthetist	A	10		104	L	N	5.4.05SP2	Insert Anaesthetist Code for procedure
H5TBCD	Anaesthesia Type	Anaesthetic Type	A	2		114	L	N	5.4.05SP2	Insert Anaesthetic type
H5V7CE	Perfusionist	Perfusionist	A	10		116	L	N	5.4.05SP2	Insert Perfusionist Code where applicable
H5V8CE	Nurse Anaesthetist	Anaesthetic Technician or Nurse	A	10		126	R	N	5.4.05SP2	Insert Anaesthetic technician Code or applicable Nurse code
H5BATM	Anaesthesia Start Time	Start Anaesthetic	N	6	0	136	R	N	5.4.05SP2	Insert Anaesthetic Start Time (OP start by default)
H5BBTM	Anaesthesia Stop Time	Stop Anaesthetic	N	6	0	142	R	N	5.4.05SP2	Insert Anaesthetic Stop time (OP stop by default)
H5BCTM	Surgery Start Time	Start Surgery	N	6	0	148	R	N	5.4.05SP2	Insert Procedure start time
H5BDTM	Surgery Stop Time	Stop Surgery	N	6	0	154	R	N	5.4.05SP2	Insert procedure stop time
H5BETM	Entered Op Rm Time	Transfer In to Operating Suite	N	6	0	160	R	N	5.4.05SP2	Insert time of transfer in to Operating suite
H5BFTM	Left Op Rm Time	Transfer Out of Operating Suite	N	6	0	166	R	N	5.4.05SP2	Insert time of transfer out of Operating Suite
H5BGTM	PACU Admit Time	Start Recovery	N	6	0	172	R	N	5.4.05SP2	Insert admit time to recovery Bay
H5BHTM	PACU Discharge Time	Stop Recovery	N	6	0	178	R	N	5.4.05SP2	Insert Discharge time into recovery bay
H5V9CE	User Defined 1	Principal Scrub Nurse	A	30		184	L	N	5.4.05SP2	Insert Code for Principal Scub Nurse from operation record
H5WACE	User Defined 2	Assistant Scrub Nurse	A	30		214	L	N	5.4.05SP2	Insert Code for Assistant Scub Nurse from operation record
H5WBCE	User Defined 3	Scout Nurse	A	30		244	L	N	5.4.05SP2	Insert Code For Scout Nurse
H5WCCE	User Defined 4	Other Nurse code	A	30		274	L	N	5.4.05SP2	Insert code for Other Nurse
H5WDCE	User Defined 5	Other OT Staff Code	A	30		304	L	N	5.4.05SP2	Insert code for other staff

Field Name	Field Description	Queensland Description	Type	Length	Decimals	Start Position	Justification	Currently Populated	TII Version	Comments
H5WECE	User Defined 6	Operation or Procedure Time	A	30		334	L	N	5.4.05SP2	Insert " Operation" where associated times for each individual procedure cannot be accurately determined - else "Procedure"
H5WFCE	User Defined 7	Operation or Procedure Codes	A	30		364	L	N	5.4.05SP2	Insert " Operation" where associated codes for each individual procedure cannot be accurately determined - else "Procedure"
H5WGCE	User Defined 8	Waiting List category	A	30		394	L	N	5.4.05SP2	Insert category from EAM
H5HTBR	User defined Number 1	Associated Procedure No.	N	15	4	424	R	N	5.4.05SP2	insert total number of procedures on operation record
H5ABDZ	User defined Date 1	User defined Date 1	N	8	0	439	R	N	5.4.05SP2	use date of discharge
H5V1SS	Principle/Secondary Proc	Principle/Secondary Proc	A	1		447	L	N	5.4.05SP2	insert P or S
H5AFSA	Refresh Flag	Refresh Flag	A	1		448	L	N	5.4.05SP2	Insert Default "Y"

RTI Release

Extract File Format : T1T8CPP Secondary Diagnosis Input Physical file

Field Name	Field Description	Type	Length	Decimals	Start Position	Justification	Currently Populated	TII Version	Comments
T8AACD	Company Code	A	5		1	L	Y	5.4.05SP2	Insert three alpha chareceter company code
T8RQCD	Encounter Number	A	20		6	L	Y	5.4.05SP2	Insert Encounter Number from ?
T8P3CE	Secondary Diagnosis	A	10		26	L	Y	5.4.05SP2	Insert Diagnosis from ATD
T8GRBR	Secondary Diag Sequence	N	3	0	36	R	Y	5.4.05SP2	Use a counter with leading zeros 001,002 etc
T8EOTE	Secondary Diagnosis Type	A	10		39	L	Y	5.4.05SP2	Insert from source HBCIS field ?
T8P0CE	Physician	A	10		49	L	Y	5.4.05SP2	Insert Attending Doctor code from field ?
T8FCD1	Date	N	8	0	59	R	Y	5.4.05SP2	Insert Date from field ?
T8B7VD	User Numeric	N	11	2	67	R	N	5.4.05SP2	Leave field blank
T8FBD1	User Date	N	8	0	78	R	N	5.4.05SP2	Insert Date of Extract
T8P1CE	User Alpha 1	A	10		86	L	N	5.4.05SP2	HBCIS Present on Admission Code. Include the whole code. For example, AI20.9
T8P2CE	User Alpha 2	A	10		96	L	N	5.4.05SP2	Leave field blank
T8VCSS	Principal/Secondary Flag	A	1		106	L	Y	5.4.05SP2	Insert flag from field
T8JYSA	Present on Admission Flag	A	1		107	L	N	5.4.05SP2	Eclypsis Code. Insert from POA field
T8P0ST	Reject Reason	A	1		108	L	Y	5.4.05SP2	Insert Default "N"

RTI Released

Attachment D – PRIME Data Collection Sheets

See attached 20 pages.

RTI Release



PRIME CLINICAL INCIDENT REPORTING FORM

(Affix patient identification label here)

URN: (Mandatory)

Surname (Mandatory):

First Name (Mandatory):

Date of Birth (Mandatory):

Sex: M F

Facility:

PLEASE NOTE:

- This form should be used to record incidents where harm did, or could have occurred to a patient as a consequence of health care provision. It should **not** be filed in the Medical / Clinical / Patient Record. Once the data has been entered into PRIME this form should be destroyed.
- This form contains 5 pages and these must be fixed permanently together prior to sending for data entry.
- A separate form exists for staff incident use – contact your Occupational Health and Safety officer or equivalent.
- Please read Queensland Health's Clinical Incident Implementation Management Standard (30884), which provides instructions on how to manage Reportable Events (ie events which have a SAC 1 Rating).

REPORTING PERSONS DETAILS – This form to be completed by the reporting person

1. PERSON AFFECTED DETAILS – Mandatory

Status: Inpatient Outpatient Aged Care Resident Emergency Presentation
 Inpatient on approved leave Client of Community-based Service

Was this person under the care of a Mental Health Team? Yes No

2. WHAT HAPPENED - Mandatory

Date of Incident: / / Time of Incident: hrs
District: Facility: Division/Unit/Institute:
Ward/Area: Place: (eg corridor, shower)

What was the patient outcome? No Harm Minimal Harm Temporary Harm Likely permanent Harm Death

If harmed, what was the harm sustained? Soft tissue Eye Oral/dental Skeletal Gastrointestinal upset Cardiac
 Respiratory Neurological Circulatory/vascular Other internal injury Psychological None of the above

If nil harm, why not? Chance Intervention by: Staff Patient Family/visitor Existing safety system

What Happened? – Mandatory (Please describe the clinical incident - Additional pages can be attached if required eg, if potential incident, then describe how harm was avoided. If an actual incident then was the person harmed)

Immediate action(s) taken – Mandatory for harm only. If no harm, record any suggestions to prevent reoccurrence.

Results of Immediate action(s) – Mandatory for harm only

Incident Category 1: Admission/ Transfer/ Discharge/ Handover

1. Type (One selection only)

- Advice/ consult
- Referral
- Admission
- Transfer
- Discharge
- Follow up / Ongoing care

2. Stage (One selection only)

- Between team members
- Between wards
- Between QH facilities
- Between QH facility & community
- Between QH facility & external service provider
- Between QH facility & retrieval authority
- Between QH & patient/ family/ carer

3. Issue (multiple selections allowed)

- Deterioration not observed or recorded
- Deterioration observed & recorded but not interpreted
- Deterioration interpreted but response inappropriate
- Delay
- Inappropriate
- Unable to perform
- Unexpected
- Responsibility for continuity of care unclear

Incident Category 2: Diagnosis / Investigation

<p>1. Type (One selection only)</p> <input type="checkbox"/> Pathology <input type="checkbox"/> Medical Imaging <input type="checkbox"/> Other diagnostic procedure <input type="checkbox"/> Clinical diagnosis <p>2. Stage: <input type="checkbox"/> History <input type="checkbox"/> Examination <input type="checkbox"/> Interpretation</p>	<p>2. Stage (One selection only)</p> <input type="checkbox"/> Request <input type="checkbox"/> Specimen Collection <input type="checkbox"/> Transport <input type="checkbox"/> Performance of test/ procedure <input type="checkbox"/> Interpretation of test results <input type="checkbox"/> Reporting of test results <input type="checkbox"/> Verification/ Review of test results	<p>3. Issue (multiple selections allowed)</p> <input type="checkbox"/> Delay <input type="checkbox"/> Failure to <input type="checkbox"/> Inappropriate / Unsuitable <input type="checkbox"/> Wrong procedure <input type="checkbox"/> Retained object / instrument <input type="checkbox"/> Wrong patient <input type="checkbox"/> Wrong body part / side / site <input type="checkbox"/> Patient reaction <input type="checkbox"/> Additional intervention required <input type="checkbox"/> Deterioration not observed or recorded <input type="checkbox"/> Deterioration observed & recorded but not interpreted <input type="checkbox"/> Deterioration interpreted but response inappropriate			
<p>4. Patient reaction/ Complication (multiple selections allowed)</p> <table border="1"> <tr> <td style="vertical-align: top;"> <p>Pathology only</p> <input type="checkbox"/> None <input type="checkbox"/> Excessive bleeding <input type="checkbox"/> Thrombophlebitis <input type="checkbox"/> Haematoma <input type="checkbox"/> Fainting <input type="checkbox"/> Allergic reaction <input type="checkbox"/> Peripheral nerve damage <input type="checkbox"/> Other unexpected clinical outcome </td> <td style="vertical-align: top;"> <p>Medical Imaging only</p> <input type="checkbox"/> None <input type="checkbox"/> Contrast reaction <input type="checkbox"/> Inadvertent perforation <input type="checkbox"/> Unintended exposure <input type="checkbox"/> Overexposure <input type="checkbox"/> Reaction with foreign body <input type="checkbox"/> Unexpected clinical outcome </td> <td style="vertical-align: top;"> <p>Other diagnostic procedure</p> <input type="checkbox"/> None <input type="checkbox"/> Unexpected clinical outcome </td> </tr> </table>			<p>Pathology only</p> <input type="checkbox"/> None <input type="checkbox"/> Excessive bleeding <input type="checkbox"/> Thrombophlebitis <input type="checkbox"/> Haematoma <input type="checkbox"/> Fainting <input type="checkbox"/> Allergic reaction <input type="checkbox"/> Peripheral nerve damage <input type="checkbox"/> Other unexpected clinical outcome	<p>Medical Imaging only</p> <input type="checkbox"/> None <input type="checkbox"/> Contrast reaction <input type="checkbox"/> Inadvertent perforation <input type="checkbox"/> Unintended exposure <input type="checkbox"/> Overexposure <input type="checkbox"/> Reaction with foreign body <input type="checkbox"/> Unexpected clinical outcome	<p>Other diagnostic procedure</p> <input type="checkbox"/> None <input type="checkbox"/> Unexpected clinical outcome
<p>Pathology only</p> <input type="checkbox"/> None <input type="checkbox"/> Excessive bleeding <input type="checkbox"/> Thrombophlebitis <input type="checkbox"/> Haematoma <input type="checkbox"/> Fainting <input type="checkbox"/> Allergic reaction <input type="checkbox"/> Peripheral nerve damage <input type="checkbox"/> Other unexpected clinical outcome	<p>Medical Imaging only</p> <input type="checkbox"/> None <input type="checkbox"/> Contrast reaction <input type="checkbox"/> Inadvertent perforation <input type="checkbox"/> Unintended exposure <input type="checkbox"/> Overexposure <input type="checkbox"/> Reaction with foreign body <input type="checkbox"/> Unexpected clinical outcome	<p>Other diagnostic procedure</p> <input type="checkbox"/> None <input type="checkbox"/> Unexpected clinical outcome			

Incident Category 3: Intervention / Treatment

<p>1. Type</p> <input type="checkbox"/> Invasive / non invasive care	<p>2. Stage (One selection only)</p> <input type="checkbox"/> Before commencement of intervention <input type="checkbox"/> During intervention <input type="checkbox"/> After intervention	<p>3. Issue (multiple selections allowed)</p> <input type="checkbox"/> Deterioration not observed or recorded <input type="checkbox"/> Deterioration observed & recorded but not interpreted <input type="checkbox"/> Deterioration interpreted but response inappropriate <input type="checkbox"/> Non consented procedure performed <input type="checkbox"/> Patient reaction <input type="checkbox"/> Not ceased when indicated <input type="checkbox"/> Delay <input type="checkbox"/> Not performed/ Inadequate <input type="checkbox"/> Incorrectly performed <input type="checkbox"/> Wrong body part / side / site <input type="checkbox"/> Inappropriate <input type="checkbox"/> Retained object / instrument <input type="checkbox"/> Withdrawn <input type="checkbox"/> Unplanned readmission <input type="checkbox"/> Wrong patient <input type="checkbox"/> Additional intervention required
<p>4. Patient reaction/ Complication (more than 1 allowed)</p> <input type="checkbox"/> None <input type="checkbox"/> Unexpected clinical outcome <input type="checkbox"/> Inadvertent perforation <input type="checkbox"/> Intravascular gas embolism <input type="checkbox"/> Complications of delivery - maternal <input type="checkbox"/> Complications of delivery - foetal		

<p>1. Type</p> <input type="checkbox"/> Blood Products, Transfusion and Haemovigilance <p>Select Product / Component:</p> <input type="checkbox"/> Red cell concentrates <input type="checkbox"/> Platelets <input type="checkbox"/> Fresh frozen plasma (FFP) <input type="checkbox"/> Cryoprecipitate <input type="checkbox"/> Cryodepleted plasma (CPP) <input type="checkbox"/> Plasma derived factor concentrates - Prothrombinex VF <input type="checkbox"/> Plasma derived factor concentrates - other <input type="checkbox"/> Stem cells (haemopoietic) <input type="checkbox"/> Other blood products	<p>2. Stage (One selection only)</p> <input type="checkbox"/> Prior to administration <input type="checkbox"/> During administration <input type="checkbox"/> After administration	<p>3. Issue (multiple selections allowed)</p> <input type="checkbox"/> Incorrect blood component transfused (IBCT) – wrong patient <input type="checkbox"/> Incorrect blood component transfused (IBCT) – not suitable <input type="checkbox"/> Transfusion time outside of prescribed rate, without circulatory overload <input type="checkbox"/> Wrong dose / volume <input type="checkbox"/> Administered with contraindicated substance <input type="checkbox"/> Patient reaction
<p>4. Patient reaction/ Complication (more than 1 allowed)</p> <input type="checkbox"/> None <input type="checkbox"/> Febrile non haemolytic transfusion reaction (FNHTR) <input type="checkbox"/> Transfusion associated cardiac overload (TACO) <input type="checkbox"/> Severe Allergic reaction <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Transfusion related Acute Lung Injury (TRALI) <input type="checkbox"/> Post Transfusion Purpura (PTP) <input type="checkbox"/> Delayed Haemolytic Transfusion Reaction (DHTR) <input type="checkbox"/> Acute non-ABO Haemolytic Transfusion reaction <input type="checkbox"/> Transfusion Associated Acute Graft versus Host Disease (TaGVHD) <input type="checkbox"/> Transfusion Transmitted Infection (including bacterial contamination of blood component) <input type="checkbox"/> ABO haemolytic transfusion reaction		

<p>1. Type</p> <input type="checkbox"/> Diet / Nutrition	<p>2. Stage (One selection only)</p> <input type="checkbox"/> Ordering <input type="checkbox"/> Preparation <input type="checkbox"/> Feeding	<p>3. Issue (multiple selections allowed)</p> <input type="checkbox"/> Contamination of food / fluid <input type="checkbox"/> Inappropriate diet <input type="checkbox"/> Inappropriate fasting <input type="checkbox"/> Wrong breast milk <input type="checkbox"/> Incorrect route <input type="checkbox"/> Wrong patient <input type="checkbox"/> Missed/ delayed meal <input type="checkbox"/> Patient reaction
<p>4. Patient reaction/ Complication (more than 1 allowed)</p> <input type="checkbox"/> None <input type="checkbox"/> Dehydration <input type="checkbox"/> Hypoglycaemia <input type="checkbox"/> Aspiration <input type="checkbox"/> Allergic reaction/ anaphylaxis		

Medication Select at which stage error occurred (more than one may be selected), and subcategory/s:

<input type="checkbox"/> 1. Prescribing/Ordering <input type="checkbox"/> Wrong dose - extra <input type="checkbox"/> Wrong dose - overdose <input type="checkbox"/> Wrong dose - underdose <input type="checkbox"/> Wrong formulation <input type="checkbox"/> Wrong medication <input type="checkbox"/> Wrong rate <input type="checkbox"/> Wrong route <input type="checkbox"/> Wrong patient <input type="checkbox"/> Drug omission	<input type="checkbox"/> 2. Dispensing / Supply <input type="checkbox"/> Wrong dose - extra <input type="checkbox"/> Wrong dose - overdose <input type="checkbox"/> Wrong dose - underdose <input type="checkbox"/> Wrong medication form <input type="checkbox"/> Wrong medication <input type="checkbox"/> Wrong patient <input type="checkbox"/> Unauthorised drug substitution <input type="checkbox"/> Unauthorised drug <input type="checkbox"/> Drug omission	<input type="checkbox"/> 3. Transcribing <input type="checkbox"/> Wrong medication <input type="checkbox"/> Wrong chart <input type="checkbox"/> Wrong quantity <input type="checkbox"/> Reconciliation <input type="checkbox"/> Drug Omission <input type="checkbox"/> 5. Monitoring <input type="checkbox"/> Inadequate <input type="checkbox"/> Patient reaction Patient reaction/ Complication <input type="checkbox"/> None <input type="checkbox"/> ADR new <input type="checkbox"/> Drug interaction	<input type="checkbox"/> 4. Administration <input type="checkbox"/> Wrong administration technique <input type="checkbox"/> Wrong dose - extra <input type="checkbox"/> Wrong dose - overdose <input type="checkbox"/> Wrong dose - underdose <input type="checkbox"/> Wrong dose - omission <input type="checkbox"/> Wrong form <input type="checkbox"/> Wrong frequency <input type="checkbox"/> Wrong medication <input type="checkbox"/> Wrong patient <input type="checkbox"/> Wrong rate <input type="checkbox"/> Wrong route <input type="checkbox"/> Wrong time <input type="checkbox"/> Not received by patient <input type="checkbox"/> Unauthorised drug <input type="checkbox"/> Unauthorised administrator <input type="checkbox"/> Patient reaction
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	Medication - Intended	Medication - Administered
Medication Brand Name:		
Generic Name:		
Strength:		
Form:		
CDS Pack:		
Route:		

Incident Category 4: Behavioural

1. Issue (more than 1 allowed) <input type="checkbox"/> Attempted to abscond <input type="checkbox"/> Absconded / missing <input type="checkbox"/> Sexually inappropriate behaviour <input type="checkbox"/> Aggressive behaviour <input type="checkbox"/> Self harm <input type="checkbox"/> Attempted suicide <input type="checkbox"/> Suspected suicide 2. Immediate intervention attempted <input type="checkbox"/> None <input type="checkbox"/> N/A <input type="checkbox"/> De-escalation <input type="checkbox"/> Distraction <input type="checkbox"/> Voluntary time out <input type="checkbox"/> Sensory intervention <input type="checkbox"/> Environmental destimulation <input type="checkbox"/> Clinical intervention <input type="checkbox"/> Removal to restrictive area <input type="checkbox"/> Initiate Search <input type="checkbox"/> Increase frequency of observation <input type="checkbox"/> PRN: <input type="checkbox"/> Oral <input type="checkbox"/> IM <input type="checkbox"/> IV	3. Restrictive Intervention applied <input type="checkbox"/> A) None <input type="checkbox"/> B) Restraint: Time commenced: _____ ... Time ended _____ a) Physical <input type="checkbox"/> 1: Escort, verbal convincing <input type="checkbox"/> 2: Escort, verbal and physical coercion. <input type="checkbox"/> 3: Escort, physical coercion and pain compliance. <input type="checkbox"/> 4: Physical restraint, 3 man take down <input type="checkbox"/> 5: Physical restraint, other. b) Mechanical: <input type="checkbox"/> <input type="checkbox"/> C) Seclusion: Time commenced: _____ ... Time ended _____ <input type="checkbox"/> D) Acute Sedation: <input type="checkbox"/> Oral <input type="checkbox"/> IM <input type="checkbox"/> IV 4. Number of persons Involved Nursing Medical Allied Health Security..... Police Other.....
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Incident Category 5: Other Pt Incident a) Patient accident b) Harm from unknown cause c) Victim of aggression

d) Pressure Ulcer Waterlow Score (2-55) OR Braden Q Score (28-7) = _____

Was pressure area present on admission?
 Yes, present on transfer from other QH facility Yes, present on admission from non QH location No, acquired during admission

Stage: _____ Site (ie leg, arm) _____ Site location (eg left, right) _____

Wound description & size: _____

Pressure equipment in use: _____ Interventional strategies implemented: _____

e) Fall Was the patient being assisted by staff to perform a task? Yes No
 Was a falls risk established prior to incident? Yes No If yes, was patient identified as being at increased risk?: Yes No
 If no, why not? _____

Type of fall as reported by patient: <input type="checkbox"/> Slip <input type="checkbox"/> Trip <input type="checkbox"/> Dizziness <input type="checkbox"/> Faint <input type="checkbox"/> Legs gave way <input type="checkbox"/> Overbalance <input type="checkbox"/> Patient unable to report	Activity at time of fall: <input type="checkbox"/> Walking <input type="checkbox"/> Standing <input type="checkbox"/> Sitting to standing <input type="checkbox"/> Standing to sitting <input type="checkbox"/> Standing from lying position <input type="checkbox"/> Standing to lying position <input type="checkbox"/> Rolling out of bed <input type="checkbox"/> Sitting <input type="checkbox"/> Seating to seating <input type="checkbox"/> Reaching for object while seated <input type="checkbox"/> Reaching for object while standing <input type="checkbox"/> Staff transferring patient <input type="checkbox"/> Patient unable to report	Post Fall management: <input type="checkbox"/> Falls reassessment <input type="checkbox"/> Therapeutic treatment <input type="checkbox"/> Increased frequency of observation <input type="checkbox"/> Fall prevention strategies implemented <input type="checkbox"/> Diagnostic procedures <input type="checkbox"/> None
---	---	--

Function attempted by patient at time of fall:
 Toileting Bathing/ showering
 Resting Grooming or dressing
 Exercising (eg go for a walk)
 Use entertainment (eg pick up book, turn on TV)
 Patient unable to report

Above information obtained via:
 Patient reported Other person
 Staff observation Not witnessed

Current Diagnosis / Problem - Optional

Was an alert related to this incident already in place? Yes No (Optional)
 If No, then "Have you now documented or updated the alert?" Yes No (Optional)

Documented in clinical record? Yes No (Optional)

3. REPORTING PERSON'S DETAILS – (Mandatory) Report completed by:

Surname (Print): _____ First Name (Print): _____

Staff Category:
 Nursing Allied Health/Professional Pharmacy Oral Health Administrative
 Medical Technical Pathology Non QH Staff/ external party Operational
 Security

Position Held: (Print): _____

Date Incident was reported / / Time incident was reported ____ hrs

Signature: _____

4. WITNESS DETAILS - Additional witnesses? Please attach

Any witnesses to the incident? Yes No If Yes, then please record their details below

Surname (Print): _____ First Name (Print): _____
 Position (Print): _____ Contact Number (Print): _____

5. INCIDENT REPORTED TO (Mandatory)

Surname (Print): _____ First Name (Print): _____ Position (Print): _____

6. MEDICAL OFFICER REVIEW

a) Medical Officer Notified? Yes No If no, you **must** specify reason:

If yes then, review requested by: Name (Print): _____

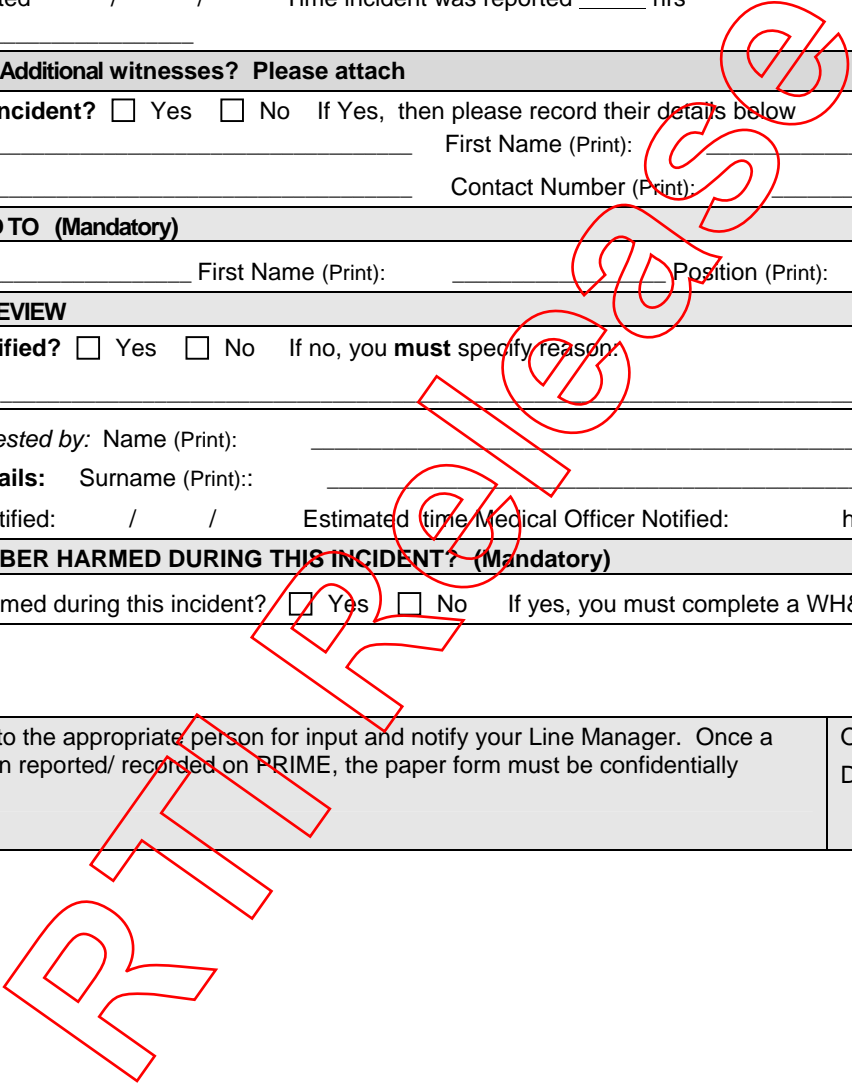
b) Medical Officer Details: Surname (Print): _____
 Date Medical Officer Notified: / / Estimated time Medical Officer Notified: hrs

7. WAS A STAFF MEMBER HARMED DURING THIS INCIDENT? (Mandatory)

Was a staff member harmed during this incident? Yes No If yes, you must complete a WH&S form.

Please send this report to the appropriate person for input and notify your Line Manager. Once a clinical incident has been reported/ recorded on PRIME, the paper form must be confidentially destroyed.

Office Use Only:
 Date Received: _____



8. RISK FACTORS: Providing this information assists your line manager to better understand the incident (multiple selections allowed)

Patient Factors

- Physical status compromised (eg emotional state)
- Physical Status compromised
- Other (free will)

Communication Factors

- Patient identification incorrect
- Information sharing was not timely
- Documentation insufficient
- Communication between supervisors and staff inadequate
- Communication between multidisciplinary team members inadequate
- Communication of policies / procedures inadequate
- Sharing of technical information inadequate
- Methods to optimise communication not used
- Communication of risk factors impeded adequate care
- Communication of product alert/advisory inadequate
- Communication with patient/significant others inadequate
- Methods / processes used to share information inadequate
- Organisational culture impeded communication
- Communication across organisational boundaries inadequate
- Social/cultural factors impeded communication
- Other (free will)

Training Factors

- Program to identify training needs absent
- Training not provided prior to work commencing
- Training results not adequately monitored
- Training was not sufficient
- Training in the use of equipment inadequate
- Training programs not focused on error prevention
- Procedures/equipment did not align with staff and their tasks
- Inadequate training in the use of barriers/controls

Environmental Factors

- Environmental conditions were inappropriate
- Environmental codes/ specifications/ regulations not met
- Environmental stressors were not adequately anticipated
- Environmental distractions
- Environment stress levels inappropriate
- Unfamiliar task
- Work area design not fit for purpose
- Risk assessment/audit not completed
- Safety audits/disaster drills not conducted
- Inability for patient to access treatment

Fatigue / Scheduling Factors

- Personnel had inadequate sleep – personal factors
- Personnel had inadequate sleep - scheduling factors
- Personnel missed meal break
- Personnel experiencing emotional/ personal distractions
- Personnel experiencing time pressure to complete task
- Fatigue was not anticipated
- Staffing inadequate for the workload
- Level of automation was inappropriate – too high
- Level of automation was inappropriate – too low

Product/sample Factors

- Duplication
- Unavailable product/result (lost specimen)
- Not usable/ unsatisfactory (ie damaged, expired)
- Incorrect product used/ or sample provided
- Calculation / concentration error
- Wrong diluent
- No administration access
- Not signed for

Medical Device/ Equipment Factors

- Sterilisation breach
- Poor product / equipment design
- Equipment codes/specifications/regulations not met
- Equipment maintenance program not in place
- Previous maintenance checks indicated a problem
- Corrective actions for known equipment problems not actioned/ effective
- Time/ resources inadequate to conduct equipment upgrades
- Equipment inadequate to perform the task
- Backup equipment/emergency systems unavailable
- Equipment is known to have failed in the past
- Design specifications not adhered to
- Equipment used in a manner it was not designed to
- Equipment design hindered timely recognition of error
- Equipment design hindered implementation of corrective actions
- Equipment displays not working/ interpretable
- Device re-used inappropriately

Consent Factors

- Consent form absent at time of need
- Consent form absent - private patient
- Consent form absent - emergency patient
- Consent form expired / lapsed
- Consent form not signed by relevant person
- Consent form undated
- Incorrect/ missing pt ID label or incorrect/ missing pt ID documented on the Consent form
- Side/ site of treatment not documented on consent form (eg laterality)

Rules/ Policies/ Procedures

- Risk management plan not in place
- Management lacked a quality system to inform risks
- Previous audits for similar event had noted cause/corrective actions
- Problem not identified/corrected despite audit/review
- Care outside scope of facility's service capability
- Staff not qualified or adequately trained to perform function
- Staff not orientated to job/facility/unit policies
- Policies/procedures not documented and/or up-to-date
- Not clear, understandable and/or accessible to staff
- Not consistent with Federal/QH policies, standards or regulations
- Not adhered to routinely by staff
- Obstacles prevented their use by staff
- Lack of incentive for staff to use policy/ procedure

Barriers

- Barriers and controls were involved
- Barriers designed were not effective
- Patient risk was not considered in barrier/control design
- Barriers/controls not in place before the event/near miss
- Barriers/controls not evaluated for reliability
- Other barriers/controls did not exist
- Concept of "fault tolerance" not applied to system design
- Barriers/controls not monitored
- Barrier/control would not have been effective despite functioning correctly
- Systems/processes not tested prior to implementation
- Review of barriers excluded adequate evaluation
- No method for identifying impact of system changes pre implementation



**PRIME Consumer Feedback
Management Actions Form**

Feedback
ID Number:

Complaint Compliment

This form is used to record management actions for complaints
Please note: (*) denotes mandatory fields in the PRIME CF Information System

- Refer to Queensland Health: Consumer Complaints Management Policy, 2007
 - Refer to PRIME CF Management Actions Handbook
- Both of the above are available on QHEPS.

PART B: Management Actions (accompanies Part A)

To be completed by:

1. Delegated Senior Staff Member, District Manager, Line Manager, Investigating Officer and District Complaints Coordinators.
2. Forward to the District Complaints Coordinator.

MANAGEMENT ACTIONS

Please complete the complaint risk analysis, as per the Queensland Health 'Complaints Policy and 'Integrated Risk Management Policy 13355'.

INVESTIGATION OUTCOME

(A)	Complaint Issue/s Narrative:	Issue 1.
		Issue 2.
		Issue 3.
(B)	Process of Investigation	

RTI Release

(C)	Findings	
QST: Is further CLINICAL analysis required? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, contact the Patient Safety Officer		

NB: High, Very High and Extreme Risk Assessed complaints attract MANDATORY CORRECTIVE ACTION.

(D)	Corrective/ Recommended Actions	
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Identify Issue (main and subcategory) from the list on the next page.

Main Category*	Sub Category*
Issue 1.	
Issue 2.	
Issue 3.	

Overall Organisational Risk Assessment (refer to the risk matrix)

Factor of Consequence* (eg adverse clinical incident, litigation etc)	Likelihood (1-5)	Consequence (1-5)	Level of Risk* (eg Low, Medium...)
Issue 1.			
Issue 2.			
Issue 3.			

Corrective/Recommended Actions:

List actions below	Officer Responsible	Position	Action due date:

***District Executive Member/Accountable Officer Authorisation: Signature:**

*First & Surname: _____ *Position: _____

Is **FOLLOW-UP** with Complainant recommended?
(eg to assess complainant satisfaction with the management of their complaint and outcome?) Yes No

COMPLAINT CATEGORY DEFINITIONS & RISK ASSESSMENT MATRICES

* Issue Categories and Sub Categories

<p>Access</p> <input type="checkbox"/> Attendance <input type="checkbox"/> Car parking <input type="checkbox"/> Delay in Admission or Treatment <input type="checkbox"/> Discharge or Transfer Arrangements <input type="checkbox"/> Referral <input type="checkbox"/> Refusal to Admit or Treat <input type="checkbox"/> Service Availability <input type="checkbox"/> Transport <input type="checkbox"/> Waiting lists	<p>Communication</p> <input type="checkbox"/> Attitude (Arrogance, Discourtesy) <input type="checkbox"/> Inadequate Information <input type="checkbox"/> Interpreter/Special Needs Services <input type="checkbox"/> Staff language barrier <input type="checkbox"/> Wrong/Misleading Information	<p>Corporate Services</p> <input type="checkbox"/> Administrative Services <input type="checkbox"/> Food <input type="checkbox"/> Hotel Services <input type="checkbox"/> Hygiene/ Environmental Standards <input type="checkbox"/> Lost property
<p>Privacy/Discrimination (Rights)</p> <input type="checkbox"/> Access to Records (Medical Record) <input type="checkbox"/> Discrimination by sex, age, race, etc <input type="checkbox"/> Discrimination re: private vs. public status <input type="checkbox"/> Inconsiderate Service (Failure to treat with respect, excludes Attitude, Lack of dignity) <input type="checkbox"/> Privacy/Confidentiality	<p>Treatment</p> <input type="checkbox"/> Coordination of Treatment <input type="checkbox"/> Diagnosis <input type="checkbox"/> Inadequate Treatment <input type="checkbox"/> Infection Control <input type="checkbox"/> Medication <input type="checkbox"/> Negligent Treatment <input type="checkbox"/> Rough/Painful Treatment <input type="checkbox"/> Withdrawal/Denial of Treatment <input type="checkbox"/> Wrong/Inappropriate Treatment	<p>Consent</p> <input type="checkbox"/> Consent Invalid <input type="checkbox"/> Consent not informed/Failure to warn <input type="checkbox"/> Consent not obtained <input type="checkbox"/> Failure to consult consumer <input type="checkbox"/> Involuntary Admission
<p>Costs</p> <input type="checkbox"/> Billing Practices (unfair etc) <input type="checkbox"/> Govt Subsidies (PBS, travel subsidy) <input type="checkbox"/> Information about costs (i.e. inadequate) <input type="checkbox"/> Overcharging (Over servicing) <input type="checkbox"/> Private Health Funds <input type="checkbox"/> Public/Private Election	<p>Professional Conduct</p> <input type="checkbox"/> Accuracy/Inadequacy of records <input type="checkbox"/> Assault <input type="checkbox"/> Certificates/reports <input type="checkbox"/> Competence <input type="checkbox"/> Financial Fraud <input type="checkbox"/> Illegal practices <input type="checkbox"/> Impairment <input type="checkbox"/> Sexual Misconduct	<p>Grievances</p> <input type="checkbox"/> Inadequate/No Response to Complaint <input type="checkbox"/> Reprisal/Retaliation

* Risk Determination Matrix

Source: Queensland Health QH Integrated Risk Management Imp Std 3, No 31237 (August 2006)

Likelihood	Consequences				
	Negligible	Minor	Moderate	Major	Extreme
Rare	Low	Low	Low	Medium	High
Unlikely	Low	Medium	Medium	High	Very High
Possible	Low	Medium	High	Very High	Very High
Likely	Medium	High	Very High	Very High	Extreme
Almost certain	Medium	Very High	Very High	Extreme	Extreme

* Level of Risk and Actions Required

Low risk	Manage by routine procedures, unlikely to need specific application of resources
Medium risk	Manage by specific monitoring or response procedures
High risk	Senior executive management attention needed and management responsibility specified
Very high risk	Detailed research and management planning required at a senior level
Extreme risk	Immediate action required, senior management will be involved, preparation of detailed plan

LIKELIHOOD TABLE (The likelihood (probability) of the RISK occurring)

Rare	May occur in exceptional circumstances only
Unlikely	Might occur at some time (not to be expected)
Possible	Could occur at least once (capable of happening / foreseeable)
Likely	Is expected to occur occasionally (to be expected)
Almost certain	Is expected to occur frequently (in most circumstances)

* **Factor of Consequences** Source: The QH Integrated Risk Management Guidance Document identifies 12 primary *Factors of Consequence*.

Type of Consequence	Degree of Severity				
	NEGLIGIBLE	MINOR	MODERATE	MAJOR	EXTREME
Adverse Clinical Incident	C No injury or harm caused, minor adjustment to operational routine	Minimal harm caused, minor interruption to routine	Loss of function, major harm caused	Loss of life	Multiple deaths
Outrage/Damage to Reputation	O Minimal adverse local publicity	Significant adverse local publicity	Significant adverse statewide publicity	Significant and sustained statewide adverse publicity	Sustained national adverse publicity, Queensland Health's reputation significantly damaged
Litigation	L Potential exposure to Queensland Health	Minor exposure to Queensland Health	Exposure will result in a single claim	Claims greater than \$500,000 or multiple claims resulting from single exposure	Claims greater than \$1M or multiple claims resulting from multiple similar exposures
Disruption to Established routines/ Operational delivery (may include industrial action, power failure, natural or man-made disaster, etc)	D No interruption to service	Some disruption manageable by altered operational routine	Disruption to a number of areas within a location or district, possible flow on to other locations	All operational areas of a location or district compromised, other locations or districts are affected	Total system dysfunction and/or total shut-down of operations
Staff Morale (may include absenteeism, establishment)	SM Staff dissatisfaction within local unit. No effect on services or programs	Alteration to routine practice required in local area or district	Disruption spreads across services or programs	Disruption spreads to routine practice statewide	Statewide cessation of service or programs
Workplace Health & Safety	H No injury / illness - no time lost, minor adjustment to operational routine	Injury / illness – lost time of less than 4 days	Serious injury / illness eg more than 4 days lost, or an event which is notifiable.	Fatality	Multiple fatalities
Security (may include major fraud/theft, IT failure, security breach at secure facility)	S Event noted by local staff/ management, no changes to routine required	Monitored by local staff, some effect on routine operations	Reportable event some threat to program / service that requires investigation and review	Major event threatens program / service across the wider organisation	Extreme event affecting organisations ability to continue program / service
Environmental Impact	E No lasting detrimental effect on the environment	Local detrimental effect on the environment	Short term local detrimental effect	Long term detrimental effect (eg significant discharge of pollutant)	Extensive detrimental long term effect (eg extensive discharge of persistent hazardous pollutant)
Workforce Issues (may include recruitment and retention, capability)	W No effect on services or programs	Some effect on specific service or program – alterations to routine practice required	Restrictions to service / program availability within a location or district, with possible flow on to other locations	Cessation of service / program of a location or district, which could impact other locations or districts	Statewide cessation of a program or multiple programs
Operational Management	OM No impact on local operations	Minor impact on local operations	Moderate to long-term impact on wider operations	Major impact on operations across other areas of organisation	Cessation of some operations
Corporate Management	M Local management review	Management review on broader basis	Local executive management review	Zonal / Branch / whole services management review	Statewide management review
Financial (anything that has the potential to cost the organisation or any of its unit (s) money)	F ~ 1% of monthly / cost centre budget	~ 2% of monthly / cost centre budget	~ 5% of monthly / cost centre budget	~ 10% of monthly / cost centre budget	~ 15% of monthly / cost centre budget



**PRIME Consumer Feedback
State-wide Form**

Feedback
ID Number:

THIS FORM SHOULD BE USED TO REPORT COMPLAINTS

Please note (*) denotes mandatory fields in PRIME CF Information System

- Refer to Queensland Health: Consumer Complaints Management Policy, 2007 – available on QHEPS.
- Refer to Quick reference Guide for Reporting Consumer Feedback
- Complaint Management Procedure – available on QHEPS.

Part A. Consumer Feedback Form (Part B. Management Actions Form)

To be completed by:

1. Staff member receiving consumer feedback.
2. Line Manager/Accountable officer for review/investigation
3. Forward to the District Complaints Coordinator or equivalent staff member.

CONSUMER FEEDBACK

*Date Feedback Received: / /

Date Event Occurred: / /

Consumer/Patient Details: *label can be affixed*

Anonymous Feedback Provider? Yes No

Title:

First Name:

Last Name:

Address:

Suburb:

Post Code:

State:

Home Phone:

Mobile:

Email address:

Gender: M / F

URN:

Date of Birth: / /

Interpreter Required?: Yes No

Election status: Private Public NA

Admission status: Pt – admitted Pt – non admitted (eg OPD)

***Feedback Provider Details (only required if different from Consumer/Patient Details)**

Consent Provided to Investigate?: Yes No

Title:

First Name:

Last Name:

Address:

Suburb:

Post Code:

State:

Home Phone:

Mobile:

Email address:

Communication
Type

- Verbal - In person
- Verbal - Phone
- Survey
- Written (fax, email, letter)
- Internet (electronic form)

- Media
- Feedback form (eg Have Your Say)
- Unknown
- Other:

*Location of Event: (eg Cairns HSD)

*Facility:

*Division/Unit/Institute:

*Ward/Area:

Source - How was the feedback received?

- Consumer (Service recipient)
- Complainant – staff
- Other:
- Complainant – client advocate
- Member of public

Feedback received by - *First name:

*Last name:

*Position:

Ward/ Service/ Division:

Feedback Details: (must be as *factual* and *objective* as possible)

OR see attached document

Initial Assessment and immediate actions taken

Complaint Severity Assessment

<input checked="" type="checkbox"/> Category	Definitions
<input type="checkbox"/> Negligible	No impact or risk to provision of care or the organisation; resolvable at point of service
<input type="checkbox"/> Minor	Issues that can be or should be able to be investigated and resolved at the point of service; issues not causing lasting detriment.
<input type="checkbox"/> Moderate	Issues that may require investigation (e.g. about organisational or professional issues, communication and practice management issues that are repetitive or not minor in nature); issue not causing lasting detriment.
<input type="checkbox"/> Major	Significant issues of standards, quality of care or denial of rights; issues causing lasting detriment that require investigation.
<input type="checkbox"/> Extreme	Issues about serious adverse events, sentinel events, long term damage or death that require formal investigation.

What are the Complainant's **Desired Feedback Outcomes?** (*tick all that apply*)

- | | | |
|--|--|---|
| <input type="checkbox"/> Register Concern | <input type="checkbox"/> Receive Explanation | <input type="checkbox"/> Obtain Apology |
| <input type="checkbox"/> Obtain Refund | <input type="checkbox"/> Access Service | <input type="checkbox"/> Change Procedure/Process |
| <input type="checkbox"/> Change Policy | <input type="checkbox"/> Compensation | <input type="checkbox"/> Staff Performance Management |
| <input type="checkbox"/> Change Physical Environment | <input type="checkbox"/> Provide Staff Training | <input type="checkbox"/> Resource Availability |
| | <input type="checkbox"/> Not Stated/Inadequately Described | <input type="checkbox"/> Other: |

Acknowledgement Required? Yes No



PRIME Consumer Feedback Management Actions Form

Feedback
ID Number:

This form is used to record management actions for complaints
Please note: (*) denotes mandatory fields in the PRIME CF Information System

- Refer to **Queensland Health: Consumer Complaints Management Policy, 2007**
- Refer to **PRIME CF Management Actions Manual**

Both of the above are available on QHEPS.

PART B: Management Actions (accompanies Part A)

To be completed by:

1. Delegated Senior Staff Member, District Manager, Line Manager, Investigating Officer and District Complaints Coordinators.
2. Forward to the District Complaints Coordinator.

MANAGEMENT ACTIONS

IDENTIFY ISSUE (Category and Subcategory from the list on the next page)

Category*	Sub Category*
Issue 1.	
Issue 2.	
Issue 3.	

INVESTIGATION INVESTIGATING OFFICER DETAILS:

INVESTIGATION RESULT

RTI RELEASES

Corrective/Recommended Actions:

List actions below	Officer Responsible	Position	Action due date:

Please complete the complaint risk analysis, as per the Queensland Health 'Complaints Policy and 'Integrated Risk Management Policy 13355' and Implementation Standard 3, No 31237 (September 2008)

NB: High, Very High and Extreme Risk Assessed complaints require MANDATORY CORRECTIVE ACTION.

Overall Organisational Risk Assessment (refer to the risk matrix)

Factor of Consequence* (eg adverse clinical incident, litigation etc)	Likelihood (1-5)	Consequence (1-5)	Level of Risk* (eg Low, Medium...)
Issue 1.			
Issue 2.			
Issue 3.			

***District Executive Member/Accountable Officer Authorisation: Signature:**

*First & Surname: _____ *Position: _____

Is **FOLLOW-UP** with Complainant recommended?
(eg to assess complainant satisfaction with the management of their complaint and outcome?) Yes No

Evaluation Required Yes No

Was complainant satisfied with **MANAGEMENT** of complaint? Satisfied Somewhat satisfied Not satisfied Unknown

Was complainant satisfied with **OUTCOME** of complaint? Satisfied Somewhat satisfied Not satisfied Unknown

Issue Categories and Sub Categories/Risk Assessment Matrix

<p>Compliment</p> <input type="checkbox"/> Care/Treatment <input type="checkbox"/> Professionalism <input type="checkbox"/> Service Provided <input type="checkbox"/> Food/Operational Services <input type="checkbox"/> Costs <input type="checkbox"/> Complaint handling <input type="checkbox"/> None of the above/not specified	<p>Environment/Facility management</p> <input type="checkbox"/> Administrative Services <input type="checkbox"/> Operational Services <input type="checkbox"/> Food Services <input type="checkbox"/> Hygiene/ Environmental Standards <input type="checkbox"/> Lost property <input type="checkbox"/> Access to Facility	<p>Privacy/Discrimination (Rights)</p> <input type="checkbox"/> Discrimination <input type="checkbox"/> Discrimination Public/Private <input type="checkbox"/> Disrespectful Service <input type="checkbox"/> Privacy/Confidentiality
<p>Access</p> <input type="checkbox"/> Delay in Admission or Treatment <input type="checkbox"/> Refusal to Admit or Treat <input type="checkbox"/> Waiting lists <input type="checkbox"/> Referral <input type="checkbox"/> Service Availability <input type="checkbox"/> Cancellations	<p>Fees/Costs</p> <input type="checkbox"/> Billing Practices <input type="checkbox"/> Access to Subsidies <input type="checkbox"/> Information about costs <input type="checkbox"/> Overcharging <input type="checkbox"/> Private Health Insurance <input type="checkbox"/> Public/Private Election	<p>Professional Conduct</p> <input type="checkbox"/> Assault <input type="checkbox"/> Abuse <input type="checkbox"/> Competence <input type="checkbox"/> Impairment <input type="checkbox"/> Financial Fraud <input type="checkbox"/> Illegal practices <input type="checkbox"/> Sexual Misconduct <input type="checkbox"/> Credentialling
<p>Communication</p> <input type="checkbox"/> Attitude/manner <input type="checkbox"/> Inadequate/no Information <input type="checkbox"/> Incorrect/Misleading Information <input type="checkbox"/> Interpreter/Special Needs Services <input type="checkbox"/> Staff language barrier	<p>Grievances/Complaint Process</p> <input type="checkbox"/> Inadequate/No Response to Complaint <input type="checkbox"/> Reprisal/Retaliation	<p>Treatment</p> <input type="checkbox"/> Diagnosis <input type="checkbox"/> Infection Control <input type="checkbox"/> Coordination of Treatment <input type="checkbox"/> Treatment Inadequate <input type="checkbox"/> Treatment Rough/Painful <input type="checkbox"/> Treatment Withdrawn/Denied <input type="checkbox"/> Treatment Wrong/Inappropriate <input type="checkbox"/> Treatment Negligent <input type="checkbox"/> Inadequate Consultation <input type="checkbox"/> Unexpected treatment outcome/complications <input type="checkbox"/> Experimental treatment <input type="checkbox"/> Excessive treatment
<p>Consent</p> <input type="checkbox"/> Consent Invalid <input type="checkbox"/> Uninformed Consent/Failure to Warn <input type="checkbox"/> Consent not obtained <input type="checkbox"/> Failure to consult consumer <input type="checkbox"/> Involuntary Admission <input type="checkbox"/> End of Life Decisions	<p>Inquiry Service Only</p> <input type="checkbox"/> Resources <input type="checkbox"/> Request for information – Complaint mechanisms	
<p>Discharge & Transfer Arrangements</p> <input type="checkbox"/> Patient not reviewed <input type="checkbox"/> Transport <input type="checkbox"/> Inadequate discharge/transfer <input type="checkbox"/> Delay	<p>Medical Records</p> <input type="checkbox"/> Records Management <input type="checkbox"/> Record keeping <input type="checkbox"/> Access to/transfer of records <input type="checkbox"/> Certificates/reports	
	<p>Medication</p> <input type="checkbox"/> Supply/security/storage of medication <input type="checkbox"/> Prescribing Medication <input type="checkbox"/> Dispensing Medication <input type="checkbox"/> Administering Medication	

INTEGRATED RISK MANAGEMENT ANALYSIS MATRIX

Likelihood ↓	← Consequences →				
	Negligible	Minor	Moderate	Major	Extreme
Rare	Low	Low	Low	Medium	High
Unlikely	Low	Medium	Medium	High	Very High
Possible	Low	Medium	High	Very High	Very High
Likely	Medium	High	Very High	Very High	Extreme
Almost certain	Medium	Very High	Very High	Extreme	Extreme

* LEVEL OF RISK AND ACTIONS REQUIRED

Low	Manage by routine procedures, unlikely to need specific application of resources
Medium	Manage by specific monitoring or response procedures locally
High	Management attention needed and management responsibility specified to control the risk
Very High	Detailed research and management planning required at a senior management/executive level
Extreme	Immediate action and involvement required at a senior management/executive level to control the risk.

LIKELIHOOD TABLE (The likelihood (probability) of the RISK occurring)

Rare	May occur in exceptional circumstances only /May occur at least once in a period of five years or more
Unlikely	Might occur at some time but not to be expected / Might occur at least once during a period of five years or less
Possible	Could occur , capable of happening, foreseeable / Could occur at least once in twelve months
Likely	Is expected to occur occasionally / Is expected to occur at least once per month
Almost certain	Is expected to occur frequently, in most circumstances / Is expected to occur at least once per week

*** FACTOR OF CONSEQUENCES** Source: *Guidance Document to the QH Complaints Management Policy*
 The QH Integrated Risk Management Guidance Document identifies 12 primary *Factors of Consequence*.

Degree of Severity

Type of Consequence		1 = NEGLIGIBLE	2 = MINOR	3 = MODERATE	4 = MAJOR	5 = EXTREME
Adverse Clinical Incident	C	No injury or harm caused, minor adjustment to operational routine	Minimal harm caused, minor interruption to routine	Loss of function, major harm caused	Permanent loss of function or disability	A loss of life
Outrage/Damage to Reputation	O	Minimal adverse local publicity	Significant adverse local publicity	Significant adverse statewide publicity	Significant and sustained statewide adverse publicity	Sustained national adverse publicity, Queensland Health's reputation significantly damaged
Litigation	L	Potential exposure to Queensland Health	Minor exposure to Queensland Health	Exposure will result in a single claim	Claims greater than \$500,000 or multiple claims resulting from single exposure	Claims greater than \$1M or multiple claims resulting from multiple similar exposures
Disruption to Established routines/ Operational delivery (may include industrial action, power failure, natural or man-made disaster, etc)	D	No interruption to service	Some disruption manageable by altered operational routine	Disruption to a number of areas within a location or district, possible flow on to other locations	All operational areas of a location or district compromised, other locations or districts are affected	Total system dysfunction and/or total shut-down of operations
Staff Morale (may include absenteeism, establishment)	SM	Staff dissatisfaction within local unit. No effect on services or programs	Alteration to routine practice required in local area or district	Disruption spreads across services or programs	Disruption spreads to routine practice statewide	Statewide cessation of service or programs
Workplace Health & Safety	H	No injury / illness - no time lost, minor adjustment to operational routine	No lost time injury. First aid or medical treatment required	Lost time injury involving a temporary loss of function or a notifiable event	Permanent loss of function or disability	A loss of life
Security (may include major fraud/theft, unauthorised access and areas of suspected official misconduct)	S	Event noted by local staff/management, no changes to routine operations	Monitored by local staff, some effect on routine operations	A security event that may threaten a program/service. An event requiring internal investigation	Major event that threatens a program / service across the wider organisation. Events requiring referral to Police/CMC	Extreme event affecting a program/ service area's ability to continue it's operation resulting in total shut-down
Environmental Impact (may include discharge of hazardous or dangerous substances, carbon footprint, etc)	E	No lasting detrimental effect on the environment	Local detrimental effect on the environment	Short term local detrimental effect contained with outside assistance (i.e. QFRS, EPA)	Long term detrimental effect even with outside assistance (i.e. QFRS, EPA)	Having a long-lasting detrimental effect on the environment
Workforce Issues (may include recruitment and retention, capability)	W	No effect on services or programs	Some effect on specific service or program – alterations to routine practice required	Restrictions to service / program availability within a location or district, with possible flow on to other locations	Cessation of service / program of a location or district, which could impact other locations or districts	Statewide cessation of a program or multiple programs
Operational Management	OM	No impact on local operations	Minor impact on local operations	Moderate to long-term impact on wider operations	Major impact on operations across other areas of organisation	Cessation of some operations
Corporate Management	M	Local management review	Local management review on broader basis	Senior Management review or intervention	Directorate/District/ Health Service Executive Management review or intervention	Statewide management review or intervention by EMT/D-G
Financial (anything that has a financial impact)	F	~ 1% of monthly / cost centre budget	~ 2% of monthly / cost centre budget	~ 5% of monthly / cost centre budget	~ 10% of monthly / cost centre budget	~ 15% of monthly / cost centre budget



**PRIME Consumer Feedback
State-wide Form**

Feedback ID Number:

Complaint Compliment

**THIS FORM SHOULD BE USED TO REPORT COMPLIMENTS & COMPLAINTS
RESOLVED AT FRONTLINE**

- Please note (*) denotes mandatory fields in PRIME CF Information System
- Refer to Queensland Health: Consumer Complaints Management Policy, 2007 – available on QHEPS.
 - Refer to Quick reference Guide for Reporting Consumer Feedback
 - Complaint Management Procedure – available on QHEPS.

Part A. Consumer Feedback Form

To be completed by:

- Staff member receiving consumer feedback.
- Forward to the District Complaints Coordinator or equivalent staff member.

CONSUMER FEEDBACK

*Date Feedback Received: / /

Date Event Occurred: / /

Consumer/Patient Details: *label can be affixed*

Anonymous Feedback Provider? Yes No

Title:

First Name:

Last Name:

Address:

Suburb:

Post Code:

State:

Home Phone:

Mobile:

Email address:

Gender: M / F

URN:

Date of Birth: / /

Interpreter Required?: Yes No

Election status: Private Public NA

Admission status: Pt – admitted Pt – non admitted (eg OPD)

***Feedback Provider Details (only required if different from Consumer/Patient Details)**

Consent Provided to Investigate?: Yes No

Title:

First Name:

Last Name:

Address:

Suburb:

Post Code:

State:

Home Phone:

Mobile:

Email address:

Communication Type

- Verbal - In person
 Verbal – Phone
 Survey
 Written (fax, email, letter)
 Internet (electronic form)

- Media
 Feedback form (eg Have Your Say)
 Unknown
 Other:

*Location of Event: (eg Cairns HSD)

*Facility:

*Division/Unit/Institute:

*Ward/Area:

Source - How was the feedback received ?

- Consumer (Service recipient) Complainant – staff Other:
 Complainant – client advocate Member of public

Feedback received by - *First name:

*Last name:

*Position:

Ward/ Service/ Division:

Feedback Details: (must be as *factual* and *objective* as possible)

OR see attached document

Initial Assessment and immediate actions taken (not applicable for compliments)

Complaint Severity Assessment NB CSA of Moderate, Major or Extreme refer to your District Complaints Coordinator

<input checked="" type="checkbox"/> Category	Definitions
<input type="checkbox"/> Negligible	No impact or risk to provision of care or the organisation; resolvable at point of service
<input type="checkbox"/> Minor	Issues that can be or should be able to be investigated and resolved at the point of service; issues not causing lasting detriment
<input type="checkbox"/> Moderate	Issues that may require investigation (e.g. about organisational or professional issues, communication and practice management issues that are repetitive or not minor in nature); issue not causing lasting detriment.
<input type="checkbox"/> Major	Significant issues of standards, quality of care or denial of rights; issues causing lasting detriment that require investigation.
<input type="checkbox"/> Extreme	Issues about serious adverse events, sentinel events, long term damage or death that require formal investigation.

What were the **Resolution Outcomes** and /or **Actions Taken?** (tick all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Apology provided | <input type="checkbox"/> Change practice/procedure (local) | <input type="checkbox"/> Complainant dissatisfied – |
| <input type="checkbox"/> Concern registered | <input type="checkbox"/> Environment changed | <input type="checkbox"/> Staff Training– |
| <input type="checkbox"/> Explanation given | <input type="checkbox"/> Recommend policy change | <input type="checkbox"/> Complaint withdrawn |
| <input type="checkbox"/> Compensation provided | <input type="checkbox"/> Staff performance mgmt. process implemented | <input type="checkbox"/> Service provided |
| <input type="checkbox"/> Cost refunded | <input type="checkbox"/> No further action possible | <input type="checkbox"/> Other: |

*** Issue Categories and Sub Categories**

<p>Compliment</p> <p><input type="checkbox"/> Care/Treatment</p> <p><input type="checkbox"/> Professionalism</p> <p><input type="checkbox"/> Service Provided</p> <p><input type="checkbox"/> Food/Operational Services</p> <p><input type="checkbox"/> Costs</p> <p><input type="checkbox"/> Complaint handling</p> <p><input type="checkbox"/> None of the above/not specified</p> <p>Access</p> <p><input type="checkbox"/> Delay in Admission or Treatment</p> <p><input type="checkbox"/> Refusal to Admit or Treat</p> <p><input type="checkbox"/> Waiting lists</p> <p><input type="checkbox"/> Referral</p> <p><input type="checkbox"/> Service Availability</p> <p><input type="checkbox"/> Cancellations</p> <p>Communication</p> <p><input type="checkbox"/> Attitude/manner</p> <p><input type="checkbox"/> Inadequate/no Information</p> <p><input type="checkbox"/> Incorrect/Misleading Information</p> <p><input type="checkbox"/> Interpreter/Special Needs Services</p> <p><input type="checkbox"/> Staff language barrier</p> <p>Consent</p> <p><input type="checkbox"/> Consent Invalid</p> <p><input type="checkbox"/> Uninformed Consent/Failure to Warn</p> <p><input type="checkbox"/> Consent not obtained</p> <p><input type="checkbox"/> Failure to consult consumer</p> <p><input type="checkbox"/> Involuntary Admission</p> <p><input type="checkbox"/> End of Life Decisions</p> <p>Discharge & Transfer Arrangements</p> <p><input type="checkbox"/> Patient not reviewed</p> <p><input type="checkbox"/> Transport</p> <p><input type="checkbox"/> Inadequate discharge/transfer</p> <p><input type="checkbox"/> Delay</p>	<p>Environment/Facility management</p> <p><input type="checkbox"/> Administrative Services</p> <p><input type="checkbox"/> Operational Services</p> <p><input type="checkbox"/> Food Services</p> <p><input type="checkbox"/> Hygiene/ Environmental Standards</p> <p><input type="checkbox"/> Lost property</p> <p><input type="checkbox"/> Access to Facility</p> <p>Fees/Costs</p> <p><input type="checkbox"/> Billing Practices</p> <p><input type="checkbox"/> Access to Subsidies</p> <p><input type="checkbox"/> Information about costs</p> <p><input type="checkbox"/> Overcharging</p> <p><input type="checkbox"/> Private Health Insurance</p> <p><input type="checkbox"/> Public/Private Election</p> <p>Grievances/Complaint Process</p> <p><input type="checkbox"/> Inadequate/No Response to Complaint</p> <p><input type="checkbox"/> Reprisal/Retaliation</p> <p>Inquiry Service Only</p> <p><input type="checkbox"/> Resources</p> <p><input type="checkbox"/> Request for information – Complaint mechanisms</p> <p>Medical Records</p> <p><input type="checkbox"/> Records Management</p> <p><input type="checkbox"/> Record keeping</p> <p><input type="checkbox"/> Access to/transfer of records</p> <p><input type="checkbox"/> Certificates/reports</p> <p>Medication</p> <p><input type="checkbox"/> Supply/security/storage of medication</p> <p><input type="checkbox"/> Prescribing Medication</p> <p><input type="checkbox"/> Dispensing Medication</p> <p><input type="checkbox"/> Administering Medication</p>	<p>Privacy/Discrimination (Rights)</p> <p><input type="checkbox"/> Discrimination</p> <p><input type="checkbox"/> Discrimination Public/Private</p> <p><input type="checkbox"/> Disrespectful Service</p> <p><input type="checkbox"/> Privacy/Confidentiality</p> <p>Professional Conduct</p> <p><input type="checkbox"/> Assault</p> <p><input type="checkbox"/> Abuse</p> <p><input type="checkbox"/> Competence</p> <p><input type="checkbox"/> Impairment</p> <p><input type="checkbox"/> Financial Fraud</p> <p><input type="checkbox"/> Illegal practices</p> <p><input type="checkbox"/> Sexual Misconduct</p> <p><input type="checkbox"/> Credentialling</p> <p>Treatment</p> <p><input type="checkbox"/> Diagnosis</p> <p><input type="checkbox"/> Infection Control</p> <p><input type="checkbox"/> Coordination of Treatment</p> <p><input type="checkbox"/> Treatment Inadequate</p> <p><input type="checkbox"/> Treatment Rough/Painful</p> <p><input type="checkbox"/> Treatment Withdrawn/Denied</p> <p><input type="checkbox"/> Treatment Wrong/Inappropriate</p> <p><input type="checkbox"/> Treatment Negligent</p> <p><input type="checkbox"/> Inadequate Consultation</p> <p><input type="checkbox"/> Unexpected treatment outcome/complications</p> <p><input checked="" type="checkbox"/> Experimental treatment</p> <p><input type="checkbox"/> Excessive treatment</p>
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RTI REQUEST

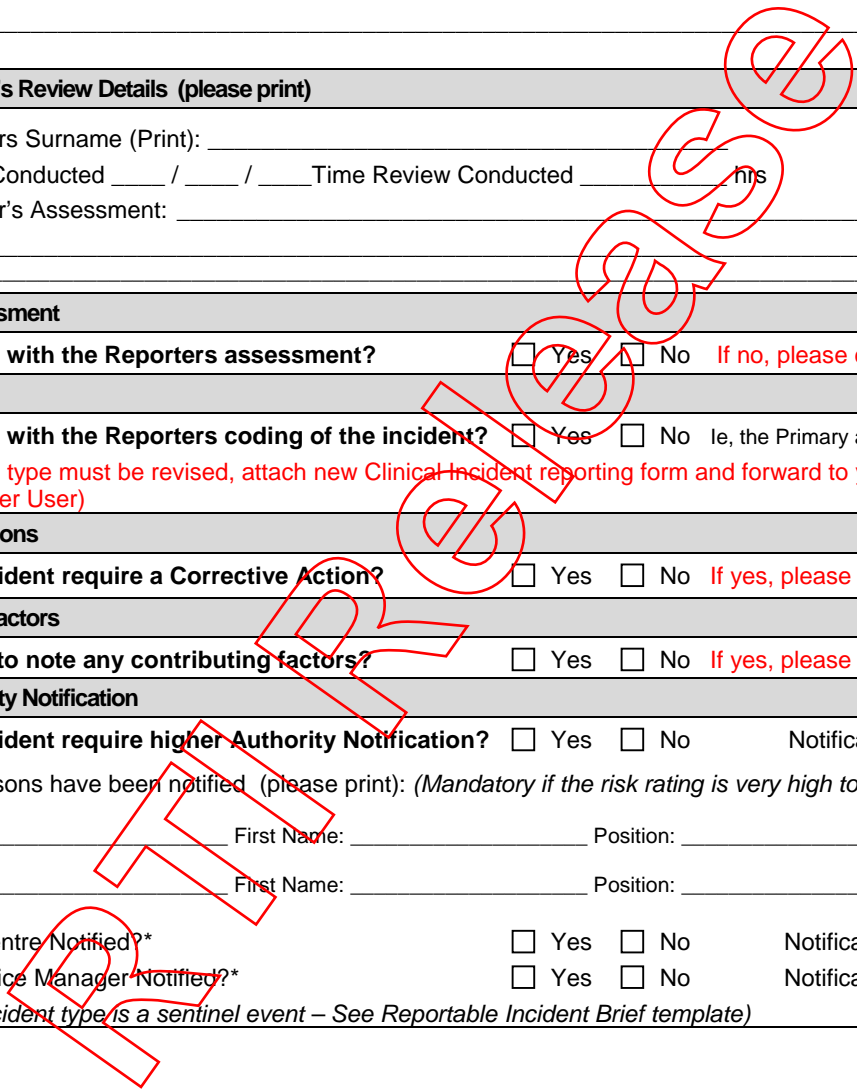


PRIME – Clinical Incident Management Actions Form

PLEASE NOTE:

- This management actions form should only be used for the management of cases of adverse patient/client events when timely access to PRIME is not possible.
- Affix this form to initial Clinical Incident Reporting form
- Once this information has been recorded in PRIME, the paper form must be confidentially destroyed.

1. Line Manager's Review (please print)		Date: ____ / ____ / ____
Surname (Print): _____ First Name (Print): _____ Position: (Print): _____		
Mental Health Act Status - Mandatory for Mental Health Clients Only:		
<input type="checkbox"/> Voluntary	<input type="checkbox"/> Assessment Period	<input type="checkbox"/> ITO - Inpt <input type="checkbox"/> ITO - Community
<input type="checkbox"/> Classified Patient	<input type="checkbox"/> PSN	<i>Select if applicable:</i> <input type="checkbox"/> Limited Community Treatment
<input type="checkbox"/> Forensic Order	<input type="checkbox"/> Absent without permission	
Issues identified relevant to this incident: _____ _____		
2. Medical Officer's Review Details (please print)		
Medical Officers Surname (Print): _____		
Date Review Conducted ____ / ____ / ____ Time Review Conducted _____ hrs		
Medical Officer's Assessment: _____ _____		
3. Severity Assessment		
Do you agree with the Reporters assessment? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, please complete Section 9 ></i>		
4. Incident Type		
Do you agree with the Reporters coding of the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>ie, the Primary and Secondary Incident Type</i> <i>(If the Incident type must be revised, attach new Clinical Incident reporting form and forward to your Patient Safety Officer or District Super User)</i>		
5. Corrective Actions		
Does this incident require a Corrective Action? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please complete section 11 ></i>		
6. Contributing Factors		
Do you wish to note any contributing factors? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please complete section 12 ></i>		
7. Higher Authority Notification		
Does this incident require higher Authority Notification? <input type="checkbox"/> Yes <input type="checkbox"/> No Notification Date: ____ / ____ / ____		
The following persons have been notified (please print): <i>(Mandatory if the risk rating is very high to extreme)</i>		
Surname: _____ First Name: _____ Position: _____		
Surname: _____ First Name: _____ Position: _____		
Patient Safety Centre Notified?* <input type="checkbox"/> Yes <input type="checkbox"/> No Notification Date: ____ / ____ / ____		
Area Health Service Manager Notified?* <input type="checkbox"/> Yes <input type="checkbox"/> No Notification Date: ____ / ____ / ____		
<i>(*Mandatory if incident type is a sentinel event – See Reportable Incident Brief template)</i>		
Comments: _____ _____ _____		
8. Feedback Status		
a) Incident Status: <input type="checkbox"/> Open <input type="checkbox"/> in process <input type="checkbox"/> Closed		
b) Staff involved have been notified? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Surname: _____ First Name: _____ Position: _____		
Surname: _____ First Name: _____ Position: _____		



9. Line Manager's Severity Assessment Review (Mandatory for SAC 1s)

- SAC 1 = **Death or likely permanent harm** which is *not reasonably expected* (by the treating clinician/s, patient or family) as an outcome of healthcare.
- SAC 2 = **Temporary harm** which is *not reasonably expected* as an outcome of healthcare. Includes increased length of stay, additional investigations performed, referral to another clinician, or surgical intervention.
- SAC 3 = **Minimal or no harm**. Includes first aid treatment only.

d) Reason for Re-assessment:

e) Feedback to Reporting Person? (Mandatory if the adverse clinical incident risk rating has been changed) Yes No

10. Incident Analysis

a) Is this incident to be investigated? Yes No Date to commence: ___ / ___ / ___

b) Type of Investigation:

- Root Cause Analysis Heaps Analysis Task System Analysis Clinical Review Aggregated (local Review)

11. Corrective Actions

Description of the corrective actions – *please attach separate page*. Date corrective actions proposed: ___ / ___ / ___

Date corrective actions authorised: ___ / ___ / ___ Authorised by (Print): _____

Responsibility for taking action

Responsible person (Print): _____ Responsible person notified : Yes No

Notification Method: Email Fax In person Internet Phone Written Notification Date: ___ / ___ / ___

Action Due Date: ___ / ___ / ___ Action Commenced Date: ___ / ___ / ___ Action Completed Date: ___ / ___ / ___

Corrective Action Outcome:

- No impact beyond this incident
- Requires ongoing monitoring
- Processes implemented to avoid future incidents
- Processes implemented to trap future incidents
- Processes implemented to mitigate future incidents

12. Contributing Factors Optional (Please specify one or more **main** categories. One or more **subcategories** can also be selected)

Patient Factors

- Affected by Medication
- Age
- Alcohol or drug intoxication
- Attempting to abscond
- Confusion
- Decreased level of consciousness
- Deliberate self inflicted injury
- Dementia
- Diagnosis/prognosis/comorbidities
- Discharge against medical advice
- Distraction or inattention
- Family conflict
- High risk waterlow score > 10
- Intellectual disability
- Malnutrition
- Language or speech barriers
- Responding to psychotic processes

Staff Factors

- Communication – care/treatment
- Distraction or inattention
- Fatigue/stress/unwell
- Instructions not followed or misinterpreted
- Lack of knowledge of workplace
- Position/rank issues
- Staff approaching consumer for treatment
- Teamwork/supervision factors

System / Equipment Factors

- Call bell or paging problem
- Environment – access/isolation
- Environment – lighting/temp/noise
- Environment – physical layout
- Equipment – fault
- Equipment – inappropriate
- Equipment – maintenance issues
- Equipment – training issue
- Protocols/policies – not workable
- Security problem

Task Factors

- Complex
- Emergency
- Routine
- Simple

Team Factors

- Authority gradients
- Irregular team
- Lack of defined roles
- Team culture / morale

Organisational Factors

- Administrative support issues
- Lack of access to appropriate information
- Organisational culture issues
- Staffing patterns – organisational requirement

13. Open Disclosure

Step 1, answer the OD question on the LM Review screen:

Should a Formal Disclosure process be initiated for this incident? Yes No

If no, why not?:

Step 2. If yes, you must complete all of the mandatory fields on PRIME Open Disclosure Details page.

Part 2 – Operator’s Submission

See attached 20 pages.

RTI Release

Schedule 1 Part 2 – Management Response

1 Management Response

Ramsay is Australia's largest operator of private hospitals providing high quality healthcare across a broad range of specialties. Ramsay will ensure that services provided to Public Patients under the Services Agreement will meet or exceed the specified standards and be subject to constant performance monitoring using a comprehensive range of key performance indicators, both contractual and for in-house monitoring. Ramsay ensures the high quality delivery of care through effective Clinical, Risk and Corporate Governance systems. Ramsay will operate the Facility at the Kawana Site utilising our current suite of management systems and programs including:

- Hospital Wide Quality Improvement Program;
- Patient Management System including bed and theatre utilisation and scheduling;
- Risk Management System, which incorporates our Incident Management System and Workplace Health and Safety programs;
- Medical Record and other Information Management Systems; and
- Complaints Management System.

The above management systems reflect those in place in all Ramsay facilities including

Ramsay has compared our systems and reports with those of QH's as specified. Ramsay is confident that our systems and processes referred to above are of an equivalent standard to those of QH and will provide QH with the desired outcomes.

All of these systems provide excellent facility wide key performance indicators which are used for continuous performance monitoring, performance reporting and identification of areas in need of improvement/recertification and progress towards such improvement.

Ramsay uses Meditech as our standard patient management system across all facilities. The Meditech system covers inpatient, and day patient admissions incorporating:

- Medical record number and sequencing;
- Patient personal details;
- Bed Management system;
- Theatre booking and utilisation system;
- CMBS records and DRG grouper;
- Patient billings system; and
- Patient management reporting system.

The Meditech system contains some basic clinical information (eg admission diagnosis, procedures undertaken, coding information etc) which QH will be provided visibility to. RHC will work with QH as systems are implemented for electronic records management, to integrate these into the Facility.

RISK MANAGEMENT

Ramsay has a comprehensive Risk Management system which underpins the delivery of quality health services. Our systems include:

- Hospital By-laws / Facility Rules which provide a framework for clinical governance (refer Schedule 2 Part 2);
- Riskman Incident recording and reporting system;

- Workplace Health and Safety System which includes amongst other things, the hospital wide Risk Register, safety policies and safe operating procedures. The Ramsay National Safety Team provides advice and support to hospitals on all aspects of workplace safety and injury management. The national team also provide a range of reports covering hospital and national performance. A major role of the national team is to co-ordinate and oversee the national auditing program to assess a hospital's compliance against safety standards; and
- A complaints management system.

Ramsay has implemented the 'Riskman' incident management and reporting system which is available online in all facilities. Ramsay will implement Riskman at the Facility on the Kawana Site.

Riskman is used to collect all clinical and non-clinical incidents and near misses. Access to the system is available to all staff to ensure that any member of staff can lodge an incident report at any time.

The Riskman system collects relevant information in relation to incidents including:

- Patient / staff / visitor details
- Time and place of incident
- What occurred
- Immediate actions taken
- Results of any initial investigations
- Recommendations for change

Riskman entries will be forwarded electronically by the system to the Facility Director of Clinical Services and Quality Manager who will be required to review all incidents. All incidents are risk rated. Following this initial review, other actions and recommendations may be made. The Riskman system records all personnel who view incidents and/or add information to an incident report. The Ramsay Clinical Governance Unit (Refer Schedule 2, Part 2) are also forwarded electronically all incidents entered into the system.

Incident data will be reviewed by the relevant Facility committees including the Clinical Review Committee. Risk rated 1 and 2 incidents must be reviewed individually by the Clinical Review Committee as well as any recommendations from Root Cause Analyses conducted.

Examples of risk classification are set out in Attachment 1.

Ramsay agrees to notify QH of all Sentinel Events at the Facility in accordance with Schedule 1 Part 1 section 9.

QUALITY MANAGEMENT

Ramsay will develop and implement a Quality Management Plan in the Facility on the Kawana Site. The Plan will incorporate the requirements of either ACHS or ISO 9001 accreditation. The Quality Management Plan will also incorporate the requirements of the Health Quality and Complaints Commission (**HQCC**).

Ramsay further agrees to provide QH with Public Patient data and reports under our Performance Management Plan. Our Performance Monitoring System will include:

- ACHS Clinical Indicators – 'Hospital-wide' and 'Infection Control' indicator sets;
- Public Patient Activity information;
- Quality Indicators as described in Table 8 of Schedule 3 Part 1;
- Patient Satisfaction results; and
- Complaint data.

Ramsay's quality improvement systems ensure that whenever significant adverse variances to expected outcomes occur, an improvement plan is developed and implemented. Ongoing evaluation of progress against improvement plans also occurs.

2 Contracted Services Management Methodology

2.a Approach to Working Co-operatively with QH

2.a.1 Developing and Reaching Agreement on the Activity Forecast

Ramsay will work cooperatively with QH to confirm the appropriateness of (or amend, if required) the initial activity forecast for year 1 set out in Attachment B to Part 1 of Schedule 1, and then to agree on and establish subsequent forecasts for each year of the contracted services period, in accordance with in Section 6 of Part 1 of Schedule 1 of the Services Agreement.

The Activity Forecast will reflect the types of services QH wishes to purchase from the Facility and the capacity and capability of the Facility in each period.

Ramsay agrees that the appropriate time to develop the Activity Forecast is 6 months prior to the commencement of each financial year. Upon receipt of the activity targets for each services stream from QH, representatives from the Ramsay Facility executive management team will work with QH representatives to develop and finalise the activity forecast. The Facility CEO, Commercial Manager and Contract Manager will be involved in this process.

In determining the proposed referral targets and referral limits for each service stream by calendar month, Ramsay will consider issues such as:

- Activity data and trends for the past period by clinical specialty;
- Number of referrals to the Facility from QH EDs;
- Available beds within the Facility and any plans by the Facility to increase capability in certain areas – e.g. additional staff or bed allocations for a particular clinical specialty;
- Seasonal variations - examples of this include spikes in medical occupancy during winter months, and episodes of VMO annual and conference leave; and
- Quality and outcome data for clinical specialty areas.

Based on the above considerations, Ramsay will submit a proposed Activity Forecast to QH to enable the Contract Managers to meet and discuss its implications and acceptability. Ramsay is able to provide the information in the manner and format specified in Schedule 1 Part 1, section 6.3 (d) of the Services Agreement. As per the 'Review' requirements, the parties will meet to review any supporting data and progress discussions to agree activity targets. In the event that agreement on activity levels cannot be reached at this level, Ramsay agrees that the matter should be referred to the Services Review Committee.

2.a.2 Promoting the Safe and Efficient Delivery of the Contracted Services

Ramsay acknowledges that the primary focus of the activity planning process should be to agree on activity levels which will be delivered in a safe and efficient manner. Efficiency issues will be considered when reviewing information mentioned above such as past activity data and trends, bed availability by clinical specialty and seasonal variations.

During the term of the Services Agreement, Ramsay will convene a monthly meeting with QH to review the previous month's actual activity against target levels as well as monitoring progress on a year to date basis. At this meeting, any measures required to change or re-align activity levels can be discussed and agreed (without limiting Schedule 1, Part 1, section 6.5(a) of the Services Agreement).

2.a.3 Quarterly and Annual Reconciliation of Activity

After the close of each Quarter, Ramsay will provide a reconciliation of actual activity against the forecast and agreed targets levels. The reconciliation will include the monthly activity data by clinical service streams in accordance with Schedule 4, Part 1, section 4.1 and compare this activity to the Quarterly Percentage of the Lower Limit for each service stream and in aggregate and, in the last Quarter of each Financial Year, against the aggregate annual Lower Limit.

2.b Performance Management

Performance management of the contracted services will be centred upon review of information contained in the Ramsay monthly 'Management Report' and any agreed management actions that arise from this review.

The Monthly Management Report will incorporate:

- An activity report from Meditech in a format providing equivalent information to that specified in the Schedule 1, Part 1, Attachment C. Ramsay does not operate the HBCIS system and will provide an equivalent report from the Meditech Patient Management System;
- KPI report showing any results of KPI monitoring and reporting that may fall due in that month (e.g. clinical indicator data for ACHS, which is collected and reported on a six monthly basis);
- Quality and risk data including incident summary, complaints data and HQCC audit data and reports; and
- Action plans and progress reports on matters arising from previous meetings.

An agenda covering the above issues will be provided prior to the meeting. The systems to be used to gather and monitor performance data are outlined in Schedule 3, Part 2.

2.c Workforce Training and Education

Ramsay recognises that one of the key retention strategies for staff is access to training and development. Ongoing training and development also underpins the consistent delivery of high quality services.

Training and education in Ramsay facilities, which will include the Facility, is managed at both a Ramsay organisation wide level and at a local level within the hospital.

RAMSAY TRAINING INSTITUTE

Resources provided at a national level include the Ramsay Training Institute (RTI). The RTI is a registered training organisation. The RTI's function is to provide accessible, up-to-date and appropriate training resources for staff anywhere across the organisation.

The RTI offers clinical, non-clinical and management development training and education. Previously hospital orientation, initial and ongoing mandatory competency training occurred entirely at site level on a face to face basis. A component of all these education programs is now provided in an e-learning environment developed and administered by the RTI. This ensures consistency of content across the country and provides an accurate record of individual staff members training dates and progress, thus ensuring strict compliance reporting by hospitals. The on line modules include an assessment component to ensure staff achieve the required competency. The e-learning modules are then complimented with local face to face programs specific to that hospital.

This RTI E-learning Orientation program covers: General Orientation; Customer Service; Fire & Security; Workplace Diversity; Occupational Health & Safety; Infection Control.

The RTI also provides a range of modules for the ongoing education of staff. Examples of some of the many modules include:

- 5 modules of ortho-anatomy;
- Medications and calculations;
- Online Diploma of Nursing;
- People skills on line;
- Peri operative fundamentals;
- Maternity Fundamentals;
- Manager Fundamentals; and
- Future Leaders.

The training modules currently in use across Ramsay will be used to skill up new staff at the Facility.

CLINICAL TRAINING

Ramsay is regarded as one of the leaders in clinical training in the private health sector.

Ramsay will apply for accredited training status with a number of Medical Colleges in order to provide accredited training positions for Registrars at the Facility on the Kawana Site. Ramsay currently enjoys accredited training status with all relevant medical specialist training Colleges with which it engages in Registrar training at other hospitals. Specialties to target will include medicine, surgery, anaesthetics, and orthopaedics. These accredited training positions could be shared across the Kawana Site to enable registrars to undertake rotations through both SCUH and the Facility, thereby providing an extremely comprehensive casemix training experience for specialist trainees.

RAMSAY NATIONAL LIBRARY SERVICE

The Ramsay National Library Service currently provides a broad range of online reference resources to all Ramsay staff and is available 24/7 via the Ramsay Intranet and the Internet. The Ramsay National Library Service subscribes to reference resources such as:

- Medline
- ProQuest
- Psychology and Behavioural Sciences Collection
- Best Practice (a medical decision support tools from BMJ)
- A comprehensive selection of journals
- More than 200 on-line books

In addition to providing learned article sourcing to staff utilising its own subscription base, Ramsay's inter-library loan services enable journal articles to be obtained through a range of collaborative arrangements in place with other academic information providers.

TRAINING AND EDUCATION AT A LOCAL LEVEL

The Facility will employ staff dedicated to education and training in the Facility. In addition to hospital wide education staff, many specialty areas will have dedicated Staff Development positions for example in ICU and Operating Theatre and Cardiac Services. The site Staff Development Co-ordinator will be responsible for developing and implementing an organisation wide education plan which covers the education needs of all categories of staff. The specific education needs of each department will be identified and programs will be developed to target these areas. In addition to clinical education, these programs will also target non-clinical competencies such as customer service, food handling, workplace health and safety and administrative issues such as the Privacy Act.

2.d Patient and Stakeholder Management and Communication

Ramsay acknowledges that there will be a need to conduct significant communication with patients and stakeholders both during the commissioning phase and at the commencement of and during the Term. Ramsay recognises the need to work closely in conjunction with QH to ensure that a consistent message is communicated by all parties. The appointed Chief Executive Officer will be responsible for working with QH particularly in relation to media releases and formal communication initiatives.

A significant part of the success of our existing Ramsay facilities has been our effective integration into the local communities in which we operate through a range of management strategies and structured communication plans. We will further develop the existing relationships that Ramsay already has on the Sunshine Coast with specialists, GPs, patients and other stakeholders and we believe that these strong relationships will help us to further integrate with all local stakeholders and ensure that we continue to meet their needs and requirements.

PATIENTS

Ramsay will use extensive patient information tools and resources such as websites, preadmission information brochures, videos and open days to ensure effective communication to patients regarding the services available at the Facility. In addition, close liaison with the major clinical non-government organisations (e.g. National Heart Foundation, National Stroke Foundation, Diabetes Australia) will ensure that the clinical services at the Facility will reflect the NHMRC endorsed evidence-based clinical practice guidelines promulgated by these health consumer organisations. Ramsay has very well established links to many of these consumer groups. Through these resources we aim to provide patients with better access and information regarding our services and also to allow them to familiarise themselves with our facilities and services before admission thereby reducing their anxiety and any unknown factors.

We will take into consideration the special needs of ethnic groups through ensuring appropriate information/interpretation services are available.

The website will be a main tool for communication and information containing:

- lists of services;
- doctors accredited to the Facility;
- access and parking arrangements;
- visiting hours; and
- support services and accommodation for carers.

SPECIALISTS

Specialists on the Sunshine Coast will be a key stakeholder group in communications about the commissioning of this Facility and during the operational phase. Ramsay management has excellent working relationships with specialists and the strength and depth of these relationships are a performance measure for our hospital managers. We propose to draw upon our existing relationships with specialists on the Sunshine Coast to establish information about services to assist in developing their practices on the Sunshine Coast and develop services to meet the current and future needs of the community. We also propose to communicate with specialists in other regions, and to market the advantages of establishing specialist practice on the Sunshine Coast region via promotional meetings, e-newsletters and our doctor website (www.opp4docs.com.au) to bring more specialists to the region. The attractiveness of the Sunshine Coast as a destination for specialist practitioners – particularly those seeking to establish practice for the first time – should not be underestimated and Ramsay will invest considerable resources into specialist establishment programs and other attraction and retention initiatives.

GENERAL PRACTITIONERS (GPs)

Ramsay's ability to effectively cooperate and communicate with local GPs is regarded as one of our key management successes. Local referring GPs will be kept fully informed both during the commissioning phase and after opening through regular newsletters, GP education forums and through direct communication from the Chief Executive Officer of the hospital. We will also facilitate formal presentations at local Divisions of General Practice and the Sunshine Coast Local Medical Association, where required and will involve GPs in discussions about the development of future services, discharge communication and access issues.

GP education evenings will be used as a way of promoting the specialists and services at the hospital and provide a communication channel between the hospital and GP's. Ramsay is an accredited provider of GP education with the Royal Australian College of General Practitioners (**RACGP**).

The Electronic Discharge Summary module of Ramsay's 'Meditech' patient information system will allow for comprehensive discharge information to be transmitted to participating General Practices. This system is currently being developed at Joondalup in Western Australia and can also be implemented at the Sunshine Coast.

NAMBOUR HOSPITAL

We propose to have regular meetings with the Nambour Senior Management team to ensure smooth operations between the facilities.

QUEENSLAND AMBULANCE SERVICE (QAS)

Ramsay has very effective working relationships with the QAS on the Sunshine Coast. This works to the benefit of both parties and Ramsay will be proposing that regular meetings with the QAS occur as part of our management approach.

OTHER SOCIAL CARE ORGANISATIONS

Ramsay has extensive links to local social care organisations on the Sunshine Coast through existing hospitals. These organisations include

- aged care assessment teams (**ACATs**);
- Nursing Homes;
- Home support organisation such as Domiciliary Nurses, Meals on Wheels, and Home Help;
- Patient support groups such as Palliative Care Support Services, Carer Support Services; and
- National organisations such as National Heart Foundation, National Stroke Foundation and Cancer Council of Australia.

Ramsay will draw upon these relationships to ensure that patients of this Facility are linked where necessary with these important social care organisations and that information is appropriately available for our patients and their carers in the Facility.

OTHER STAKEHOLDERS

Practice managers, pharmacists, optometrists, physiotherapists, MPs, local council, local community groups and the media make up the list of other stakeholders who we believe need to be kept informed of developments at the hospital and Ramsay will aim to do this to the best of our ability and in conjunction with QH where required.

2.e Bed Management System

Bed management will be done via the Meditech patient information system.

Within Meditech's admission modules, a specific component is 'the Bed Board'. The Bed Board shows the status of all beds including

- Occupied beds
- Available beds by
 - Ward / location
 - Cleaned and ready to occupy
 - Gender (in the case of shared rooms)
- Beds becoming available
 - Discharged, but not yet cleaned
 - Pending Discharge
 - Available but nominally reserved for an incoming patient. (This may be for patients currently in a QH ED to be transferred and admitted to the Facility, patients in Day of Surgery Admission Centre or booked and confirmed elective patients.)

Access to the Bed Board is provided to bookings and admission staff, ward clerks, A&E clerical staff and after hours co-ordinators. The system updates on a live basis. Using the information on the Bed Board, patients are able to be booked to an appropriate ward and bed in the system.

The system is also able to handle day chairs, such as renal dialysis and chemotherapy chairs, on the same basis as described above for inpatient beds. Reference is made above to reserving beds for patients being admitted through the DOSA – Day of Surgery Admission Centre. Whilst not specifically allocated to a bed whilst in DOSA, the system is able to track overnight patients being admitted via the DOSA and allocate a ward bed to be available on their return from theatre.

Day beds can be designated public or private on a daily basis to accommodate that day's demand and clearly show on the bed board, the number of Public Patients in the Facility.

Ramsay will provide QH with visibility of the Meditech Bed Board. This will enable visibility of bed utilisation and availability.

Ramsay does not have a clinical electronic patient record system, however the Meditech system contains some basic clinical information (eg admission diagnosis, procedures undertaken, coding information etc) which Ramsay will provide QH electronic visibility to. Ramsay notes that QH visibility will be granted whilst ensuring that confidentiality is maintained for Private Patients who will also have records in the database and to ensure compliance with privacy laws.

Ramsay will provide a dedicated email or web based booking system for QH.

Access to Meditech and the web based booking system will be established well before opening to ensure time for testing and verification.

3 Infection Control

MISSION STATEMENT

The Facility will maintain a safe environment for patients, visitors and health care workers through the effective implementation of a comprehensive Infection Control Management Program ensuring compliance with guidelines outlined by the Centre for Healthcare related Infection Surveillance and Prevention and Queensland Health, current legislation and best practice standards.

INFECTION CONTROL MANAGEMENT PROGRAM

The initial stage of this program involves the minimisation of infection risks through the appropriate design and construction of the Facility in accordance with:

- Australasian Health Facility Guidelines Part D – Infection Prevention and Control (May 2009);
- Australasian Health Facility Guidelines Part E – Building Services and Environmental Design (May 2009);
- Australian Guidelines for the Prevention and Control of Infection in Healthcare (currently draft - NHMRC);
- Australian Standards;
- HB 260-2003 Handbook: Hospital acquired infections – Engineering down the risk (2003);
- Infection control guidelines for the prevention of transmission of infectious diseases in the health care setting (January 2004);
- Queensland Development Code MP5.5 Private Health Facilities (November 2007);
- Queensland Health Capital Works Guidelines Building and Refurbishment: Infection Control Guidelines (January 2002);
- Queensland Health Private Health Facilities Act Standards 1999;

Of design and construction importance there are a number of features that ensure the Facility aligns with the proposed Infection Control Management Program which includes:

- 100% of inpatient accommodation is in a single room (excluding ICU/CCU) with clinical hand basins and private ensuites significantly minimising the risk of infection transmission;
- All walls and ceilings are high impact resistant and surface coatings are easily cleanable;
- All bench and splash back surfaces are impervious and continuous to ensure ease of cleaning and prevent the harbour of micro-organisms;
- Provision of isolation rooms in both ICU, Emergency and inpatient accommodation as per Standards Australia HB2607 AHCFG Part D;
- Separated clean and dirty utility rooms on the inpatient units to reduce all risk of cross contamination;
- CSSD has been designed to reduce the risk any process backflow and movement of staff through different work areas. The use of mechanical decontamination processes reduces the risk of transmission or injury mechanism to staff;
- All operating theatres, procedure rooms and CSSD will be appropriately ventilated according to the above guidelines;
- Cooling towers and reticulated water systems will be designed to minimise microbiological contamination; and

OBJECTIVES

The objectives of the program are to ensure the risk of transmission of infection to patients, employees and visitors is minimised and that the safety and quality of health care at the Facility is continually improved in relation to infection prevention and control.

EXPECTED OUTCOMES

Infection prevention and control will be a core part of the Facility's Clinical Governance framework and will maintain a high clinical profile which will be achieved by:

- The development and annual review of an infection control business/management plan;

- Early identification of infection risks or events through a comprehensive surveillance and monitoring program and reported to appropriate parties;
- Effective outbreak management complying with Queensland Health and Ramsay requirements;
- Staff will be educated in infection prevention and control through orientation and ongoing education and the compliance monitored with the hospital's infection control policies and procedures.

To ensure the outcomes are achieved the program will be supported by:

- The Facility's executive team;
- A Committee membership, with appropriate expertise and commitment, and the authority to develop and enforce infection control policies and procedures;
- Regular meetings and the broad dissemination of findings;
- Use of the risk management process to identify context specific infection risks and target resources appropriately;
- Application of the principles of continuous quality improvement;
- Clear lines of communication, internally and externally;
- A means for evaluation of program effectiveness.

ELEMENTS

The elements of the Facility's Infection Control Management Program will include:

- Hand hygiene;
- Personal protective equipment;
- Management of blood and body fluid exposures;
- Infection control and employee health;
- Staff immunisation;
- Environmental hygiene;
- Pre-treatment assessment of infection control risk;
- Non-reuse of single use medical devices and reprocessing of reusable medical devices;
- Delegation of responsibility for infection control;
- Process for investigation of infection control incidents;
- Surveillance of healthcare associated infections, and monitoring trends in microbiological antimicrobial sensitivity in conjunction with pathology providers;
- Environmental surveillance of cooling tower, warm water systems and water for renal dialysis;
- Continuous staff education.

Further to this and as per the recommendations of the Australian Commission on Safety and Quality in Health Care, the Private Hospital Infection Control Program will provide a focus on prevention, performance improvement and research and will include the following:

- Implementation and participation in periodic intensive local, state, national or global health care associated reduction campaigns including application of recommendations for Healthcare Associated Infection (HAI) surveillance and reporting;
- Education regarding infection prevention core principles to all new staff and to existing staff at least annually;
- Ensuring appropriate and optimal use of antimicrobial agents (antimicrobial stewardship);
- Assessment of the infection prevention implications of new devices, procedures and technologies;

- Providing regular, meaningful feedback of HAI data to individual clinicians, specific speciality, departments/units, quality improvement, senior management and others as stipulated in the annual infection prevention business plan;
- Appraising all staff of new and emerging infectious disease threats and trends;
- Providing systems and protocols to actively manage all infection prevention components of accreditation;
- Designing, undertaking and responding to results of periodic audits and formal reviews of relevant clinical practice and performance;
- Developing appropriate methods for rapid response, remediation, investigation and evaluation of infection prevention critical incidents;
- Provision of alcohol hand hygiene products at the point of care;
- Regular education of staff and monitoring of hand hygiene compliance in accordance with the Hand Hygiene Australia 5 moments of Hand Hygiene program;
- Monitor, address and evaluate the educational needs of staff;
- Ensure surveillance and HAI monitoring strategies are designed and driven according to local active, performance and epidemiologically significant organism trends.

RESOURCES

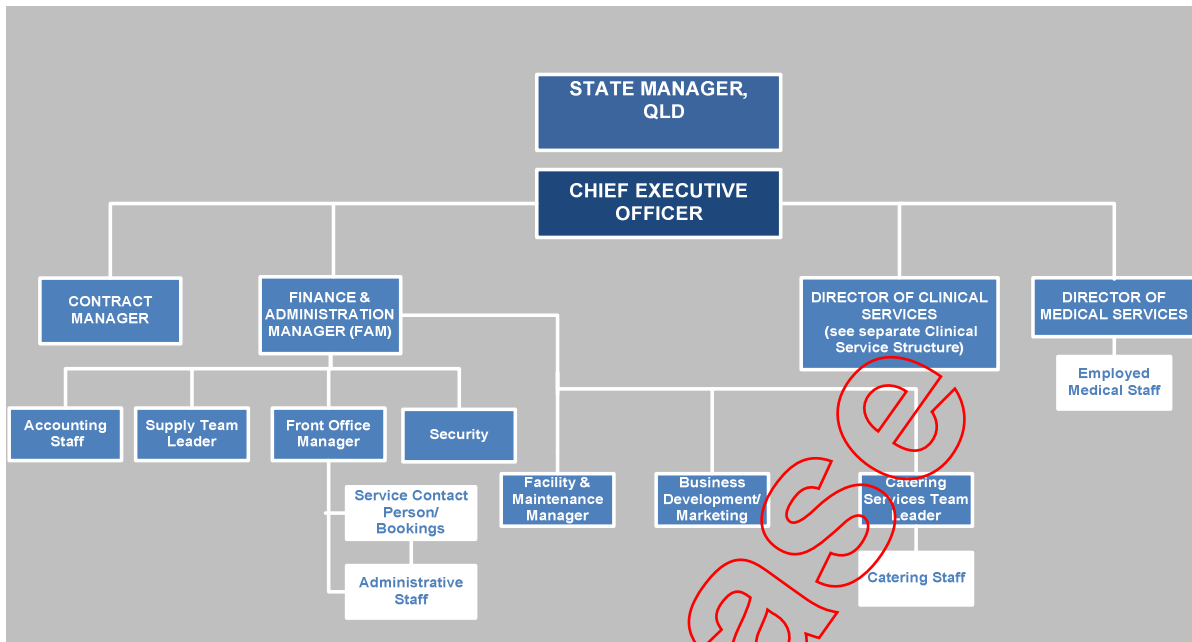
The Infection Control Management Plan will be coordinated by an appropriately qualified infection control practitioner, resourced in accordance with national infection control guidance. The role and responsibilities of this person will include:

- Education and training of employees;
- Data collection and surveillance activities;
- Development and/or implementation of policies and procedures;
- Staff health;
- Consultancy – to staff, patients, visitors and others;
- Risk management;
- Incident management, Blood and Body Fluid Exposure Incidents, Outbreak Management, Adverse Events.

4 Operational Organisation Chart

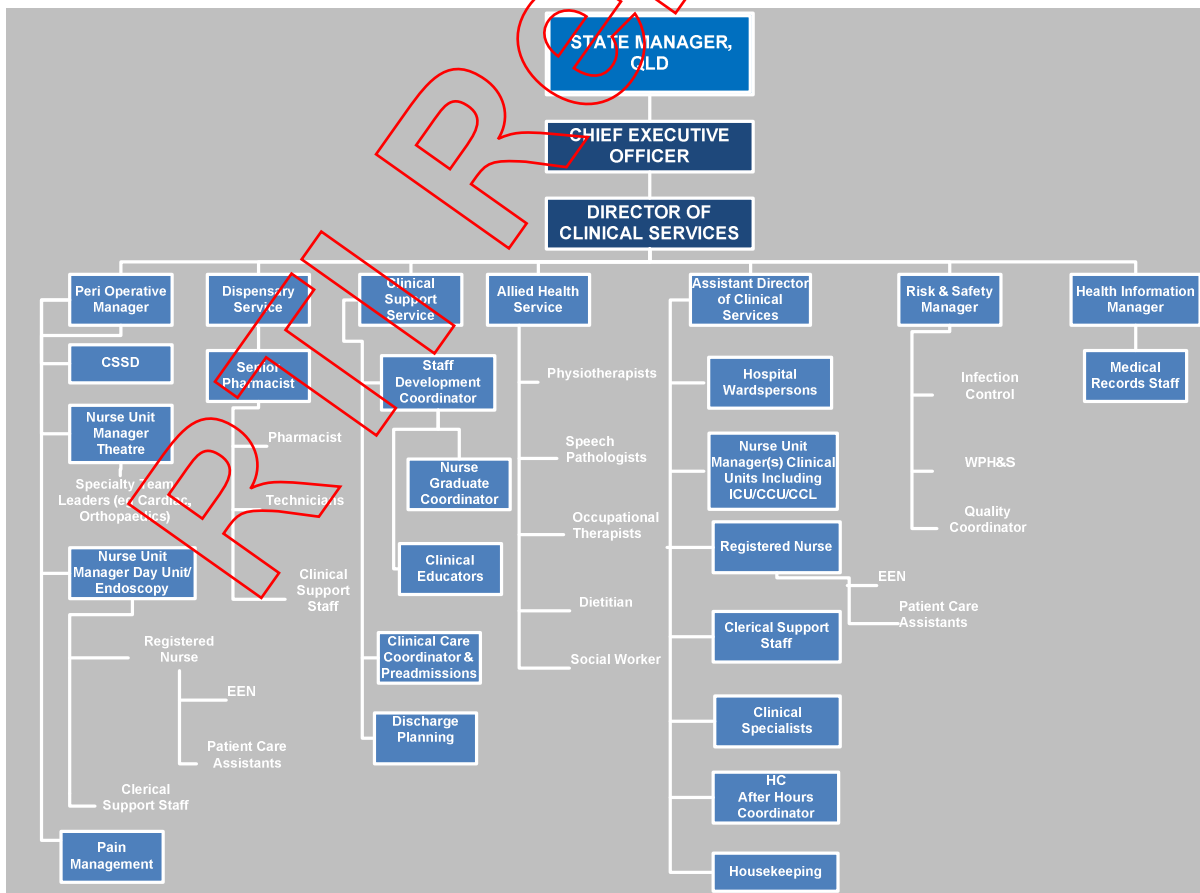
The chart below sets out the structure of Ramsay's team for the delivery of Contracted Services.

THE FACILITY
(Hospital Support Services Structure)



The chart below expands on the structure of the team reporting to the Director of Clinical Services.

THE FACILITY
(Clinical Services Structure)



5 Key Role Descriptions

The executive management team for the Facility will comprise of a Chief Executive Officer, Director of Clinical Services, Director of Medical Services, Finance and Administration Manager and a Contract Manager. Full position descriptions have not been provided given the lengthy nature of those documents. A role summary has been provided.

CHIEF EXECUTIVE OFFICER

Position Title	Chief Executive Officer
Reports to:	State Operations Manager - Qld
Position Summary:	To provide leadership and strategic direction for hospital staff and functioning whilst establishing and maintaining strong links with the medical community so that the Facility provides excellent patient care while meeting its operational and business objectives.
Key Elements of the Role Include:	<ul style="list-style-type: none"> ▪ Leadership and Management: <ul style="list-style-type: none"> - Foster a culture that embraces and supports The Ramsay Way - Leadership and team building - Communication, consultation and change management - Stakeholder management (internal/external) - Foster a cooperative relationship with SCUH management team ▪ Strategic Direction: <ul style="list-style-type: none"> - Development and implementation of: <ul style="list-style-type: none"> ▪ Strategic Plan ▪ Corporate Governance Plan ▪ Services and Facilities Management Plan ▪ HR / Workforce Plan ▪ Clinical Governance Plan ▪ Risk Management Plan ▪ Operational/Financial Plan ▪ Workplace Health and Safety Plan ▪ Operational: <ul style="list-style-type: none"> - Monitor and manage the overall performance of the organisation against key performance criteria ▪ Organisation Culture <ul style="list-style-type: none"> - Promote a culture of continuous improvement - Promote a customer focused culture

DIRECTOR OF CLINICAL SERVICES

Position Title	Director of Clinical Services and Quality Manager
Reports to:	Chief Executive Officer
Position Summary:	The Director of Clinical Services and Quality Manager provides clinical leadership and operational management to support and meet the business clinical and workforce objectives of the Facility and Ramsay.
Key Elements of the Role Include:	<ul style="list-style-type: none"> ▪ Leadership and Management: <ul style="list-style-type: none"> - Lead and manage the nursing service in accordance with <i>The</i>

	<p><i>Ramsay Way</i></p> <ul style="list-style-type: none"> - Team building - Communication, consultation and change management <ul style="list-style-type: none"> ▪ Clinical Governance: <ul style="list-style-type: none"> - Develop and implement Clinical Governance systems to support: <ul style="list-style-type: none"> ▪ The delivery of high quality patient care ▪ A culture of continuous improvement ▪ Risk identification and minimisation strategies ▪ A safe environment for staff, patients and visitors ▪ Strategic Direction: <ul style="list-style-type: none"> - Contribute as a member of the Executive Management Team to the development of the Strategic Plan, Workforce Plan, Service, Facilities and SCUH Campus Plan and Governance and Risk Management Plan ▪ Workforce: <ul style="list-style-type: none"> - HR planning and management - Workforce utilisation and reporting
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DIRECTOR OF MEDICAL SERVICES

Position Title	Director of Medical Services
Reports to:	Chief Executive Officer/Director of Clinical Services and Quality Manager
Position Summary:	The Director of Medical Services' position forms part of the executive management team. The role provides leadership and direction to employed and credentialed medical staff and is responsible for ensuring appropriate standards are maintained, timely and effective clinical review occurs and an environment of learning and development is achieved.
Key Elements of the Role Include:	<ul style="list-style-type: none"> ▪ Leadership and Management: <ul style="list-style-type: none"> - Actively lead and manage the medical workforce according to <i>The Ramsay Way</i> - Leadership and team building - Communication, consultation and change management ▪ Operational Quality: <ul style="list-style-type: none"> - Policies and Procedures - Appropriate clinical review - Risk minimisation strategies - A culture of clinical service improvement - A safe environment ▪ Other: <ul style="list-style-type: none"> - Internal and external medical stakeholder liaison and management

CONTRACT MANAGER

Position Title	Contract Manager
Reports to:	Chief Executive Officer

<p>Position Summary:</p>	<p>The Contract Manager is responsible for the management of the day to day relationship and contract between the Facility and QH to ensure an effective working partnership for the delivery of Public Patient care and a co-operative relationship across the Kawana Site.</p>
<p>Key Elements of the Role Include:</p>	<ul style="list-style-type: none"> ▪ Leadership and Management: <ul style="list-style-type: none"> - Actively lead and manage according to <i>The Ramsay Way</i> - Foster a cooperative and constructive relationship with key QH staff - Communication with key stakeholders ▪ Operational: <ul style="list-style-type: none"> - Monitor and report on key aspects of the Services Agreement including activity reporting, clinical indicators and other quality performance measures - Development of action plans as required - Be responsible for organising and chairing the Services Review Committee - Develop activity forecasts for the establishment of annual activity plans - Develop transition plans for the start up as well as transfer of public patient services.

FINANCE AND ADMINISTRATION MANAGER

<p>Position Title</p>	<p>Finance and Administration Manager</p>
<p>Reports to:</p>	<p>Chief Executive Officer</p>
<p>Position Summary:</p>	<p>The Finance and Administration Manager is responsible for managing the day-to-day finance and administrative functions; and providing management information and reports on a broad range of financial and administrative issues.</p>
<p>Responsibilities Include:</p>	<ul style="list-style-type: none"> ▪ Operational: <ul style="list-style-type: none"> - Financial and management reporting - Budgets - Fixed assets - Revenue management - Preparation of financial indicators - Data collection - Audit - Taxation ▪ Workforce: <ul style="list-style-type: none"> - HR Planning and management - Workforce utilisation reports - Training and development - Reporting. ▪ Leadership: <ul style="list-style-type: none"> - Contribute to executive management key initiatives - Team building - Change management and consultation

- Lead and manage adhering to the principles of *The Ramsay Way*
- Other:
 - Contribute to Business Development activities
 - Foster a culture of Continuous Improvement
 - Actively participate in risk minimisation strategies

6 Key Role Selection Criteria

Ramsay agrees to establish a Services Review Committee within 20 days of the commencement of the Services Agreement. The committee will be attended by the Contract Manager accompanied by either the Facility Chief Executive Officer or the Finance and Administration Manager.

The key selection criteria as it appears in each of the relevant position descriptions is provided below.

6.a Contract Manager

CONTRACT MANAGER

Position Title	Contract Manager
Qualifications/Key Selection Criteria – Essential:	<ul style="list-style-type: none"> ▪ Possession of or progressing towards a relevant tertiary qualification and or relevant experience ▪ Well developed skills in <ul style="list-style-type: none"> - Report analysis and report writing skills - Problem solving and analytical skills - Financial, commercial and administration and organisation skills - Communication, (written and verbal) and interpersonal skills - Negotiation and conflict resolution - Computer literacy skills ▪ Extensive experience in hospital data analysis and reporting ▪ Demonstrated experience and understanding of hospital casemix ▪ Knowledge of current healthcare issues ▪ Experience in strategic planning and implementation of service improvement strategies ▪ Demonstrated management skills at a senior level ▪ Experience in interpretation of legal contracts ▪ Ability to use initiative, self motivation and work as a team member

6.b Senior Representatives on the Services Review Committee

CHIEF EXECUTIVE OFFICER

Position Title	Chief Executive Officer
Qualifications/Key	<ul style="list-style-type: none"> ▪ Relevant tertiary qualifications (preferably Masters level) and an

Selection Criteria – Essential:	<p>excellent understanding of current health industry issues</p> <ul style="list-style-type: none"> ▪ Proven leadership, strategic planning experience and risk management skills ▪ Experience managing a large group in a commercial context – must possess strong business acumen ▪ Demonstrated experience in leading change in a health care environment ▪ Knowledge of health funding pertaining to private/public health sectors and working knowledge of statutory and local government requirements ▪ Excellent decision-making capabilities, people management skills, communication, negotiation and interpersonal skills including demonstrated experience in liaising with a wide range of internal and external stakeholders
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FINANCE AND ADMINISTRATION MANAGER

Position Title	Finance and Administration Manager
Qualifications/Key Selection Criteria – Essential:	<ul style="list-style-type: none"> ▪ CPA or ACA qualifications/relevant tertiary qualifications, with strong business acumen and the ability to analyse, interpret and utilise data to improve organisational performance and identify opportunities ▪ Proven ability to successfully lead and motivate a diverse group of management and staff providing strong strategic direction ▪ A successful track record managing change in a complex, multidisciplinary environment ▪ Excellent communication and interpersonal skills and a demonstrated ability to liaise with and influence those in senior management positions ▪ Demonstrated commitment to quality improvement activities and excellence in customer service ▪ Sound computer skills
Qualifications/Key Selection Criteria – Desirable:	<ul style="list-style-type: none"> ▪ Previous experience in the health care sector

6.c Service Contact

SERVICE CONTACT OFFICER / BOOKINGS

Position Title	Service Contact Office / Bookings
Qualifications/Key Selection Criteria – Essential:	<ul style="list-style-type: none"> ▪ Effective communication and interpersonal skills ▪ Proven ability to work effectively in a team environment and independently as required ▪ Strong Customer services skills ▪ Computer literacy ▪ Previous experience in a health care administrative role ▪ Certificate of proficiency in medical terminology ▪ Experience with hospital IT systems preferably Meditech

- Experience with bookings systems
- Relevant health services experience

7 Ramp Up and Transition of Services

Ramsay acknowledges that the commissioning periods for both the Facility and the SCUH will be significant events on the Kawana Site that will require complex management and co-ordination. In particular, the ramp up of the SCUH and transition of public patient care to the new facility must be done in a way that results in a seamless transition that maintains high quality care to patients.

COMMISSIONING AND RAMP UP OF THE FACILITY

Ramsay will complete commissioning of the Facility before 2 December 2013 and will use its best endeavours to commission the Facility and commence services to Private Patients prior to this date to provide a period where the Facility can operate with limited capacity in order to verify that all systems and services are fully functional prior to commencement of the Services Agreement. During this time, Ramsay will commence Private Patient services, which will generally be similar services to those required by the Services Agreement, but lower patient volumes.

Ramsay will therefore be able to operate the Facility on a lower activity level to ensure that patient flows and procedures are fully trialled, settled and operational prior to commencing services for the larger volume of Public Patients.

Prior to any patients being cared for in the Facility, the pre-commissioning phase will be used to train and orientate staff to the Facility. All staff will be required to undertake the Ramsay e-learning orientation package followed by face to face training in the Facility to achieve competencies in safety and emergency procedures. Further orientation will then occur in their specific department environment.

To manage the Commissioning and Ramp Up Stage, Ramsay will (in consultation with QH) prepare a Pre-Opening Ramp Up Plan incorporating issues such as:

- The development of a detailed communication plan that will incorporate a process for consultation
- Strategies to mitigate or minimise key risks with key stakeholders and ensure that QH, staff, doctors and the local community are kept fully informed of opening activities, admission protocols etc
- Detailed timetable for commencement of services
- Commissioning schedule for each clinical specialty and clinical support areas
- Workforce recruitment strategies and timetables
- Development of key policies and procedures particularly relating to admission, treatment and discharge/transfer of Public Patients, monitoring of KPI's and key reporting protocols
- Identification of key staff and roles and responsibilities, and
- Establishment of key campus committees.

The Facility will have a Strategic and Operational Plan. The plans will cover strategic initiatives, risk management plan, workforce plan, quality plan and operational plan (including throughput by specialty). The initial plans for the Facility will include commissioning and initial operational considerations and strategies including:

- Workforce strategies to recruit the required staff (HR and Workforce Plan)
- Performance monitoring (Quality Plan)
- Activity forecast.

All plans will clearly delineate timelines and responsibilities.

On opening, all hospital wide and departmental policy and procedure manuals will be available in hard copy and on the Facility Intranet.

RAMP UP AND TRANSITION OF SERVICE TO SCUH

Ramsay will work in partnership with QH to ensure safe and efficient services are provided during this period. Ramsay will provide all reasonable assistance to QH to co-ordinate the orderly transition of services.

Integral to this will be the development of a “Transition Plan”. The Transition Plan will be developed by Ramsay in consultation with QH. The Plan will cover issues such as:

- A timeline showing the timing that each service stream will transition to the SCUH. Ramsay agrees that the transition should be done service stream by individual service stream to ensure an orderly and planned transition to SCUH. In this way, an individual service will only be provided in one facility at a time and they will not become fragmented across both facilities;
- Details on how each service stream will wind down for Public Patients in the Facility and commence in SCUH;
- A nominated person responsible for the transition of each service. The nominated person will be required to have a detailed action plan setting out tasks, responsibilities and timelines for each stage of the transition of each service stream
- Any additional staffing required during the transition and transfer period
- Any additional equipment that may be required during the transition and transfer period
- Details of how patient information will be transferred across to SCUH
- A detailed communication plan to ensure that all stakeholders are aware of key components of the transition plan, including staff at the Facility, patients, QH and District representatives and any community organisations and services associated with the SCUH.

Ramsay will at the conclusion of the Services Agreement work closely and cooperatively with QH to identify any staff who are no longer required to work at the Facility and who may wish to take up employment with QH in the SCUH. Such co-operation could include access to staff to conduct information sessions about employment opportunity with QH and negotiating finish and start dates to mirror the transfer of services to minimise disruption.

Attachments

- 1 – Ramsay incident classification

TABLE 1: RAMSAY HEALTH CARE RISK CODES

DEFINITIONS	Minimal	Minor	Moderate	Major	Serious	DEFINITIONS	
	An Incident* with no injury, increased level of care or length of stay	An incident* that requires an increased level of care, additional investigations or referral to another clinician	An incident* that results in temporary reduction in bodily functioning	An incident* that results in permanent reduction in bodily functioning	An incident* that results in an unexpected death or any of the National Sentinel Events		
EXAMPLES							
EXAMPLES	Missed medication	Medication error requiring medical review and additional observations	Meconium aspiration resulting in transfer / admission to SCN / NICU without intubation	Meconium aspiration resulting intubation / ventilation	Suicide within 7 days of discharge from hospital	EXAMPLES	
	Slip/Trip/Fall with no injury	Fall requiring review by orthopaedic team and investigation / X-Ray with no injury	Neonatal shoulder dystocia with no evidence of neurological damage	Neonatal shoulder dystocia resulting in fracture and / or ERBS palsy	National Sentinel Events 1. Inpatient Suicide, 2. Maternal or neonatal death associated with labour and delivery, 3. Medication error resulting in death, 4. Procedures involving wrong patient or body part, 5. Retained instruments, 6. Retained material requiring surgical removal, 7. Intravascular gas embolism resulting in death, 8. Wrong patient blood transfusion or ABO incompatibility, 9. Infant discharge to wrong family		
	Results filed in wrong medical record	Investigation results not acted upon requiring further review and investigation	Neonatal transfer of baby > 38 weeks	Failure to detect a neonatal abnormality			
	Patient with no identification label		Neonate with acidotic pH requiring admission to SCN or NICU	Neurological damage following any surgical procedure			
			Neonate with apgars < 5 at 10 minutes	Hypoxic brain damage			
	The examples provide in this matrix are for guidance only. They do not represent a comprehensive list of healthcare incidents. Each incident should be reviewed independently against the definitions, for consequence or outcome.		Patients requiring an increased length of stay	Patients suffering significant disfigurement as a consequence of the incident			
			Patients requiring surgical intervention as a result of the incident**	Incidents affecting more than one patient			
			Incidents involving patient / neonatal identification**	Outbreak / occurrence of disease or colonisation of 2 or more related cases			
			Incidents involving breach in infection control / sterilising systems**				
			*An incident is an unplanned event that results in or has the potential to result in injury, damage or loss. It is unrelated to the natural course of illness and differs from the expected outcome of patient management				
		**Incidents requiring surgical intervention, involving patient identification and breaches in infection control and sterilising may be rated as moderate, major or serious depending on outcome					
	Minimum	Minor	Moderate	Major	Serious		

Schedule 2 Performance Standards

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RTI Release

Part 1 - Specification

1 Clinical services capability

During the Term, the Operator shall offer the clinical services set out in Table 2 to Public Patients:

- (a) to at least the capability set out in Table 2, with such capability determined in accordance with the CSCF; and
- (b) for services listed as 'on-site' services, at the Facility.

TABLE 2: CLINICAL SERVICES CAPABILITY

Core clinical Service Streams (on-site)	Level
General Medicine	5
General Surgery	5
Respiratory Medicine	5
Orthopaedics	5
ENT	5
Other clinical Service Streams (on-site)	Level
Gastroenterology	5
Colorectal Surgery	5
Neurosurgery	4
Plastics Surgery	5
Urology	5
Cardiology	5
Endocrinology	5
Supporting clinical services (on-site)	Level
Anaesthetics	5
Critical Care	ICU5/CCU5
Diagnostic Imaging	4
Operating Suite	5
Pathology	4
Pharmacy	4
Supporting clinical services (on-site or off-site)	Level
Nuclear Medicine	4

2 Clinical services capacity

2.1 Aggregate activity limits

Each Financial Year during the Term, the Operator shall make available clinical services capacity at the Facility, in aggregate for all Service Streams, of at least the Upper Limit for the Financial Year set out in Table 3.

TABLE 3: AGGREGATE ACTIVITY LIMITS (IN WAUs) FOR ALL SERVICE STREAMS

Financial Year	Aggregate activity target (in WAUs)	Aggregate Lower Limit (in WAUs)	Aggregate Upper Limit (in WAUs)
2013/14			
2014/15			
2015/16			
2016/17			
2017/18			

2.2 Per Service Stream activity limits

- (a) Subject to section 2.2(b), each Financial Year during the Term, the Operator shall make available clinical services capacity at the Facility, for each Service Stream, of at least the Upper Limit for the Service Stream for the Financial Year set out in Table 4.
- (b) However, once the Upper Limit for all Service Streams is reached in a Financial Year (refer section 2.1), the Operator is not obliged to make available further clinical services capacity in any Service Stream for the remainder of that Financial Year.

TABLE 4: ACTIVITY LIMITS (IN WAUs) BY SERVICE STREAM

Service Stream	2013/14		2014/15		2015/16		2016/17		2017/18	
	Lower	Upper	Lower	Upper	Lower	Upper	Lower	Upper	Lower	Upper
General Medicine										
General Surgery										
Respiratory Medicine										
Orthopaedics										
ENT										
Gastroenterology										
Colorectal Surgery										
Neurosurgery										

Service Stream	2013/14		2014/15		2015/16		2016/17		2017/18	
	Lower	Upper	Lower	Upper	Lower	Upper	Lower	Upper	Lower	Upper
Plastics Surgery										
Urology										
Cardiology										
Endocrinology										

3 Managing referrals

3.1 Contact point

At all times during the Term, the Operator shall identify to QH the Operator's service contact point for the referral of Public Patients to the Facility and discharge or transfer of Public Patients from the Facility, which will be available 24 hours a day, 7 days a week.

3.2 Accepting referrals

Subject to section 3.3, the Operator acknowledges that the Operator is expected to accept all referrals from QH provided that:

- (a) QH has issued a Referral Order for the relevant Public Patient via the Agreed Platform in accordance with clause 7.1 of the Services Agreement;
- (b) the Public Patient has completed a Service Initiation Pathway and is appropriate for treatment at the Facility;
- (c) for Direct Admission Patients, the Facility has:
 - (1) for a medical Direct Admission Patient, a Dedicated Medical Acute Bed or a Dedicated Flexible Acute Bed;
 - (2) for a non-medical Direct Admission Patient, a Dedicated Flexible Acute Bed, or
 - (3) in either a case, another bed, available as shown on the Bed Management System at the time the Referral Order is issued. The parties acknowledge that Direct Admission Patient demand for beds at the Facility is likely to exceed the number of Dedicated Medical Acute Beds and Dedicated Flexible Acute Beds, and the Operator:
 - (4) is not required to keep beds available for Direct Admission Patients other than under sections 3.3 and 3.4 of Part 1 of Schedule 1; but
 - (5) must use all reasonable endeavours to work cooperatively with QH to ensure that the Operator accepts a sufficient number of referrals in the medical Service Streams to enable the Referral Target for those Service Stream to be reached in each month; and
 - (6) for the avoidance of doubt, provided that the Operator generally manages its admissions in accordance with section 3.2(c)(5), is not required to cancel or defer any booked Private Patient in order to make a bed available for a Direct Admission Patient under section 3.2(c)(3); and

- (d) in respect of the Contracted Services provided by the Operator at the Facility:
- (1) during the relevant month, the number of referrals has not already exceeded the Referral Limit for the relevant Service Stream for that month; and
 - (2) during the relevant Financial Year to date, the activity (expressed in WAUs) has not already exceeded:
 - (A) the Upper Limit for the relevant Service Stream for the Financial Year; or
 - (B) the aggregate Upper Limit for all Service Streams for the Financial Year.

3.3 Additional rules in relation to referrals

- (a) For the purposes of section 3.2:
- (1) a Public Patient will be deemed to be 'appropriate for treatment at the Facility' if the primary purpose of the admission is to receive treatment in a Service Stream, and the Public Patient is within the Contracted Services capability set out in Table 2 of this Schedule;
 - (2) before issuing a Referral Order for a Direct Admission Patient, QH must telephone the Operator's service contact point referred to in section 3.1 and verbally summarise the information about the Direct Admission Patient which is or will be included in the Referral Order. During that telephone call, the Operator's service contact must advise QH:
 - (A) whether the Operator will accept the Direct Admission Patient; and
 - (B) if the Operator refuses to accept the Direct Admission Patient, whether this is because the Operator considers that the referral does not satisfy section 3.2 (other than section 3.2(a)).
 - (3) if the Operator's service contact point advises QH that the Operator refuses to accept the Direct Admission Patient because the Operator considers that the referral does not satisfy section 3.2 (other than section 3.2(a)), and QH disagrees, QH may transmit the Referral Order for the relevant Public Patient to the Operator via the Agreed Platform. Within a reasonable period of receiving the Referral Order, the Operator's service contact must advise QH:
 - (A) whether the Operator will accept the Direct Admission Patient; and
 - (B) if the Operator refuses to accept the Direct Admission Patient, whether this is because the Operator considers that the referral does not satisfy section 3.2,

and after the Operator will be deemed to have refused to accept the Direct Admission Patient.
 - (4) QH shall not arrange or authorise the presentation of a Direct Admission Patient at the Facility unless and until the Operator's service contact point advises that the Operator accepts the Direct Admission Patient;
 - (5) if the Operator initially accepts a referral from QH in respect of a Direct Admission Patient, and the Direct Admission Patient presents at the Facility, but the Operator does not admit the Direct Admission

Patient to the Facility and the Direct Admission Patient is transferred to a QH Facility, that shall be treated as a refusal to accept the Direct Admission Patient. At the time the Operator requests the transfer to a QH Facility, the Operator must advise QH whether the Operator considers that the referral does not satisfy section 3.2 (including whether section 3.2 was satisfied when the Referral Order was made, but has ceased to be satisfied including because of a deterioration in the condition of the Direct Admission Patient); and

- (6) the Operator will be deemed to have accepted all referrals of Public Patients other than Direct Admission Patients unless the Operator advises QH otherwise via the Agreed Platform within after receiving the Referral Order.
- (b) For the avoidance of doubt, if it would be clinically inappropriate for the Operator to accept a Public Patient, including because of staff shortages at the Facility or because a suitable bed is not available, the Operator shall refuse the referral and, if the referral satisfied section 3.2, the refusal will be considered for the purposes of section 2.4 of Schedule 4.
- (c) A refused referral does not count towards the Referral Limit for the relevant Service Stream.

3.4 Operator may accept additional referrals

The Operator may, but is not required to, accept a referral from QH which does not satisfy the requirement set out in section 3.2(d). If the Operator does accept such a referral, the Operator will be paid in accordance with section 3 of Schedule 4 for the relevant Contracted Services.

3.5 Process if the Operator does not accept a referral

- (a) If the Operator is unable to accept a referral because the referral does not comply with section 3.2(a), 3.2(b) or 3.2(c), the Operator shall contact QH's point of contact for the referral of Public Patients to the Facility, discuss the reasons why the Operator is unable to accept the referral and, if capable of remedy, seek to agree how the impediment to referral can be resolved.
- (b) In the event that the impediment to referral referred to in section 3.5(a) cannot be resolved, QH will withdraw its Referral Order and refer the matter to QH's Contract Manager the next Business Day.
- (c) If the Operator does not accept a referral because the referral does not comply with section 3.2(d):
 - (1) in respect of Direct Admission Patients, the Operator shall notify QH's point of contact for the referral of Public Patients to the Facility as soon as practicable, and QH's point of contact for the referral of Public Patients may seek to agree with the Operator, and the Operator must negotiate in good faith to agree with QH's point of contact for the referral of Public Patients, how the impediment to referral can otherwise be resolved; and
 - (2) in respect of all other Public Patients, the Operator shall notify QH's Contract Manager the next Business Day and place the Referral Order 'on hold' pending agreement between the Contract Managers on either:
 - (A) withdrawal of the Referral Order, which may be re-issued at a later date; or
 - (B) a change to the Activity Forecast in accordance with section 6.5(b) of Part 1 of Schedule 1.

3.6 Timing of admissions

Subject to section 3.7, where the Operator accepts a referral in accordance with this section 3:

- (a) the Operator shall commence treatment of Direct Admission Patients within [] after receiving the Referral Order, or within [] of the Public Patient arriving at the Facility if this arrival is more than [] after receipt of the Referral Order, and must admit the Direct Admission Patient within [] after the patient arrives at the Facility;
- (b) the Operator shall commence the inpatient episode of care for all Public Patients other than Direct Admission Patients within [] after receiving the Referral Order and having regard to patient needs and clinical outcomes; and
- (c) the Operator shall communicate with all Public Patients referred to in section 3.6(b) within [] after accepting the Referral Order, or being deemed to have accepted the Referral Order under section 3.3(a)(6), to notify them of the admission process and timing.

3.7 Application of time limits to non-Direct Admission Patients

- (a) If, in any week:
 - (1) QH makes a number of referrals to the Operator in a Service Stream which exceeds [] of the Referral Limit for that Service Stream for the month in which the week occurs; or
 - (2) as a result of the prior application of section 3.7(a)(1) in the month, the aggregate of the referrals treated as having been made in the week and the referrals actually made in that week exceeds [] of the Referral Limit for that Service Stream for the month in which the week occurs,

for the purpose of applying sections 3.6(b) and 3.6(c), the referrals in excess of [] of the Referral Limit will be treated as having been made in the following week.

- (b) The referrals treated as excess referrals under clause 3.7(a) for a week will be dealt with as follows:
 - (1) on the basis of the order in which the referrals are sent to the Operator; or
 - (2) where QH sends the Operator a 'batch' of referrals, some of which are in excess of [] of the Referral Limit:
 - (A) QH may recommend a priority for some or all of the referrals in the batch, and the Operator shall take that recommendation into account in managing that batch of referrals; or
 - (B) to the extent section 3.7(b)(2)(A) does not apply, by the Operator acting reasonably having regard to the clinical needs of the Public Patients comprising the batch so far as is evident from the Referral Orders.
- (c) For the purpose of applying sections 3.6(b) and 3.6(c), the 'deemed' referral date of a deferred referral is:
 - (1) on the first occasion that referral is deferred, the day which is 7 days after the actual referral; or
 - (2) for a second or subsequent deferral, the day which is 7 days after the previous deemed referral date.

3.8 Acknowledgement

The Operator acknowledges that:

- (a) QH has no obligation to refer any particular number of Public Patients to the Facility (either overall or for any particular Service Stream); and

4 Components of the Contracted Services

4.1 Facility management services

The Operator shall provide all necessary facility management services to support the provision of clinical services to Public Patients at the Facility including:

- (a) **(facility management)** providing a high quality, effective and efficient facility management service for patients, staff and visitors using the Facility including providing a security service to a standard at least equivalent to that of comparable hospitals;
- (b) **(catering/refreshments/vending)** providing food and beverage services to support the Facility, including for patients, staff and visitors. These arrangements will offer a range of appetizing and nutritious food and drink to enable all patients, staff and visitors to have a choice which reflects their dietary needs and tastes and shall be provided to a standard at least equivalent to the QH Food Services Policy;
- (c) **(cleaning services)** maintaining a safe, hygienic and pleasing environment, incorporating safe working practices including the use of a recognised risk assessment/management system and shall in respect of infection control, comply with the standards under the *Private Health Facilities Act*;
- (d) **(linen and laundry)** providing or hiring a comprehensive linen and laundry service compliant with all relevant standards to ensure clean and appropriate linen is available in all areas and for all users at the times required and in the volumes necessary to support the smooth running of the Facility, including assurance that adequate stocks of linen are held at the Facility;
- (e) **(ward housekeeping)** providing a flexible, innovative and sensitive resource to co-ordinate all hotel services in the ward area as part of the ward team;
- (f) **(portering)** providing a high quality portering service which offers a timely, responsive and pro-active system for the movement of patients, and patient materials and equipment within the Facility;
- (g) **(reception, postal and telephony services)** establishing arrangements for and providing reception and telephony services at all times during the hours that the Facility is operational, providing a welcoming, courteous and high level of customer care to all staff, patients and visitors;
- (h) **(information and communications technology support)** establishing arrangements for and providing information and communications technology support and maintenance, including infrastructure, fast response telephone support and escalation;
- (i) **(staff work wear)** establishing arrangements for and providing staff uniforms, gowns and functional clothing;

- (j) **(sterile services)** establishing arrangements for and providing sterile services required for the Facility, compliant with all relevant standards and legislation;
- (k) **(energy and utilities management)** providing an energy and utilities management service to meet the needs of the Facility; and
- (l) **(equipment)** ensuring that equipment used in providing the Contracted Services is maintained in a safe, serviceable and clean condition, is adequately maintained, and conforms to generally accepted industry standards for equipment of the relevant type.

4.2 Clinical services

The Operator shall manage and provide all aspects of the inpatient episode of care for Public Patients including, but not limited to:

- (a) **(admission)** the admission process, once the referral of the Public Patient has been accepted by the Operator;
- (b) **(scheduling)** communications with the Public Patient, including for planned and Direct Admission Patients, notifying the Public Patient of the admission process and timing within 2 Business Days after referral from QH or (in the case of a Direct Admission Patient) as soon as reasonably practicable;
- (c) **(assessment)** undertaking any further assessment the Operator deems necessary, including diagnostic testing;
- (d) **(treatment)** provision of the required treatment to a high standard of care and in accordance with the standards set out in this Schedule 2 and having regard to what is best for the patient, including, as required:
 - (1) providing anaesthesiology treatment appropriate to the admission;
 - (2) supplying radiology and pathology testing as required for the admission; and
 - (3) supplying pharmaceutical products required for the admission, including pre, during and post surgery pharmaceutical treatment as well as a discharge pack of pharmaceuticals containing no less than 3 days' worth of pharmaceutical products;
- (e) **(discharge)** planning and implementing an effective discharge process in accordance with section 6; and
- (f) **(no fees)** ensuring the Public Patient is not charged for any aspect of their inpatient care or stay by the Operator, or for any post discharge visits associated with this care (with the exception of charges consistent with those levied by public hospitals in Queensland).

5 Standards for Contracted Services

5.1 Compliance

The Operator shall:

- (a) **(Laws etc.)** comply with, and ensure that the Contracted Services are provided in a manner that complies with, any applicable:
 - (1) Laws;
 - (2) codes of practice; and
 - (3) professional requirements,

including, without limitation:

- (4) the standards made under part 3 of the *Private Health Facilities Act*;
 - (5) the CSCF; and
 - (6) to the extent required by the *Private Health Facilities Act*, guidelines relating to best practice for specific services that are released from time to time by other recognised bodies including, but not limited to health professional registration boards, the professional colleges, the National Health and Medical Research Council (NHMRC), the Australian Health Ethics Committee (AHEC), the Australian Health Technology Advisory Committee (AHTAC), the Australian Commission on Safety and Quality in Healthcare and the Centre for Healthcare Related Infection Surveillance and Prevention (CHRISP);
- (b) **(occupational health)** without limiting section 5.1(a), ensure that the Operator's practices in providing the Contracted Services comply with any applicable occupational health and safety legislation; and
- (c) **(liaison)** liaise properly and appropriately as necessary with the Government Entities and other recognised bodies administering the Laws, ordinances, regulations, codes and requirements referred to in section 5.1(a).

5.2 Privacy and confidentiality

The Operator shall comply with the Privacy Laws. In collecting, using, disclosing or otherwise dealing with any information in respect of a Public Patient obtained by the Operator in the course of providing the Contracted Services.

5.3 Standards generally

The Operator shall:

- (a) **(quality)** ensure that the Contracted Services are provided to a standard of care and skill ordinarily required for that type of medical and hospital treatment in accordance with evidence based best clinical practice, and having regard to the overriding principle of what is best for the patient;
- (b) **(efficiency)** ensure the Contracted Services are provided in a prompt and efficient manner;
- (c) **(clinical need)** prioritise the treatment of admitted Public Patients based on clinical need; and
- (d) **(new technologies)** apply new technologies as appropriate and reasonable to meet and service the clinical needs of Public Patients.

5.4 Authorised Medical Personnel

- (a) The Operator shall ensure that the Contracted Services are performed using the Authorised Medical Personnel.
- (b) The Operator shall at all times be responsible for the performance of the Authorised Medical Personnel in performing the Contracted Services.
- (c) The Operator shall use all reasonable endeavours to ensure that the Authorised Medical Personnel:
 - (1) each have and maintain for the Term registration sufficient to authorise the performance of those Contracted Services proposed to be performed or performed by that medical practitioner:

- (A) with the Medical Board of Australia as a medical practitioner and (where relevant) in the medical specialities required for the relevant Contracted Services; and
 - (B) with the professional college(s) responsible for the medical specialties required for the relevant Contracted Services,
- and will provide evidence of such registrations if requested by QH;
- (2) provide Contracted Services only within the range of their respective approved Credentials and Clinical Privileges, qualifications and experience and the standards accepted by the professional college(s) responsible for the medical specialties required for the relevant Contracted Services and otherwise for the discipline(s) in which the Authorised Medical Personnel practise;
 - (3) without limiting section 5.4(c)(2):
 - (A) perform the Contracted Services in accordance with the permissions granted by the relevant Credentials and Clinical Privileges Committee;
 - (B) obtain and maintain for the Term all necessary Credentials and Clinical Privileges as granted by the relevant Credentials and Clinical Privileging Committee and as are required for the provision of the Contracted Services;
 - (C) not perform any Contracted Services or otherwise perform any clinical procedures for which the Authorised Medical Personnel have not been granted permission by the relevant Credentials and Clinical Privileging Committee;
 - (4) comply with all ethical and professional standards required of the Authorised Medical Personnel and of medical practitioners generally including any such ethical and professional standards as may be required by the relevant professional college(s) responsible for the specialties required for the Contracted Services and otherwise for the discipline(s) in which the Authorised Medical Personnel practise;
 - (5) comply with all Laws applicable to the Authorised Medical Personnel and as are required or necessary for the performance of the Contracted Services;
 - (6) comply with the policies and procedures of the Facility as amended from time to time in relation to the performance of the Contracted Services and of clinical services generally;
 - (7) participate and co-operate in any clinical audits that may be required by the Operator from time to time;
 - (8) comply with the quality assurance, quality improvement and peer review policies, procedures and requirements of the Facility and the professional college(s) responsible for the medical specialties required for the Contracted Services and otherwise for the discipline(s) in which the Authorised Medical Personnel practise;
 - (9) provide care and treatment to Public Patients in accordance with clinical priorities; and
 - (10) notify QH and the Operator as early as reasonably possible of any potential or possible claims against the Authorised Medical Personnel in respect of the Contracted Services and provide all such details and information as QH or the Operator may reasonably require in respect of any claim.

6 Managing discharge and transfer

6.1 Summary

The process for discharging Public Patients from the Facility, and the respective roles of the parties in relation to this process, are summarised in Attachment B.

6.2 Discharge planning

The Operator shall:

- (a) include discharge planning as an element of the Contracted Services provided in respect of each Public Patient from an early stage in that Public Patient's inpatient care at the Facility including by requesting an ACAT assessment of the Public Patient as soon as is practicable after it becomes apparent that the Public Patient will need to be discharged to a residential aged care facility;
- (b) use good discharge planning practice for an Australian private hospital, including by maintaining links with residential aged care facilities and community care providers in the District;
- (c) keep QH informed as to the likelihood of any Public Patient admitted to the Facility at the relevant time requiring discharge to a QH Facility or a residential aged care facility and the likely date on which the Public Patient will be ready to be discharged; and
- (d) specifically in respect of Public Patients requiring discharge to a residential aged care facility, use its best endeavours to find a suitable place before the date on which the Public Patient's inpatient care at the Facility under that Public Patient's original Referral Order is due to be completed.

6.3 Extended Length of Stay

- (a) If a Public Patient requires inpatient care at the Facility for a period exceeding the 'high trim point' for the relevant diagnostic related group set out in the funding model applied to public hospital facilities in Queensland at the relevant time (**Extended Length of Stay**) for any reason, the Operator's service contact shall contact QH's service contact and review the reasons for the Extended Length of Stay and the most appropriate on-going treatment for the Public Patient having regard to:
 - (1) what is best for the Public Patient;
 - (2) the available capacity at the Facility and the District's facilities;
 - (3) the impact (if any) on the Operator's ability to deliver the Contracted Services to the Performance Standards if the Public Patient were to complete their treatment at the Facility; and
 - (4) the objectives of the activity planning process set out in section 6 of Part 1 of Schedule 1,and the Operator shall inform QH's Contract Manager of the outcomes of such a review.
- (b) After the review conducted under section 6.3(a), the affected Public Patient's case shall be reviewed again at intervals determined by QH (acting reasonably) until the Public Patient is discharged or transferred. A further review must at least be conducted at the point where (if applicable) the period of the Public Patient's inpatient care exceeds the 'extra high trim point' for the relevant diagnostic related group set out in the funding model applied to public hospital

facilities in Queensland at the relevant time. Each further review must have regard to the matters referred to in section 6.3(a).

6.4 Discharge arrangements

On discharge of a Public Patient the Operator shall:

- (a) transmit a discharge summary for the Public Patient to QH via the Agreed Platform;
- (b) ensure the Public Patient receives appropriate referrals to other health professionals to ensure complete and if necessary continued treatment;
- (c) if continued non-inpatient treatment is required from District services, communicate this plan in an effective and timely manner to QH's service contact point for referrals and discharges;
- (d) if continued treatment is required from elsewhere, arrange all appropriate referrals, including referrals and discharge summaries to the Public Patient's general practitioner;
- (e) where a specialist post discharge consultation is required with the admitting medical practitioner and the medical practitioner does not provide public clinics within the District:
 - (1) provide a maximum of post discharge visits with the medical practitioner; and
 - (2) if more than post discharge visits are required, discuss options with QH to either approve extra visits (at an additional cost to be agreed) or transfer the patient to a District outpatient clinic; and
- (f) use its reasonable endeavours to ensure discharge information is sent to the continuing care provider within of discharge.

6.5 Public Patient requiring further inpatient care

- (a) If the Operator determines that a Public Patient admitted to the Facility is likely to require continuing inpatient care but is no longer appropriate for treatment at the Facility because of an increase in the level of the Public Patient's clinical acuity to a level above the capability set out in Table 2, or because the Public Patient requires services in a modality other than a Service Stream:
 - (1) the Operator shall notify QH of the nature of the required further inpatient care as soon as is practicable and, in any case, at least before the Public Patient is due to be discharged; and
 - (2) subject to the Operator first having complied with its obligations under sections 6.2 and 6.5(a)(1), QH shall nominate a QH Facility which must accept a transfer of the Public Patient within of the notification.
- (b) The Operator shall transfer the Public Patient to the nominated QH Facility, and shall:
 - (1) transmit an inter-hospital transfer form for the Public Patient to QH; and
 - (2) provide transport to the nominated QH Facility.

6.6 Public Patient requiring residential aged care

- (a) If the Operator:

- (1) has obtained an ACAT assessment confirming that a Public Patient is likely to require accommodation in a residential aged care facility after the completion of the inpatient component of the Contracted Services; and
- (2) is unable to find a suitable place before the date on which the Public Patient's inpatient care at the Facility under that Public Patient's original Referral Order is due to be completed, despite having complied with its obligations under section 6.2,

the Operator shall notify QH of the situation as soon as is practicable and, in any case, at least before the Public Patient is due to be discharged.

(b) In respect of a Public Patient notified under section 6.6(a), QH may:

- (1) if a Dedicated Medical Acute Bed is available at the relevant time, issue a new Referral Order referring the Public Patient back to the Facility under the 'General Medicine' Service Stream, in which case:
 - (A) the patient will stay at the Facility and not be discharged until suitable discharge arrangements are identified through the mechanisms set out in sections 6.6(b)(1)(B) and 6.6(b)(1)(C);
 - (B) the Operator will continue to implement good discharge planning practices in respect of the Public Patient in accordance with section 6.2; and
 - (C) the parties will implement consultation and review mechanisms similar to those set out in section 6.3 in respect of the Public Patient; or
- (2) if no Dedicated Medical Acute Bed is available at the relevant time, subject to section 6.6(c), require the Operator to continue to provide suitable inpatient care on a temporary basis until such time as the Public Patient is able to be transferred or discharged (including to a QH Facility, if nominated by QH for this purpose),

(c) QH may not require the Operator to continue to provide inpatient care under section 6.4(b)(2) to more than Public Patients at any one time. In the situation where there are more than Public Patients the subject of a notification under section 6.6(a) who cannot be dealt with under section 6.4(b)(1) (unless the Operator otherwise agrees), QH must arrange for the excess Public Patient(s) (which QH will identify from amongst the affected Public Patients) to be transferred out of the Facility within after the situation arises.

(d) If a Public Patient the subject of a notification under section 6.6(a):

- (1) is not referred back to the Facility under section 6.6(b)(1) or accommodated under section 6.6(b)(2); or
- (2) is identified as requiring transfer under section 6.6(c),

subject to the Operator first having complied with its obligations under section 6.2, QH shall nominate a QH Facility which can (within of the notification or identification (as applicable)) accept a transfer of the Public Patient and section 6.5(b) shall apply in respect of the transfer.

(e) If, as a result of QH exercising its rights under section 6.6(b)(1), the Operator needs to defer the admission of a Public Patient (not being a Direct Admission Patient) in the 'General Medicine' Service Stream and this results in the time limit in section 3.6(b) being exceeded:

- (1) the resulting delay will not count towards any KPI Failure or for the purposes of section 2.4 of Part 1 of Schedule 4; and
- (2) the Operator must commence the inpatient episode of care for the affected Public Patient as quickly as is reasonably practicable after the scheduled date for admission of that Public Patient.

RTI Release

Attachment A – Form of Referral Order

See attached 2 pages.

RTI Release



Queensland Government

Queensland Health

Sunshine Coast Health Service District

Nambour General Hospital Caloundra Health Service

REQUEST FOR PLANNED PATIENT TRANSFER TO PRIVATE HOSPITAL

PATIENT IDENTIFICATION LABEL

Surname: _____ UR: _____

Other Names: _____

Address: _____

Ph No.: _____

Date of Birth: _____ Sex: _____

To be completed by the doctor or nurse manager requesting transfer

DATE	TIME	WARD
Doctor making request	UNIT	PAGER NO.
Doctor receiving request	TELEPHONE NO.	
NOK Name & Relationship	Notified of impending transfer	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Health Insurance status	
	<input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> DVA	
Primary Diagnosis		
Secondary Diagnosis/es		
Diagnosis for transfer (what will the patient be admitted for at Noosa?)		
Summary of relevant investigations (NB: Patient's health record to accompany)		
Current treatment and medications		
ACAT	<input type="checkbox"/> Attended	Date
	<input type="checkbox"/> Booked	Date
Rehab	<input type="checkbox"/> Booked	Date
Date of admission to NGH		Expected length of stay at Noosa
Request for transfer accepted? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If NO, reason why?		
Transfer arranged for (day & time)		
Mode of transport		
Nursing information – level of dependency		

BINDING MARGIN – DO NOT WRITE

PATIENT TRANSFER

RT Released

Please fax to [name] Hospital on Facsimile No. [XXXX XXXX]

Original copy to be filed in the NGH Health Record

Copy 1 to be retained by Central Allocations, NGH

Copy 2 to be sent to the General Practitioner and 7 of Referring Doctor if transfer accepted.



Queensland Government
Queensland Health

Sunshine Coast - Wide Bay Health Service District
..... (Service/ Facility)

**REQUEST FOR DIRECT PATIENT
TRANSFER TO PRIVATE HOSPITAL**

(Affix Patient Label Here)

UR: _____
Family name: _____
Given names: _____
Date of birth: _____ Sex: M F

The intent of this Inter-Hospital Transfer Fax is to improve communication of vital information to improve the quality and safety of Clinical Handover, manage the priority of referral and track completion of tasks:

- Step 1: complete the Minimum Safe Patient Dataset in Section 1
- Step 2: phone unit registrar/PHO or DEM coordinator to identify mutually agreed accepting unit, venue and priority of transfer in Section 2
- Step 3: phone hospital Nurse Manager and fax this form to obtain QAS ambulance booking number and initiate transfer – see bottom of page for fax numbers
- Step 4: use Interim Care Plan and final checklist in Section 3 to communicate requirements on arrival

SECTION 1 – PATIENT REFERRER DETAILS MINIMUM DATASET

Referrer details: Referring hospital: _____
Referring doctor: _____
Contact details: page: _____ mobile: _____ extension: _____

Date and time of referral: _____ / _____ / _____ time: _____

Patient name: _____	DOB: _____	Last Observations	
Primary diagnosis and _____		Time taken:	
Reason for transfer: _____		Temp	
Additional diagnoses/ injuries/ history: _____		Pulse	
		BP	
		RR	
		Sats	
		L/min	
		GCS	
		BSL	

SECTION 2 – ACCEPTING TEAM AGREEMENT

Accepting Registrar (name): _____	Venue agreed: _____	<input type="checkbox"/> DEM <input type="checkbox"/> Ward _____ (up unit 2100hrs)
Accepting Unit/ Speciality: _____	Priority agreed: _____	<input type="checkbox"/> emergent (next available transport)
Contact Number: _____		<input type="checkbox"/> urgent (within 4 hours)
		<input type="checkbox"/> up to next business day

SECTION 3 – CARE PLAN CHECKLIST

- | | | | |
|---|---|---|---|
| 1. Escort level required <input type="checkbox"/> Dr | <input type="checkbox"/> RN | <input type="checkbox"/> QAS | <input type="checkbox"/> Self |
| 2. Type of transport <input type="checkbox"/> QAS | <input type="checkbox"/> Aeromed | <input type="checkbox"/> Private | |
| 3. Nursing observations <input type="checkbox"/> Routine | <input type="checkbox"/> Neuro | <input type="checkbox"/> Circulation | <input type="checkbox"/> BSL |
| 4. Observation frequency <input type="checkbox"/> Hourly | <input type="checkbox"/> 2 hourly | <input type="checkbox"/> 4 hourly | |
| 5. Dietary instructions <input type="checkbox"/> Nil by mouth | <input type="checkbox"/> Clear fluid | <input type="checkbox"/> Thickened | <input type="checkbox"/> Diabetic <input type="checkbox"/> Full |
| 6. Special instructions <input type="checkbox"/> Falls risk | <input type="checkbox"/> Oximetry | <input type="checkbox"/> Hourly BSL | <input type="checkbox"/> Fluid balance |
| <input type="checkbox"/> Cardiac monitor | <input type="checkbox"/> Pressure area risk | <input type="checkbox"/> Alcohol withdrawal scale | |

FINAL PRE-TRANSPORT CHECKLIST

- Receiving hospital notified
- QH medication chart completed
- QH fluid order completed
- Medical handover letter presented
- Imaging/ X-rays present
- Analgesia charted regularly
- Antibiotics required to be given

FAX AND CONTACT NUMBERS

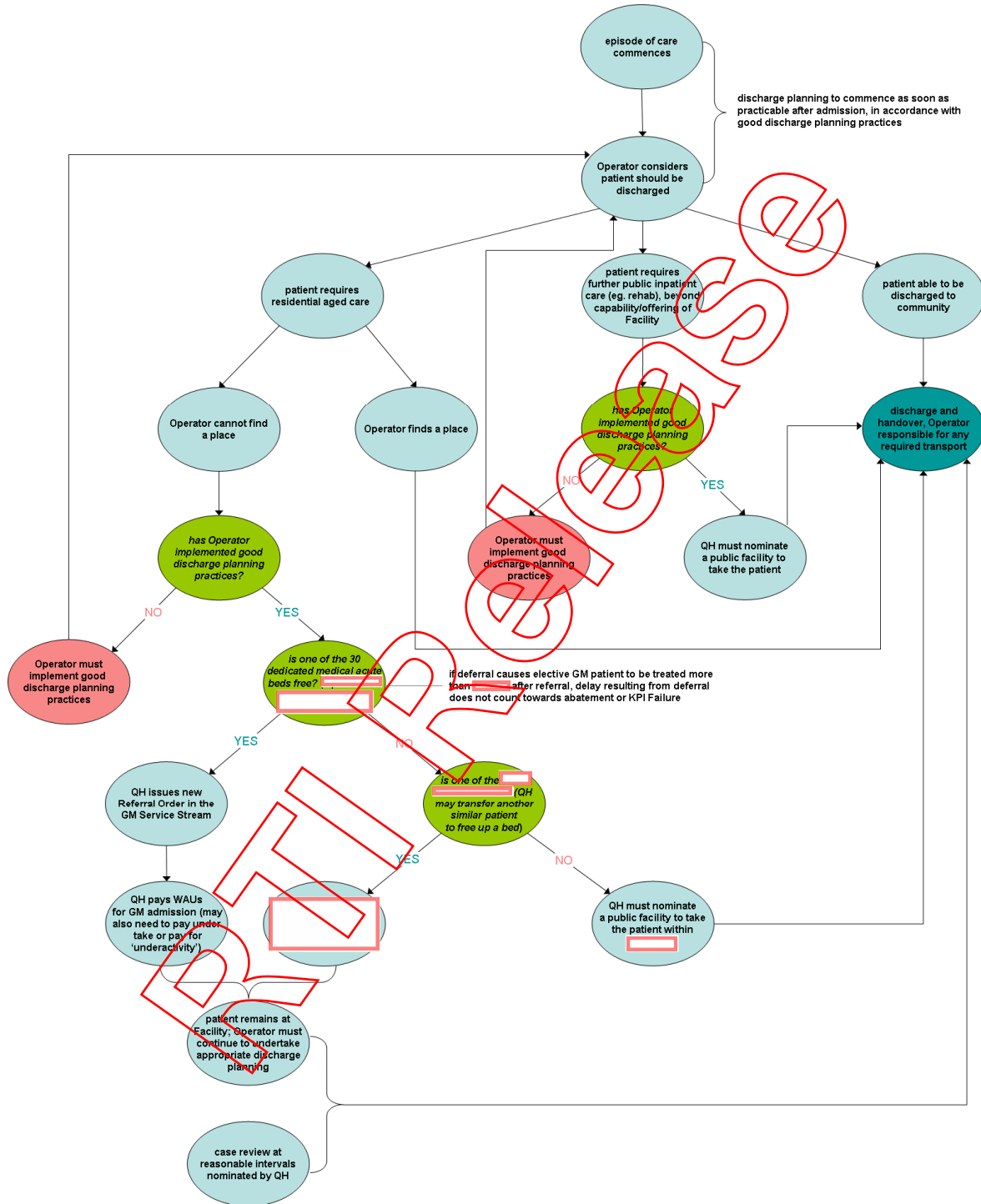
Nambour Nurse Manager: 5470-5178 (fax 5470-6842)
Nambour DEM Coordinator: 5470- 5170 (fax 5470-5480)
Gympie Nurse Manager: 0414-269-379 (fax 5489-8535)
Caloundra Nurse Manager: 5436-8655 (fax 5436-8615)
Please notify the above if condition of patient or priority of transfer changes

QAS Log Number: _____ Job complete time: _____

DO NOT WRITE IN THIS BINDING MARGIN

REQUEST FOR TRANSFER FAX

Attachment B – Summary of discharge process



Part 2 – Operator’s Submission

See attached 9 pages.

RTI Release

Schedule 2 Part 2 – Performance Standards Response

1 Management Response

Ramsay is Australia's largest Private Hospital Operator and provides a comprehensive range of high quality health care services. Our services are predominantly delivered to privately insured patients. However, Ramsay is also the most experienced provider in this country of public patient services through 'public-private partnerships' with State Governments.

Ramsay will work co-operatively with QH to develop a collocated campus which will:

- Improve access to public and private health services in the District
- Provide Qld Health with 24-hour, 7 days per week access to beds for acutely sick Public Patients
- Increase the health services capacity and capability on the Sunshine Coast, and Ramsay will provide services beyond the minimum requirements as outlined in the CSCF table below
- Provide high quality services now and into the future which specifically target the reduction of patient outflows to Brisbane
- Be a magnet campus to attract high quality healthcare professionals to work in both the Facility and the SCUH.

Ramsay will construct and operate a Facility on the Kawana Site that complies with the minimum requirements of Part 1 of Schedule 3 of the Collocation Agreement, and Part 1 of Schedule 2 of the Services Agreement.

Ramsay will:

- Provide the Contracted Services for the Term in accordance with the with Performance Standards set out in the Services Agreement;
- Operate the Facility in accordance with all Authorisations required;
- Provide services to the CSCF levels tabled below in Section 2 (a) - Service Profile and CSCF Levels; and
- Commission the Facility with the capacity required.

2 Clinical Services Capability and Capacity

2.a Service levels according to CSCF

Ramsay will commission the Facility with a broad range of medical and surgical services. A broad casemix will benefit QH in a number of ways including:

- A wider range of services that will better complement the existing services provided by Qld Health to public patients in the District
- The provision of greater flexibility and choice to QH in determining the mix and range and services to be purchased from the Facility during the Term
- Meeting the growth in demand for public patient services in the District
- The ability to accept a wider variety of transfers of acutely sick patients, and
- The attraction of a greater number of specialists to the Kawana Site.

During the Term, Ramsay will provide clinical services at the CSCF Levels specified in Schedule 2, Part 1 – Specification, of the Services Agreement, in addition to the following.

CLINICAL SERVICES CAPABILITY DURING TERM

Clinical Services Capability Streams (on site)	Level
Breast Surgery	5
Upper GIT Surgery	5
Vascular	5
Oncology	4

2.b Licensed Inpatient Bed Capacity

Inpatient Beds	Beds
Medical/Surgical Inpatient Beds	160
ICU/CCU (Level 5)	8
Total Licensed Inpatient Beds	168
Approved Day Facilities	Chairs
Day Oncology Chairs	8
Day Surgery/Endoscopy Chairs	24
Other Clinical Infrastructure	Number
Operating Theatres	6
Day Procedure/Endoscopy Rooms	1

Whilst Paediatrics is not a service listed separately, Ramsay will include paediatric surgery in the licence application. This will allow surgery on children over the age of one in specialty areas such as ENT, orthopaedics and general surgery. Ramsay will not be providing a medical paediatric unit during the Term, but will review this decision in any expansion plans if there is sufficient Private Patient demand to justify a viable unit.

3 Public Patient Care - Contracted Services

3.a Achieving Performance Standards

Ramsay has a reputation as a high quality provider of health care services.

In order to ensure that Ramsay achieves the Performance Standards in the management of referrals, it will ensure provision of quality facility management and clinical services, compliance with laws and standards, adherence to privacy and confidentiality requirements, and the adoption of the very highest standards of health professional credentialing to achieve

efficient and effective discharges and referrals. Ramsay will implement a comprehensive Quality and Risk Management Program at the Facility, and all of these programs will be specifically tailored to meet the special requirements of the Facility on the Kawana Site.

These systems provide extensive data and key performance indicators that will clearly demonstrate performance against the target benchmarks and identify any areas that are in need of improvement. Ramsay will share all relevant data with QH in order to demonstrate the achievement of targets and provide details where rectification/improvement plans are required.

A brief description of how Ramsay will meet the Performance Standards follows:

MANAGING REFERRALS, DISCHARGE AND TRANSFERS

A dedicated bookings and referral officer will be appointed by Ramsay to manage Public Patient referrals and liaise with QH about the status of the hospital and other relevant issues. After hours (ie overnight) this would be the in change/after hours co-ordinator. The dedicated bookings and referral officer will be identified and notified to QH for the referral and discharge or transfer of Public Patients from the Facility which will be available 24 hours a day, 7 days a week.

Ramsay will establish a dedicated email or web based booking system for QH. This would operate in conjunction with a dedicated Ramsay bookings and referral officer.

For Public Patients who are not Direct Admission Patients, once the Service Initiation Pathway is complete (within three Business Days of accepting or being deemed to have accepted the Referral Order) the Public Patient will be communicated with by Facility administrative staff to ensure that information is captured to facilitate the Public Patient's admission process. Information will be gathered through the patient admission form which can be completed in hard copy or on-line.

Some patients for elective surgery will attend a preadmission clinic (this may not be required for some Public Patients who have already attended a QH clinic). The identification of any patient risk factors during the preadmission clinic will allow the health care team to tailor care to meet individual needs, therefore, minimising adverse outcomes and ensuring patients receive the highest standard of safe, efficient and effective care. The clinic will also provide an opportunity for nurses to provide education, preoperative instructions and reassurance to patients.

A brief medical history will be taken and in addition, the patient will undergo relevant diagnostic testing, (e.g. ECG, pathology, radiology tests). The preadmission clinic will also provide an opportunity to plan additional services that may be required on discharge to meet the patient's ongoing physical, social or psychological care needs.

The Meditech system is capable of producing a wide range of management reports and Ramsay will work with QH to determine an appropriate suite of reports and reporting frequency to enhance both parties ability to manage the Services Agreement.

ADMISSION

Due to the pre-acute planning that occurs prior to admission, the admission process will be streamlined and efficient. Staggered admission times will ensure that patients are waiting for the minimum time possible, to help decrease anxiety preoperatively. Ramsay will admit all appropriate elective surgical patients through the Day of Surgery Admission Centre (**DOSA**) to ensure consistency of pre-surgical care and to assist with bed management. Some complex patients requiring admission on the day prior to surgery may be admitted directly to a bed. Similarly, emergency surgical patients may proceed directly to the operating theatres.

Ramsay will utilise clinical care pathways specific to each procedure. These care pathways will be utilised to systematically plan and follow up a patient focused care program. Ramsay

care pathways will define the goals and key elements of care based on evidence, best practice and patient's expectations. The pathways will facilitate communication with the patient and their family, coordinate care across the entire health care team, monitor and evaluate variances and outcomes and enhance the quality of care across the continuum by improving patient safety and outcomes, increasing patient satisfaction and optimising the use of resources.

POST OPERATIVELY

The Ramsay model of care will be a team approach and will include nursing staff and allied health team members including physiotherapy, occupational therapy, speech pathology and dieticians. The Ramsay ward teams will also include discharge planners.

Prior to discharge, the plans that were commenced preoperatively are reviewed and strengthened. Patients will be provided with detailed information regarding medications, physical limitations, dietary needs and the recognition of signs/symptoms that should prompt them to seek immediate attention. Support services such as domiciliary care, district nurses or meals on wheels will be coordinated prior to discharge and written referrals will be initiated by nursing staff communicating patient care needs to the discharge service. Allied health staff will ensure that any identified home aids and adaptations are attended to with full instructions on their use.

Patients will be provided with discharge medications of sufficient quantity to last until their next doctor visit (for up to three days).

The Operator's service contact will ensure that a discharge summary will be transmitted to QH and ensure that all appropriate referrals for ongoing treatment are arranged prior to discharge. Where transfers to another District facility operated by QH are required, the service contact will notify QH to confirm the facility and then Ramsay will organise the transfer.

ENSURING COMPLIANCE WITH THE CLINICAL STANDARDS

Ramsay will ensure that the standard of care for Public Patients achieves and often exceeds the Performance Thresholds and meets equivalent QH targets. This will be achieved via the Ramsay Quality and Risk Management programs which underpin the delivery of quality care in our facilities.

HOSPITAL BY-LAWS / FACILITY RULES

The activities within the Facility will be governed by Ramsay By-laws / Facility Rules. The By-laws / Facility Rules will ensure a minimum standard of clinical governance in the Facility. Ramsay By-laws provide for the following:

- *Credentialing and defined scope of practice* for all health practitioners, including Staff specialists, VMOs, junior medical staff and trainees, allied health practitioners and any other service provider who has access to or treats patients.

Ramsay By-laws establish a Credentialing Committee which will specify the process for appropriate peer review of applicants and consider specific matters such as:

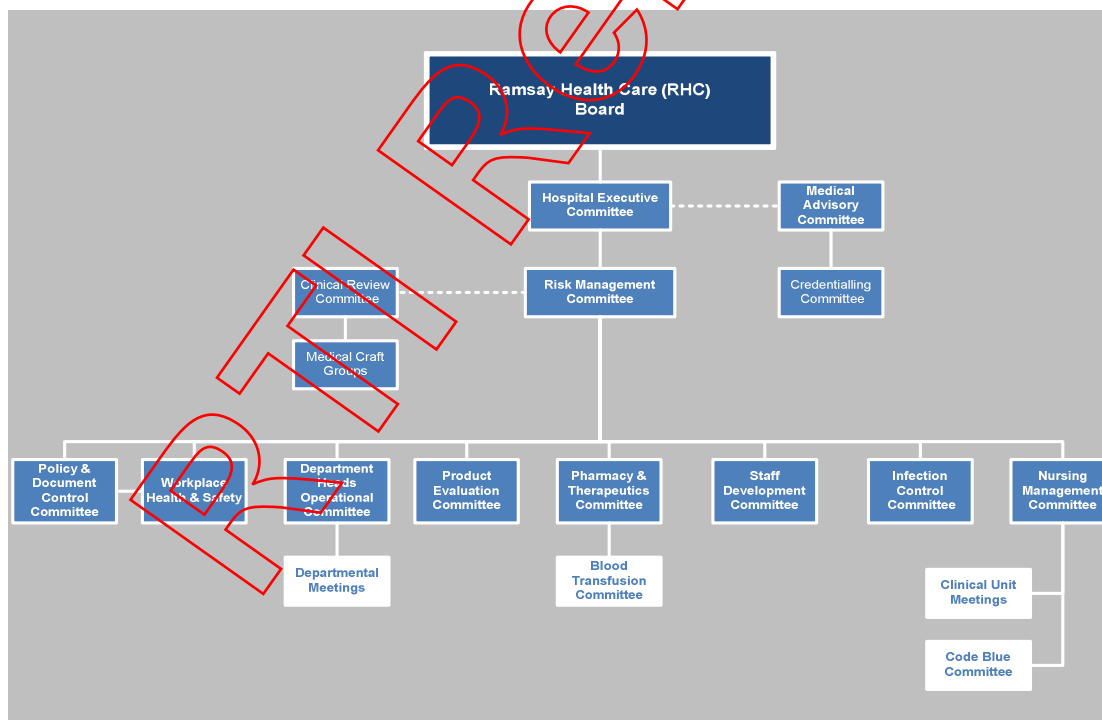
- training
- recent experience
- competence
- judgement
- current fitness
- character
- demonstrated knowledge and skill

The By-laws include the conditions of accreditation which include among other things, matters such as ongoing registration and indemnity cover, professional conduct, minimum requirements for documentation and consultation with patients, on call arrangements and the need to disclose certain issues to Ramsay.

- *Multidisciplinary clinical review* of clinical incidents, morbidity and mortality. The By-laws / Facility Rules will require the Facility to establish a multidisciplinary Clinical Review Committee. This Committee will consider morbidity and mortality data, clinical indicator results, patient complaints, transfers in and out of the Facility and patient survey results.
- *Formation of a Medical Advisory Committee (MAC)* to provide advice to Ramsay hospital management on the governance and operation of the Facility. The By-laws specify the required membership, which as a minimum must include representation from all major specialty areas as well as referring GPs from the local community. The MAC provides advice on patient care standards and hospital policies and procedures.
- *A Process for reviewing and monitoring the performance of accredited medical practitioners* is also covered by the By-laws. The By-laws provide Facility management and committees with a framework to investigate and manage suspected or alleged poor performance.

COMMITTEE STRUCTURE

In addition to the committees prescribed by the By-laws, the Facility will have a comprehensive medical committee structure as indicated below. The medical committee structure ensures that all accredited VMOs are included in decisions regarding their craft group and are actively involved in peer clinical review. The chart below provides an outline of the proposed Committee structure.



Other committees Ramsay will establish to ensure high quality patient care include:

- Infection Control
- Quality and Risk Management
- Workplace Health and Safety

- Product Evaluation
- Pharmacy and Therapeutics
- Staff Development and Education
- Emergency Management and Response

COMPLAINTS MANAGEMENT SYSTEM

Ramsay recognises that customer complaints are a unique source of information regarding the needs of its customers and the quality of care provided through its hospitals. Active review of customer concerns and complaints assists Ramsay to understand potential problems and to identify ways to improve the service.

On admission, patients are notified of their rights and responsibilities via the 'Australian Charter of Healthcare Rights'. This includes an explanation of how patients can make a complaint and an elevation of a complaint to the Health Quality and Complaints Commission (HQCC).

Ramsay has a comprehensive Complaints Management Policy and System to ensure all complaints are responded to promptly. All complaints are recorded using the Ramsay Complaint Management Form to gather information such as details of the patient/visitor/staff member making the complaint and the nature of their concerns. Complaints forms are initiated for complaints made via all communication methods including written, telephone and in person complaints.

Many complaints will be resolved immediately during the admission. All Ramsay staff will be encouraged to resolve complaints at the point of service. Ramsay staff will undergo training during orientation and then annually to deal with complaints.

All complaints will be classified according to their primary nature – e.g. patient care, communication, access etc. All complaints will be given a severity rating and those with a high severity are reviewed individually by the Clinical Review Committee. Complaint data will also be analysed over time to identify any trends or recurrent issues.

The Ramsay policy will provide maximum timelines in which to both initially respond to a complaint and for follow up or resolution of complaints. The Ramsay Complaint Management Policy and System is compliant with current HQCC standards.

PATIENT SATISFACTION

Ramsay has a strong commitment to the provision of excellence in customer service and has an excellent record of delivering quality patient care. Ramsay is dedicated to improving the quality and safety of the healthcare services it provides by participating in a process of self and external assessment.

Ramsay's philosophy of "People Caring for People" was developed over 25 years ago and has become synonymous with Ramsay and the way in which it operates its business. Ramsay recognises that we operate in an industry where "care" is not just a value statement, but a critical way we must go about our daily operations in order to meet the expectations of our customers – our patients.

In order to ensure that a high standard of service is maintained, all new employees to Ramsay undertake formal customer service training as part of their initial induction to the organisation. As part of an annual mandatory training program, all existing employees also attend customer service training.

Ramsay utilises Press Ganey Inc to undertake patient satisfaction surveys at all facilities as set out in Schedule 3, Part 2.

In addition to the annual Press Ganey survey, the Facility will utilise Patient Satisfaction/Feedback cards throughout the year to provide ongoing feedback. The cards

will be available in all patient rooms and public areas and invite patients and visitors to rate their overall satisfaction and provide comments on aspect of their care they like as well as areas they feel improvement is needed.

The collation of Feedback Cards, Press Ganey surveys and complaint data will be utilised to develop action plans for the improvement of service provision.

CLINICAL GOVERNANCE UNIT

All quality and risk activities within Ramsay are overseen by the Group Clinical Governance Unit (**CGU**).

CGU has access to all hospital information databases and is able to monitor and identify trends. One of the key strengths of the Ramsay Group is the ability to benchmark data across all 62 facilities. Benchmarking occurs for Incident Management, Clinical Indicators and Patient Satisfaction.

Once a group wide trend or risk has been identified, CGU are able to implement national risk minimisation strategies. Such actions include:

- National policies – for example a comprehensive suite of maternity policies have been developed to specifically target the high risk areas of practice in our Obstetric Units;
- Specialty User Groups – CGU convene a number of specialty working parties including Maternity and Neo-natal, Operating Theatres and Cardiac Catheter Labs; and
- Clinical Audits – the CGU co-ordinate a national audit program to ensure compliance with national policies and procedures.

The CGU are also responsible for ensuring hospitals set and achieve action plans for areas identified for improvement.

In addition to the national CGU, strong and responsive hospital-level clinical governance will be established through a range of committees established to monitor clinical risk, clinical outcomes, safety and quality consistent with the approach adopted at all other Ramsay sites. This 'architecture' for clinical governance has been widely endorsed through hospital accreditation surveys at all Ramsay sites.

3.b Areas of Difference - Public and Private Patients

[There will be no difference in the clinical care of Public Patients and Private Patients at the Facility. There will be no differentiation in finish or otherwise between the beds occupied by Private Patients. A somewhat more extensive menu may be offered to Private Patients.

4 Service Providers

The intended authority holder for the purposes of the Private Health Facilities Act 1999 (**PHFA**) will be 'Ramsay Health Care Australia Pty Ltd'. This company is a wholly owned subsidiary of Ramsay Health Care Limited and, as one of the main operating companies of Ramsay, currently holds authority for a number of hospitals including Greenslopes Private Hospital, Cairns Private Hospital and Cairns Day Surgery in Queensland. All Service Providers will be appointed in due course and cannot be specifically identified at this time. The following is a brief description of the Service Providers that will be engaged and/or contracted during this project.

MEDICAL STAFF AND VISITING MEDICAL OFFICES (VMO)

The Ramsay By-laws and the PHFA prescribe that all medical practitioners who admit, treat or consult with patients must be registered and hold current medical indemnity insurance.



On initial application, medical practitioners, whether they are to be employed, contracted or engaged and credentialed as a VMO, are required to provide evidence of their registration with the Medical Board of Australia. On an ongoing and annual basis, registrations are checked and confirmed for every accredited medical practitioner in the Facility.

Specific additional qualifications and experience will be required for key positions such as the Director of Emergency Medicine and Director of Intensive Care. The Director of Emergency Medicine will be a Fellow of the Australian College of Emergency Medicine (FACEM). The Director of Intensive Care will be a qualified Intensivist and accredited as per the requirements of the PHFA and CSCF.

NURSING STAFF

On appointment, all nursing staff are required to provide evidence of registration with the Nursing and Midwifery Board of Australia. On an ongoing and annual basis, all nursing registrations are checked and confirmed.

ALLIED HEALTH

Allied health staff may be employed by Ramsay or engaged on a contracted service basis. Generally high volume services such as physiotherapy, occupational therapy, radiography, pharmacy and dietetics are employed by the Facility. Other lower volume services such as speech pathology may be provided under a contract basis.

Whether employed or contracted, Ramsay require evidence of registration (and indemnity insurance for contracted service providers). As with medical and nursing staff, evidence of current and ongoing registration is required on an annual basis.

The Ramsay By-laws prescribe that all credentialed medical and allied health practitioners be re-credentialed every 5 years. In the Facility, this may be reduced to 3 years to comply with PHRU licensing requirements. The requirements of the new National Registration and Accreditation Scheme for health professionals will also be strictly adhered to.

OTHER CLINICAL SERVICE PROVIDERS

Ramsay will ensure diagnostic imaging and pathology services are available at the Facility via third party arrangements. In summary, Ramsay will enter into two separate arrangements with third party services providers – a sub-lease and Service Level Agreement (SLA).

The SLA will require the operator to ensure that all staff treating patients on the site are registered and credentialed at the Facility. It will further prescribe that the operator must maintain accreditation with their relevant body. It will also require both services to provide an on call 24/7 service.

Detailed clinical and non-clinical key performance indicators will be incorporated in the SLA to ensure continued high performance and the ability to terminate where performance is less than satisfactory.

5 Workforce Arrangements

Ramsay will recruit high quality, skilled and competent health professionals to work at the Facility. Ramsay has proven strategies aimed at attracting and recruiting staff as well as a range of programs to retain staff for the long term. At all of Ramsay's collocated facilities the Ramsay executive team works closely with its public hospital partner to attract staff and doctors to the campus. Doctors inevitably hold joint appointments at both hospitals and by providing consulting suites on the site they are attracted to treat all of their patients on one campus. Clinical staff are also offered flexible working arrangements and many staff work across both hospitals, particularly theatre staff.





Section 1 ('Attraction and Retention of Staff') of Schedule 5 to the Site Management Deed is taken to form part of this Operator's Submission.

6 Compliance with Standards

Ramsay operates 13 health care facilities in Queensland, all of which are licensed by the PHRU. We are aware of the requirements of PHRU licencing.

Ramsay will ensure that the Facility meets all standards required by the PHFA. Ramsay's initial licence application to the PHRU will necessarily include all details of this. Currently the PHRU conduct annual audits of private facilities to ensure their ongoing compliance with the PHFA.

The annual audit also covers confirmation that services are operating in accordance with the requirements of the CSCF and the necessary support structure is in place as defined by each CSCF level.

In relation to 'Guidelines' which are provided by a range of Health Organisations and Medical Colleges, Ramsay consider all guidelines when determining policies and procedures at both a national level (CGU) and local hospital level. In considering guidelines, Ramsay engage and consult with accredited medical staff via the Medical Advisory Committee and other relevant specialty review committees as required.

RTI Released



Schedule 3 Performance Monitoring

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RTI Release

Part 1 - Specification

1 Performance Monitoring Plan

- (a) The Operator shall develop, implement and maintain during the Term a plan setting out how the Operator shall measure and assess compliance of the Contracted Services with the Performance Standards, the other Minimum Requirements and the Operator's Submission (**Performance Monitoring Plan**).
- (b) The Performance Monitoring Plan shall contain, as a minimum, performance measurement and assessment of the KPIs.

1.2 Performance reporting

The Operator shall in relation to Contracted Services:

- (a) collate and submit data required by ACHS via the Performance Indicator Reporting Tool (**PIRT**), in line with the established collection periods twice annually;
- (b) compare the performance of the Contracted Services against the peer comparison data published by ACHS and report such comparison to QH in the next monthly Management Report (**Comparative Report**);
- (c) report to QH on the performance of the Contracted Services against each KPI and submit:
 - (1) a non-conformance report (**NCR**) setting out the details of any material non-conformance and remedial actions taken or to be undertaken in respect of a failure to achieve the Performance Threshold for any KPI. The NCR shall be submitted to QH's Contract Manager within 2 Business Days of the Operator becoming aware of a failure to achieve the Performance Threshold; and
 - (2) subject to section 7.3 of Part 1 of Schedule 1, a report (**KPI Report**) providing a summary of the performance of the Contracted Services against all KPIs (including assessment of the Operator's performance against both the Performance Threshold and the Target Level of each KPI) in each month and over a rolling 12 month period. The KPI Report shall be submitted to QH's Contract Manager each month as part of the Operator's Management Report.
- (d) provide, or make available, any records that form the basis for the KPI Report in a manipulable format (such as MS Excel) which is capable of being analysed;
- (e) ensure that all data used in the performance management of the Contracted Services and performance assessment against the KPIs is collected and retained; and
- (f) provide QH with access to the data referred to in section 1.2(e) at all reasonable times on reasonable notice for the purposes of audit in accordance with clause 9 of this Agreement.

1.3 Activity Data

The activity data in Table 5 is to be submitted for trend analysis only.

TABLE 5: ACTIVITY DATA

Indicator	Frequency of reporting
In-hospital mortality rates (L)	Monthly, Financial Year to date
Transfers back to District facilities (N)	Monthly, Financial Year to date
Transfers to non-District facilities (N)	Monthly, Financial Year to date
No. of patients requiring additional treatment during admission (N)	Monthly, Financial Year to date
No. of patients requiring a different intervention than that for which they were referred (N)	Monthly, Financial Year to date
Bed utilisation by referred public patients by day (N)	Monthly, Financial Year to date
Average length of stay (ALOS) by service stream (N)	Monthly, Financial Year to date
(L) - a low rate is desirable, (H) - a high rate is desirable (N) – not stated	

2 KPIs

2.1 Clinical KPIs

The clinical KPIs are set out in Table 6 and Table 7. The Target Levels and Performance Thresholds for the Contracted Services refer to performance levels as specified in Comparative Reports prepared utilising PIRT. The Operator shall be expected to generate reports for review at the monthly Services Review Committee meetings.

TABLE 6: HOSPITAL WIDE CLINICAL INDICATORS

Clinical Indicator	Target Level	Performance Threshold	Frequency of reporting
1.1 Medication incidents resulting in an adverse event (L)			Six monthly, Financial Year to date
4.1 Inpatients who develop pressure ulcers during their admission (L)			Six monthly, Financial Year to date
5.1 Patient falls (L)			Six monthly, Financial Year to date
5.2 Patient falls that require intervention (L)			Six monthly, Financial Year to date

Clinical Indicator	Target Level	Performance Threshold	Frequency of reporting
7.1 Adverse transfusion events (L)			Six monthly, Financial Year to date
(L) - a low rate is desirable, (H) - a high rate is desirable			

TABLE 7: INFECTION CONTROL INDICATORS

Clinical Indicator	Target Level	Performance Threshold	Frequency of reporting
5.1 ICU-associated new MRSA healthcare-associated infections in a sterile site (L)			Six monthly, Financial Year to date
5.2 ICU-associated new MRSA healthcare-associated infections in a non-sterile site (L)			Six monthly, Financial Year to date
5.3 Non ICU-associated new MRSA healthcare-associated infections in a sterile site (L)			Six monthly, Financial Year to date
5.4 Non ICU-associated new MRSA inpatient healthcare-associated infections in a non-sterile site (L)			Six monthly, Financial Year to date
6.1 Reported parenteral exposures sustained by staff (L)			Six monthly, Financial Year to date
(L) - a low rate is desirable, (H) - a high rate is desirable			

2.2 Quality indicators

The quality indicators are set out in Table 8.

TABLE 8: QUALITY INDICATORS

Quality Indicator	Target Level	Performance Threshold	Frequency of reporting
No. of Clinical Incidents rated as Equivalent to SAC1 under CIMIS (L)			Monthly, Year to date
No. of Clinical Incidents rated as Equivalent to SAC2 under CIMIS (L)			Monthly, Year to date
Compliance with Incident Management Plan (H)			Monthly, Year to date

Quality Indicator	Target Level	Performance Threshold	Frequency of reporting
Confidentiality and Data Protection breaches (breach of Privacy Laws under section 5.2 of Part 1 of Schedule 2) (L)	<input type="checkbox"/>	<input type="checkbox"/>	Monthly, Year to date
Compliance with requirements for Public Patient Records on transfer from the Facility as stated in section 5.3 of Part 1 of Schedule 1 (H)	<input type="checkbox"/>	<input type="checkbox"/>	Monthly, Year to date
Compliance with requirements of discharge information received by continuing care provider as required by section 6.2(f) of Part 1 of Schedule 2 (H)	<input type="checkbox"/>	<input type="checkbox"/>	Monthly, Year to date
Unplanned and unexpected readmissions to the Facility or a public hospital in the District within 28 days (L)	<input type="checkbox"/>	<input type="checkbox"/>	Monthly, Year to date

(L) - a low rate is desirable, (H) - a high rate is desirable

2.3 Availability KPIs

The availability KPIs are set out in Table 9.

TABLE 9: AVAILABILITY KPIs

Availability Indicator	Target Level	Performance Threshold	Frequency of reporting
Unavailability of clinical services capacity, where activity limits set out in section 2.2 of Part 1 of Schedule 2 have not been exceeded (L).	<input type="checkbox"/>	<input type="checkbox"/>	Monthly, Year to date

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Availability Indicator	Target Level	Performance Threshold	Frequency of reporting
Operator refusal to accept a Public Patient referred to the Facility in accordance with the process set out in section 3 of Part 1 of Schedule 2(L).	[]	[]	Monthly, Year to date
Operator failure to communicate with, admit, or commence an episode of care for a referred Public Patient within the required timeframes specified in section 3.6 of Part 1 of Schedule 2(L).	[]	[]	Monthly, Year to date
% of medical practitioners who treat Public Patients credentialed (H)	[]	[]	Monthly, Year to date
(L) - a low rate is desirable, (H) - a high rate is desirable, (N) – not applicable			

2.4 Facility Management KPIs

- (a) The Operator shall, at the start of each Financial Year, submit to QH for approval a proposed regime for undertaking Public Patient satisfaction surveys/questionnaires relating to the overall Public Patient experience as it relates to the maintenance and non-clinical operation of the Facility, including as to content, frequency, interpretation of satisfaction results and performance thresholds.
- (b) The Operator shall undertake patient satisfaction surveys/questionnaires in accordance with the regime agreed by QH. A patient satisfaction surveys/questionnaires program which produces reports substantially similar to the sample report set out as Attachment A is agreed for the purposes of this section.
- (c) The Operator shall produce annually, a summary identifying areas of concern where patient satisfaction was low. The survey shall include but shall not be limited to such areas of the non-clinical service as catering, patient environment, portering, parking, cleanliness, way finding, communication etc.

TABLE 10: TARGET LEVELS FOR PATIENT SATISFACTION SURVEYS/QUESTIONNAIRES

Patient Satisfaction Surveys/Questionnaires	Target Level	Performance Threshold	Frequency of reporting
Surveys issued in accordance with proposed regime (H)	[]	[]	Yearly
Overall score, corresponding to a result measured in a similar manner to that set out in section 2 of the Press Ganey results in Attachment A	[]	[]	Yearly

(L) - a low rate is desirable, (H) - a high rate is desirable, (N) – not applicable

- (d) The Operator must comply with its Complaints Management Plan.
- (e) The complaint KPIs are set out in Table 11

TABLE 11: COMPLAINT KPIs

Complaint Indicator	Target Level	Performance Threshold	Frequency of reporting
Number of complaints received relating to the management and operation of the Facility (L)	[]	[]	Monthly, Year to date
Complaints categorised as ‘Major’ or ‘Extreme’ under QH Consumer Complaints Management Implementation Standard (L)	[]	[]	Monthly, Year to date
Complaints responded to within policy timeframes (H)	[]	[]	Monthly, Year to date

(L) - a low rate is desirable, (H) - a high rate is desirable, (N) – not applicable

3 Rectification Plan

- (a) In the event that the Operator fails to achieve the Performance Threshold for any KPI (**KPI Failure**), unless otherwise notified by QH, the Operator will develop and diligently pursue a plan (**Rectification Plan**) to remedy the KPI Failure. QH may group together more than one related KPI Failure for the purposes of requiring the Operator to deal with those KPI Failures in a single Rectification Plan.
- (b) The Rectification Plan shall be:
 - (1) developed within 10 Business Days of the KPI Failure and include:
 - (A) proposed actions by stated timeframes including a date by which the KPI Failure shall be addressed;
 - (B) roles and responsibilities for implementation;

- (C) a review process to assess if the Rectification Plan is effective and a procedure to adjust the plan if necessary following review; and
 - (D) documentation of any action required to comply with applicable QH policy or standards;
- (2) submitted to QH for review and approval (not to be unreasonably withheld);
 - (3) updated based on QH's reasonable comments; and
 - (4) implemented as soon as practicable and in any case within 10 Business Days of being approved by QH.
- (c) If QH agrees, the Rectification Plan may provide for:
- (1) the measurement of one or more KPIs to be suspended;
 - (2) the Performance Threshold for one or more KPIs to be decreased;
 - (3) the scope of one or more KPIs to be reduced (for example, so that a particular matter is not included in numbers of complaints or satisfaction rates for the purposes of applying the KPI),
- for a period specified in the Rectification Plan (which, except for Availability KPIs, must be a period of one or more whole months), in which case the KPIs apply in accordance with the Rectification Plan for the relevant period.

4 Relevance of Target Levels

- (a) During the Term, the Operator will strive for continuous improvement in the delivery of the Contracted Services, including by seeking to achieve or better the Target Levels and assessing its performance against the Target Levels in its Management Reports.
- (b) For the avoidance of doubt, a failure to meet a Target Level (which does not also amount to a failure to meet a Performance Threshold) is not a KPI Failure and does not require the development of a Rectification Plan.

Attachment A – Sample survey result

See attached 6 pages.

RTI Release

Part 2 – Operator’s Submission

See attached 3 pages.

RTI Release

Schedule 3 Part 2 - Performance Monitoring Response

1 Key Performance Indicators

Ramsay will monitor and report performance in relation to Public Patient care during the Term using the KPIs. The KPIs will be tabled and reviewed at the monthly contract meeting as they fall due.

ACTIVITY DATA

Ramsay will provide all activity data indicators as detailed in Table 5 Schedule 3 Part 1.

In-hospital mortality rates are a required agenda item on the Clinical Review Committee under Ramsay By-laws / Facility Rules. These are also reported to HQCC.

Transfers in and out of the Facility by type and destination is a standard report available from the Meditech Patient Management System. Similarly, transfers out is a required agenda item for the Clinical Review Committee under the Ramsay By-Laws / Facility Rules.

Public Patients requiring additional treatments or different treatments to those specified in the Referral Order will need to be collected manually. This is likely to be a small subset of Public Patients, and thus can be managed with a manual collection tool.

Bed utilisation and average length of stay (**ALOS**) are standard reports from the Meditech Patient Management System.

CLINICAL KPIs

Ramsay will collect, review and report the ACHS Hospital Wide Clinical Indicator data set as described in Table 6 of Schedule 3 Part 1. Medical incidents are included in the Ramsay criteria as a reportable incident for inclusion in the Riskman system. Medication incidents are collected and reviewed at the Pharmacy and Therapeutics Committee meeting with any recommendations for policy or procedure change referred through to the Clinical Review Committee or Medical Advisory Committee. Similarly a specific report for Adverse Transfusion events is provided from Riskman and reviewed at relevant committees.

The Riskman system will also be used at the Facility to collect incident information in relation to Public Patient falls, including the subset of falls resulting in injury or requiring further intervention. Falls data is tabled and discussed at a number of clinical review committees including specialty specific committees – e.g. Department of Medicine, Clinical Review Committee, and Department Heads / Operational Committee. As previously highlighted, Riskman is a national database and data and outcomes are reviewed at both hospital level and nationally, thus enabling clinical benchmarking between comparable hospitals. Information such as falls data can be provided for any Ramsay facility benchmarked against Ramsay national levels as well as in comparison with a Ramsay 'Peer Group'.

The role of all of the above mentioned clinical risk and quality committees is to identify shortfalls in performance standards, review plans for addressing and rectifying these shortfalls, and to ensure that performance monitoring is ongoing against these KPIs.

Ramsay has established a number of peer groups in order to provide more meaningful comparison of results with comparable hospitals in terms of size and acuity/casemix. Ramsay currently has a '200 bed plus, with ICU' peer group and it is proposed that the Facility belong to this group for the purpose of benchmarking results internally. Ramsay facilities within this Peer Group include [REDACTED]

INFECTION CONTROL

Ramsay collects and reports all Infection Control Indicators listed in Table 7 Schedule 3 Part 1. Ramsay agrees that the performance monitoring criteria for Facility-wide and Infection Control Indicators should be as per the Target Levels and Confidence interval thresholds provided by ACHS for like facilities. Similar to the KPI monitoring referred to above any adverse infection control indicators will be reviewed by the Infection Control Committee and the relevant clinical review committees and ongoing performance closely monitored.

QUALITY

Ramsay is able to comply with the KPI requirements of Table 8 Schedule 3 Part 1. Ramsay will provide information on Ramsay Risk Code RRC 1 and 2 incidents from the Riskman system. Ramsay risk ratings are equivalent to SAC codes (refer Attachment 1 to Schedule 1 Part 2). Ramsay agrees to furnish copies of Public Patient records to QH as required, and to report monthly on quality indicators. Similarly Ramsay will provide referring GPs and ongoing care providers with discharge summaries and will monitor and report compliance. Unplanned readmissions is a standard clinical indicator collected by all Ramsay facilities, Ramsay will collect and report data regarding unplanned readmissions to the Facility and to other District Facilities, with QH to provide applicable data required for other District facilities.

Once again, performance is closely reviewed by the relevant committees and all rectification plans are closely supervised.

AVAILABILITY

Ramsay will collect and report Availability KPIs as defined in Table 9 of Schedule 3 Part 1.

Ramsay will ensure that Public Patients referred to the Facility are managed to ensure acceptance in a timely manner in accordance with Schedule 2, Part 1, section 3 to achieve compliance with these indicators.

PATIENT SATISFACTION INDICATORS

Table 10 of Schedule 3 Part 1 provides indicators in relation to Patient Satisfaction.

Ramsay utilises Press Ganey Inc to undertake patient satisfaction surveys at all facilities. Press Ganey is a leading international patient survey organisation with over 20 years experience. Within Australia, Press Ganey conduct surveys on behalf of a large number and range of public and private facilities in Australia, providing them with a comprehensive collection of comparative data. The Australian office of Press Ganey Inc is based in Queensland.

The Press Ganey / Ramsay regime includes two separate annual surveys - inpatients and day patients.

The Press Ganey surveys obtain patient feedback on:

- The pre-admission and admission process
- Nursing care
- Medical care
- Rooms and the hospital environment
- Hotel services
- Discharge process

Press Ganey surveys Ramsay patients once per year using a larger sample size conducted covering a 2 month period during the busy months of July, August and September. The Facility will be provided with a comprehensive report showing its individual score benchmarked against Ramsay National, National Private and National Public scores. Each

individual issue surveyed is also scored and benchmarked – for example courtesy of nursing staff, discharge information, quality of the food.

The Target Level and Performance Threshold have been set according to benchmarks established by Press Ganey for a peer group of similar sized private facilities. Management action and improvement plans will be established for areas falling outside the agreed benchmark.

In addition to the annual Press Ganey survey, Ramsay hospitals utilise Patient Satisfaction / Feedback cards throughout the year to provide ongoing feedback. These cards are available in all patient rooms and public areas and invite patients and visitors to rate their overall satisfaction and provide comments on aspect of their care they like as well as areas they feel improvement is needed. Information received via these cards will be collated monthly and reported to QH.

The collation of Feedback Cards, Press Ganey surveys and complaint data will be utilised to develop action plans for the improvement of service provision. Ramsay will table patient feedback data at the monthly contract meeting together with Press Ganey results as they fall due.

COMPLAINTS

Ramsay is able to comply with reporting requirements for Complaints Management as defined in Table 11 of Schedule 3 Part 1.

Ramsay has a comprehensive Complaints Management Policy and System to ensure all complaints are responded to promptly.

All complaints are recorded using the RHC Complaint Management Form to gather information such as details of the patient/visitor/staff member making the complaint and the nature of their concerns. Complaint forms are initiated for complaints made via all communication methods including written, telephone and in person presentations.

All complaints are classified according to their primary nature – e.g. patient care, communication, access etc. All complaints are given a severity rating and those with a high severity are reviewed individually by the Clinical Review Committee as mentioned above. Complaint data is also analysed over time to identify any trends or recurrent issues.

The Ramsay policy provides maximum timelines in which to both initially respond to a complaint and for follow up or resolution of complaints. The Ramsay Complaint Management Policy and System is compliant with current HQCC standards.

Schedule 4
Fees and Payment

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Part 1 - Specification

1 Fees

1.1

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1.2

Redacted content for section 1.2.

2

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2.1

Redacted content for section 2.1.

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2.2

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2.3

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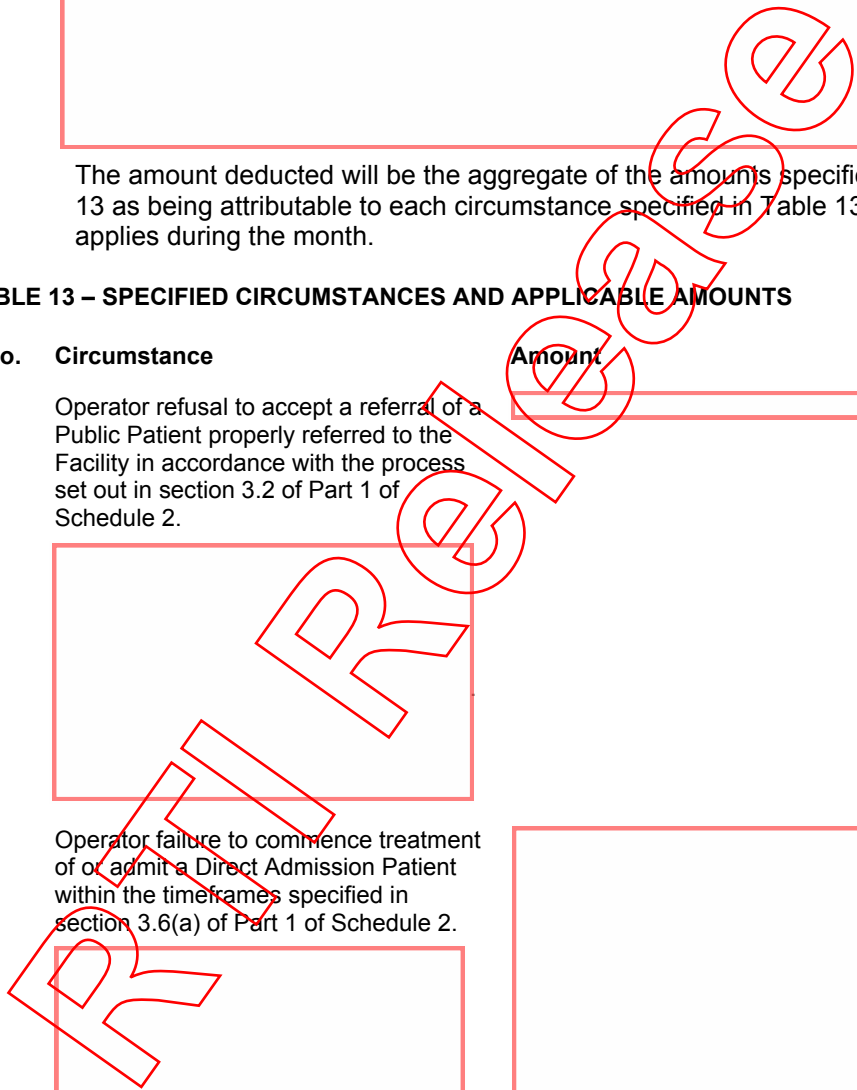
2.4 Performance deduction

(a)

(b) The amount deducted will be the aggregate of the amounts specified in Table 13 as being attributable to each circumstance specified in Table 13 which applies during the month.

TABLE 13 – SPECIFIED CIRCUMSTANCES AND APPLICABLE AMOUNTS

No.	Circumstance	Amount
1	Operator refusal to accept a referral of a Public Patient properly referred to the Facility in accordance with the process set out in section 3.2 of Part 1 of Schedule 2.	
2	Operator failure to commence treatment of or admit a Direct Admission Patient within the timeframes specified in section 3.6(a) of Part 1 of Schedule 2.	
3	Operator failure to commence an episode of care for a Public Patient	



within the timeframe specified in section 3.6(b) of Part 1 of Schedule 2.

- 4 Operator failure to communicate with a Public Patient in accordance with, and within the timeframe specified in section 3.6(c) of Part 1 of Schedule 2.

- 5 Instances of medical practitioners who treat Public Patients not holding appropriate credentialing.

- 6 Failure to submit an NCR in respect of a failure to meet a Performance Threshold within 2 Business Days on 3 or more occasions in any 12 month period.

- 7 Failure to provide a Rectification Plan within 10 Business Days of a KPI Failure.

- 8 Failure to comply with, or achieve the outcome required by, a Rectification Plan within the timeframe required by the Rectification Plan.

- (c) The performance deduction for any Financial Year cannot exceed

- (d) For the purposes of applying this section 2.4:

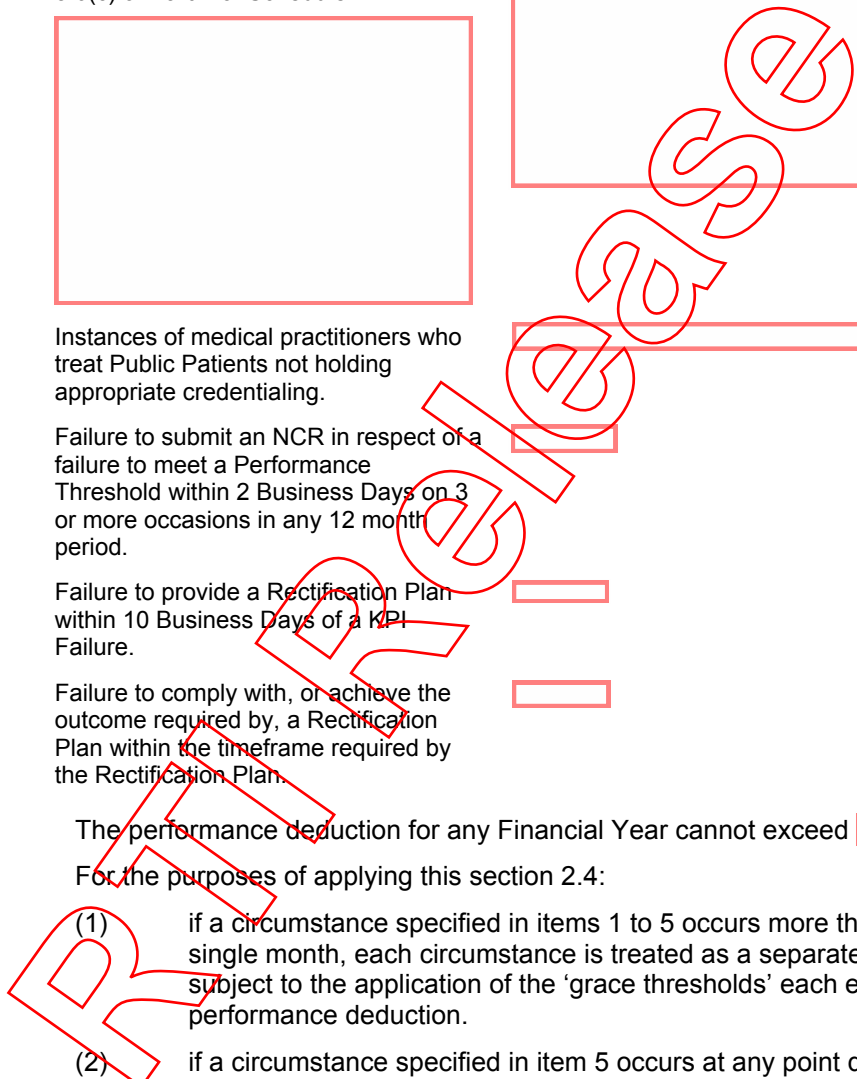
- (1) if a circumstance specified in items 1 to 5 occurs more than once in a single month, each circumstance is treated as a separate event, and subject to the application of the 'grace thresholds' each event incurs a performance deduction.

- (2) if a circumstance specified in item 5 occurs at any point during a month, that circumstance incurs a performance deduction, notwithstanding that the practitioner concerned becomes credentialed during the same month

Example:

Medical Practitioner D starts to treat Public Patients on 3 April. The credentialing process in respect of Medical Practitioner D is completed on 10 April. The deduction is for the month of April.

- (3) for item 6, the measurement will reset each time three occasions in a 12 month period has occurred, to avoid double counting (noting the required three failures can occur in a single month, or in more than



one month, providing that they occur within a 12 month period). If there are failures in January, February, March and May, a deduction would only be made in March. If further failures occur in November, and the following January, a performance deduction would be made in January as well (for the May, November and January events).

(e)

3 Fees for Contracted Services

3.1 Services Fee

The Services Fee is the amount per month determined in accordance with the following formula:

3.2 Additional Services Fee

If section 6.4(b)(2) of Part 1 of Schedule 2 applies in respect of a Public Patient during a month,

3.3 Accounts

Within 10 Business Days after the end of each month, the Operator must issue to QH an account for the fees payable by QH to the Operator for that month, which must contain the information specified in Attachment A to this Schedule.

3.4 Price per WAU

Subject to clause 4.5, for a Financial Year,

TABLE 14 – WAU PRICE FOR EACH FINANCIAL YEAR


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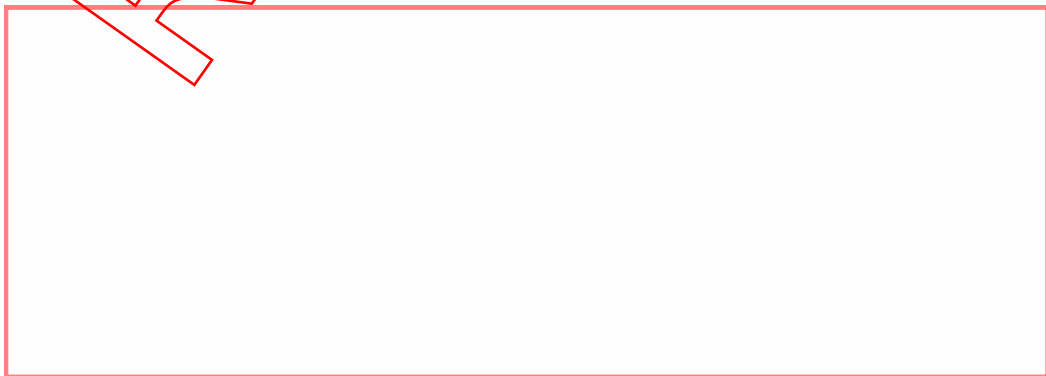
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5 Annual Financial Report

- (a) Within 20 Business Days after the end of each Financial Year during the Term, the Operator shall submit to QH an Annual Financial Report.
- (b) The Annual Financial Report shall present a summary of the performance of the Facility during the Financial Year and will as a minimum include:
 - (1) an Activity Report for the Financial Year, substantially in the form of Attachment C to Part 1 of Schedule 1, including the outcomes of the annual reconciliation process set out in section 4 
 - (2) a summary of all invoices for the Financial Year, including details of each component of the Service Fee and any performance deductions; and
 - (3) occupancy and other activity data;
 - (4) expense KPIs such as pharmacy or supply costs per patient day as benchmarked against other like Operator facilities; and
 - (5) HR reports such as turnover, and absenteeism.
- (c) The Annual Financial Report shall be updated and resubmitted within 10 Business Days of the annual reconciliation process set out in section 4.1 being completed.

6 Calculation of comparative costs





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Attachment A – Form of Account

The Form of Account provided by the Operator on a monthly basis must include the following information:

Account Component	\$
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Part 2 – Operator’s Submission

Nil.

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Signing page

Executed as an agreement

Signed by
The State of Queensland through the Director-General Department of Health

sign here ▶
Director-General
print name Michael Reid

in the presence of
sign here ▶
Witness
print name *PETER C BUTLER*

Executed for and on behalf of
Ramsay Health Care Australia Pty Limited
by its attorney

sign here ▶
Attorney
print name

in the presence of
sign here ▶
Witness
print name

FOR RELEASE

Sunshine Coast University Private Hospital

Quality Manual ISO 9001:2008 2013

Approved by:



Kimberley Pierce
Chief Executive Officer
Sunshine Coast University Private Hospital
Date: September 2013

Version 1.0
September 2013

ACKNOWLEDGEMENTS

1. ISO Standard 9001:2008
2. Quality Manual – Pindara Private Hospital
3. Quality Manual – St Andrews Private Hospital
4. Quality Manual – Greenslopes Private Hospital

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2. Hard Copy – Executive, Quality and Risk Coordinator, After Hours Manager Office

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i Introduction

Ramsay Health Care seeks to be the leading private provider of health care services in Australia by delivering high quality outcomes for patients. Our commitment to quality is based on the concept of Quality Management is a guiding principle of Ramsay Health Care where individual hospitals determine their own improvement priorities in a culture of autonomy, support and trust whilst ensuring all risk management systems identified by Corporate are also met.

Based on this philosophy, Sunshine Coast University Private Hospital has developed and implemented its Quality Management System to the requirements of ISO 9001:2008. At Sunshine Coast University Private Hospital, management philosophy seeks to attain a culture of continuous improvement in the quality of all its processes and services. It emphasises the importance of using evidence based or best practice principles, measurement, response to variation, the role of the customer and the involvement of employees at all levels in the pursuit of such improvements.

This Quality Manual is designed to provide all employees of Sunshine Coast University Private Hospital with an explanation of how Sunshine Coast University Private Hospital has implemented its Quality Management System in accordance with the requirements of ISO 9001:2008. The Manual is comprised of regulatory standards, procedures, instructions, and other quality-related documentation. The Quality Manual is broad and includes Quality Improvement policy systems, process and procedure related information.

This Quality Manual describes the Quality Management System (QMS) used by Sunshine Coast University Private Hospital (SCUPH). The QMS of Sunshine Coast University Private Hospital complies with the National Safety and Quality in Health Service Standards. This Quality Manual is available on the SCUPH Policy and Procedures Intranet page and in hard copy in the Executive Suites, After Hours Manager's Office and Quality and Risk Coordinator office.

Descriptions of the structure of the QMS will reference the sequential numbering of the International Standard ISO 9001:2008 (ISO 9001:2008). While "Associated Documents" are referred for each standard it must be noted that these lists are examples only and by no means exhaustive.

Sunshine Coast University Private Hospital is currently implementing the National Safety and Quality Health Standards (NSQHS). Reference to these standards shall be included in this document following the completion of a gap analysis on all standards.

Exclusions claimed for compliance for ISO 9001:2008 are be listed and justified as applicable.

0.2 EXCLUSIONS

STANDARD 7.3 DESIGN AND DEVELOPMENT

This Standard has been excluded from the QMS of the organisation as no design or development activities are conducted by the organisation, including but not limited to: Design and implementation of research programs Development of a program of clinical trials Design and development undertaken on behalf of the organisation by engaged contractors or other bodies.

THIRD PARTY SERVICES

Radiology, Pathology, Pharmacy and Linen services are contracted to SCUPH and are excluded from the scope of the QMS.

0.3 NORMATIVE REFERENCES

The following referenced documents are indispensable for the application of this manual. For dated references, only the edition cited applies. For undated references the latest edition of the referenced document including any amendments applies to:

ISO 9000:2005, Quality Management Systems – Fundamentals and Vocabulary.

0.4 DEFINITIONS

For the purpose of this Quality Manual, the terms and definitions of ISO 9001:2008 apply.

The term “product” when used in this manual, can also mean “service”.

Integrated Risk Management is a continuous, proactive and systematic process to understand, manage and communicate risk from a hospital wide perspective. It is about making strategic decisions that contribute to the achievement of the hospitals overall corporate objectives and requires ongoing assessment of potential risks for the hospital in every department, then aggregating the results at the Executive Management level to facilitate priority setting and improved decision-making.

National Safety and Quality Health Service Standards (NSQHS. Sept 2012) aim to create an integrated governance systems that maintain and improve the reliability of patient care as well as improving patient outcomes. It provides the framework for safety and quality by outlining the expected governance structures and processes of a safety organisation.

Risk Management is a management process that should be integrated in all levels of the management of the organisation. It applies at all levels of the organisation: enterprise level, function level or business level.

Risk Assessment is a systematic process whereby supervisors, Managers and staff proactively identify, assess and control hazards that may affect people at the place of work.

Policy is a set of principles that reflect the organisation’s mission and direction. All procedures and guidelines are linked to a policy statement.

Procedure: the set of instructions to make policies and protocols operational and are specific to an organisation.

Guidelines are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific circumstances.

Safe Operating Procedures (S.O.P’s) are written instruction identifying health & safety requirements to complete a task.

Monitor to check, supervise, observe critically or measure the progress of an activity, action or system on a regular basis in order to identify change from the performance level required or expected.

Risk Register is a database of risks that face an organisation at any one time. Always changing to reflect the dynamic nature of risks and the organisation’s management of them, its purpose is to help managers prioritise available resources to minimise risk and target improvements to best effect.

Clinical Governance is defined in the Ramsay Health Care Risk Management Framework the way by which the governing body, Managers and clinicians share responsibility and are held accountable for patient care, minimizing risk to consumers and for continuously monitoring and improving the quality of clinical care. Health Quality & Complaints Commission (HQCC) Act 2006 (Qld) Health Care providers have a duty to establish, maintain and implement processes to improve quality of Health Services, to monitor the services and protect the health and wellbeing of users.

HQCC provides an oversight and guidance role to health service providers as to what is expected with regard to monitoring and improving quality of their health services. An annual Quality and Activity Return (AQAR) report is required to be submitted to HQCC of reportable events based on section 29 of the Hospital and Health Boards Regulation 2012.

CLINICAL SERVICES CAPABILITY FRAMEWORK

The following represents the CSCF of the Sunshine Coast University Hospital:

Core clinical Service Streams (on-site)	Level
General Medicine	5
General Surgery	5
Respiratory Medicine	5
Orthopaedics	5
ENT	5
Other clinical Service Streams (on-site)	Level
Gastroenterology	5
Colorectal Surgery	5
Neurosurgery	4
Plastics Surgery	5
Urology	5
Cardiology	5
Endocrinology	5
Supporting clinical services (on-site)	Level
Anaesthetics	5
Critical Care	ICU5/CCU5

0.5 PROPRIETORS DETAILS

Trading Name: Sunshine Coast University Private Hospital
 Proprietor: Ramsay Health Care
 Contact Person: Kimberley Pierce
 Chief Executive Officer
 Business address: 3 Doherty Street, Birtinya. QLD 4575
 Business Telephone: 07 5390 6000
 Business Facsimile: 6001
 E-mail: @ramsayhealth.com.au
 ABN Number: 36 003 184 889

0.6 APPOINTED CERTIFICATION AUTHORITY DETAILS

Company: International Standards Certification (ISC)
 Address: The Quality Centre.
 Suite 2/10 Gladstone Road
 Castle Hill. NSW. 2154
 Contact:
 Telephone: 02 9894 6242
 Fax: 02 9894 6808
 Certifying Standard: ISO 9001:2008
 National Safety & Quality Health Service Standards

1.0 SUNSHINE COAST UNIVERSITY PRIVATE HOSPITAL QUALITY MANUAL

Sunshine Coast University Private Hospital is a Ramsay Health Care facility.

1.1 RAMSAY HEALTH CARE

Ramsay Health Care seeks to be the leading private provider of health care services in Australia by delivering high quality outcomes for patients. Our commitment to quality based on the concept of Quality Management is a guiding principle of Ramsay Health Care where individual hospitals determine their own improvement priorities in a culture of autonomy, support and trust whilst ensuring all risk management systems identified by Corporate are also met.

The Ramsay Way

- We are caring, progressive, enjoy our work and use a positive spirit to succeed.
- We take pride in our achievements and actively seek new ways of doing things better.
- We value integrity, credibility and respect for the individual.
- We build constructive relationships to achieve positive outcomes for all.
- We believe that success comes through recognising and encouraging the value of people and teams.
- We aim to grow our business while maintaining sustainable levels of profitability, providing a basis for stakeholder loyalty.

1.2 SUNSHINE COAST UNIVERSITY PRIVATE HOSPITAL

Sunshine Coast University Private Hospital is a Greenfield development located within Kawana Health Campus.

The aim of Kawana Health Campus is to maximise health benefits by co-locating:

- Sunshine Coast University Hospital (SCUH), new public tertiary teaching hospital commencing services 2016.
- SCUH Skills Academic and Research Centre
- Kawana Health Innovation Park (health related commercial developments), and
- Sunshine Coast University Private Hospital

Sunshine Coast University Private Hospital (SCUPH) is the first service to commence on site; SCUPH will open on 4th November 2013.

The new private hospital located in Birtinya has 200 beds. It provides a significant range and volume of services to both private and public patients. Public patients are managed through a service purchase arrangement with Queensland Health whilst the Sunshine Coast University Hospital itself is being built and commissioned.

SCUPH offers the following services:

- Cardiology
- Endocrinology
- ENT (ear, nose & throat)
- Gastroenterology
- General Medicine
- General Surgery
- Gynaecology
- Oncology
- Orthopaedic Surgery
- Plastic Surgery
- Respiratory Medicine
- Urology

There are six state-of-the-art operating theatres, a cardiac catheter laboratory, a minor procedure room, a day surgery unit, an 8 bed intensive care unit and an 8 chair day oncology/Infusion unit.

The facility includes more than 1000sqm of medical consulting suites. Pathology and radiology services are also available onsite.

The hospital has all single rooms with ensuites. Rooms have a view to the Sunshine Coast hinterland and over Lake Kawana.

SCUPH will deliver private health services to the population of the Sunshine Coast. Providing direct and elective admissions for patients of credentialed Visiting Medical Officers. In addition SCUPH under a contractual arrangement with Sunshine Coast Hospital and Health Service will provide services for directly admitted public medical patients and elective public surgical patients.

To achieve service excellence focused on our customers and in the spirit of continuous improvement, the organisation will structure and maintain the QMS to comply with the Standards of ISO 9001:2008 and incorporate the values encapsulated in "The Ramsay Way" and the organisation's own values.

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ii Organisational Structure

Sunshine Coast University Private Hospital is owned and operated by Ramsay Health Care Australia.

The Executive consists of the following positions which all support and meet the business and workforce objectives of the hospital and Ramsay Health Care.

CHIEF EXECUTIVE OFFICER (CEO)

Provides leadership and strategic direction for hospital staff and functioning; whilst establishing and maintaining strong links with the medical community and third party providers so that the facility provides excellent patient care while meeting its operational and business objectives. Responsible for the operational management of marketing and human resources.

COMMERCIAL MANAGER

Supports and meets the business and workforce objectives of the hospital and Ramsay Health Care by providing leadership and operational management in the areas of administration, health information, finance, information management, stores, building and property and the operational management of environmental and catering services.

DIRECTOR OF CLINICAL SERVICES (DCS)

Provides clinical leadership and operational management of medical, surgical, intensive care, perioperative and allied health services and support services of Learning & Development, Quality & Risk, Volunteers and Resident Medical Officers.

The following management structure supports the Executive team.

DEPARTMENT MANAGERS/SUPERVISORS

Have a responsibility to implement and maintain the procedures required by the Quality Manual and to ensure systems and processes are in place to conform to these requirements which also includes the identification, management and monitoring of risks within their area of responsibility. Each manager/supervisor should conduct risk assessments, at least on an annual basis in accordance with the SCUPH Risk Policy.

QUALITY AND RISK COORDINATOR

Is appointed by hospital Executive and is responsible for ensuring that processes required for the SCUPH quality management system are established, implemented and maintained. The development, monitoring and review of the Risk Register & Risk Management Plan, coordinating and providing risk related reports to SCUPH CEO on the performance of the quality management system and improvements as required. Providing advice and support to staff within SCUPH in relation to the integrated risk management process and liaises with other experts within the hospital such as Work, Health and Safety Manager, Fire Safety Officer, Infection Prevention & Control Co-ordinator, Learning & Development Manager and Executive Management Team.

WORK, HEALTH AND SAFETY MANAGER

Ramsay Health Care's commitment to the health and safety of our employees and all persons who visit our work places, or access our services, together with our commitment to environmental sustainability is central to our business culture.

In this regard, we believe that all injuries and industry related diseases are preventable, and that striving continuously to improve our health, safety and environmental performance is fundamental to our business success.

The Ramsay Health Care Board recognises its corporate responsibility under safety, environmental and associated legislation.

INFECTION PREVENTION AND CONTROL COORDINATOR

RHC is committed to ensuring the safety of patients, employees and contractors in the facility and maintains a high level of Infection prevention practice awareness. HICMR provides guidance in current best practice through policy documentation

VISITING MEDICAL OFFICERS

Accredited to the hospital comply with RHC policy and procedure as a condition of clinical privilege in keeping with the Facility Rules. VMO's participate in hospital committees in relevant areas of expertise and through the Medical Advisory Committee and clinical review sub-committees.

ALL STAFF AND CONTRACTORS

All members of staff have a responsibility to follow the procedures required by the Quality Manual by participating in the integrated risk management process to minimise the risk to patients, staff and visitors and help strive for continuous improvement in all activities and process of SCUPH.

Staff are responsible for:

- Taking action to protect themselves and others from risk.
- Providing safe clinical practice in diagnosis and treatment.
- Participating with other staff in the management of the SCUPH risks.
- Comprehensive and timeliness of reporting to Department Managers of any clinical or non-clinical risks, including hazards, incidents, near misses and concerns.
- Comply with SCUPH policies, procedures, work practices, safe operating procedures and guidelines.
- Annual attendance at mandatory training as determined by RHC and SCUPH.
- Bring to the attention of others the nature of risks which they are facing in order to ensure that they are taking appropriate protective action.
- Contractors to undertake a risk assessment prior to commencing work.

Sunshine Coast University Private Hospital is committed to ensuring and promoting a safety culture with regard to incident management in accordance with Ramsay Health Care (RHC) Incident Management (Policy No: CGU 01:011:01:00P).

Refer Organisation Chart - Appendix A.

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iii Committee Structure

Committees are an integral part of the Quality Management of Sunshine Coast University Private Hospital.

Formal committees are:

HOSPITAL COMMITTEES

EXECUTIVE COMMITTEE

The Executive Committee is responsible for financial, staff, operational, clinical and strategic management and ensuring that the organisation and its risks are effectively and efficiently governed and managed.

MEDICAL ADVISORY COMMITTEE

The Medical Advisory Committee (MAC) as established under the Ramsay Facility Rules forms the senior coordinating clinical body of accredited practitioners (medical staff organisation) at Sunshine Coast University Private Hospital. The committee provides advice to the Executive on relevant hospital policy and planning issues as well as particular medical issues and changes in medical practice including appointment of Visiting Medical Officers.

CREDENTIAL & CLINICAL PRIVILEGES COMMITTEE

The Credential and Clinical Privileges Committee coordinates the credentialing process and ensures that Medical, Perioperative Nurse Assistants and Allied Health Practitioners utilising Sunshine Coast University Private Hospital are competent and practice high quality care.

MEDICAL REVIEW COMMITTEE

The Medical Review Committee facilitates peer review and provides a forum for the medical review of information reflecting the clinical performance of the hospital.

CONSUMER & COMMUNITY ADVISORY COMMITTEE

Ensuring the involvement of and partnership with our Community and Consumers and provision of a forum for generating exchange of ideas.

CLINICAL STANDARDS COMMITTEE

The Clinical Standards Committee provides a forum to ensure a coordinated approach to the delivery of care for patients attending Sunshine Coast University Private Hospital and to monitor the adherence to professional standards and legislative requirements. In addition, reports of outcomes of clinical activities as conducted through the hospital are tabled. The committee includes collaborative groups of internal clinical care providers of the multidisciplinary care team. The committee provides a forum for reporting of outcomes of quality control and quality improvements and advises the Executive Committee. Departmental reports assist with ongoing evaluation of the Quality Management System & Program and activities throughout the hospital.

CLINICAL POLICY SUB COMMITTEE

To ensure all clinical policies are reviewed in a systematic process, reflect best practice, relevant legislation and professional standards, are evidence based and provide appropriate guidance to staff.

CLINICAL PATHWAY SUB COMMITTEE

To ensure all care paths are developed and reviewed according to SCUPH policy and align with SCUPH clinical policies, medical orders, documentation requirements, accepted practice and available clinical evidence.

QUALITY IMPROVEMENT COMMITTEE

The role of this committee is to review the existing quality management system in the hospital and make recommendations on appropriate improvements to enhance service excellence for internal and external customers. Review the completion and results of quality activities and internal audits and take the appropriate action in respect to these results. To ensure all policies comply with current legislation and best practice guidelines.

HUMAN RESOURCE COMMITTEE

To advise on the development, evaluation and revision of human resource practices, policies and procedures. The committee reviews at every meeting the Human Resource KPI's for the organisation to ensure they remain consistent within Ramsay Health Care requirements.

LEARNING & DEVELOPMENT POLICY SUB COMMITTEE

This subcommittee ensures that all organisational competencies (clinical, non-clinical and hospital support services) are developed, reviewed and monitored using a systematic process, are consistent with hospital policy guidelines, are evidence based, reflect best practice, relevant legislation and professional standards and provide appropriate evidence of competence.

LOCAL CONSULTATION SUB COMMITTEE

This subcommittee fulfils the requirements of staff consultation as agreed within the terms of the Enterprise agreement.

PHARMACY & THERAPEUTICS COMMITTEE

A committee aimed at ensuring safe and legal practices is maintained in the use of all pharmaceutical products and services provided within the hospital, whilst it maintains adherence to Qld Department of Health, Australian Commission of Quality and Safety in Healthcare guidelines and statutory legislative requirements. It is the formal committee through which hospital wide pharmacy and medications safety can be monitored and evaluated and appropriate recommendations be made to the Executive and Medical Advisory Committee

WORK, HEALTH & SAFETY COMMITTEE

The committee promotes and facilitates the health, welfare and safety of all staff, visitors and patients at Sunshine Coast University Private Hospital. This is achieved in collaboration with personnel to maintain and promote a safe workplace environment for staff, patients and visitors. Management is committed to regular consultation and communication with staff and relevant stakeholders to:

- ensure that the policy operates effectively;
- build relationships based on honesty, openness, mutual trust and involvement; and
- share the responsibility for meeting the requirements of this policy.

INFECTION PREVENTION & CONTROL COMMITTEE

This Committee is the formal body to review and monitor all infection control issues, standards and policies at Sunshine Coast University Private Hospital, with the ultimate aim being to minimise the transmission of infection and reflect best practice with infection control practices within the hospital.

TRANSFUSION SUB COMMITTEE

To promote a safe and effective transfusion practice within the hospital.

INFORMATION MANAGEMENT COMMITTEE

This is the formal committee to coordinate and manage all information and information systems to ensure that the appropriate standards are maintained, business objectives are met and information needs to internal and external customers are met in accordance with legislative requirements.

FORMS MANAGEMENT SUB COMMITTEE

This is the formal mechanism to ensure that all hospital forms created at SCUPH and used hospital wide or placed on the patient medical record are document controlled, accessible electronically in one centralised repository and reviewed regularly.

HEADS OF DEPARTMENT COMMITTEE

The Hospital Management Meeting supports the Executive in the attaining the strategic goals of the hospital. In addition the meeting discuss operational issues and matters that relate to the delivery of care and culture of the hospital and its staff. Each Management representative communicates back to their team via their departmental and specialty meetings.

PRODUCT REVIEW COMMITTEE

This is the formal committee through which new and existing products are reviewed to ensure cost benefits, evidence based practice, quality care and optimum outcomes are achieved for all hospital products. With the introduction of the SAP system, the committee will monitor compliance with preferred supplier agreements.

HOSPITAL MEETINGS

MEDICAL SPECIALTY/CRAFT MEETINGS

The Visiting Medical Officer (VMO) Speciality Departments of Medicine and Surgery meet to evaluate the clinical outcomes and clinical issues for their specialty. They act as a forum for members of each specialty group to communicate relevant issues and liaise with the Medical Advisory Committee and the Hospital Executive about issues within the department and future planning within the hospital.

HOSPITAL DEPARTMENTAL MEETING

Each Department holds meetings of staff as required by the relevant Director to disseminate information from hospital committees and Executive. These meetings provide a forum for staff at the department level to review local issues and information from the hospital committees and Executive. In addition, financial and service activities of the hospital are reviewed at a departmental / cost centre level.

THIRD PARTY LIAISON MEETINGS

To discuss and address issues relating to service provision and to ensure service levels are consistent with those agreed. To further develop service provision to ensure that it meets the standards required in the changing requirements.

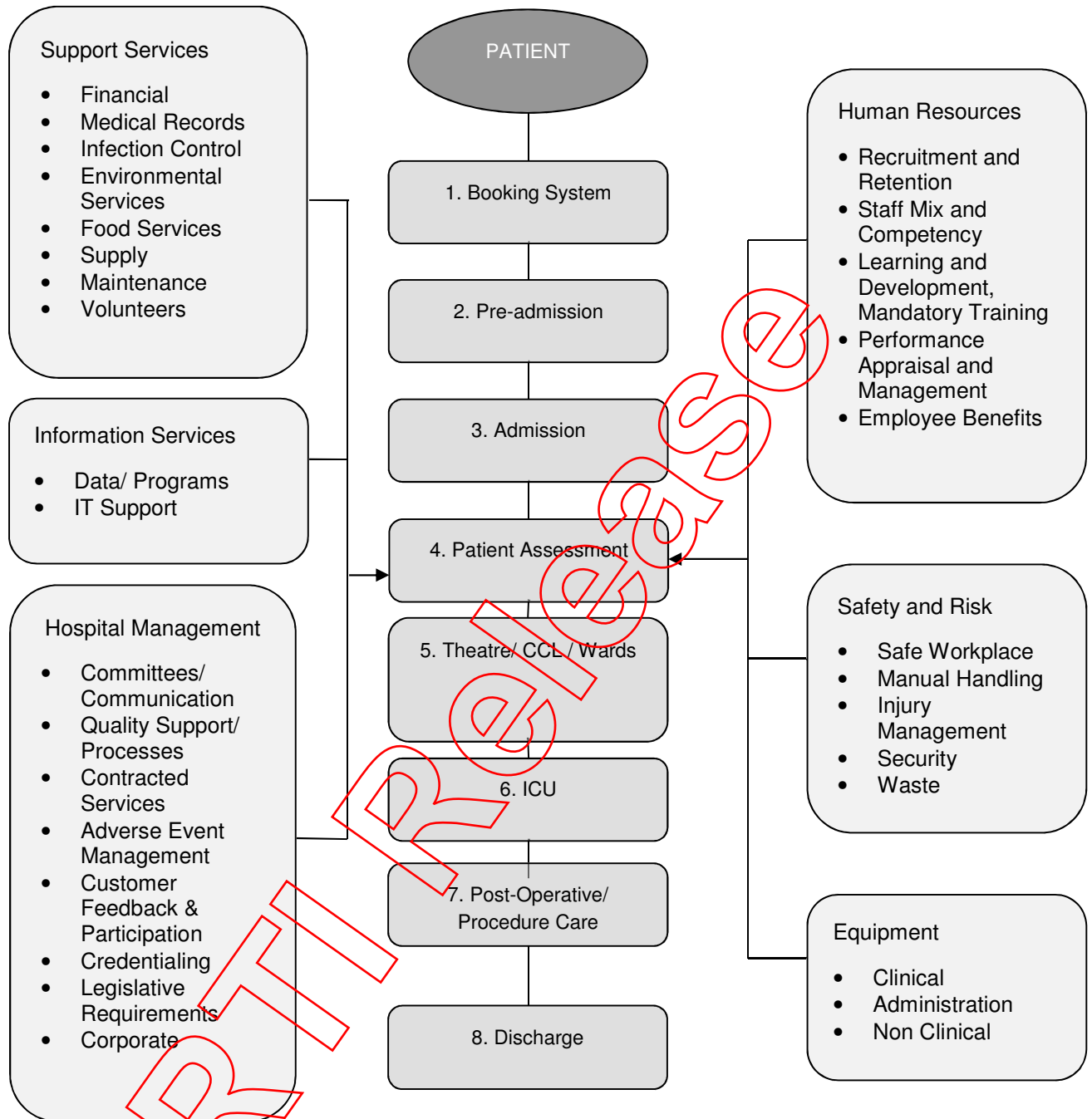
RELATED DOCUMENTS

Hospital Manual

- Organisational Chart: Appendix A
- Hospital Committee Structure: Appendix B
- Committee Terms of Reference: Soft copy on shared I:Drive.
- Committee and meeting Performance Scorecards

Committee minutes/agendas are located on the Hospital I: drive/Committees folder in electronic form and in hard copy in the Executive Suites. Department meeting minutes and agendas are located in each department.

iv Process Map



v History

Ramsay Health Care was selected to build and operate a private hospital collocated on the campus with the future Sunshine Coast University Hospital at Birtinya. Ramsay Health Care is Australia's largest private hospital operator. Founded by Paul Ramsay in Sydney in 1964, the Company has over 47 years experience in the private hospital industry and has extensive experience in providing services to public patients through privately operated public hospitals (Noosa Hospital, Mildura Base Hospital & Joondalup Health Campus) or contracting through private hospitals both in Australia and overseas. Ramsay Health Care also has extensive experience throughout Australia in operating private hospitals collocated with public hospitals.

The Sunshine Coast University Private Hospital opened its doors to private patients on the 4th November 2013 and to public patients on the 2nd December 2013.

The hospital has also started to forge close relationship with the Sunshine Coast University and TAFE to develop under graduate placements for Registered and Enrolled nurses, allied health and support services, for example biomedical engineering, administration and catering.

There are 84 VMOs and 20 Junior Doctors and approximately 400 FTE of staff.

vi Scope of the Quality Management System

The scope of the QMS includes Sunshine Coast University Private Hospital. The hospital has 200 beds and provides an extensive range of inpatient, outpatient and critical care services. This includes 6 Operating Theatres, 8 bed level 5 Intensive Care Unit, Medical Wards, Surgical Wards, 1 Cardiac Catheter Laboratory, a Day of Surgery area, 1 Procedure room, 8 chair Day Oncology Unit,

Sunshine Coast University Private Hospital provides 6 well equipped Operating Theatres that are supported by a 16 bed 1st stage recovery in theatre, and Stage 3 recovery chairs in Day Surgery Lounge. These are also used by the Gastroenterology Unit and Cardiac Catheter Laboratory.

Allied Health Professionals are employed or contracted to provide a comprehensive Allied Health Service. This includes physiotherapy, occupational therapy, psychology, speech pathology, and dietetics. Other support services provided by the hospital include case management, catering, maintenance, environmental services, medical records and biomedical engineering. The Pharmacy services both hospital and retail is provided within Sunshine Coast University Private Hospital and is a contracted service provided by Ramsay Pharmacy Services. Sullivan Nicolaides and Sunshine Coast Radiology provide the pathology and imaging services respectively.

vii Exclusions

The QMS of Sunshine Coast University Private Hospital complies with the requirements of the clauses of ISO 9001:2008 excluding 7.3 Design and Development.

STANDARD 7.3 DESIGN AND DEVELOPMENT

This Standard has been excluded from the QMS of the organisation as no design or development activities are conducted by the organisation, including but not limited to:

- Design and implementation of research programs
- Development of a program of clinical trials
- Design and development undertaken on behalf of the organisation by engaged contractors or other bodies.

Contracted Services are excluded from the scope of the Sunshine Coast University Private Hospital QMS and includes:

- Radiology, Pathology, and Linen services
- Iron Mountain for document storage
- Coffee shop
- Tenancies, and
- ISS (Pest Control)

viii References

1. HB90.8-2000 *Healthcare Services Guide to ISO 9001:2000* (Standards Australia)
2. AS ISO 10013-2003 *Guidelines for quality management system documentation* (Standards Australia).
3. AS/NZS ISO 9000:2006 *Quality management systems – Fundamentals and vocabulary* (Standards Australia & Standards New Zealand Paerewa Aotearoa)
4. AS/NZS ISO 9001:2008 *Quality Management Systems – Requirements* (Standards Australia & Standards New Zealand)

NOTE: The numbering of this manual directly corresponds to the numbering systems of the Standards for which compliance is claimed.

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STANDARD 4: QUALITY MANAGEMENT SYSTEMS

The Quality Management System (QMS) is the mechanism by which SCUPH assures that service delivery is of a recognisably high standard. The QMS is the organisational structures, processes, procedures and resources required to implement quality management within SCUPH.

The SCUPH QMS aligns with the requirements of ISO 9001:2008 Quality Management System and National Safety & Quality Health Service Standards (2011).

KEY PRINCIPLES OF QUALITY

The key principles of quality, as they apply in assessing the performance and/or standards of our work practices, include:

- **Systems thinking** – the perception of the work environment as a system – a collection of interconnecting and interrelated processes.
- **Scientific approach** – including data collection and analysis – agreeing to make decisions which are based on data rather than hunches and opinions. To look for root causes of problems (variation) rather than react to superficial symptoms or anecdotal evidence, hence seeking long term solutions instead of quick fixes.
- **Teamwork** – working as a team to improve processes, facilitate dialogue and understanding and knowledge of those processes that cross formal departmental boundaries.
- **Leadership** – any quality transformation requires strong leadership to provide appropriate direction to the improvement process.
- **Continuous improvement** – the methods and technique for sustaining improvement

QUALITY MANAGEMENT SYSTEM

The Quality Management System is a process within its self. Management are responsible for service delivery, this responsibility is evidenced in establishing clear objectives, appropriate standards of practice and provision of appropriate resources: be that financial, physical or people. At the core of the QMS are customer requirements, understanding your customer requirements are fundamental to successfully meet the quality objectives. Customers' requirements / expectations must be reflected in service delivery in order to achieve customer satisfaction. Continuous monitoring and measurement of service delivery is an essential element of the QMS. Continuous improvement is driven by an understanding of service delivery outcomes as a reflection of the expectations of the QMS. QMS is illustrated in the following diagram.

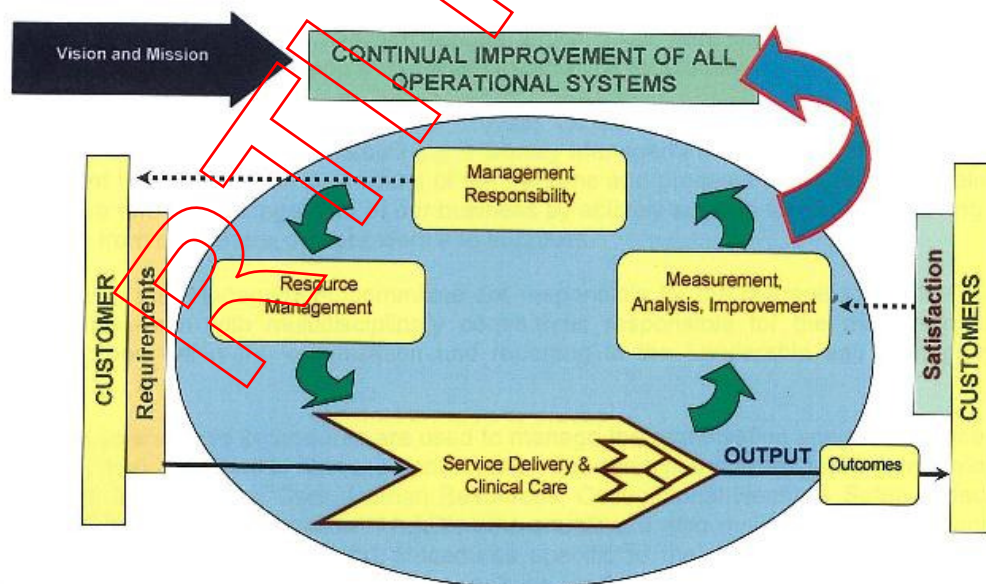


Fig 1: Illustrative model of Quality Management System

SCUPH has integrated a continuous improvement cycle to achieve its quality objectives:

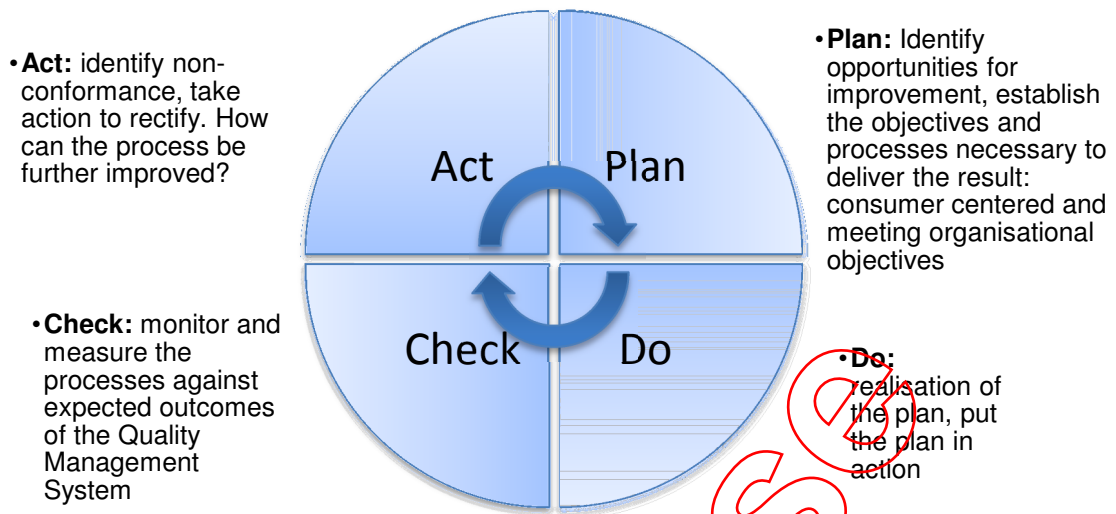


Fig 2: Cycle of continuous improvement

Cycle of continuous improvement: Plan, Do, Check, Act: is a change management tool integrated with ease into all aspects of the organisation from a basic planning framework for significant organisational change to a tool readily utilised in everyday practice. Cycle of continuous improvement is fundamental and complimentary tool within the Quality Management System.

VISION & MISSION

Strategic plan – this is currently being developed for the initial 12 months of operation.

SCUPH Quality Policy (Reference 0001 - Attachments) details SCUPH Quality objectives.

SCUPH Executive Management Team and employees are committed to achieve our quality objectives.

The SCUPH QMS has been developed with the quality objective at its core:

Sunshine Coast University Private Hospital is committed to providing a safe and effective health service of a recognisably high standard that is consumer centred and risk aware. SCUPH will continually aim for service improvement as part of its systemic processes that align with relevant Australian Standards, Codes, Legislation and Best Practice.

4.1 GENERAL REQUIREMENTS

The Executive and employees of Sunshine Coast University Private Hospital have committed to establishing, documenting, implementing and maintaining a Quality Management System (QMS). This includes a commitment to the continuous improvement of the systems and processes used in the delivery of patient care and in the management of the business. This is done in accordance with the requirements of ISO 9001:2008 and Private Hospital and Day Procedure Regulations.

The Executive Committee oversees the implementation and management of the Quality Management System. The Hospital Management Meeting and formal hospital Committees are responsible for the management of specific functions of the organisation and processes within the quality management system.

Policy manuals include policies, guidelines and standard operating procedures to manage the organisation are documented and contained in the following manuals:

- General Hospital Policies
- Department Manuals including
 - Administration
 - Human Resources
 - Environmental Services
 - Food Services
 - Facility management services
 - Grounds and Gardens
 - Supply
 - Learning and Development
 - Health Information Services
- Quality Manual
- Clinical
 - Intensive Care
 - Medical
 - Surgical
- Infection Control
- Work, Health and Safety
- Documented Emergency Response procedures are detailed in the following plans:
 - Disaster and Business Contingency Plan
 - Fire & Evacuation Plan

All personnel have Position Descriptions and have access to policies and procedures relevant to their role requirements.

An audit program ensures monitoring and measurement of processes. Data collection and benchmarking is undertaken to assist in the continuous improvement of these processes. Data is obtained from multiple sources and used to evaluate processes involved in care and services. Non-clinical sources include: regular financial reviews, cost benefit analysis, service utilisation reviews, staff performance reviews, minutes of functional and departmental meetings, education reviews, safety audits and incidents. Clinical and patient related sources include: medical records, case reviews, patient care paths/plans, variance analysis, incident reports, and reports from infection control, patient satisfaction surveys and clinical indicators.

The Quality Framework at Sunshine Coast University Private Hospital is based upon the following key principles:

1. Establish the objectives and processes necessary to deliver results in accordance with internal and external customer requirements and hospital policies and procedures.
2. Implement the processes.
3. Monitor and measure processes and service provision against policies, standards, statutory requirements, and objectives and report the results.
4. React to process variance and demonstrate actions to continually improve process performance.

Requirements of the International Standard ISO 9001:2008, National Safety and Quality Health Service Standards (NSQHS) are considered applicable to our Quality Management System.

CUSTOMER REQUIREMENTS

Ramsay Health Care and SCUPH recognise and endorse the Australian Charter of Health Care Rights. The Charter details the rights of healthcare consumers:

Right to:

Access:	Access healthcare
Safety:	Receive safe and high quality care
Respect:	Be shown respect, dignity and consideration
Communication:	Be informed about services, treatment options and costs in a clear way
Participation:	Be included in decision about their healthcare
Privacy:	Privacy and confidentiality of personal information
Comment:	Comment about services received and have these concerns addressed.

The Charter allows for a shared understanding between patients, families and healthcare providers of the rights of people receiving healthcare. It is the role of healthcare providers to take every opportunity to promote and respect these rights.

Further information is available at www.safetyandquality.gov.au

4.2 DOCUMENTATION REQUIREMENTS

4.2.1 GENERAL

The documented QMS of Sunshine Coast University Private Hospital is in electronic format on the SCUPH Policy and Procedure Intranet page and is accessible through departmental Personal Computers (PCs). A hard copy is accessible in the Executive Suites, After Hours Manager office and the Quality and Risk office.

The QMS is the responsibility of the Director of Clinical Services. Day to day management of the controlled documentation is delegated to the Quality and Risk Coordinator. QMS documentation that is not controlled is in hard copy and is the responsibility of the Quality and Risk Coordinator.

- (a) The Sunshine Coast University Private Hospital Quality Manual gives broad statements of compliance and lists associated documentation examples to meet the requirements of ISO 9001:2008 and the Core Standards.
- (b) The collection of policies, procedures, forms and where relevant, work instructions, ensures the effective operation and control of the Sunshine Coast University Private Hospital processes.

The extent of the documentation takes into account:

- (a) The size and type of the health care service as described in the organisation structure of this manual, scope of the business and the relationship to other businesses in close proximity and which may be associated with Sunshine Coast University Private Hospital.
- (b) Competency of personnel. Sunshine Coast University Private Hospital employs staff in alignment to professional scope of practice and delivery of services. This includes registered nursing staff (RN and EN), assistants in nursing, medical staff, credentialed Allied Health practitioners, sterilising technicians, catering and environmental services personnel, biomedical engineers and technicians and administration staff. Credentialed Medical Officers have admitting privileges as per the Ramsay Facility Rules. External Allied Health professionals are credentialed as per Ramsay Facility Rules prior to being requested to see patients.
- (c) The documented policies and procedures required by the ISO 9001:2008 and the QMS are included in this Quality Manual as an Attachment and are accessible via the SCUPH Policy and Procedure intranet site. They include:
 - Quality Management & Improvement (Ref 0001)
 - Control of Documents (Ref 0002)
 - Control of Records (Ref 0005)
 - Internal Audit Program (Ref 0009)
 - Control of Non-conformances, Preventive and Corrective Actions (Ref0006)

ASSOCIATED DOCUMENTS

- SCUPH Strategic Plan
- Food Safety Plan
- Emergency Plans
- Hospital Policy and Procedure Manual
- Clinical Policy and Procedure Manual
- Health and Safety Policy and Procedure Manual
- Department Policy and Procedure Manuals
- Infection Control Policy and Procedure Manuals
- Orientation Staff Manuals
- Meditech Manual – online
- External Documents Register
- SCUPH Forms Register

4.2.2 QUALITY MANUAL

The Quality Manual describes in broad terms the QMS used by Sunshine Coast University Private Hospital.

The “Associated Documents” section of each part of the Quality Manual makes reference to examples of documented procedures pertinent to each clause. The documented procedure in turn, describes the sequence and interaction of the process included in the QMS.

The Quality Manual is a controlled document. Ref. Clause 4.2.3.

SYSTEM DOCUMENTS

Documents contained within the Quality Management System include the following:

- Documented policies and procedures as required by ISO 9001: 2008 Quality Management Systems Standard.
- Organisational documents, which describe and define how the business processes are undertaken, and record the results of the monitoring and measurement of the business management system processes.
- Clinical documents which contribute to the patient’s clinical care.

RECORDS

Records include completed forms, monitoring and measurement records as well as documents needed for clinical care, and to ensure the effective planning, operations and control of the business, including management review and internal audit reports.

These records are retained electronically in response to legal requirements, contractual obligations or as objective evidence of compliance to the Quality Management System.

4.2.3 CONTROL OF DOCUMENTS

Sunshine Coast University Private Hospital has a documented procedure to ensure that the documents required for the QMS described in 4.2 are controlled. The procedure incorporates the requirements of clause 4.2.3 (a) for approval of documents prior to use and communication methods of revised documents to the appropriate people. This includes documented procedures for separate departments and functions within the organisation.

The documented control procedure includes provision for review, update and approval and disposal of obsolete documents.

A master list of policies for the manual is maintained by the Quality and Risk Coordinator electronically via Share Point. The master list is continually under review with new additions made and tabled at the relevant committee. A notification list is circulated to Hospital Management monthly advising of new and updated policies. The review dates, issue dates and title of the electronic manual where the policy may be located are contained in the footer of each document.

All documents are computer generated, and amendments are updated at the earliest opportunity following the policy review. All policies and procedures are uploaded to the SCUPH Policy and Procedure intranet page in PDF by the Administration Assistant for Quality and Safety following approval of amendments. The document registers maintained by the organisation, reference departmental and QMS documents.

A master list of documents of external origin showing each document title, issue date and distribution is maintained by the Quality & Risk Coordinator. Changes in the system are reflected by changes in the master list. Documents can be accessed in our SCUPH Policy and Procedures intranet page (this includes forms). The internal and external register of documents is viewable on the SCUPH Policy and Procedures intranet page via the Forms link.

The Health Information Manager is responsible for the management of the medical record and applying a medical record number to any relevant form. A master index inclusive of revision dates is maintained by the Health Information Manager and this is located on the SCUPH Policy and Procedures intranet page via the Forms link.

The continuing integrity of electronic data is managed by the Ramsay Health Care Corporate information management team and the Quality and Safety Manager at a local level.

ASSOCIATED DOCUMENTS

- Control of Documents, Forms and Records Policy
- Forms Ordering/Approval Policy
- Retention and Disposal Policy
- Master Document Control Register
- SCUPH Strategic Plan
- Ramsay Medical Documentation Audit

4.2.4 CONTROL OF RECORDS

Sunshine Coast University Private Hospital controls the records it maintains as evidence of conformance to the requirements of the QMS. Records are managed by the Health Information Services department. The organisation reflects the importance of the medical records it controls with a separately managed and physically contained department. Consideration in building developments will ensure records are stored and protected from water & fire damage.

All medical records are scanned electronically when the patient is discharged. The computer system backs up immediately, once back up has occurred the medical record can be destroyed.

Documentation includes the requirements for storage, identification, retrieval, protection, retention time and disposition. Nightly backups of both the Finance & Supply and Patient Administration systems occur; this information is written to a tape library in the Ramsay Corporate Data Centre. The tape library holds sufficient data tapes for a full week's backup and tape changes are managed weekly by the Data Centre hosting provider. Daily, monthly and end of year backups are performed. In the Cardiac Catheter Laboratory records are maintained on a master server maintained by the vendor.

A record control system has been implemented for the preparation and maintenance of records. This system provides compliance with the requirement of the Quality Management System, legislative requirements, and the management of the business. It includes the identification, storage, protection, retrieval, retention times, and disposal of records.

Retention and Disposal of clinical records will be, as a minimum managed in line with Electronic Transactions Act 2001 (Qld), Australian Standard AS2828 (int)-2102 Part 2 Digitized (scanned) health records system requirements, Queensland Health (Clinical Records) Retention and Disposal Schedule QDAN 546 V3 and Queensland State Archives Digitisation Disposal Policy.

SCOPE OF RECORD MANAGEMENT SYSTEM

The system applies to:

- Patient clinical records.
- Personnel and training records.
- Specific business and financial records.
- Documentation relating to quality management systems such as results of internal and external audits, inspections and reports.

ELECTRONIC REGISTERS

Electronic registers are maintained for

- Organisational documents – General
- Organisation documents – Policies and Procedures
- Forms and Patient Information (internal)
- External Documents
- Record management

ASSOCIATED DOCUMENTS

- Control of Documents, Forms and Records Policy (attached)
- Records maintained at Sunshine Coast University Private Hospital include but are not limited to:
 - a) Medical Records
 - b) Cardiac Catheter Laboratory images and haemodynamic data
 - c) Management reviews
 - d) Personnel records
 - e) Minutes of meetings
 - f) Maintenance records
 - g) Training records
 - h) Inspection records
 - i) Audit records
 - j) Non-conformance, Corrective & Preventive actions taken including fixes and reporting
 - k) Purchasing records
- Australian Standards – Paper based Health Care Records AS2828-2012

EXTERNALLY SUPPLIED DOCUMENTS

Documents that are provided by an external source are included either directly on the SCUPH forms intranet site under external document register with as much identifiable information as possible from the document. If Sunshine Coast University Private Hospital need to only use the external document as a base then the document is amended using the Document Control procedure. The document will be recorded in the External Register.

DOCUMENT ACCESS & VIRUS PROTECTION

The IT network and equipment at Sunshine Coast University Private Hospital is maintained by the IT Services team for Ramsay Health Care with regional support provided by the IT Services Team – Qld, located at Greenslopes Private Hospital and also on site at Sunshine Coast University Private Hospital. All PCs are securely connected to the Ramsay corporate private network. A limited number of servers are located on site in the IT Server Room (secure access) which are backed up nightly via an automated tapeless backup process. The various hospitals servers for file (H: & I: drive), Exchange (email), Finance, Supply, HR, Riskman and Windows applications are located in the Corporate Data Centres in Sydney. All servers located in the Corporate Data Centres, are backed up via an automated nightly backup process and reported on daily. A Disaster Recovery data centre (secondary hub) is located in the Fujitsu data centre at Homebush, this DR site contains a data & application fail over mechanism with real time data replication from the primary data centre. Located within the Ramsay intranet site is the disaster recovery plan in the event of server malfunction and instructions regarding the Meditech offline process

There are shared folders of which one is specifically for the Executive Office to ensure access to confidential information is kept limited. The SCUPH intranet is for all staff with access to a computer and this website provides all documents, forms and general information that staff may require at any time. All staff (with computer access) also has access to an individual H: drive for storing of private documents and access to their Department and Hospital public staff access documents (I: drive). The Managers Resources Intranet page on this site is restricted access for managers only and provides access to specific documents. Generally the shared folders and the SCUPH intranet are able to be accessed by all staff however access to shared folders, folders and documents can be restricted, and this can be arranged through the IT Helpdesk by logging a request either via email, phone or the IT support system on the intranet.

All PCs are loaded with McAfee antivirus software which does real-time scanning of web pages and documents accessed from the PC. McAfee is set to check its own security settings on the individual PC every 15 minutes and will check for antivirus security updates from the policy server every 4 hours to ensure that the system is current and the latest antivirus definitions are in use.

SUNSHINE COAST HOSPITAL AND HEALTH SERVICE (SCHHS) AGREED PLATFORM

The Sunshine Coast University Private Hospital (SCUPH) and the Sunshine Coast Hospital and Health Service (SCHHS) Portal has been developed as a component of the agreed platform under the Services Level Agreement. The electronic transmission of referral orders via the portal will improve the time and resources used for the completion of referral orders. The portal will also provide real-time visibility to SCUPH's Bed Management system.

BENEFITS

- The development of a secure, modern, efficient and effective Portal for the electronic referral of patients to SCUPH and the visibility of SCUPH's Bed Management system will significantly enhance services between SCUPH and SCHHS.
- Implementing a system for electronic referrals and data transfer process, will provide a consistent transmission process.

KEY CONCEPTS OF THE PORTAL

The portal has been developed to enable the secure online transmission of referral orders and provide visibility of SCUPH's bed availability. It allows

- Sending single or batched Direct and Elective online Referral orders via the portal
- Batched records (max 20mb) may be uploaded as a csv file
- Ability to attach scanned medical information against a referral order
- Visibility of SCUPH's Bed Management System
- Linking of discharge summary information against Referral orders

RTI Release

STANDARD 5: MANAGEMENT RESPONSIBILITY

5.1 MANAGEMENT COMMITMENT

Hospital Management led by the Executive, demonstrate commitment to the Quality Management System by:

- (a) Communicating with employees the importance of meeting customer, statutory and regulatory requirements. Communication occurs via the Hospital Management Meeting and as outlined in the Quality Improvement policy (attached).
- (b) The Quality Improvement policy has been established and approved by the Hospital Executive.
- (c) Developing and implementing quality policies and objectives. These objectives articulate a "Policy Purpose and Scope" and "Policy Statement".
- (d) Sunshine Coast University Private Hospital Executive is committed to management review demonstrated by documented Terms of Reference, Standing Agenda items, and minuted management meetings.
- (e) Sunshine Coast University Private Hospital Executive identifies the required resources through the management review process. The CEO has delegated responsibility and authority from Ramsay Health Care Australia to make resources available as they are required.
- (f) Participating in Ramsay Health Care projects and committees as required.
- (g) Reporting Quality Specifications as directed by the Governing Bodies on a routine basis
- (h) Participating in external peer review and benchmarking activities

ASSOCIATED DOCUMENTS

- Quality Management and Improvement policy (Ref 0001 attached)
- SCUPH Strategic Plan
- Committee Terms of Reference (attached)
- Committee and Meetings Agendas & Minutes
- Reports tabled from formal committees

5.2 CUSTOMER FOCUS

The Executive of Sunshine Coast University Private Hospital ensures customer needs and expectations is identified and fulfilled.

Feedback from patients is obtained via patient feedback forms and participation in Press Ganey 2nd annual patient satisfaction surveys. The feedback forms are placed in every patient's room and upon completion these forms are placed in a locked box located in every ward and procedural area. At the end of every month the Administration Assistant for Quality and Safety collects the feedback forms and enters the information into a database located in the Compliments and Complaints folder on the Quality and Safety Unit shared drive. The Patient Liaison Manager also reviews the feedback forms and compiles a report presented monthly to the Nurse Unit Managers and Quality Improvement Committee. The Patient Liaison Manager also contacts those patients who have requested this on their form. Staff recognition is also collated from these cards

Satisfaction Surveys are conducted for Employees, Inpatients, and Day Surgery patients, survey results are communicated to all employees and action plans developed and implemented to address opportunities for improvement. The results from these improvement initiatives are evaluated in subsequent surveys. VMO's are able to table comments and suggestions via the Medical Specialty/Unit Meetings and the Medical Advisory Committee. Actions developed are documented in department business unit plans.

The regulatory, stated and implied needs for each group are met by knowledge and adherence to the relevant Acts and Codes of Practice. The organisation has a policy of employing appropriately credentialed and certified staff. A customer defined focus is evidenced by the planned outcomes indicated by the clinical care paths in use throughout the organisation.

Customer service programs are in place and regularly reviewed to ensure customer satisfaction is prioritised. All staff complete mandatory training during the orientation process and annually thereafter.

ASSOCIATED DOCUMENTS

- Customer feedback forms
- Results of Press Ganey Surveys
- Press Ganey Action Plan
- Minutes of Department meetings
- Patient information Brochures
- Customer Service Training Programs

LEGISLATION/STANDARDS/POLICIES

- Private Hospital & Day Procedures Act & Regulations
- Nurses & Midwives Act & Regulations
- Health and Safety Act, Regulations and Codes of Practice Qld
- Medical Practice Act
- Health Records and Information Privacy Act
- Health Care Liability Act
- Health Care Complaints Act
- Health Services Act
- Privacy and Personal Information Protection Act
- Mental Health Act 2000
- Public Health Act 1953
- Qld Health Department Policy Directives
- Clinical Services Capability Framework
- Private Facilities Act and licensing
- Commonwealth Department of Health Circulars and Directives
- Core Standards for Safety & Quality in Healthcare
- EPA Radiology Licensing Requirements
- ACORN Standards
- Australian Standard ASNZ 4187-2003
- Ramsay Facility Rules
- Electronic Transactions Act 2001 (Qld)
- Australian Standard AS2828 (int)-2102 Part 2 Digitized (scanned) health records system requirements
- Queensland Health (Clinical Records) Retention and Disposal Schedule QDAN 546 V3
- Queensland State Archives Digitisation Disposal Policy
- Freedom of Information Act
- Administrative Access
- Information Standard 42
- Privacy Act 1988

5.3 QUALITY POLICY

The Quality Management & Improvement Policy of Sunshine Coast University Private Hospital meets Standard 5.3 through ensuring:

- Appropriateness to the purposes of Sunshine Coast University Private Hospital refer to Policy "Objective" which includes a commitment for the culture of the organisation to reflect the Ramsay Way. The Ramsay Way is also displayed in public areas, e.g. the foyer.
- The commitment to meeting requirements and to continual improvement see "Policy" statement.
- The framework for establishing and reviewing the quality objectives of Sunshine Coast University Private Hospital is established in the "Policy".
- The hospital Executive of Sunshine Coast University Private Hospital has ensured the Quality Improvement policy is communicated and understood within the organisation through the "Policy" and "Policy Procedure."
- The Quality Improvement policy of Sunshine Coast University Private Hospital has clear provision for review for continuing suitability; refer "Policy Statement".

ASSOCIATED DOCUMENTS

- The Ramsay Way
- Quality Management & Improvement policy (Ref 0001) in Attachment
- Quality Improvement Committee Minutes
- Executive Committee Minutes

5.4 PLANNING

5.4.1 QUALITY OBJECTIVES

The quality objectives of Sunshine Coast University Private Hospital are set by the senior management at Hospital Committees and Department meetings and are incorporated into the Strategic Plan. Achievement of quality objectives is measured through comprehensive patient and staff surveys, clinical indicators, audit reports, key performance indicators and Riskman data which is reported at formal committees and management meetings. The Quality Improvement policy is reviewed annually or more often as required by the Quality Improvement Committee and the CEO.

The Executive and all employees will ensure that through the Quality Management System, the quality objectives will be understood, achieved, measured and recorded.

The Quality objectives are incorporated throughout the SCUPH Strategic Plan and include:

- We aim to be the leader in private hospital services and to this end SCUPH is committed to the highest quality health care
- We will conduct our business with integrity, credibility and respect for the rights and views of others
- Sunshine Coast University Private Hospital will provide a positive and supportive work environment that recognises that staff are our greatest asset
- We will recognise the value of SCUPH staff through encouraging personal and professional development
- We aim to grow our business while maintaining sustainable levels of profitability
- We will build constructive relationships with all stakeholders to ensure positive outcomes for Sunshine Coast University Private Hospital and Ramsay Health Care

ASSOCIATED DOCUMENTS

- Quality Management & Improvement policy (Ref 0001)
- SCUPH Strategic Plan and departmental business plans
- Quality Plan
- Minutes of the Quality Improvement and other Committee meetings.
- Documents of the QMS, e.g. Policy and Procedure Manuals.
- Clinical indicator data
- Audit reports
- Riskman database

Sunshine Coast University Private Hospital demonstrates its commitment to continuous improvement through the monthly meetings of the Quality Improvement Committee, other committee meetings, the establishment and utilisation of audit activities, use of projects and the quality improvement intranet site.

ASSOCIATED DOCUMENTS

- Minutes of Quality Improvement Committee
- Terms of Reference of Hospital Committees (Attachment)
- Quality Improvement & Corrective / Preventive Action Register
- Strategic Project listing and reporting table

5.4.2 QUALITY MANAGEMENT SYSTEM PLANNING

The Executive of Sunshine Coast University Private Hospital ensures that the Quality Management System is planned in order to meet the requirements of the Standard and for the achievement of the Quality Objectives. It also ensures that the integrity of the system is maintained. Planning is incorporated into the strategic planning process.

A new strategic plan incorporating quality management objectives is developed every three years with input from staff. The action plan component is reviewed and updated annually after Management planning workshops. This plan outlines the organisation's strategic and quality goals and objectives, actions and KPIs for the following financial year. Ongoing monitoring of achievements in the strategic plan occurs at the Executive Committee and issues tabled at Committees and Hospital Management and Department meetings as required.

The hospital Executive annually identifies the resources needed to meet the quality objectives in the Quality Improvement policy.

The resources are identified in:

- SCUPH Strategic Plan
- Quality Plan
- Quality Management & Improvement policy (Ref 0001)
- Minutes of Executive and Quality Improvement
- Clinical Pathways & guidelines
- Staffing KPIs
- Annual budget
- CAPEX applications and approvals

QUALITY PLANNING FOR CHANGE MANAGEMENT

A plan will be documented for any significant change in Sunshine Coast University Private Hospital functions and/or services. The plan will specifically address how the integrity of the quality management system is maintained during any significant change period.

ASSOCIATED DOCUMENTS

- Project Plans
- SCUPH Strategic Plan
- Department Business Plan
- Meeting Minutes

5.5 RESPONSIBILITY, AUTHORITY & COMMUNICATION

5.5.1 RESPONSIBILITY AND AUTHORITY

It is the Executive's objective to involve all staff in adopting a quality approach, integrating the principles of continuous improvement. On commencement of employment, all employees receive and sign a Position Description, which outlines their responsibility for Quality Improvement and performance. This is reviewed within 6 months after commencement and annually as part of the Performance Appraisal Process. Completed Performance Appraisals are retained in employee personnel files.

This information is communicated to the organisation via the organisation charts, defining the relationship to Ramsay Health Care and the interrelationships within the organisation.

These are further defined in the documented QMS. Refer clause 4.2.

Electronic copies of Position Descriptions are managed by the Human Resources Department using a shared drive with restricted access. Performance Appraisal documents are located on the forms page of the SCUPH intranet and Ramsay Health Care Intranet (People & Culture). In addition staff can access a hard copy of their position description from the Human Resources Department.

The procedural details in the policy documents have included authority and responsibility.

ASSOCIATED DOCUMENTS

- Organisational Chart (Appendix A)
- Position descriptions
- Performance Appraisal documents
- Departmental policies, guidelines and safe operating procedures

5.5.2 MANAGEMENT REPRESENTATIVE

The Director of Clinical Services is delegated by the CEO as the Executive representative for the Quality Management System with responsibility and authority for ensuring that the Quality Management System is implemented and maintained in accordance with the requirements of the ISO 9001:2008 standard. This is achieved in liaison with the Quality and Risk Coordinator.

In the absence of the Director of Clinical Services, responsibility and authority will revert to the Chief Executive Officer.

- The processes of the QMS are established and maintained by the Quality and Risk Coordinator through Quality Improvement Committee meetings and where required, in consultation with a suitably qualified external consultant on matters relating to the quality system.
- The Quality and Risk Coordinator provides monthly reports to the Clinical Standards Committee, Executive Committee and Quality Improvement Committee meetings, which may include recommendations for improvement of the QMS.
- Departmental Managers are responsible for communicating the identified needs of customers to their direct reports via committee and staff meetings, email, one-on-one discussions, and organisation procedures.
- All managers are responsible for reporting and maintaining quality activities in their areas.

ASSOCIATED DOCUMENTS

- Position description
- Position requirements
- Patient feedback forms
- Internal newsletters
- Minutes of committee meetings
- Press Ganey Reports
- Audit reports

5.5.3 INTERNAL COMMUNICATION

Effective internal communication is maintained through regular committee meetings, department meetings, memos, emails, Ramsay Health Care Intranet, notice board displays, and the quarterly publication of the hospital newsletter. Communication at a clinical level is maintained through clinical records, progress notes and verbal communication.

ASSOCIATED DOCUMENTS

- Newsletters
- Noticeboards – Hospital & Staff rooms
- Patient medical records
- Minutes of meetings
- SCUPH Strategic Plan
- Departmental Business Plans
- Riskman
- Audit Reports

5.6 MANAGEMENT REVIEW

5.6.1 GENERAL

Sunshine Coast University Private Hospital's management team review the hospital's Quality Management System annually as part of the Strategic Plan review and development, to ensure the suitability, adequacy and effectiveness of the QMS. The quality processes are reviewed monthly in the Quality Improvement Committee and in discussion throughout the monthly Hospital Management meetings to ensure its continuing sustainability, adequacy and effectiveness.

The quality, risk management and document control system is refined, in response to user requests, by Quality and Risk Co-ordinator to meet changing needs.

The audit results and quality improvement activities and logs are reviewed monthly at Quality Improvement Committee and other relevant hospital Committees. Relevant results are then tabled at the appropriate committee meeting e.g. MAC, Clinical Standards and Infection Control. Internal audit results and Preventive and Corrective Actions are a standard agenda item for all committee meetings and the minutes record discussion, outcomes and actions. The review includes the Quality Improvement policy and quality objectives.

Records of management reviews are held as minutes and filed with the relevant meeting agenda. Reports from management reviews are cascaded down through the organisation via the department managers. These reviews assess improvement opportunities and evaluate the need for changes to the quality management system, including business policy and objectives as aligned with Ramsay Health Care.

ASSOCIATED DOCUMENTS

- SCUPH Strategic Planning documents
- SCUPH Strategic Plan
- Set Agendas
- Quality Management & Improvement policy (Ref 0001)
- Committee Terms of Reference (Attachment)

5.6.2 REVIEW INPUT

People participating in the Hospital Planning Workshop which incorporates management review include the Hospital Management group. Documents or presentations on performance, hospital wide risks, progress to the action plan are prepared and distributed to attendees.

ASSOCIATED DOCUMENTS

- Organisational Chart (Appendix A)
- Strategic Plan action plan updates
- Risk Assessment worksheet
- CEO/ DCS / CM presentations
- Press Ganey Survey reports

5.6.3 REVIEW OUTPUT

Decisions and ideas generated at the workshops, which include resolution of issues and improvements to the system, are recorded and incorporated into the SCUPH Strategic Plan action plan. This updated plan is reviewed by the Executive prior to finalisation and Executive approval. The updated plan is communicated to the organisation. Resources required for improvements are identified and documented. Delegation for resource application resides with the Executive representatives and/or CEO.

Information that is used in the formal review process includes but is not limited to:

RESULTS OF AUDITS

- Results of external reviews, such as Department of Health Inspections, Fire Inspections & environmental audits
- Internal audits.

CUSTOMER FEEDBACK

- Customer feedback gained from complaints, comment forms, and satisfaction surveys.
- Training requirements.
- Feedback from Committees.

PROCESS PERFORMANCE & PRODUCT CONFORMITY

- Achievement of the organisation's strategic goals.
- Analysis of data and trends in health outcomes.
- Reports on quality improvement activities from departments.
- Results from supplier service evaluation.
- Results from professional contract service evaluations.

FOLLOW UP ACTION FROM PREVIOUS MANAGEMENT REVIEWS

- Outcomes from corrective and preventive action taken.

CHANGES THAT COULD AFFECT THE QUALITY MANAGEMENT SYSTEM

- Changes to legislation or statutory regulations, which may affect the organisation's activities.
- Changes in case mix.
- Changes in business /services.
- Review of resources.

FINANCIAL RESOURCES

- Budget Review
- Business Case submissions
- Special Capital funding submissions

ASSOCIATED DOCUMENTS

- Budget
- Quality Management & Improvement policy
- SCUPH Strategic Plan
- Departmental Business Plans
- SCUPH Risk Register
- Agenda and Minutes of Meetings
- Hospital Policy Manuals
- Audit reports- SCUPH intranet
- Budget – Executive
- Complaints Register- Riskman
- Compliment Register
- Customer survey results

RHP Releases

STANDARD 6: RESOURCE MANAGEMENT

6.1 PROVISION OF RESOURCES

In accordance with the requirements of ISO 9001:2008 Sunshine Coast University Private Hospital has identified and provided the people, facilities, equipment and structures needed to enhance customer satisfaction by meeting customer needs, and to implement and improve the Organisation's QMS.

Resources are reviewed on a regular basis at budget meetings, Executive, Hospital Management Meeting, Clinical Standards Committee Meeting etc, and are aligned with identified customer needs. Refer to clause 5.6 Management Review.

ASSOCIATED DOCUMENTS AND IT PROGRAMS

- SCUPH Strategic Plan
- Meeting Minutes
- Committee Terms of Reference (Attachment)
- Customer feedback forms and complaints mechanisms
- Asset register
- Budget
- CAPEX requests/approvals
- CHRIS 21

6.2 HUMAN RESOURCES

6.2.1 GENERAL

Sunshine Coast University Private Hospital has policies and procedures for the recruitment of staff to ensure that staff have completed the appropriate education and experience prior to commencement. The Chief Executive Officer is responsible for the overall management of human resources. Day to day management is delegated to the Human Resources Manager. The Learning and Development and Clinical Units are responsible for the development and implementation of training and development programs to meet the needs of individual employees and the organisation, to support the delivery of safe care and services.

The policy documents provide guidance regarding aspects of human resource management, including the recruitment, selection, and employment of new employees.

6.2.2 COMPETENCE, AWARENESS AND TRAINING

On commencement of employment, all new employees are requested to complete an online orientation process prior to commencement of first shift, which outlines key Ramsay Health Care policies and procedures. All staff are also required to attend a half day face to face orientation workshop to address key hospital specific policies and procedures. Environmental and food services staff are required to attend an additional half day interactive session where they are introduced to the practical elements of their role. Nursing staff also are required to attend a half-day interactive session focussing on the practical elements of their role including scope of practice, patient care and safe patient management. All staff also undertake a structured orientation program in their department where they are introduced to their department and role requirements.

All registration and certification requirements are identified in position descriptions and verified upon commencement of employment. Registration details are monitored to ensure currency and registration renewals are verified and recorded in the Human Resource Information System. A competency program is in place to ensure employees meet and maintain set standards for safe practice and to minimise risk.

Employees are required to complete mandatory competencies related to their position, within three months whilst non-mandatory competencies are extended to within twelve months of employment. This is evaluated at their probationary review and thereafter annually during their performance review.

The Executive of Sunshine Coast University Private Hospital demonstrates their commitment to the training and development of its employees by allocating the necessary financial resources for training and development in the annual budget. Financial resources are provided to support internal and external training. In addition, all staff are encouraged to access external education grants and scholarship funds which are available each year.

Training is provided in order to meet safety requirements, ensure best practice standards, for succession planning and in response to:

- Changes in case mix
- The introduction of new procedures
- Advances in technology
- Feedback from performance reviews
- Adverse and significant events where a training need is identified
- Customer feedback

Training needs are reviewed regularly and the training program adjusted to meet these needs. Training programs both internal and external are evaluated and improvements/changes made as necessary in response to these evaluations.

An annual education and training plan is developed, and the implementation of the specific program is monitored on a monthly basis by the education teams. The training plan is evaluated annually.

Appraisals are performed after appointment at the expiry of the probationary period and thereafter annually or as appropriate to the tenure of the employee to confirm competency and fitness for the role.

Personnel files are maintained with registration, qualifications, appraisals, health information, position descriptions, and employment contracts providing details of specific terms and conditions of employment.

Internal training is recorded on Chris21 maintained by the HR Department. Sunshine Coast University Private Hospital requires people providing training to be appropriately qualified and to have criteria for evaluation of the effectiveness of the training. Where gaps are identified in the required competency of the individual, training is provided.

ASSOCIATED DOCUMENTS

- Employment contracts
- Personnel files
- Human Resources policies
- Agency contracts
- Orientation programme including Health & Safety
- Human Resources Business Plan
- Human Resources Committee minutes
- The Ramsay Way
- Quality Management & Improvement policy (Attachment)
- Education calendar including mandatory requirements
- Competency programmes and testing
- Executive Meeting minutes
- Training evaluation records
- Health and Safety Representative (HSR) training
- Internal auditor training
- Human Resources Committee Scorecard

6.3 INFRASTRUCTURE

The organisation maintains a current licence to operate as a Level 4/5 hospital (please refer to the CSCF page 6).

The hospital has 200 beds and provides an extensive range of inpatient, outpatient, and critical care services. This includes 6 Operating Theatres, 1 procedure room, 1 cardiac catheter laboratory, 24 day surgery chairs, 16 bed stage 1 recovery unit, 8 bed Intensive Care Unit, Medical Wards, Surgical Wards, 5 sessional suites and 8 chair oncology/day infusion unit.

Sunshine Coast University Private Hospital provides 6 well equipped Operating Theatres that includes two integrated theatres that support training and education, these are supported by a 16 bed 1st stage recovery in theatres and 24 Stage 3 recovery chairs in Day of Surgery Lounge. Both the cardiac catheter laboratory and procedure room share these areas.

Patient areas all have appropriate and sufficient monitoring equipment to ensure patient safety is maintained.

Medical monitoring and measuring devices are calibrated and tested as recommended or required by the manufacturer. A register of all equipment with recommended calibration intervals and due dates is maintained by the Biomedical Engineering Department and each piece of equipment has a current calibration sticker. Audits are performed to confirm compliance with calibration requirements.

Sunshine Coast University Private Hospital uses computerised technology for organisation management. Internal communication is supported with a shared database, the SCUPH Intranet and the Ramsay Intranet. The system is appropriately backed up – Ref. Clause 4.2.4.

Radiological services are provided to Sunshine Coast University Private Hospital by a private provider Sunshine Coast Radiology. All investigations other than PET scans are performed on-site. Theatre Suites and the Procedure room have image intensifiers. This hospital operates under a Radiation Safety Plan approved by Queensland Health and complies with the Diagnostic Imaging Accreditation Standards. This process is audited by HDDA.

Pathology Services are provided by Sullivan Nicolaides which is on site and if necessary, Qld Medical Laboratories.

Sunshine Coast University Private Hospital has a variety of contracts with:

- Greenslopes and Nambour General Hospital for Junior Medical Officers,
- University of the Sunshine Coast for undergraduate nursing and allied health placements, and
- participants in the National Ramsay Gradplus Framework for nurse graduate and transitional programmes.
- Other nursing programs are in partnership between vocational bodies such as GCIT and Ramsay Training Institute.

Copies of the contracts are maintained by Ramsay Head Office and on the Ramsay intranet.

Hotel Services in the organisation include the Food Services and Environmental Services Departments.

- Sunshine Coast University Private Hospital Food Services – all meals are prepared on site.
- Cleaning services are coordinated via the Environmental Services Department and the Operating Suite and cardiac catheter laboratory are cleaned by the Operating Theatre Assistants during the day following each case and daily and high cleaning is conducted by Environmental Services at night.

Sunshine Coast University Private Hospital has a regular and comprehensive Maintenance Program that ensures that the facility is well maintained. The maintenance team includes a Facility Manager, trade qualified (plumber) and trade assistant. The maintenance program is managed by Facility Management Services, who also provide relevant policies and procedures that are located on the Intranet for access by all staff. The Maintenance Program is supplemented with external contractors, engaged as required.

The organisation complies with legislative and clinical requirements for emergency equipment provision and maintenance. The emergency diesel generator has a running time of 48 hours and is connected to some lighting, red power points and theatre areas, emergency call bells, paging and fire systems.

Sunshine Coast University Private Hospital has three cooling towers located on level 2. The systems are independent, used for dissipating heat from chillers and have fully automated water treatment systems.

A Biomedical Engineer and Biomedical Technical Officer are employed to ensure the periodic preventative maintenance and function testing of equipment within the asset register at Sunshine Coast University Private Hospital according to the relevant Australian Standards. The Biomedical Engineering Department also manages contractors to assist with this work where applicable. The status of preventative maintenance and electrical safety and performance testing is managed using an asset management and maintenance system and reported by the Biomedical Engineer to the Commercial Manager, who includes the details in a monthly report to the Executive.

ASSOCIATED DOCUMENTS

- Qld Department of Health Licence
- Equipment Asset Registers
- Departmental Policy Manuals
- External Contractor Agreement/Contracts
- Australian Standards 1807.6 and 1807.7 Cleanrooms, Workstations, Safety Cabinets and Pharmaceutical Isolators – Methods of Testing.

6.4 WORK ENVIRONMENT

Sunshine Coast University Private Hospital provides adequate space to meet the standard required for ISO 9001:2008 Standard 6.4.

Air conditioning is available throughout the buildings for customer and staff comfort.

The operating theatres have a positive air pressure to meet client requirements for Infection Control. Pressures, flow rates and temperatures and humidity are maintained in an acceptable range by the building management system. Temperatures can be manually controlled over a restricted range. HEPA filters in all theatres are periodically checked in accordance with the Australian Standards 1807.6 and 1807.7.

Employees have access to a dedicated staff dining room and outdoor area to enjoy meal breaks.

Compliance with Work, Health and Safety current requirements is considered in all equipment purchases and new process and service planning. Safety Data Sheets (SDS) are provided at point of use for chemicals and other hazardous substances.

Clerical workstations are subject to ongoing assessment to ensure compatibility with operator requirements.

There is provision for review of equipment and space allocation when capital expenditure is approved each financial year.

ASSOCIATED DOCUMENTS

- Ergonomic assessments for workstations
- Australian Standards 1807.6 and 1807.7 Cleanrooms, Workstations, Safety Cabinets and Pharmaceutical Isolators – Methods of Testing.
- Safety Data Sheets (SDS)
- Product Trial and Evaluation form

STANDARD 7: PRODUCT REALISATION HEALTHCARE SERVICE PLANNING

7.1 PLANNING OF PRODUCT REALISATION

Sunshine Coast University Private Hospital's management team plans and develops the service processes consistent with the requirements of the Quality Management System. Clinical Care is planned as a continuum from pre admission to separation.

The Quality Improvement policy and objectives show Sunshine Coast University Private Hospital's commitment to providing a high standard of clinical care. Policies, procedures, clinical care paths, patient pathways, and clinical protocols provide direction in delivering care.

Patient outcomes are measured through collection of performance indicators, satisfaction survey data, clinical care path analysis, clinical indicator review, and adverse event review.

Records of treatments and interventions are maintained in the patient's medical record.

- (a) Sunshine Coast University Private Hospital's Executive have defined objectives for the services provided in the Quality Management & Improvement policy, new services, projects or contracts are integrated into the QMS ref. clause 5.4.2. Additional documented quality systems shall be created where a service, project, or constraint creates a need as per quality planning process.
- (b) Sunshine Coast University Private Hospital has developed policies and procedures and local work instructions to ensure that the process features are documented. The processes followed in providing these services in order to produce suitable outputs and outcomes are fully defined as policies, procedures, and local work instructions in the documented Quality System. Refer Clause 4.2.
- (c) Validation and verification procedures are contained in the policies, procedures, and local work instructions specific to each department. Acceptability is stipulated through skills, knowledge and training. Verification has two main forms.
 - (i) The checks required as documented in checklist forms, e.g. theatre set up lists
 - (ii) Checks made utilising skills, knowledge, and training, e.g. clinical observation charts.
- (d) The policies and procedures include requirements for recording procedures and results where that is applicable. Audits and clinical quality activities are performed to ensure conformity of the processes and outputs.

ASSOCIATED DOCUMENTS

- Quality Management & Improvement policy (Ref 0001)
- Patient medical records
- Clinical care plans include review and evaluation.
- Operation & Anaesthetic records
- Clinical pathways
- Operating theatre lists
- Clinical policies
- Administration policies and procedures
- Committee minutes
- Equipment calibration register
- WH&S policies & procedures, guidelines and internal audits
- Variance monitoring and reporting
- Infection Control policies & procedures
- Laboratory & Radiology reports
- Internal Audit results
- Quality activity results
- Performance appraisals, orientation manuals
- Recovery discharge criteria
- Hospital discharge summary
- Clinical mandatory and specialty competencies
- Admission Criteria

7.2 CUSTOMER RELATED PROCESSES

7.2.1 DETERMINATION OF REQUIREMENTS RELATED TO THE PRODUCT

Sunshine Coast University Private Hospital informs the community of services available via general and specific information brochures detailing services provided, such as newsletters and GP education evenings. In addition information relating to the hospital is available on the hospital website.

Accredited VMO's and General Practitioners inform patients of services through information packs provided to them by SCUPH.

Planning is implemented from the patient's initial point of contact through to discharge, and may also include rehabilitation and/or facilitation of community services.

The continuum of care prior to admission includes:

- Lodgement of admission forms
- Provision of informed financial consent
- Pre-admission assessment of patients
- Pre-admission education provided by a multi-disciplinary team
- Commencement of discharge planning
- The clinical path is commenced prior to admission and includes preadmission assessments and actions.

Patients booked for admission are provided with information to complete an online admission form.

Patients who are booked for surgical admission undergo a preadmission clinical assessment using one of the following processes. Where the referring doctor requests, a patient will be seen in the multidisciplinary preadmission clinic for assessment and preadmission education. Alternatively, if a patient is flagged at the preadmission administration point as meeting the standard criteria for a pre assessment they will refer this to the pre assessment registered nurse for review, the RN will then contact the surgeon to recommend a pre assessment visit. Other patients receive a preadmission phone call from a nurse to complete their clinical assessment. This process is the same for referred public patients.

On admission a patient's documentation including admission forms are reviewed by the clinical team (admitting nurse and doctor). The team review the forms to determine the needs of the patients are met. Referrals to members of the multidisciplinary team are made as required. Patients' needs are continually assessed throughout their stay. Treatment interventions and outcomes are documented in the patients' medical record.

Feedback from customers is obtained via regular customer satisfaction surveys, customer feedback forms and customer complaints and compliments.

- (a) Sunshine Coast University Private Hospital identify customer requirements including availability of service delivery and service support through pre-admission, admission and Health Fund contract procedures.

ASSOCIATED DOCUMENTS

- Patient Information Brochures including rights & responsibility, privacy information
 - Pre-admission and admission information and documentation.
 - Health fund contracts
 - Clinical Pathways
 - Treatment and financial consent forms
 - Clinical Risk Assessments
 - Discharge Plans
 - Medication charts
- (b) Private patients who require rehabilitation or palliative care are reviewed by the relevant specialist and referred to Nambour Selangor Private Hospital.
 - (c) Public patients who require any community services or ongoing clinical care are referred to SCHHS.

- (d) Unstated but implied requirements include competence of personnel, infection control, sterilisation processes, emergency equipment and preparedness, building and service equipment maintenance and provision of hotel services.

ASSOCIATED DOCUMENTS

- Personnel records
- Position descriptions
- Comprehensive and confidential medical records
- Maintenance schedule(s)
- Employee Health /Immunisation records
- Business Contingency & Continuity Plan
- Competency compliance records

- (e) Legislative and regulatory requirements include compliance with Private Hospital and Day Procedures Act & Regulations, Public Health Act, Poisons and Therapeutic Drugs Administration Act, Medical Records Act, Privacy Act, Mental Health Act, etc

ASSOCIATED DOCUMENTS

- Queensland Health Department Licence
- Patient Rights and Responsibilities Brochure
- Privacy Legislation

- (f) Additional requirements determined by Sunshine Coast University Private Hospital include Ramsay Health Care directives and procedures, and Facility Rules.

ASSOCIATED DOCUMENTS

- Patient Information Brochure
- Ramsay Facility Rules

7.2.2 REVIEW OF REQUIREMENTS RELATED TO THE PRODUCT

Sunshine Coast University Private Hospital reviews customer and organisational requirements prior to commitment to providing services by ensuring the equipment, processes, and resources are available to meet the defined requirements.

- (a) Product requirements are defined in the associated documents.

ASSOCIATED DOCUMENTS

- Admission/consent forms
- Health Fund contracts
- SCHHS public contract
- Leasing contracts
- Australian Charter of Healthcare Rights
- Correct patient/site/procedure protocol (Time out)
- Clinical Risk Assessments

- (b) Where the customer provides no documented statement of requirements, requirements are confirmed before acceptance, e.g. verbal agreements to provide equipment or services to credentialed surgeons.
- (c) Sunshine Coast University Private Hospital resolves contract requirements that differ from the original through review with the customer, and amended documentation.

ASSOCIATED DOCUMENTS

- Health Fund contract review: contracts located on Meditech & RHC Intranet
- Third party contracts – held on register in Executive
- Third Party Liaison meeting minutes
- Clinical Variance Reports

- Admission/consent forms
- Clinical incident Management: Riskman
- Operating Theatre lists: Meditech
- Clinical pathways
- Discharge Planning

(d) Prior to accepting a customer defined requirement, Sunshine Coast University Private Hospital management reviews the requirement to ensure it can be met by the Hospital.

ASSOCIATED DOCUMENTS

- Contract correspondence
- VMO applications for visiting privileges
- Independent contracts for the provision of services to public patients
- Refusal of Admission policy

7.2.3 CUSTOMER COMMUNICATION

Sunshine Coast University Private Hospital arranges communication with its customers to meet the requirements of ISO Standard 7.2.3 by:

(a) Product Information

ASSOCIATED DOCUMENTS

- Admission/consent forms
- Patient Information Brochure
- Patient pathways
- Treatment Plans & Clinical care paths

(b) Pre-admission and admission processes

ASSOCIATED DOCUMENTS

- Front office reception
- Health Fund contracts and reviews
- Preadmission clinic booklet
- Referral letters
- Medical Records – progress notes
- Admission/consent forms
- Clinical care paths
- Operation records

(c) Customer feedback is sought on a continual basis through customer feedback forms located on patient lockers on admission. Annual Press Ganey patient surveys are undertaken to benchmark patient satisfaction. Communication with VMOs occurs at the quarterly MAC and Medical Specialty/Unit meetings.

ASSOCIATED DOCUMENTS

- Customer feedback form records
- Patient Satisfaction Survey reports
- Complaints
- Riskman
- Minutes of Quality Improvement Committee & Medical Review Committee meetings
- Verbal feedback through the Patient Liaison Manager

PATIENTS' RIGHTS

Everyone who is seeking or receiving care in the Australian health system has certain rights regarding the nature of that care. These are described in the Australian Charter of Healthcare Rights. Sunshine Coast University Private Hospital acknowledges the rights of patients, and ensures that patients are informed of their rights on admission. We provide patients with the Australian Charter of Health Care Rights through our website, brochures, and our patient information booklet.

The rights included in the Charter relate to access, safety, respect, communication, participation, privacy and comment as outlined below.

- Access - a right to health care.
- Safety - a right to safe and high quality care.
- Respect - a right to be shown respect, dignity and consideration.
- Communication - a right to be informed about services, treatment, options and costs in a clear and open way.
- Participation - a right to be included in decisions and choices about care
- Privacy - a right to privacy and confidentiality of provided information.
- Comment - a right to comment on care and having concerns addressed.

Sunshine Coast University Private Hospital encourages patients to raise any concerns they may have early so that these can be addressed and resolved directly. If a patient is not satisfied with the local response they are advised on how to lodge their concerns with Executive and provided with advice on how to access the Health Quality and Complaints Commission (HQCC) should they wish to progress their complaint.

ASSOCIATED DOCUMENTS

- Patient's Admission booklet
- Inpatient Information booklet
- Sunshine Coast University Private Hospital Website
- Australian Charter of Healthcare Rights

7.3 DESIGN AND DEVELOPMENT

Exclusion claimed for this Standard under the ISO 9001:2008 Standard 1.2 Application.

This Standard has been excluded from the QMS of the organisation as no design or development activities are conducted by the organisation, including but not limited to:

- Design and implementation of research programs
- Development of a programme of clinical trials
- Design and development undertaken on behalf of the organisation by engaged contractors or other bodies.

Refer "Exclusions" page 4 of this Quality Manual.

7.4 PURCHASING

7.4.1 PURCHASING PROCESS

Sunshine Coast University Private Hospital controls purchasing processes by means of a preferred supplier list by choosing vendors and sub-contractors. Ramsay corporate negotiate national agreements with suppliers, which are applicable across all Ramsay facilities. These agreements also highlight which suppliers are preferred suppliers. Suppliers remain on the preferred suppliers list dependent on them meeting requirements for quality, service, and price. Evaluation of suppliers occurs through length of period of engagement, through satisfactory supply and service. We evaluate through quality control, evaluations of services, non-conformance reporting, and if required, on-site inspections of the contractor's ability to supply goods and services in accordance with the hospitals' requirements. The criteria for selection, evaluation, results of evaluations, and any necessary actions are established. Use of products and equipment include training, competency evaluation, and material safety data sheets.

All suppliers are appointed by Sunshine Coast University Private Hospital with payment terms and conditions agreed. Suppliers are then set up as a vendor on SAP and payment details uploaded by Group Procurement.

Ramsay Health Care, through Group Procurement negotiates contracts on behalf of Sunshine Coast University Private Hospital for the supply of the following:

- Medical and surgical supplies
- Pharmaceuticals
- Office supplies
- Removal of clinical and general waste
- Biomedical equipment maintenance

RHC Group Procurement assesses the suitability of the supplier to provide the goods and/or service requested, monitors compliance, and evaluates performance. Feedback is sought from Sunshine Coast University Private Hospital at the time of contract renewal. The results of evaluations are posted on the Ramsay Health Care intranet site. Should suppliers fail to meet the requirements for goods and or services, contracts are negotiated with alternative suppliers.

PURCHASE OF GOODS

All new equipment is recorded in the Asset/Equipment Register and all electrical equipment tested and tagged prior to use.

VERIFICATION OF PURCHASED SERVICES

Delivery dockets are signed on delivery for the receipt of all goods. All goods received are checked by the manager (or delegate) against the order form and copies retained, coded and sent to accounts payable for payment.

PURCHASE OF SERVICES

Commercial Services Contracts:

Contracts are provided for all contracted commercial services and for preventative maintenance services. Evaluation is included in the contract and this occurs at the time of contract renewal. An annual site visit is made to the premises of the external Linen Service and Clinical Waste Service providers to ensure conformity of product.

ASSOCIATED DOCUMENTS

- Service contract
- CAPEX forms
- Equipment Asset Register
- Clinical waste disposal receipts

7.4.2 PURCHASING INFORMATION

There is a purchasing procedure and product evaluation completed through Procurement Department of Head Office. Exemptions are available if required. Procurement facilities are accessible on the intranet. Product evaluation is provided at Product Review Committee Meetings. In addition Sunshine Coast University Private Hospital holds a local Product Review Committee meeting monthly and conducts product trials prior to any new items been utilised within the hospital.

Sunshine Coast University Private Hospital purchases its requirements from suppliers by:

- Records of purchase orders (stationery etc.)
- Contracts (contractors etc.)
- Prescriptions
- Imprest
- SAP ordering system
- Fax

ASSOCIATED DOCUMENTS

- Order books
- Invoices
- Contracts
- Delivery dockets
- Product Review Committee – Terms of Reference

7.4.3 VERIFICATION OF PURCHASED PRODUCT

Sunshine Coast University Private Hospital does not routinely visit supplier's premises to perform verification activities, however if necessary will specify verification arrangements in conjunction with the supplier. It is required that the contractors providing licensed and or accredited services, e.g. clinical waste disposal, HICMR, radiology equipment and services, biomedical maintenance and calibration, nursing agency staff, and pathology services are licensed and or accredited by the appropriate authority. WH&S orientation for external service contractors is provided by the Facility Management Services Manager

Incoming goods are signed for on delivery and checked against the purchase order when unpacking, by theatre, kitchen, maintenance, and administration staff.

ASSOCIATED DOCUMENTS

- Clinical waste disposal receipts
- EPA licence for radiology equipment kept on site
- Diagnostic imaging accreditation
- Nursing Agency Contracts
- Student placement contracts

7.5 PRODUCTION & SERVICE PROVISION

7.5.1 CONTROL OF PRODUCTION & SERVICE PROVISION

- (a) Sunshine Coast University Private Hospital has a documented system of policies and guidelines, publicity and information material that specify the characteristics of the service.
- (b) There are work instructions available as Doctors' Preferences e.g. for pain management protocols and written instructions, nursing care plans, clinical care paths and nursing progress notes to ensure conformance to the criteria of ISO Standard 7.5.1 (b).
- (c) Sunshine Coast University Private Hospital has a preventative maintenance system and register to ensure service equipment is checked before use. There is a process to identify and take equipment out of use for repair if a malfunction is identified. (Refer maintenance program).
- (d) Measuring and monitoring devices are made available at Sunshine Coast University Private Hospital in all areas as required. Where new equipment is installed appropriate training takes place before use. Where the equipment may only be used rarely or intermittently, work instructions or safe operating procedures are documented.

ASSOCIATED DOCUMENTS

- Manufacturer instructions & guarantees
 - Clinical policies
 - Safe Operating Procedures
 - Maintenance schedule and receipts
- (e) Monitoring activities are undertaken as per documented policies and procedures or following professional assessments that indicate monitoring is required.

ASSOCIATED DOCUMENTS

- Pre and Post-operative, and emergency observations protocol
 - Instrument sterilisation & biological monitoring records
 - SOPS
 - Doctors Instructions (written and verbal)
 - Clinical pathways
 - Clinical progress notes
 - Consent records
 - Clinical pre-admission & admission assessments
 - Patient risk assessments
 - Fridge and freezer temperature monitoring
 - Health Fund eligibility checks
 - Public hospital KPI audits
- (f) Sunshine Coast University Private Hospital meets the standard of Clause 7.5.1 (f) with the patient discharge plan, and post-operative appointments. VMOs/independent contractors refer patients back to General Practitioners for follow up or provide an onward referral to the rehabilitation and palliative care services at Nambour Selangor Private Hospital or SCHHS as required. Community based services are organised as required including Community nurse care, physiotherapy, Specialist clinics.

ASSOCIATED DOCUMENTS

- Discharge Plans
- Referral letters
- Community nurse referrals
- Rehabilitation referrals

7.5.2 VALIDATION OF PROCESSES FOR PRODUCTION & SERVICE PROVISION

Sunshine Coast University Private Hospital validates its processes through established protocols and the use of clinical procedures, and the skills, knowledge and expertise of the personnel delivering the service, supported by ongoing competency testing and professional development.

Sunshine Coast University Private Hospital abides by standards and codes of practice for surgical safety of patients in the operating theatres and requirements for an aseptic environment. Variance reporting and trending is monitored. The following audits and quality activities confirm validation of processes:

- Infection Control including HICMR audits
- Environmental and WH&S audits ,
- Food safety audits - HACCP,
- Clinical indicator collection
- Use of clinical pathways and best practice guidelines
- Validation processes for sterilisation equipment
- Clinical meetings including staff meetings, Clinical Standards and Medical Review Committee meetings.

Sunshine Coast University Private Hospital currently conducts clinical care path variance analysis via benchmarking across Ramsay Health Care facilities. It is a retrospective variance analysis which is conducted approximately quarterly. The facility staff responsible for clinical care paths nominate a specific care path and then a report of variance reasons is run and results summarised and compared. The results are reported to Clinical Standards Committee and the Care path Subcommittee. This process includes review of volume of activity, length of stay, complications, and variations from the designated care path.

From a financial perspective, Sunshine Coast University Private Hospital has monthly benchmarking of financial key performance indicator data. In addition a monthly CEO report is submitted to Ramsay Health Care Corporate outlining the performance of the hospital throughout the previous month. This information is available across all RHC facilities and facilities are grouped with similar size facilities to aid the benchmarking process. In addition, quarterly key performance indicator data, as per the contract, is provided to SCHHS for public patients

Equipment is maintained and calibrated according to the manufacturer's instructions/directions. Airflow in the operating theatres is measured and regulated to ensure positive pressures and correct air change frequency refer clause 6.3.

ASSOCIATED DOCUMENTS

- Clinical indicator reports
- Position descriptions
- Registration certificates
- Policy documents
- Codes/regulations
- Manufacturers instruction manuals
- Patient medical records
- Clinical pathways
- Doctors instructions
- Theatre lists/theatre record book
- Staff rosters
- Infection Control policies and procedures
- Sterilisation procedures/practices
- Checklists (data collection)
- Follow up letters and appointments
- ACORN Guidelines
- Committee minutes
- Care path variance reports

7.5.3 IDENTIFICATION & TRACEABILITY

Sunshine Coast University Private Hospital provides identification and traceability of relevant information, correspondence, data and materials related to patient care and service. The patient management system is used to record data related to all patients admitted to Sunshine Coast University Private Hospital

Prior to or on admission, all patients are issued with a unique identification number, Unit/Medical Record Number. This number is recorded on all patient documentation and records. The patient medical record provides traceability of services, and treatments provided. The label is attached to all patient records and property, and is worn by the patient while in hospital. Patients are tracked through the Meditech Patient Management System. Staff are identified by name badge. Records are signed by contributing clinical staff.

A traceability system is used to provide records of all implantable items and instruments used during Operating Room Procedures and a copy of sterilisation records are included in the patient medical record. All prostheses, e.g. mesh, plates and screws have a biological indicator in each load, as well as the test strip.

Autologous blood is identified through the transfusion service prior to receiving into Sunshine Coast University Private Hospital and checked against the patient's identification prior to use. Patient information is protected through Privacy Legislation and staff confidentiality statements. Surgeon's instruments are left for sterilising by the CSD.

Drug registers provide traceability of S4 & S8 drugs in accordance with the Health (Drugs and Poisons) Act.

Medication charts track use of prescribed and administered medications. Sterilisation records are maintained to match batches with patient procedures.

ASSOCIATED DOCUMENTS

- Patient records
- Meditech Software (label generation)
- Controlled Drug Books
- Meditrax reports
- Employee employment contracts
- Administration Manual

Goods brought into the hospital have labels attached to identify the product. Information records the date of manufacture, expiry date, and product name.

ASSOCIATED DOCUMENTS

- Prescriptions
- Medical supplies
- Blood products – receiving document
- X-rays
- Laboratory forms
- Calibration stickers on surgical monitoring equipment

Service readiness is traced through labelling and tagging.

ASSOCIATED DOCUMENTS

- Autoclave records including validation and calibration
- Equipment asset register
- Calibration register

7.5.4 CUSTOMER PROPERTY

Customer property is identified, verified, protected and maintained in the following ways.

Sunshine Coast University Private Hospital exercises care with customer property while under its control or while it is being used. This refers not only to physical property but to customer privacy and personal information. Patients have personal belongings locked in a cupboard whilst having surgery. Patients are encouraged not to bring valuables to hospital, and are asked to sign a valuables disclaimer form on admission. Any money is signed in and kept in the safe at the front office and must be signed out. Some patient rooms have safes for patient valuables.

Should customer property be damaged while under the control of Sunshine Coast University Private Hospital, a Riskman incident report will be completed and the incident investigated. Follow up action which may include compensation/ replacement of property will be implemented in consultation with the Hospital Executive.

Any incidents of loss or damage are documented through incident reporting system; Riskman. Patient medications brought into Sunshine Coast University Private Hospital are recorded on the Patient Medication Chart and kept.

Customer privacy and personal information is maintained in accordance with the Privacy Act. On commencement of employment, all employees complete an orientation which includes aspects of the Privacy Act.

ASSOCIATED DOCUMENTS

- Preventive and Corrective Actions Register records
- Minutes of MAC
- Perioperative and Anaesthetic Committee Meeting
- Patient Admission Form
- Valuables Disclaimer
- RHC Code of Conduct

Referral letters are stored in patient medical records.
Refer clause 8.2.3 and 7.5.5

7.5.5 PRESERVATION OF PRODUCT

Sunshine Coast University Private Hospital ensures that all materials used in the provision of patient care and service and for the management of the organisation are handled, stored, packaged, and maintained in order to maintain their integrity e.g. sterile goods, blood and blood products, medical gases, clinical and general waste, loan equipment and records. Sunshine Coast University Private Hospital takes care to preserve the conformity of the service through:

- (a) CSD and sterilisation procedures
- (b) Adherence to "clean" procedures
- (c) Safety practices to prevent unintended injury
- (d) Food handling techniques, HACCP process, food handlers training and fridge temperature monitoring.
- (e) Correct storage of perishable items, e.g. blood for transfusion, medications, food
- (f) Environmental temperature control
- (g) Procedures for checking drug expiry, and disposal of expired stock
- (h) Post discharge appointments,
- (i) Infection Control practices e.g. clinical waste disposal and sharps disposal

ASSOCIATED DOCUMENTS

- Infection Control policy manual
- Clinical policies and guidelines
- Food handlers certificates
- Food Safety Program
- Medication labels
- Regulations, policies and procedures for blood, medication and food storage
- Post discharge referrals and summaries

7.6 CONTROL OF MONITORING & MEASURING DEVICES

Sunshine Coast University Private Hospital uses an asset management and maintenance system utilising a maintenance schedule to ensure measuring and monitoring devices are tested and calibrated periodically to conform to required standards. When a test or calibration is due, the system will generate a work order to be actioned by the allocated Facility management services staff member. Both medical and non-medical devices are managed and any preventative or corrective maintenance and electrical safety testing is recorded using this system. Test strips are included in all packs of sterilised equipment to validate the performance of the autoclave and biological monitoring is completed.

Maintenance and testing of medical equipment, and any corresponding monitoring or measuring devices (test equipment), is managed in-house by the Biomedical Engineering Department. A yellow sticker is placed on medical equipment indicating the date it is next due for testing/calibration as a visual indicator of its test status.

Maintenance and testing of all bio-medical equipment is carried out by staff of the BME department. Maintenance and testing of non-medical equipment is performed by internal and external contractors.

Records of testing and maintenance are maintained.

In the event of measuring and monitoring devices being out of calibration, or outside customer specifications, a red or orange tag system is implemented. Clinical areas use a red "For Repair" tag to identify the device as being out of calibration, they log a request using their own access to the asset and maintenance system used by Facilities Management Services and the device is removed from service to be actioned by the relevant area of Facilities Management Services. Where it is not critical that the device be removed immediately from service and it is in use, the Biomedical Engineering Department and Central Equipment Store use a "For Service" tag when equipment is due for calibration to alert clinical users to remove the device from service as soon as it is available. This is monitored using the asset management and maintenance system and reported monthly by the Facility Management Services Manager to the Commercial Manager.

ASSOCIATED DOCUMENTS

- Records of calibration/testing
- Patient medical records (TPR charts and nursing notes, traceability stickers)
- Audit results
- Sterilising/autoclaving procedures and biological monitoring results
- Testing standards for measuring & monitoring devices

RTI Release

STANDARD 8: MEASUREMENT ANALYSIS AND IMPROVEMENT

8.1 GENERAL

The documented QMS includes measurement and monitoring activities needed to ensure conformity and achieve improvement. Data generated during Sunshine Coast University Private Hospital processes is collated and analysed using statistical techniques.

OVERVIEW – SUNSHINE COAST UNIVERSITY PRIVATE HOSPITAL STRATEGIC PLAN FOR QUALITY MANAGEMENT

The management and staff of Sunshine Coast University Private Hospital have a genuine commitment to the provision of an excellent standard of care to those for whom this unique service is intended. The Quality Management Program is the system through which Sunshine Coast University Private Hospital maintains and improves care delivery and organisational performance. The Quality Management System provides a framework, which ensures Quality Management is coordinated, has clear goals, and is aligned to organisational objectives. The Quality Management objectives of the hospital are incorporated throughout the Hospital Strategic Plan.

SUNSHINE COAST UNIVERSITY PRIVATE HOSPITAL STRATEGIC DIRECTION

The Quality Management System supports Ramsay Health Care Services and Sunshine Coast University Private Hospital's Strategic Plan including the hospital's mission, vision, and values. Quality objectives are incorporated throughout the Strategic Plan.

PURPOSE

The purpose of the Quality Management System is to ensure the delivery of optimal patient care within available resources and in a manner consistent with achievable clinical outcomes and internal and external customer satisfaction. The Quality Management Program describes the system for quality management at Sunshine Coast University Private Hospital and evaluation of departmental improvements achieved through quality activities. This is reviewed annually.

The Quality Management System is designed to ensure that ISO and Australian Standards, Department of Veterans Affairs, Qld Department of Health, and statutory, and professional standards are addressed and complied with. Further, the Quality Management Program seeks to encourage best practice and continual improvement. To this end, the hospital is also working towards the incorporating the National Safety and Quality Health Standards (NSQHS) into our Quality Management System.

The Quality Improvement Committee on an ongoing basis reviews process data and statistical data in order to plan and implement continuous quality improvement.

ASSOCIATED DOCUMENTS

- Patient feedback forms
- Patient Reports
 - ANZICS Data
- Press Ganey patient and staff surveys
- Clinical and Non-Clinical Quality Activity results:
 - Environmental Cleaning
 - Clinical Documentation
 - Emergency Trolley
 - Infection Control including Hand Hygiene
 - Medication Chart
- Internal Audit Reports
- Financial audits
- Clinical indicators
- Unit Specialty Reports

OBJECTIVES

The objectives of the Quality Management System are built into the Hospital's Strategic Plan and include the following goals:

- We aim to be the leader in private hospital services and to this end Sunshine Coast University Private Hospital is committed to the highest quality health care.
- We will conduct our business with integrity, credibility, and respect for the rights and views of others.
- Sunshine Coast University Private Hospital will provide a positive and supportive work environment that recognises that staff are our greatest asset.
- We will recognise the value of SCUPH staff through encouraging personal and professional development.
- We aim to grow our business while maintaining sustainable levels of profitability.
- We will build constructive relationships with all stakeholders to ensure positive outcomes for Sunshine Coast University Private Hospital and Ramsay Health Care.

FEEDBACK

Feedback of results is discussed at the appropriate committee meetings and staff are informed through discussion at the time of the meetings and via electronic access to minutes of meetings. To ensure the privacy of patients is maintained, de-identified results are used to identify trends and identify processes that need to be revised.

ASSOCIATED DOCUMENTS

- SCUPH Strategic Plan
- Committee Minutes

8.2 MONITORING AND MEASUREMENT

8.2.1 CUSTOMER SATISFACTION

Sunshine Coast University Private Hospital monitors and measures customer satisfaction through patient feedback forms, annual Press Ganey surveys for patients and the complaints procedure. The Medical Specialty/Unit meetings and MAC are venues where VMOs are able to provide feedback, in conjunction with the open door policy of the Executive.

Satisfying the external customer is commonly accepted as a means to stay competitive. It is also accepted that satisfying the internal customer is essential. Also, internal departments or work groups are internal customers of each other.

ASSOCIATED DOCUMENTS

- Patient feedback cards
- Press Ganey survey reports
- Complaint register (Riskman) and complaint folder
- MAC Meeting minutes
- Quality Improvement Committee minutes
- Preventive and Corrective Actions register

THE ROLE OF THE HOSPITAL EXECUTIVE

Customer comments, complaints and suggestions and the hospital wide patient satisfaction survey is how Sunshine Coast University Private Hospital obtains, monitors and acts on customer feedback. These directly reflect customer satisfaction, but there are also indirect indicators and impressions that reflect customer satisfaction. These also include word-of-mouth compliments, manager/patient rounding and other process and clinical non-conformances. These are tabled and acted on, including process change where indicated, via the hospital committee structure.

RATIONALE FOR THE COLLECTION OF CUSTOMER FEEDBACK

Questionnaires, surveys, and phone calls are methods of generating information which can be used in quality improvement activities. They are designed to determine the opinions of customers and the degree of satisfaction they have experienced with care and service delivery, the outcome of that care and service and any perceived problems. They can be a valuable tool in assessing and evaluating customer feedback, but to be effective they must be formally structured and be user friendly for ongoing monitoring.

Patient satisfaction in health care may be directed at the outcome in health care service. Satisfaction may also be considered in view of the processes of care delivered such as reception, booking, parking, and safety considerations.

Dissatisfaction occurs when expectations are not met. In some instances, these expectations are impossible or unreasonable, or simply beyond the scope of the health care provider. It is important for the health care professional to explore customer/patient expectations and manage them at the point of service. SCUPH addresses patient expectations through patient care paths, preadmission education, and ongoing education during the patient's stay.

A patient's experience is the patient's experience, whether it is an accurate description of a situation or not. A complaint that staff were disinterested or unsympathetic will be converted following discharge to general dissatisfaction with a service and may result in the pursuit of litigation. Conversely, people are often too fearful to express feelings of dissatisfaction during a visit to the hospital. Sunshine Coast University Private Hospital employs a Patient Liaison Manager to coordinate the response to complaints and proactively manage any emerging patient issues.

SUNSHINE COAST UNIVERSITY PRIVATE HOSPITAL COMPLAINTS POLICY

At Sunshine Coast University Private Hospital, a complaint is defined as any expression of dissatisfaction received by the hospital. Complaints provide a number of opportunities for service improvements including:

- 'Process' correction.
- Identification of process weaknesses.
- Encouraging patient satisfaction.
- Encouraging patient loyalty.

At Sunshine Coast University Private Hospital, we aim to provide the best quality service and care possible to patients and their families and to continually improve our processes. We therefore encourage comments, complaints and suggestions for improvement on the service provided. We provide a systematic approach when dealing with complaints as outlined in the SCUPH Complaints Policy which involves the analysis of the quality of care and service of each individual patient or complaint source. This evaluation occurs throughout the continuum of care process and is primarily aimed at ensuring appropriate care is delivered. SCUPH employs a Patient Liaison Manager to oversee and coordinate the management of patient feedback, compliments and complaints.

The rights and needs of patients are considered and respected by all staff. SCUPH provides information to patients on their rights and responsibilities prior to and on admission. Information on the Australian Charter of Healthcare Rights are also made available to patients and visitors. Supporting patient satisfaction is considered an important element of quality health care at Sunshine Coast University Private Hospital. The two main objectives in achieving this strategy are to create a difference, which is observable and measurable by the patients, and to have a real impact on the way service is offered and perceived within the hospital.

STRATEGIES IN PLACE FOR COMPLAINT PREVENTION

- Surveys and open communication with patients.
- Identification of patient goals and expectations, as instigated in the discharge planning process and use of Patient Paths and Clinical Care paths.
- Involvement of patients and their families in the decision making process.
- Welcoming of comments and complaints from patients.
- Patient education pre, post and during the continuum of care.

- Communication of complaints to staff and external customers such as allied health workers, external contractors, governing body and clinicians.
- Having trained staff available for the immediate and ongoing handling and resolution of complaints.
- Treating all complaints in a confidential manner as governed by the Hospital Executive.
- Follow up of comments on patient feedback forms by the Patient Liaison Manager.
- Service Recovery processes.
- Recording, monitoring and trending of complaints.
- Evidence of actioning complaints.
- Regular review of policy and procedure in relation to complaints.
- A pro-active approach, not just reactive to complaints.
- Clear complaint direction for patients as stipulated in the Patient Information Booklet – allowing patients information on how to access external complaints bodies and mechanisms independently if warranted.
- Providing patients with the Australian Charter of Healthcare Rights.
- Peer review of clinical adverse events.
- Tabling of complaints as part of committee meetings inclusive of Medical Review Committee.
- Reducing any delays in the complaints handling process, which can lead to an escalation of the complaint.
- External interpreter service information and service for non-English speaking patients.

ASSOCIATED DOCUMENTS

- Complaints Policy
- Privacy Policy
- Riskman database

8.2.2 INTERNAL AUDIT

Sunshine Coast University Private Hospital conducts internal audits in compliance with the audit schedule to ensure the organisational processes are working as required by customers and stakeholders. The audit program defines the audit scope and audit frequency to ensure that all aspects of the Quality Management System are audited within the audit cycle. High-risk processes or those which have the potential to impact adversely on patient outcomes are audited more frequently. Audit results are tabled, reviewed, and discussed at the relevant meetings. The committees ensure any necessary corrective action is taken to improve the process and improvement logs are commenced and actioned.

Audits are performed by people not directly involved in the process being audited this results in audits being unbiased. The organisation has a commitment to maintain a minimum of ten internal auditors on the staff who have been externally trained.

ASSOCIATED DOCUMENTS

- Medical records audit
- Infection Control audits (HICMR)
- WH&S Quality Activities
- Internal Audit Program Policy and guidelines (attachment)
- Non Conformance Preventive and Corrective Action Policy (attachment)
- Quality Management & Improvement policy (Attachment)
- Internal audit register
- Internal audit schedule
- Corrective & preventive actions register

Audit outcomes are reported at the appropriate committees and non-conformances are registered and followed up as per the corrective action process.

ASSOCIATED DOCUMENTS

- Committee meeting minutes
- Corrective and Preventive Actions Register
- SCUPH Intranet
- SCUPH System reviews for Clinical Incidents
- Riskman reports

8.2.3 MONITROING & MEASUREMENT OF PROCESSES

Sunshine Coast University Private Hospital has a monitoring and measurement program to ensure achievement of organisation objectives. These activities include, but are not limited to:

- Evaluation of patient/customer outcomes
- Monitoring of patient care programs
- Monitoring of clinical indicators
- Monitoring of administrative systems
- Monitoring of equipment function
- Monitoring of staff competence and performance
- Review of customer feedback, complaints monitoring and resolution
- Control of non-conformities

ASSOCIATED DOCUMENTS

- ACHS Clinical indicator reports
- Mandatory training compliance reports
- Performance Appraisal completion compliance
- Complaints resolution timeframes
- Human Resource & financial KPIs

8.2.4 MONITROING & MEASUREMENT OF PRODUCT (SERVICE)

Sunshine Coast University Private Hospital ensures patients are assessed pre-operatively by the nursing staff and Medical Officer - either the Preadmission Clinic GP and/or the patient's anaesthetist. Individual care plans and treatment care paths are documented for patient care requirements. Pre-operative blood tests and x-rays also meet the requirements for this clause. Equipment used for delivery of service is monitored through required checking and calibration standards, and compliance audits.

Some examples monitoring of service delivery include measurement of re-admission rates and Clinical care path variance monitoring. Reports of quality activities are provided on a regular basis to the Health Quality and Complaints Commission and the Department of Veterans Affairs.

Yearly staff appraisals are conducted to evaluate staff performance. These appraisals are performed by direct line managers. The database of completed appraisals is maintained by the Human Resources Department and results sent to hospital managers monthly and tabled at the HR Committee Meetings

ASSOCIATED DOCUMENTS

- Laboratory reports
- X-rays, scans e.g. post – operative placement verification
- Calibration and testing stickers on medical equipment
- Clinical care plans and care paths
- Clinical observation charts
- Discharge plans
- Treatment programs e.g. anticoagulant therapy
- Performance appraisals

8.3 CONTROL OF NON-CONFORMING PRODUCT

Sunshine Coast University Private Hospital identifies non-conformances in patient care through the use of Riskman incident reporting, clinical indicator collection and clinical care path variance analysis. Non-conformances relating to health, safety, or property are documented in Riskman as an incident, near miss or hazard. All non-conformances are managed so as to prevent their recurrence.

In addition process/service non-conformances are identified through the internal audit process and other quality activities, system reviews and risk assessments. These are documented on the corrective actions register located on the SCUPH intranet.

ASSOCIATED DOCUMENTS

- Patient medical records
- Quality Improvement Committee minutes
- Medical Review Committee minutes
- Complaints
- Riskman reports
- Internal Audit Program Policy
- Non Conformance, Preventive and Corrective Action Policy (attached)
- Preventive and Corrective Actions Register

8.4 ANALYSIS OF DATA

- (a) Sunshine Coast University Private Hospital collect data on customer satisfaction, clinical incident information, and conducts system reviews that can lead to improvements. This is addressed at the Quality Improvement Committee meetings, Medical Advisory Committee meetings, Clinical Standards Committee meetings, Hospital Management meetings, Medical Review Committee meetings, Medical Specialty/Unit meetings, and Infection Control Committee meetings.

ASSOCIATED DOCUMENTS

- Patient feedback cards
- Press Ganey patient survey reports
- Committee meeting minutes
- Complaint records
- Riskman reports
- VLAD data (Qld Health)

- (b) Sunshine Coast University Private Hospital collects data relating to conformance to customer requirements by monitoring Infection Control statistics, readmission rates, clinical indicators and complaints.

ASSOCIATED DOCUMENTS

- ACHS Clinical Indicator reports
- Infection Control statistics/records
- Riskman Reports
- QMS audits
- Clinical Quality Activities
- Patient surveys
- Health & Safety audit
- Medical records audit

- (c) Sunshine Coast University Private Hospital uses statistical data to identify characteristics of processes and trends where that is appropriate.

ASSOCIATED DOCUMENTS

- Internal audit reports
- Clinical Quality activities
- Patient surveys
- Health & Safety audit
- Medical Records audit

(d) Data is collected on suppliers through the Procurement Department at Head Office and the hospital's Supply Department.

ASSOCIATED DOCUMENTS

- Preferred supplier list located in SAP
- Supplier invoices and contracts

Retrospective and prospective statistics or numerical data are routinely collected for the purpose of clinical reporting. They are then utilised for quality improvement and management purposes. The hospital uses this data to determine the accuracy of specific clinical care and care processes, to compare measurement techniques, determine normal values, and monitor deviation from predicted care.

Quality documentation represents the memory of the quality systems. Without data and records, information cannot be gathered for improvement and corrective action. Historical data provides clues as to what may occur in the future and help to guide future corrective action.

Computerised data are organised on the Quality & Safety shared drive so that quality activity results, survey and clinical indicator information can be generated. Problems or patterns can then be identified, analysed and benchmarked via quality reports. These can all be tracked by the Executive team and are presented and discussed at the Clinical Standards Committee, Quality Improvement Committee, Medical Review Committee, and Hospital Management meetings.

The Improvement Register on the SCUPH Intranet provides evidence of continual improvement. It includes the type of Quality improvements being performed, relationship to appropriate legislation, regulation or standards and commencement dates.

ASSOCIATED DOCUMENTS

- SCUPH Quality and Safety Intranet site
- Quality reports
- Hospital Management meeting minutes
- SCUPH Risk Management Framework

PROCESS INDICATOR OBJECTIVES

- Provide quantitative measures of whether a standard is met and thus reflect the standard of process (care, financial or service) provision.
- Evaluation of the degree of compliance to an expected standard. They measure whether performance is acceptable or unacceptable not the reason why they are achieved or not achieved.
- Monitor various aspects of clinical care or non-clinical performance. An example of a clinical indicator is readmission rates. Non-clinical examples may be financial performance, such as the value of outstanding debtors at various time intervals, or adverse occurrences, such as staff injury rates.
- Prioritise data collection in terms of the most important aspects that impact on patient care or service provision.
- Prospective collection of data so as to avoid deficiencies in documentation, unless evaluation of success is measured over time. This would require a questionnaire or interview to be carried out at a specific time frame after the event.
- Provide a means by which to compare actual with desired performance. Indicators do not answer questions but raise them; they 'flag' potential problem areas in need of review.
- Determine acceptable levels of attainment for a standard. Benchmarks which have been established by professional bodies are available especially for clinical related issues.

- Investigation of results which are below expected standards and documentation of the actions to be taken to achieve the desired outcome.
- Completion of the Quality Improvement cycle is achieved by data collection, analysis and review, the implementation of corrective actions and evaluation of the actions taken, through discussion with, and feedback to, all relevant parties.

CLINICAL INDICATORS

Indicators are positive or negative signs of change. Indicators represent trends and forecast a deviation from the norm and may warn of impending problems. They are critical tools - focusing on a desired outcome and the essential processes for achieving that outcome. SCUPH understands the importance of appropriate statistical analysis of to ensure accurate information is provided for decision making. The Quality and Risk Coordinator is responsible for the collation and submission of all external clinical indicator reports and development of internal clinical indicator data reports as required.

A Clinical Indicator is a measure of the clinical management and outcome of care. It is an objective measure of either the process or outcome of patient care in quantitative terms. Clinical indicators are not exact standards, rather they are designed to be flags which can alert staff to possible problems and opportunities for improvement in patient care.

An indicator is an event rate versus a sentinel event. A rate-based indicator is expressed as the number of events compared to a specific universe of events. The ratio is expressed as:

(Numerator)	Number of patients for whom a specified event occurs
(Denominator)	Number of patients with the condition or procedure the indicator is measuring

Clinical indicators collected routinely include: Adverse Drug Reactions; Anaesthesia; Day Surgery; Gastroenterological endoscopy; Hospital Wide; Infection Control; Intensive Care; Queensland Health Adverse Outcome Data.

DATA COLLECTION

Data collection at Sunshine Coast University Private Hospital is planned, organised, ongoing and systematic. The responsibility for accurate data collection involves a department based data collection system, with individual departments having ownership of specific indicators.

INDICATOR RESULTS

The body empowered with the responsibility and accountability for the clinical indicators at Sunshine Coast University Private Hospital is the Executive Committee. The Executive Committee determines and delegates appropriate generic data collection to the Quality and Risk Coordinator who liaises with each department manager to coordinate the sharing and presentation of the results. Indicator results are also tabled and reviewed at the appropriate committee meetings.

ASSOCIATED DOCUMENTS

- Medical Advisory Committee minutes
- Medical Review Committee minutes
- Quality Improvement Committee minutes
- Clinical Standards Committee minutes

8.5 IMPROVEMENT

8.5.1 CONTINUAL IMPROVEMENT

Sunshine Coast University Private Hospital is committed to continual improvement of its processes as stated in its Quality Improvement policy and the Ramsay Way. Continual improvement is achieved by a variety of means including, but not limited to, the review and analysis of the following:

- The Quality Management System
- Strategic plan
- Business unit plans
- Performance indicators
- Clinical outcomes
- Adverse events
- Internal and external audit findings
- Customer feedback

Sunshine Coast University Private Hospital meets the requirements for clause 8.5.1 for planning for continual improvement through the activities of the monthly committee meetings, including the Clinical Standards, and Quality Improvement Committees, the requirements of individual position descriptions, the Board meetings, the Quality Improvement policy, the Strategic Plan, patient feedback forms, and staff and management meetings.

ASSOCIATED DOCUMENTS

- Committee meeting minutes
- Clinical policies and guidelines
- Clinical care paths
- Minutes of Board meetings
- Quality Management & Improvement Policy (Ref 0001)
- Internal Audit Program Policy (Ref 0009)
- Preventive and Corrective Action Policy (Ref 0007)
- Control of Non-conformances (Ref 0006)
- SCUPH Strategic Plan
- Executive Committee Meetings
- Management Meeting minutes
- Staff meeting minutes
- Education calendars
- Improvements Register

8.5.2 CORRECTIVE ACTION

Sunshine Coast University Private Hospital has a process in place to take corrective action to eliminate the cause of non-conformities. The procedure for corrective action is in the attachment of this manual. It includes review as part of the process, and major non-conformances become part of the management review.

ASSOCIATED DOCUMENTS

- Corrective and Preventive Actions register
- Internal Audit Program Policy
- Non Conformance Preventive and Corrective Action Policy
- Patient feedback forms and reports
- Management meeting minutes
- Committee meeting minutes
- Quality Improvement Committee meeting minutes
- Customer complaints
- Riskman reports

8.5.3 PREVENTIVE ACTION

Sunshine Coast University Private Hospital review all non-conformance records, including those on Riskman, summaries of customer feedback records, and Press Ganey survey reports to plot data and analyse trends to prevent recurrence of non-conformities. This takes place prior to the management reviews. Preventive action is determined following review of the data.

ASSOCIATED DOCUMENTS

- Corrective and Preventive Actions register
- Summaries of feedback forms
- Internal audit reports
- Management Meeting minutes
- Riskman reports
- Minutes of Quality Improvement Committee meetings
- Policies e.g. consent for treatment
- Internal audits

RTI Release