Government of **Western Australia**
Department of **Health**
Licensing and Accreditation Regulatory Unit

Licensing Standards

For the Arrangements for Management, Staffing and Equipment

Private Hospitals

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Application – Private Hospital

Licensing of private hospitals is regulated by the *Private Hospitals and Health Services Act 1927* (the Act). The Act makes provisions for the granting of licences by the Chief Executive Officer, the Director General of Health. The Director General must be satisfied about certain matters before a licence is granted or renewed, such as ensuring that the arrangements for management, staffing and equipment are satisfactory.

This document outlines the minimum standards for the arrangements for management, staffing and equipment that must be met by private health facilities licensed to operate as a Private Hospital.

The Act defines a private hospital as a "hospital that is not a public hospital". This is further explained in the *Health Services Act 2016*, Section 8 (4) that states a hospital is a "premises where medical, surgical or dental treatment, or nursing care, is provided for ill or injured persons and at which overnight accommodation may be provided; and a day hospital facility; and a nursing post".

The Department of Health Licensing and Accreditation Regulatory Unit (LARU) administers the licensing process and uses the Licensing Standards for the Arrangements for Management, Staffing and Equipment (the Standards) to ensure the licensing requirements are articulated clearly for health facilities and their stakeholders.

The Standards were developed initially in 2003 following broad consultation with stakeholders including representatives of private health care management, staff, patients and families, technical experts and audit consultants.

The Standards were welcomed by the private health industry and have been used successfully in annual inspections in licensed facilities since 2004. They were reviewed in 2006 and after 10 years of effective use, and as a result of changes in the legislative environment, an extensive review began in 2015. After two years of in-depth consultation, including surveys, interviews, presentations and focus groups, revised Standards reflecting the outcome of this consultation have been compiled.

The application of these Standards will be determined by the functionality of the licensed facility, as outlined in the LARU approved Statement of Function. Dispensation may be granted to mandatory items in circumstances where additional time is required in order to achieve compliance with the Standards or where compliance is not practically achievable due to specific circumstances. Dispensations allow for the identification of a risk mitigation strategy which shall be monitored.

These revised, Private Hospitals, Standards are applicable from 1 January 2018.

Glossary of terms

Australian standards – the current version of the relevant standard, as amended from time to time.

Accreditation – assessment to the National Safety and Quality Health Service Standards.

Admitted patient – a patient admitted to hospital.

Adult – a person 18 years or older.

Bed – a unit of accommodation provided for the treatment of a patient which is continuously at their disposal for the duration of their stay. It includes beds, trolleys and chairs but excludes surgical tables, recovery trolleys, delivery beds and cots for unqualified neonates.

Child – a person below 18 years of age.

Compliance – to act or provide in accordance with the requirements or recommendations of these standards or other relevant guidelines or regulations.

Clinical incident – an event or circumstance resulting from healthcare that could have, or did lead to unintended and/or unnecessary harm to a patient/consumer. Clinical incidents include:

- Near-miss incidents – incidents that could have, but did not, cause harm, either by chance or through timely intervention
- Sentinel events – unexpected occurrences involving death or serious physical or psychological injury, or risk thereof.

Credentialling committee – a hospital committee that oversees the credentialling of practitioners. The credentialling process includes authenticating qualifications, documentation of clinical privilege, defining scope of clinical practice and a process for notifying staff of credentialled practitioners.

Critical system – is any emergency system, equipment, electrical service, instrument, device or thing that is required to protect the safety of a person undergoing a medical procedure or in medical care.

Direct nursing care – hours of hands-on clinical nursing care by registered nurses, midwives and enrolled nurses, allocated to provide care to designated patients. Direct nursing care does not include the work of nurse managers, clinical nurse managers, unit managers and other care attendants who do not provide ‘hands-on’ nursing care, are not included.

Electroconvulsive therapy – a procedure performed under general anaesthesia, in which small electric currents are passed through the brain for the purpose of intentionally triggering a brief, controlled seizure.

Endoscopy – a medical procedure that enables a doctor to observe the inside of the body without performing major surgery.

Enrolled nurse – a nurse registered as an enrolled nurse with the Nursing and Midwifery Board of Australia as regulated by the Australian Health Practitioner Regulation Agency.

Facility – a site and its buildings, building services, fittings, furnishings and equipment.

Guidelines – a set of requirements and recommendations.

Healthcare-associated infection – infections acquired in healthcare facilities that occur as a result of healthcare interventions, arising during or after the time in the healthcare organisation.

Hospital – premises where medical, surgical or dental treatment, or nursing care, is provided for ill or injured persons and at which overnight accommodation may be provided; and a day hospital facility; and a nursing post.

Infant – a baby from two months to one year old.

Medical advisory committee – a group who advise on matters relating to medical practitioners; such as clinical practices, medical or surgical procedures, new medical technologies and policies.

Neonate – an infant less than 28 days.

Newborn – an infant from birth to two months of age.

Minimum – the lowest level of provision considered safe for a given function. Anything below this level is considered non-compliant.

Perioperative – the period before, during and after an anaesthetic, surgical or other procedure.

Private hospital – is a hospital that is not a public hospital.

Renal – relating to the kidneys.

Registered nurse – is a nurse who is registered with the Nursing and Midwifery Board of Australia as regulated by the Australian Health Practitioner Regulation Agency.

Schedule 8 medicines – (also known as Controlled Drugs) are substances that should be available for use but require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence.

Standard 1: Governance

Governance systems and processes are in place for the provision of safe and quality patient care.

Mandatory criteria

1.1 The facility is operating in accordance with its licence, including the:

- 1.1.1 name of the licence holder
- 1.1.2 name and address of the facility
- 1.1.3 period of the licence
- 1.1.4 maximum number of patients who may be treated at any one time
- 1.1.5 maximum number of beds
- 1.1.6 classes of patients who may be treated at the facility
- 1.1.7 the number and categories of staff
- 1.1.8 conditions, dispensations or exemptions on the licence (where applicable).

1.2 The current licence is displayed for public viewing in the main foyer or reception area of the facility.

1.3 The function of the facility is defined in a statement that is accessible to staff, patients, their families, carers and visitors.

1.4 Hours of operation are posted in a public area.

1.5 Organisation charts and policies identify the lines of communication, authority and responsibility for staff, visiting medical officers or authorised persons.

1.6 A medical advisory committee oversees the standards of medical practice.

1.7 A credentialling committee (separate from the medical advisory committee) oversees the credentialling of medical practitioners. The credentialling process includes authenticating qualifications, documentation of clinical privilege, defining scope of clinical practice and a process for notifying staff of credentialled practitioners. The committee has a documented process for managing and monitoring under-performing practitioners.

1.8 All professionals provide evidence of their current registration with the relevant professional body. A documented process ensures that:

- 1.8.1 all professional groups employed within the facility are identified
- 1.8.2 all registrations are current
- 1.8.3 a policy statement outlines the registration process
- 1.8.4 a current log of registrations is kept and readily available
- 1.8.5 any practice restrictions are identified.

1.9 Written job descriptions are available for all positions, and:

- 1.9.1 are current
- 1.9.2 include lines of communication, authority and responsibility
- 1.9.3 are readily accessible to staff.

1.10 Policies and procedures are developed, reviewed and updated every four years or more often if required. Staff members are made aware of these policies and procedures and are readily able to access them. Policies are monitored for compliance and include, as a minimum:

- 1.10.1 admission and discharge criteria
- 1.10.2 patient consent
- 1.10.3 patient care (clinical and personal care)
- 1.10.4 medical records (including abbreviations)
- 1.10.5 emergency procedures
- 1.10.6 occupational safety and health
- 1.10.7 infection control
- 1.10.8 medication safety
- 1.10.9 sterilisation processes
- 1.10.10 catering services
- 1.10.11 laundry services
- 1.10.12 cleaning services
- 1.10.13 reporting of adverse events, critical and clinical incidents
- 1.10.14 preventative maintenance for equipment and facility
- 1.10.15 quality management (accreditation, reporting, auditing)
- 1.10.16 complaints and grievance management
- 1.10.17 staff development and education
- 1.10.18 employment, including compliance with National Police Clearance and Working with Children legislation.

1.11 Occupational safety and health programs and practices are in place and there is a designated, qualified staff member responsible.

1.12 A committee is in place that monitors outcomes of occupational safety and health programs and audits, and reports to the hospital executive to ensure compliance and feedback to staff.

1.13 Accreditation is maintained and reported in accordance with Licensing and Accreditation Regulatory Unit requirements.

1.14 An auditable system of quality and continuous improvement is in place; there is a regular audit schedule, audit results are documented, corrective measures are enacted for under-performance and these measures are monitored.

1.15 A compliment, complaints and grievance management process is in place for patients, their families and carers, visitors and staff.

1.16 A mandatory staff training program, which is service specific to staff and patient needs, is in place.

1.17 An ongoing staff development and training program, which is service specific and meets staff and patient needs, is in place.

Standard 2: Workforce

The workforce is competent, qualified and sufficient. The organisation has clear roles and responsibilities for the provision of safe, quality patient care.

Mandatory criteria

2.1 Staffing arrangements comply with the licence including the:

- 2.1.1 number and categories of staff, which includes 3.5 hours of general nursing care per patient per day, of which 2.0 hours is provided by a registered general nurse
- 2.1.2 kinds of nursing and other care provided or available at the facility
- 2.1.3 periods and times at which the services are provided or available.

2.2 The licence holder demonstrates that:

- 2.2.1 sufficient numbers of support staff, determined with reference to the numbers and care needs of the patients, are present at the hospital at all times
- 2.2.2 suitable staffing arrangements are in place in the event of unusual or unexpected events, for example, sufficient staff must be on duty to safely manage an emergency.

2.3 A designated Chief Executive (however titled) is employed by the facility and is responsible for the governance of the facility.

2.4 A designated Director of Nursing (however titled), or their suitably qualified replacement, is present at the facility at all times. This person:

- 2.4.1 has qualifications approved by the Chief Executive Officer, the Director General of Health (i.e. Registered Nurse)
- 2.4.2 is responsible for standards of nursing practice within the facility.

2.5 A Medical Director (however titled) is designated to be responsible for the standards of medical practice at the facility.

2.6 Only registered nurses, registered midwives, registered psychiatric nurses, nurse practitioners or enrolled nurses provide direct nursing care.

Standard 3: Clinical risk

The provision of health care services is provided in a way that reduces clinical risk to patients, staff and visitors.

Mandatory criteria

3.1 Clinical incidents have a documented process that is managed, enacted and reported as prescribed by the Severity Assessment Code, which requires that:

- 3.1.1 the Department of Health Patient Safety Surveillance Unit is notified within seven working days of the incident occurring
- 3.1.2 the Licensing and Accreditation Regulatory Unit is notified within seven working days of the incident occurring
- 3.1.3 where applicable, the Office of the Chief Psychiatrist is notified within seven working days of the incident occurring.

3.2 Critical incidents, such as fire, outbreak of infection, building or structural collapse, serious equipment failure, serious environmental hazard (for example, chemical spill), major security breach, serious criminal acts, power or water failure, have a documented process that is managed, enacted and reported, including notification to the Licensing and Accreditation Regulatory Unit within 48 hours of the incident occurring.

3.3 New technologies and procedures have a documented process that is managed, enacted and reported, to ensure they are examined and approved by the relevant authority within the organisation, including:

- 3.3.1 scope of practice identified
- 3.3.2 relevant policies and procedures
- 3.3.3 a review process
- 3.3.4 infection control product review
- 3.3.5 a process for feedback regarding outcomes.

3.4 The acquisition, prescribing, dispensing, administration and storage of medications have a documented process that is managed, enacted and reported.

3.5 Medications are prescribed by medical practitioners, dentists and/or nurse practitioners and/or other authorised practitioners and signed for by clinical staff when administered.

3.6 Verbal medication orders, if required, are documented and signed by the authorising medical practitioner within 24 hours.

3.7 Schedule 8 medications are stored and administered in accordance with the relevant regulations and documented processes, including:

3.7.1 that they are kept in a locked medication cupboard in a secure clinical area and only accessed by authorised staff

3.7.2 a register of these medications is maintained and audited

3.7.3 a medication key register is kept at the facility

3.7.4 a signature register is kept at the facility of all clinical staff that uses the registers.

3.8 Medication errors and incidents are reviewed and reported in accordance with documented processes, including:

3.8.1 a process for staff feedback regarding outcomes

3.8.2 staff education and training

3.8.3 monitoring of reported medication errors and incidents.

3.9 The temperature of refrigerators and freezers is monitored to ensure that contents such as medicines and vaccines are stored in accordance with manufacturer instructions. There is a documented reporting and response process in place should temperatures fall outside the recommended range.

Standard 4: Infection control

The surveillance, prevention and control of healthcare associated infections are in line with best practice and industry requirements and supported by appropriate systems and processes.

Mandatory criteria

4.1 A qualified staff member, who has completed a nationally accredited infection control course, is delegated to coordinate the infection control program.

4.2 Infection control programs are in place, with a scope and focus that addresses risk factors specific to the patient population and nature of the facility.

4.3 Infection control policies and procedures are monitored through auditing, and include, as a minimum:

- 4.3.1 standard and transmission based precautions
- 4.3.2 hygiene standards
- 4.3.3 procedural standards
- 4.3.4 physical environment
- 4.3.5 sterility of instruments and equipment
- 4.3.6 reprocessing of re-useable instruments and equipment
- 4.3.7 instruments and equipment requiring special processing
- 4.3.8 protection for health care workers
- 4.3.9 quality management
- 4.3.10 surveillance programme
- 4.3.11 product review.

4.4 An Infection Control Committee (however titled) is in place to monitor outcomes of the infection control programs and audits, and reports to the Hospital Executive Committee (however titled) to ensure compliance and feedback to staff.

Standard 5: Patient care environment, equipment and supplies

The patient care environment, equipment and supplies are managed to maximise safety and quality for patients and staff and are supported by appropriate systems and processes.

Mandatory criteria

5.1 Equipment is available to support the provision of safe and quality health care at the facility, including:

- 5.1.1 appropriate equipment for the type of surgery/procedure
- 5.1.2 a sufficient number of each type of instrument required
- 5.1.3 equipment in accordance with bariatric policy
- 5.1.4 manual handling aids.

5.2 Equipment is located and stored in a way that ensures safe and effective use.

5.3 Equipment is clean and maintained in a safe working condition, including exhibiting a current service sticker where appropriate.

5.4 Mobile resuscitation trolleys, equipped to manage a patient collapse or cardio-pulmonary emergency, are located in wards, perioperative suites, intensive care / coronary care units and emergency departments.

5.5 Where paediatric services are provided, the mobile resuscitation trolley shall include readily identified paediatric equipment and medications.

5.6 Resuscitation trolleys are ready for use at all times, and:

- 5.6.1 there is evidence of daily trolley checks and checks after use
- 5.6.2 all medication and equipment must be within the “expiry date”
- 5.6.3 a written list of contents must be attached to each trolley
- 5.6.4 practice is demonstrated in policy.

5.7 Defibrillators are ready for use at all times, and a:

- 5.7.1 log is kept of current service and maintenance
- 5.7.2 current service sticker is attached to each machine.

5.8 An emergency call system is in place throughout the facility, call bells are tested and a checking log kept on site, including for:

- 5.8.1 medical emergency, duress, resuscitation
- 5.8.2 fire and emergency.

5.9 Response to emergency calls is governed by established guidelines for attendance.

5.10 Staff are trained in the use of the equipment including:

5.10.1 specific training for speciality areas

5.10.2 mandatory training for the use of manual handling equipment.

5.11 Medical and non-medical supplies are safely stored and monitored, in accordance with documented:

5.11.1 policies and procedures

5.11.2 review processes.

5.12 New instruments and equipment are:

5.12.1 examined and approved by the relevant authority within the organisation

5.12.2 subject to a process for feedback to and from staff.

Standard 6: Information management

Information is captured, managed, stored and maintained in a way that facilitates continuity of care and protects the privacy of patients.

Mandatory criteria

6.1 A designated staff member coordinates information management within the facility.

6.2 Patient confidentiality is protected and managed in accordance with documented processes.

6.3 A current register of patients in the facility is maintained, and includes:

- 6.3.1 full name, date of birth, gender, home address and next of kin
- 6.3.2 date of admission
- 6.3.3 name and address of the medical or other health professional who managed the patient's health care needs immediately prior to admission
- 6.3.4 date and time of discharge from the facility.

6.4 Inpatient data is provided to the Department of Health as specified on the Inpatient Summary Form (HA22).

6.5 Accurate medical records are maintained for each patient and are sufficiently detailed to allow another health professional to assume or support the care of the patient, and to facilitate effective continuity and standards of care. The medical records must include:

- 6.5.1 the patient's condition
- 6.5.2 the patient's diagnosis
- 6.5.3 a daily account of the patient's care
- 6.5.4 date, time, name, designation and signature of persons making the entries.

6.6 Medical record keeping complies with the facility's medical record policy.

6.7 Storage of medical records is effective, ensuring:

- 6.7.1 active medical records are readily accessible to clinical staff
- 6.7.2 active medical records are securely stored to ensure patient confidentiality and to protect against unauthorised persons gaining access to those records
- 6.7.3 storage of archived records (including electronic records) ensures that no access is available to unauthorised persons, including password protection that captures the identity of the person accessing the records
- 6.7.4 protection from fire, vermin and dust.

6.8 Patient information is only released in accordance with the Australian Privacy Principles set out in Schedule 1 to the *Privacy Act 1988* (Cth.) and when this is given it is recorded in the patient's medical record.

6.9 Disposal of medical records occurs in a manner which protects patient confidentiality and complies with regulations.

6.10 If medical records are electronic, an adequate system exists for off-site back-ups to be maintained.

Standard 7: Non-clinical support services

Non-clinical support services, including food, laundry and cleaning / waste management, support the safety and quality of health care services for patients, staff and visitors.

Mandatory criteria

Food and drink

7.1 A designated staff member coordinates the monitoring of all food and drink services provided at the facility.

7.2 Food and drink services, either on site or contracted, comply with the relevant guidelines; where outsourced, food and drink services comply with the service agreement.

7.3 The variety and quantity of food and drink is supplied in accordance with the dietary allowances as recommended by the National Health and Medical Research Council Guidelines to ensure that:

- 7.3.1 patients on therapeutic or special diets are provided with appropriate food and drink
- 7.3.2 patients receive fresh fruit or fruit juice daily
- 7.3.3 a dietician is available for consultation and has input into the development of and changes to the menus
- 7.3.4 menus are not repeated at intervals of less than four weeks
- 7.3.5 standard portion sizes are developed and used as a guide to preparing and ordering food
- 7.3.6 components of a puree diet are prepared and served as individual food items
- 7.3.7 meals are not served before 7am, 12noon and 5pm
- 7.3.8 where the evening meal is served before 5.30pm, supper is served between 7.30pm and 9.30pm.

7.4 Designated food storage areas include separate storage areas for dry, raw and cooked food.

7.5 No food products, equipment or consumables are stored on the floor.

7.6 All food storage area surfaces are made of an impervious material.

7.7 Equipment is clean and maintained in a safe working condition, including exhibiting a current service sticker.

7.8 Cleaning audits of food and drink preparation areas and equipment are undertaken in compliance with the infection control policy of the facility and associated food regulations.

7.9 Refrigerators and freezers used for storing food products operate at the recommended temperature range, being <5°C and minus 15°C respectively. The refrigerators and freezers are monitored for temperature control on a daily basis. There are policies outlining actions required when temperatures fall outside the recommended temperature range.

7.10 Staff involved in food handling and storage receive relevant training, and certification of completion of training is maintained.

7.11 Hand washing practices are applied and monitored, and an audit schedule is in place.

Laundry

7.13 A designated staff member coordinates laundry services.

7.14 Laundry services, either onsite or contracted, comply with Australian/New Zealand Standard – AS/NZS 4146, 'Laundry practice', specifically:

- 7.14.1 management of laundry services
- 7.14.2 laundry transportation system
- 7.14.3 collection, loading, storage and sorting of soiled laundry
- 7.14.4 laundry operation, evaluation, performance indicators
- 7.14.5 storage and packaging of clean laundry.

7.15 Where outsourced, laundry services comply with the service agreement.

7.16 The supply of laundry meets the function and throughput of the facility.

7.17 Transport and storage of laundry is managed in a safe manner and is demonstrated in policy.

7.18 Designated areas for storage of laundry are provided including:

- 7.18.1 clean and soiled laundry are stored in separate areas
- 7.18.2 storage areas are ventilated to minimise air contamination
- 7.18.3 designated laundry drop off / pickup areas are provided.

Cleaning / waste management

7.20 A designated staff member is responsible for coordinating overall cleaning and waste management practices and related staffing.

7.21 The facility is clean and safe at all times for patients, staff and visitors.

7.22 Clinical and related waste is managed in a safe manner.

7.23 Clinical waste carts/bins are securely stored to prevent unauthorised access.

7.24 Collection, storage and sorting of waste materials is conducted in a covered space, which:

- 7.24.1 is maintained at a temperature which helps control odours
- 7.24.2 is vermin and rodent proof
- 7.24.3 has a wash down facility for the waste carts.

7.25 Documented processes are in place to ensure the safe management of:

7.25.1 contaminated medical waste

7.25.2 waste material generated by the use of chemicals

7.25.3 sharp objects disposal.

7.26 Storage and disposal of general waste complies with local council regulations.

Standard 8: Facility design and function

The facility design and function provide a safe and functional environment that meets the needs of patients, staff and visitors.

Mandatory criteria

8.1 The number, size and function of rooms available in the facility are consistent with services to be provided for anticipated patient volumes and the delivery of safe and quality care.

8.2 All treatment spaces, bedrooms, isolation rooms, bathrooms and toilets comply with licensing building guidelines and are adequate in size and function, to ensure that:

- 8.2.1 patient and staff safety is maximised
- 8.2.2 staff are able to fulfil their duties
- 8.2.3 privacy and confidentiality is maintained.

8.3 Configuration, layout and workflows meet the requirements of facility operations ensuring separation of “clean” and “dirty”.

8.4 In addition to patient areas and patient treatment spaces, the facility also provides:

- 8.4.1 a reception area which protects patient confidentiality
- 8.4.2 designated separate clean and dirty utilities
- 8.4.3 designated clean and soiled linen storage
- 8.4.4 separate and sufficient storage areas for equipment and general stores
- 8.4.5 staff toilets, showers and change rooms
- 8.4.6 secure lockers for staff
- 8.4.7 staff dining areas.

8.5 All areas of the facility are used for the intended purpose as agreed in the licensing building approval.

8.6 Compliance is demonstrated for all refurbishments, redevelopments and new builds at the facility in accordance with licensing requirements and documented evidence is available on site.

8.7 Signage and way finding throughout the facility enables safe passage for patients, staff and visitors.

8.8 Parking is made available to accommodate the number and mix of patients, staff and visitors to the facility.

Standard 9: Fire, security and emergency response

Fire, security and emergency response is governed by systems and processes which promote patient, staff and visitor safety.

Mandatory criteria

9.1 Staff are trained to recognise and respond to emergencies, including:

- 9.1.1 fire / smoke
- 9.1.2 medical
- 9.1.3 bomb / arson threat
- 9.1.4 internal
- 9.1.5 personal threat
- 9.1.6 external
- 9.1.7 evacuation.

9.2 Fire orders and up to date evacuation plans are displayed throughout the facility for patients, staff and visitors and are easy to find, interpret and clearly show your location on the plan (for example, “you are here”).

9.3 Fire drills, equipment training and evacuation procedures are carried out annually for all staff and attendance logs and records are kept.

9.4 Exits are available for egress, either at all times, or the door hardware releases on fire alarm or power failure.

9.5 Fire hydrants and fire exit doors are:

- 9.5.1 clearly marked
- 9.5.2 easily accessible
- 9.5.3 free from clutter or equipment.

9.6 All exit signs are illuminated at all times.

9.7 A generator or battery operates fire exit markers.

9.8 Fire equipment, including extinguishers and hose reels, is ready for immediate use and tested six monthly as evidenced by a current service tag.

9.9 Flammable rubbish is managed in a way that it does not pose a fire risk.

9.10 A smoking policy is readily available to all staff, patients and visitors.

9.11 A functioning smoke alarm detection system is in place, is tested in accordance with Australian Standard AS 1851.8 ‘Maintenance of Fire Protection and Alarm Systems, Part 8 – Automatic Fire Detection and Alarm Systems’ (AS 1851.8), and service and maintenance log books are kept.

9.12 Automatic fire detection and alarm systems are functioning and tested in accordance with AS 1851.8, and service and maintenance log books are kept in the fire indicator panel.

9.13 Security processes are managed and enacted to ensure that unauthorised persons do not access or interfere with the operation of the facility to the detriment of patients, staff and visitors.

Standard 10: Facility maintenance

Facility maintenance is managed and maintained to ensure a safe, quality environment for patients, staff and visitors.

Mandatory criteria

10.1 A designated staff member coordinates the management, maintenance and servicing of buildings, systems, plant, equipment, signage and utilities.

10.2 Systems performance, monitoring and improvement processes are in accordance with the relevant codes, guidelines and standards, and evidence is available including:

- 10.2.1 the testing of all critical systems
- 10.2.2 documented back-up contingency plans in case of critical system failure
- 10.2.3 documented operational and maintenance records for each critical system.

10.3 Preventative maintenance of the physical facility and furniture is carried out in accordance with a documented program which demonstrates appropriateness, effectiveness and safety, including:

- 10.3.1 a schedule for planned building services maintenance, upgrade and replacement requirements
- 10.3.2 a log of deferred and/or outstanding building services maintenance, upgrade and replacement requirements
- 10.3.3 current maintenance records for cleaning, servicing, repairs and vermin and insect control.

10.4 Preventative and managed breakdown maintenance of all building services systems, including all mechanical, medical gas, electrical, communication, transportation and hydraulic systems, plant and equipment is carried out in accordance with a documented program which includes onsite:

- 10.4.1 registers of all building services systems, plant and equipment
- 10.4.2 maintenance and operational manuals
- 10.4.3 “As Constructed” (approval to construct) drawings
- 10.4.4 records for all routine and breakdown maintenance conducted.

10.5 Preventative and managed breakdown maintenance of biomedical and surgical equipment is carried out in accordance with a documented program, including:

- 10.5.1 biomedical equipment is tested to manufacturer’s recommendations
- 10.5.2 annual testing as evidenced by a current service tag
- 10.5.3 an onsite register of biomedical and surgical equipment
- 10.5.4 onsite maintenance and operational manuals
- 10.5.5 onsite records of all routine and breakdown maintenance conducted.

10.6 Patient, staff assist, emergency, and duress call bells are provided in all patient areas and include:

10.6.1 onsite schedules and logs for the testing of bells

10.6.2 a documented staff response process.

10.7 Oxygen and suction outlets are available and adjacent to each bed.

10.8 Portable oxygen and suction cylinders are safely stored and restrained and are accessible for resuscitation with readily available emergency backup.

10.9 A back-up generator is readily available in the event of a power failure which is tested regularly as evidenced by onsite service maintenance logs.

10.10 Chemicals, detergents and gases are stored in a safe and secure manner.

Standard 11: Perioperative suite

The perioperative suite is governed by systems and processes which promote optimal patient care and a safe environment for patients and staff.

Mandatory criteria

11.1 There is a dedicated senior nurse (however titled) who has completed additional or specialty training in the perioperative area, coordinating all perioperative activities and responsible for monitoring and ensuring compliance.

11.2 A designated anaesthetist is responsible for monitoring and ensuring compliance with the Australian and New Zealand College of Anaesthetists guidelines.

11.3 Staffing arrangements comply with the Australian College of Operating Room Nurses standards, Gastroenterological Nurses College of Australia and Australian and New Zealand College of Anaesthetists guidelines.

11.4 There are processes in place to ensure supervising medical staff are promptly available when clinical needs arise.

11.5 Perioperative practice complies with the Australian College of Operating Room Nurses standards.

11.6 Policies and procedures reflect the Australian College of Operating Room Nurses standards and include monitoring for compliance.

11.7 Separate registers are maintained as follows:

- 11.7.1 operations/procedure register
- 11.7.2 implantable device register
- 11.7.3 laser register.

11.8 Operations and procedures are registered, including:

- 11.8.1 date
- 11.8.2 patient name
- 11.8.3 record number
- 11.8.4 birth date
- 11.8.5 sex
- 11.8.6 procedure performed
- 11.8.7 names of the surgeon, anaesthetist and nursing personnel involved
- 11.8.8 start and finish time of the procedure
- 11.8.9 type of anaesthesia or sedation used.

11.9 There is a documented process of patient identification, consent and safety check list.

11.10 Sterilised items used on a patient are logged through use of a tracing system which is documented in the patient medical record, in accordance with Australian/New Zealand Standard – AS/NZS 4187, 'Reprocessing of reusable medical devices in health service organisations'.

11.11 If lasers are used in the facility, laser safety is monitored in accordance with Australian/New Zealand Standard – AS/NZS 4173, 'Guide to the safe use of lasers in health care'.

11.12 Patient care equipment and supplies are available to support the safe practice of all procedures and care provided.

11.13 Anaesthetic machines and equipment meet Australian and New Zealand College of Anaesthetists' guidelines.

11.14 Designated storage areas are provided for all equipment, ensuring items are not stored in operating rooms or corridors.

11.15 The three zones in the perioperative suite include:

11.15.1 an unrestricted area which has a central control point, to monitor the entrance of patients, personnel, stock and supplies. Limited traffic is permitted in this area and personnel may wear street clothes

11.15.2 a semi–restricted area which provides for storage areas for clean supplies, a pre-operation holding bay, a Post Anaesthetic Care Unit and corridors leading to restricted areas. Traffic is limited to authorised personnel wearing perioperative attire and patient attire is to be worn in these areas

11.15.3 a restricted area which includes the operating and procedure rooms, areas for processing and storing sterile items and the storage of sterile stock. Traffic is limited to authorised personnel and surgical attire is required.

11.16 Operating rooms, holding bay and recovery room are designated and equipped to safely carry out the nominated procedures and maintain patient care and privacy.

Standard 12: Endoscopy unit

The Endoscopy Unit is governed by systems and processes which promote optimal patient care and a safe environment for patients and staff.

Mandatory criteria

12.1 A qualified nurse, who has completed additional or specialty training in endoscopy, is designated to coordinate endoscopy unit activities and is responsible for monitoring and ensuring compliance.

12.2 Staffing arrangements comply with the Australian College of Operating Room Nurses standards, Gastroenterological Nurses College of Australia and Australian and New Zealand College of Anaesthetists guidelines.

12.3 Endoscopy practice complies with the Gastroenterological Nurses College of Australia and the Australian College of Operating Room Nurses standards.

12.4 Staff training is appropriate to the environment, including evidence of:

- 12.4.1 orientation and in-service training on equipment and procedures
- 12.4.2 completion of the Gastroenterological Nurses College of Australia competencies including scope cleaning
- 12.4.3 endoscopy training for all staff, with all staff in a leading or supervisory role qualified at national competency levels in endoscopy and at least 70 per cent of remaining staff qualified or undertaking training.

12.5 Policies and procedures reflect Gastroenterological Nurses College of Australia, Australian College of Operating Room Nurses standards, and Australian and New Zealand College of Anaesthetists guidelines and include audit monitoring for compliance.

12.6 Sterile supply, either onsite or contracted, must ensure compliance with:

- 12.6.1 Australian/New Zealand Standard – AS/NZS 4187, ‘Reprocessing of reusable medical devices in health service organisations’
- 12.6.2 Australian Standard – AS 3789.2, ‘Textiles for health care facilities and institutions, Part 2: Theatre linen and pre-packs’
- 12.6.3 Australian Standard – AS 3789.2, ‘Textiles for health care facilities and institutions, Part 3: Apparel for operating theatre staff’.

12.7 Operations and procedures are registered, including:

- 12.7.1 date of procedure
- 12.7.2 patient's name
- 12.7.3 record number
- 12.7.4 patient's date of birth
- 12.7.5 patient's sex
- 12.7.6 procedure performed
- 12.7.7 name of the surgeon, anaesthetist and nursing personnel involved
- 12.7.8 start and finish time of the procedure
- 12.7.9 type of anaesthesia or sedation used.

12.8 There is a documented process of patient identification, consent and safety check list.

12.9 Sterilised items used on a patient are logged through use of a tracing system which is documented in the patient's medical record.

12.10 Single use items are not re-used.

12.11 The use of chemicals within the unit is monitored and documented and Material Safety Data Sheets are available.

12.12 Patient care equipment and supplies are available to support the safe practice of procedures and care provided.

12.13 Anaesthetic machines and equipment meet Australian and New Zealand College of Anaesthetists' guidelines.

12.14 Designated storage areas are provided within the endoscopy unit and no equipment is permanently stored in procedure rooms.

Standard 13: Central sterilising department

Cleaning, disinfecting and sterilising of equipment and instruments and the sterile supply services are managed and maintained according to industry standards and guidelines.

Mandatory criteria

13.1 There is a designated person who has completed a recognised course in national competencies, coordinating all sterilisation activities and responsible for monitoring and ensuring compliance.

13.2 Staffing arrangements, at a minimum, comply with the Australian/New Zealand Standard – AS/NZS 4187, 'Reprocessing of reusable medical devices in health service organisations' (AS/NZS 4187).

13.3 All personnel involved in cleaning, packaging, sterilising and storage of sterile supplies undertake relevant education and training and comply with AS/NZS 4187. There is evidence of:

- 13.3.1 orientation and in-service training on equipment and procedures
- 13.3.2 sterilisation reprocessing training for all staff, with all staff in a leading or supervisory role qualified at national competency levels in the management of a central sterilising department and at least 70 per cent of remaining staff qualified or undertaking training
- 13.3.3 completion of the Gastroenterological Nurses College of Australia competencies including scope cleaning (if appropriate).

13.4 Sterile Supply and storage, either onsite or contracted, must ensure compliance with:

- 13.4.1 AS/NZS 4187
- 13.4.2 Australian Standard – AS 3789.2 'Textiles for health care facilities and institutions, Part 2: Theatre linen and pre-packs'
- 13.4.3 Australian Standard – AS 3789.2 'Textiles for health care facilities and institutions, Part 3: Apparel for operating theatre staff'.

13.5 Single use items are not re-used.

13.6 Equipment and supplies are available to support the safe practice of all processes carried out in the Central Sterilising Department.

13.7 Policies and procedures reflect, at a minimum, AS/NZS 4187 and include annual audit monitoring for compliance.

13.8 The infection control program for the Central Sterilising Department meets AS/NZS 4187.

13.9 Information management ensures compliance with AS/NZS 4187.

13.10 The use of chemicals within the unit is monitored and documented and Material Safety Data Sheets are available.

Standard 14: Renal unit

The Renal Unit is governed by systems and processes which promote optimal patient care and a safe environment for patients and staff.

Mandatory criteria

14.1 There is a registered nurse with qualifications and/or clinical experience in renal dialysis, responsible for the nursing care of patients.

14.2 A qualified renal physician is responsible for the clinical management of patients.

14.3 Only registered, comprehensive and enrolled nurses or nurse practitioners provide direct nursing care.

14.4 Staffing arrangements comply with the licence including, the:

- 14.4.1 number and categories of nursing and other staff
- 14.4.2 kinds of nursing and other care provided or available at the facility
- 14.4.3 periods and times at which the services are provided or available.

14.5 Staff training is appropriate to the environment, including evidence of orientation and in-service training on equipment and procedures.

14.6 Policies and procedures are developed, reviewed, maintained and updated by a renal department management committee and are readily available to staff.

14.7 The treatment spaces comply with the licensing building guidelines and are adequate in size for staff to carry out their duties and to provide privacy for patients. There needs to be sufficient space between beds / chairs for staff to deliver safe patient care.

14.8 Equipment is available to support safe practice and which is:

- 14.8.1 sufficient in volume
- 14.8.2 appropriate for the type of procedures
- 14.8.3 specialist equipment is available
- 14.8.4 annual audit evidence is kept on site.

14.9 Communication with the Water Authority regarding planned water cuts shall be provided to the unit in a timely manner, to ensure that treatments can be rescheduled.

14.10 Chemical water purity and bacterial colony counts shall meet the requirements of the Association for the Advancement of Medical Instrumentation standards.

14.11 In the event of a medical emergency, the renal unit shall have ready access to an emergency department.

14.12 Sterile supply and storage must ensure compliance with AS/NZS 4187.

Standard 15: Electroconvulsive therapy unit

The Electro Convulsive Therapy Unit is managed in accordance with the standards and guidelines published by the Office of the Chief Psychiatrist and provide a safe and quality environment for patients, visitors and staff.

Mandatory criteria

15.1 A designated registered nurse, experienced in the administration of electroconvulsive therapy (ECT), is responsible for the management and care of patients. This includes ensuring that:

- 15.1.1 the ECT machine is checked and is operational before each session
- 15.1.2 emergency resuscitation equipment is readily available
- 15.1.3 appropriate emergency drugs are available

15.2 Only a registered psychiatrist administers ECT on a patient.

15.3 Staffing arrangements for ECT are in accordance with the Australian College of Operating Room Nurses Standards and the Chief Psychiatrist's Guidelines for the use of Electroconvulsive Therapy in Western Australia.

15.4 Staffing for ECT anaesthesia and equipment are in accordance with the Australian and New Zealand College of Anaesthetists (ANZCA) Guidelines and include:

- 15.4.1 Technical Standard One – Recommendations on Minimum Facilities for Safe Anaesthesia Practice in Operating Suites
- 15.4.2 Technical Standard Two – Recommendations on Minimum Facilities for Safe Anaesthesia practice Outside the Operating Suite.

15.5 Staffing arrangements for ECT recovery are in accordance with the ANZCA Guidelines and include:

- 15.5.1 Professional Standard 4 – Recommendations for the Post-Anaesthesia Recovery Room.

15.6 Staff involved in the provision of ECT are competent in basic life support.

15.7 Policies and procedures are developed, reviewed, monitored and updated by an ECT management committee and are readily available to staff. These include:

- 15.7.1 a psychiatrist who has completed formal training in ECT and has sufficient experience in administrating ECT, is responsible for the provision of the facility's ECT program
- 15.7.2 a designated person is responsible for monitoring and ensuring compliance with the ANZCA guidelines
- 15.7.3 staff education and training programs are service specific and meet staff and or patient needs
- 15.7.4 staff are provided with education and training on the legal framework governing the provision of ECT
- 15.7.5 a designated person is responsible for monitoring and ensures compliance with the Australian College of Operating Room Nurses Standards.

15.8 Information management ensures that:

15.8.1 patients are provided with written and verbal information, to allow them to make an informed consent to undergo ECT

15.8.2 medical records include all details of ECT

15.9 An ECT register is kept and records:

15.9.1 date, start and finish time that ECT was administered

15.9.2 patient's name

15.9.3 medical record number

15.9.4 birth date

15.9.5 gender

15.9.6 procedure performed including bilateral/unilateral, brief pulse, current delivered

15.9.7 name and designation of operator and anaesthetist

15.9.8 name of treating psychiatrist and supervising psychiatrist, if present

15.9.9 name of nursing personnel assisting

15.9.10 type of analgesia, anaesthetic and muscle relaxant used

15.9.11 details of seizure induced including duration recorded on electroencephalogram

15.9.12 name of patient's psychiatrist (and second opinion psychiatrist if required)

15.9.13 treatment number and total number of treatments planned

15.9.14 where abbreviations are used, they are consistent with organisation policy on abbreviations.

15.10 The medications available in the ECT suite include as a minimum:

15.10.1 anaesthetic induction agents

15.10.2 muscle relaxants

15.10.3 Dantrolene, Atropine and sterile water

15.10.4 an emergency drug tray containing drugs to deal with psychiatric, cardiac, neurological or respiratory emergencies.

15.11 Security measures are in place to ensure that unauthorised persons do not access the ECT unit.

15.12 Patient care equipment and supplies are available to support the safe practice of all procedures and care provided. These items include:

15.12.1 an ECT machine, of a type that is registered with the Therapeutic Goods Authority, shall be provided, which has the following as a minimum set of functions:

15.12.1.1 electroencephalogram monitoring

15.12.1.2 a wide range of stimulus settings

15.12.2 at least one fully equipped resuscitation trolley is available with the drugs and equipment required to manage a patient collapse or cardio-pulmonary emergency

15.12.3 when ECT is in use, oxygen and suction is adjacent to each bed/trolley

15.12.4 the emergency call system is functional and permits both the ECT suite and recovery areas to alert an emergency.

15.13 ECT unit design and function provides a safe environment that meets the needs of patients and staff.

Standard 16: Neonatal unit

The neonatal unit is governed by systems and processes which promote optimal patient care and a safe environment for patients and staff.

Level 1 Nursery

- Normal, low risk pregnancies and births and management of babies ≥37+0 weeks gestation with minimal complications (for example, hypoglycaemia, infection screening, tube-feeding, oxygen therapy, infection screening)
- Phototherapy for physiological jaundice
- 24 hour on site access to a health professional skilled in initiating neonatal resuscitation.

Level 2a Nursery

- Low to moderate risk pregnancies and births and management of babies ≥34+0 weeks gestation with minimal neonatal complications (for example, apnoea monitoring, low-level oxygen therapy and monitoring and nasal/oral-gastric feeding)
- Short term intravenous therapy
- Referred for management by attending paediatrician
- Paediatricians are on-call 24 hours.

Level 2b Nursery

- Moderate to high-risk pregnancies and births and management of babies ≥32+0 weeks gestation (high dependency patients and provision of short-term mechanical ventilation of less than 6 hours pending transfer, nasal Continuous Positive Airway Pressure with facilities for arterial blood gas monitoring)
- Non-invasive blood pressure monitoring
- Access to clinical and diagnostic paediatric subspecialties
- Paediatric registrar or above on site 24 hours
- Paediatricians are on-call 24 hours
- May receive baby retrieval by Neonatal Emergency Transport Service, Western Australia from Level 1 neonatal facilities.

Level 3 Nursery

- High risk, high dependency pregnancies and births and management of babies <32+0 weeks gestation (high dependency patients and provision of medium-term mechanical ventilation and full life-support)
- Neonatal surgery and care for complex congenital and metabolic diseases of the baby
- Neonatal staff (paediatric registrars, paediatricians and paediatric nurses) are on site 24 hours.

16.1 There is a registered nurse or nurse practitioner, with qualifications and/or clinical experience in high dependency neonatal nursing, responsible for the neonatal department.

16.2 There is a specialist paediatrician with experience in neonatal care responsible for the clinical management of patients.

16.3 Staffing arrangements are appropriate to the department, including:

- 16.3.1 the nursing ratio is a minimum of 1:4 cots
- 16.3.2 the senior nurse has extensive experience in neonatal nursing, a post graduate qualification in neonatal nursing and midwifery qualifications
- 16.3.3 there is a minimum of one registered midwife (preferably with post-basic qualifications) rostered for each shift
- 16.3.4 a neonatal paediatric registrar or medical practitioner with experience in neonatal paediatrics is available 24 hours per day
- 16.3.5 there is a rotation of physicians / neonatologist(s) within the tertiary intensive care facility
- 16.3.6 registered midwives have paediatric or neonatal/perinatal training and neonatal advanced life support training
- 16.3.7 on call arrangements are in place to supplement staffing
- 16.3.8 other staff, including clerical and support staff, are available as required.

16.4 Policies and procedures are developed, reviewed, updated and audited by a neonatal department management committee and are made readily available to staff, and include procedures for babies who:

- 16.4.1 require continuous monitoring of respiration or heart rate or by transcutaneous transducers
- 16.4.2 are receiving additional oxygen
- 16.4.3 are being tube fed
- 16.4.4 have had minor surgery in the previous 24 hours
- 16.4.5 are being barrier nursed
- 16.4.6 are receiving phototherapy
- 16.4.7 are receiving special monitoring (for example, frequent glucose or bilirubin estimations)
- 16.4.8 are receiving constant supervision
- 16.4.9 are receiving antibiotics
- 16.4.10 require radiological examinations or other methods of imaging
- 16.4.11 are short term assisted ventilator care, pending transfer to higher levels of service
- 16.4.12 are dying
- 16.4.13 storage of expressed breast milk from infected mothers
- 16.4.14 transfer policy and procedure
- 16.4.15 emergency procedures, specifically Code Black Alpha (Infant/Child Abduction).

16.5 Neonatal department design and function provides a safe environment that meets the needs of patients, including providing:

16.5.1 clinical hand wash basins

16.5.2 an isolation room with an airlock

16.5.3 a stainless steel nursery bath with cupboards

16.5.4 an emergency power system

16.5.5 a clean utility room with pharmacy storage and a drug fridge

16.5.6 a formula room

16.5.7 a dirty utility area with appropriate utensil washers

16.5.8 a family support room with a beverage bar.

16.6 Security measures are in place and all reasonable steps are taken to ensure that unauthorised persons do not access the facility or interfere with the operation of the facility to the detriment of patients, visitors and staff.

16.7 Equipment and infrastructure is available to support safe practice, including:

16.7.1 mobile incubator

16.7.2 intensive care incubator

16.7.3 transport incubator

16.7.4 mobile infant overhead heater

16.7.5 infant resuscitation trolley

16.7.6 phototherapy unit

16.7.7 paediatric resuscitation equipment

16.7.8 formula refrigerator (daily refrigerator temperatures are recorded and documented and expressed breast milk is to store at 4°C).

16.8 Designated storage areas are provided within the unit for all equipment and supplies and allow for easy staff access.

16.9 Equipment is not stored in corridors or walkways to impede egress during fire or other emergency.

16.10 A register of patients treated in the unit is maintained.

16.11 The newly born child must be formerly admitted as a patient of the hospital in which it receives medical care. The admitting medical practitioner must certify:

16.11.1 the diagnosis of the child

16.11.2 that the newly born child was under the care of a specialist and the medical care was deemed necessary by that specialist and that the child was accommodated in an approved separate special care facility.

Standard 17: Intensive care unit

The intensive care unit is governed by systems and processes which promote optimal patient care and a safe environment for patients and staff.

Mandatory criteria

17.1 There is a registered nurse with qualifications and/or clinical experience in running an intensive care unit, responsible for the nursing care of patients at all times.

17.2 A qualified intensive care physician is responsible for the clinical management of patients.

17.3 Staffing arrangements comply with the College of Intensive Care Medicine of Australia and New Zealand, Minimum Standards for Intensive Care Units.

17.4 Policies and procedures are developed, monitored, reviewed and updated by an Intensive Care Unit management committee and are readily available to staff, and reflect the College of Intensive Care Medicine of Australia and New Zealand, Minimum Standards for Intensive Care Units.

17.5 Intensive care unit design and function provides a safe environment that meets the needs of patients and staff and ensures:

- 17.5.1 easy access to the intensive care unit, operating suite and radiology at all times
- 17.5.2 access to allied health professionals.

17.6 Security measures are in place to ensure that:

- 17.6.1 unauthorised persons do not have access to the intensive care unit
- 17.6.2 a duress alarm system is in place for staff
- 17.6.3 security staff are available at all times in the event of a security breach.

17.7 Patient care equipment and supplies are available to support the safe practice of all procedures and care provided in the intensive care unit.

17.8 Designated storage areas are provided within the unit for all equipment and supplies and allow for easy staff access.

17.9 Equipment is not stored in corridors or walkways to impede access, particularly in the event of an evacuation or other emergency.

Standard 18: Emergency department

The emergency department is governed by systems and processes which promote optimal patient care and a safe environment for patients and staff.

18.1 There is a registered nurse or nurse practitioner with qualifications and/or clinical experience in running an emergency department, responsible for the nursing care of patients at all times.

18.2 A qualified emergency department physician is responsible for the clinical management of patients.

18.3 Staffing arrangements include compliance with the following matters:

- 18.3.1 a designated person is responsible for monitoring and ensuring compliance with emergency department standards including the Australasian College for Emergency Medicine
- 18.3.2 medical staffing includes:
  - 18.3.2.1 at least two full time equivalent medical practitioners who hold the qualification of Fellow of the College of Emergency Medicine
  - 18.3.2.2 a medical practitioner of at least four years standing is dedicated to the department for 24 hours of every day as “lead” doctor
  - 18.3.2.3 a second medical practitioner is available in the hospital at all times
  - 18.3.2.4 other suitably experienced medical staff are available as required and a roster of specialist consultants is maintained in the department
  - 18.3.2.5 the department is not left without a doctor and/or appropriate nurse staffing in the event of transfers, which require a medical and/or nursing escort
- 18.3.3 nurse staffing complies with the College of Emergency Nursing Australasia ‘Quality Standards for Emergency Departments and other Hospital-based Emergency Care Services’, and includes:
  - 18.3.3.1 a Senior Registered Nurse Level 3 with appropriate qualifications is designated as nurse manager
  - 18.3.3.2 a Clinical Nurse is on duty and responsible for each shift
  - 18.3.3.3 the Clinical Nurse is supported by experienced Registered and Enrolled Nurses
- 18.3.4 other staff including clerical, and support staff are available as required
- 18.3.5 on call arrangements are in place to supplement staffing.

18.4 Policies and procedures are developed, reviewed and updated by an Emergency Department management committee and are readily available to staff.

18.5 Emergency Department design and function provides a safe environment that meets the needs of patients and staff and ensures:

18.5.1 easy access to the intensive care unit, operating theatres pharmacy, pathology and radiology at all times

18.5.2 access to allied health professionals.

18.6 Security measures are in place to ensure that:

18.6.1 unauthorised persons do not have access to the Emergency Department

18.6.2 a duress alarm system is in place for staff

18.6.3 security staff are available at all times in the event of a security breach.

18.7 Patient care equipment and supplies are available to support the safe practice of all procedures and care provided in the Emergency Department.

18.8 Designated storage areas are provided within the department for all equipment and supplies which allow for easy staff access.

18.9 Equipment is not stored in corridors or walkways to impede access particularly in the event of an evacuation or other emergency.

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