



Government of **Western Australia**
Department of **Health**

Licensing Standards

For the Arrangements for Management,
Staffing and Equipment

Sub-acute Care Services



Licensing and Accreditation Regulatory Unit

Department of Health

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Table of contents

Application – Sub-acute Services	2
Glossary of terms	3
Standard 1: Governance	5
Standard 2: Workforce	7
Standard 3: Clinical risk	9
Standard 4: Infection control	11
Standard 5: Emergency management and security	13
Standard 6: Information management	14
Standard 7: Non-clinical support services	16
Standard 8: Facility design, function and management	18
Standard 9: Sub-acute ward	20
References	21

Application – Sub-acute Care Services

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 Sub-acute Care Service.

The Standards for a Sub-acute Care Service were developed in 2025 to meet the growing demand for rehabilitation and sub-acute services in Western Australia.

Whilst the Act does not define sub-acute care, the Standards are reflective of the cohort of patients who require ongoing care and treatment for an undefined period of time, prior to discharge to home, aged care services or supported independent living/disability services.

For the purpose of this document, subacute care will be taken to mean specialised, multidisciplinary care aimed at optimising a patient's functional abilities and quality of life, typically provided to individuals who are medically stable but require ongoing treatment and rehabilitation following an acute illness or injury.

The premises and model of care must be consistent with the care needs of the cohort and ensure a safe and suitable environment for patients and staff.

The application of these Standards will be determined by the functionality of the licensed facility, as outlined in the facilities' functional brief. Conditions 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. Conditions allow for the identification of a risk mitigation strategy which shall be monitored.

The Sub-acute Care Services Standards are applicable from 1 March 2026 or as amended from time to time.

Glossary of terms

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

Admitted patient – a patient admitted to hospital.

Adult – a person 18 years or older.

Allied Health – professionals (not doctors/dentists/nurses) who provide diagnosis, treatment, prevention, rehabilitation, and health promotion, regulated either through AHPRA or via professional associations.

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.

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.

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.

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.

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

Unregulated worker - Under the Health and Disability Services (Complaints) Act 1995 (WA), anyone providing a health service not regulated by AHPRA

Sub-acute care – specialised, multidisciplinary care aimed at optimising a patient's functional abilities and quality of life, typically provided to individuals who are medically stable

but require ongoing treatment and rehabilitation following an acute illness or injury.

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

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 4 medicines – (also known as prescription only medicines) Substances, the use or supply of which should be by or on the order of persons permitted under the Act to prescribe and should be available from a pharmacist on prescription

Schedule 4 restricted medicines - A list of S4 medicines, for the purpose of this Policy, which are considered to be at higher risk of diversion and misuse Risk based requirements for medicines handling. Note: SCHEDULE 4 RESTRICTED medicines are not designated through legislation

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. Annexure A (additional licence terms and conditions)
 - 1.1.9. conditions or exemptions on the licence (where applicable).
- 1.2. The function of the facility is defined in a statement/website that is accessible to staff, patients, their families, carers, and visitors.
- 1.3. An organisational chart reflects the administrative framework that defines roles, responsibilities, and reporting relationships.
- 1.4. A committee structure identifies the formal committees through which the lines of governance, reporting and communication flow within the facility.
- 1.5. A medical governance model is in place to ensure the health and wellbeing of the patients. If a facility employs their own medical practitioners, then they must have:
 - 1.5.1. a medical director
 - 1.5.2. a medical advisory committee to oversee the standards of medical practice
 - 1.5.3. a committee that oversees the credentialling of medical practitioners
- 1.6. The facility has a governance process for the oversight of the policy framework to:
 - 1.6.1. guide policy development, review or update at least every three years
 - 1.6.2. ensures policies comply with legislation, regulation and state requirements
 - 1.6.3. ensure effective implementation
- 1.7. The facility has an admission and discharge policy that includes inclusion and/or exclusion criteria.
- 1.8. Work Health and Safety programs and practices are in place, and there is a designated, qualified staff member responsible.
- 1.9. A committee is in place that monitors outcomes of Work Health and Safety programs and audits, and reports to the hospital executive to ensure compliance and feedback

to staff.

- 1.10. Accreditation for all licensed services is maintained and reported in line with all relevant legislation, regulatory authority requirements, recognised accreditation schemes, and mandatory standards or advisories, as updated from time to time. The organisation ensures that systems, processes and governance structures support ongoing conformity with these requirements and promote continuous improvement in safety, quality, and service delivery.
- 1.11. 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.

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 Governance of workforce includes:
 - 2.1.1 oversight by a governance committee - dependent on the size and complexity of services, this may be a stand-alone committee or a standing item on a general governance committee.
 - 2.1.2 coordination by a designated staff member - dependent on the size and complexity of services, this may be a dedicated position or included in a broader role.
 - 2.1.3 the support of policies, procedures and audit
- 2.2 Pre-employment processes include the requirement for all staff to be screened for the appropriate level of police and 'Working With Children' clearances.
- 2.3 Staffing arrangements comply with the licence including:
 - 2.3.1 being appropriately resourced for the acuity of the patient cohort
 - 2.3.2 The kinds of nursing and other care provided or available at the facility
- 2.4 The licence holder demonstrates that:
 - 2.4.1 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
 - 2.4.2 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.
- 2.5 A designated Chief Executive (however titled) is employed by the facility and is responsible for the governance of the facility.
- 2.6 A designated Director of Nursing (however titled), or their suitably qualified replacement, is employed by the facility. The person shall have appropriate senior leadership and management experience and shall:
 - 2.6.1 have current registration with the Nursing and Midwifery Board of Australia (NMBA) as a Registered Nurse and is
 - 2.6.2 be responsible for standards of nursing practice within the facility.
- 2.7 At least one registered general nurse is present during all occasions the licensed facility is used for patient care. Assistance with patient care may be provided by care workers (however named) but must be under the direct supervision of a registered nurse and their scope of practice must be clearly defined.

- 2.8 All professionals provide evidence of their current registration with the relevant professional body. A documented process ensures that:
 - 2.8.1 all professional groups employed within the facility are identified
 - 2.8.2 all registrations are current
 - 2.8.3 any practice restrictions are identified
- 2.9 Processes are in place to check the suitability of non-regulated workers (however named) by:
 - 2.9.1 ensuring that recruitment processes check for character, reputation, identity, training, competencies (including English language) and police checks
 - 2.9.2 checking the Health and Disability Services Complaints Office (HaDSCO) website for prohibition notices at recruitment and periodically throughout the year.
- 2.10 Written job descriptions are available for all positions, and:
 - 2.10.1 are current
 - 2.10.2 include lines of communication, authority and responsibility
 - 2.10.3 are readily accessible to staff.
- 2.11 A mandatory staff training program, which is service specific to staff and patient needs, is in place.
- 2.12 An ongoing staff development and training program, which is service specific and meets staff and patient needs, is in place.

Standard 3: Clinical risk

Health care services are provided in a way that reduces clinical risk to patients, staff and visitors.

Mandatory criteria

- 3.1 Governance of safety, quality and risk includes:
 - 3.1.1 oversight by a governance committee - dependent on the size and complexity of services, this may be a stand-alone committee or a standing item on a general governance committee.
 - 3.1.2 coordination by a designated staff member - dependent on the size and complexity of services, this may be a dedicated position or included in a broader role.
 - 3.1.3 the support of policies, procedures and audit
- 3.2 The facility is supported by a risk management framework that is appropriate to the size and complexity of the services that are provided.
- 3.3 Clinical and critical incidents have a documented process that is managed, enacted and reported in accordance with Annexure A, including compliance with reporting timeframes.
- 3.4 Compliments, complaints, and grievance management processes are in place for patients, their families and carers, visitors, and staff.
- 3.5 New technologies, procedures and equipment are examined and approved by the relevant authority within the organisation and have a documented process that is managed, monitored, and outcomes reported.

Medications

- 3.6 Governance of medication safety includes:
 - 3.6.1 oversight by a governance committee - dependent on the size and complexity of services, this may be a stand-alone committee or a standing item on a general governance committee.
 - 3.6.2 coordination by a designated staff member - dependent on the size and complexity of services, this may be a dedicated position or included in a broader role.
 - 3.6.3 the support of policies, procedures and audit
- 3.7 The acquisition, prescribing, dispensing, administration, storage and disposal of medications have a documented process that is managed, monitored and reported. Processes must be compliant with current relevant state and federal legislation.
- 3.8 Medications are prescribed by medical practitioners, dentists, nurse practitioners, and registered nurses who have completed approved training and prescribe in partnership with a medical practitioner.

- 3.9 The acquisition, prescribing, dispensing, administration, storage and disposal of Schedule 8 and Schedule 4 Restricted medications are undertaken in accordance with the relevant legislation, regulations and guidelines and are managed in a way that allows for reconciliation in the event of a discrepancy.
- 3.10 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 Governance of infection prevention and control includes:
 - 4.1.1 Oversight by a governance committee - dependent on the size and complexity of services, this may be a stand-alone committee or a standing item on a general governance committee.
 - 4.1.2 Coordination by a staff member, who has completed a nationally accredited infection prevention and control course - dependent on the size and complexity of services. This may be a dedicated position or included in a broader role.
 - 4.1.3 The support of policies, procedures and audit
- 4.2 Where the services of an external consultant are used the services provided must be relevant and appropriate to the infection prevention and control risk profile of the facility and are to be supported by an on-site staff member with a minimum foundational training in infection prevention and control.
- 4.3 There is a comprehensive, documented infection prevention and control program that incorporates the hierarchy of controls with a scope and focus that addresses risk factors specific to the patient population and facility type.
- 4.4 There are clear processes in place for the application of state and national infection prevention and control standards and guidelines related to.
 - 4.4.1 hand hygiene
 - 4.4.2 standard and transmission-based precautions
 - 4.4.3 aseptic technique
 - 4.4.4 the management of invasive medical devices
 - 4.4.5 surveillance
 - 4.4.6 outbreak management
 - 4.4.7 sharps management
 - 4.4.8 healthcare worker occupational exposure management
 - 4.4.9 workforce screening and immunisation – for all permanent and contracted staff who have patient contact (Type A worker)
 - 4.4.10 environmental cleaning and disinfection
 - 4.4.11 water quality risk management
 - 4.4.12 management of waste

- 4.4.13 management of clean and soiled linen
- 4.4.14 reprocessing of reusable medical devices and equipment
- 4.4.15 infection prevention and control education and competency assessments.
- 4.5 Quality improvement systems that incorporate auditing and monitoring performance, implementing strategies to improve infection prevention and control systems and outcomes.
- 4.6 Surveillance systems are in place for healthcare associated infection that incorporate national and jurisdictional requirements and includes standardised definitions.
- 4.7 The health service infection prevention and control program includes maintaining building, plant, equipment, utilities, devices and other infrastructure to minimise healthcare associated infection.
- 4.8 A qualified infection prevention and control resource person provides guidance on IPC risk mitigation strategies to reduce risks associated with construction, renovation and maintenance activities.
- 4.9 The health service has an evidence-based antimicrobial stewardship program appropriate to size and complexity of the health service.

Standard 5: Emergency management and security

Emergency management and security are governed by systems and processes which promote patient, staff and visitor safety.

Mandatory criteria

- 5.1 Governance of emergency management and security includes:
 - 5.1.1 oversight by a governance committee - dependent on the size and complexity of services, this may be a stand-alone committee or a standing item on a general governance committee.
 - 5.1.2 coordination by a designated staff member - dependent on the size and complexity of services, this may be a dedicated position or included in a broader role.
 - 5.1.3 the support of policies, procedures and audit
- 5.2 Staff are trained to recognise and respond to all emergencies that could be experienced at the facility.
- 5.3 Documented back-up contingency plans (business continuity plan or however titled) are in place in case of critical system failure, including cyber-security incidents.
- 5.4 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. Fire orders and evacuation plans are dated and reviewed every 5 years and:
 - 5.4.1 Current Fire Safety Handbook shall be kept on site, as per WAHFG Engineering Services 2025
- 5.5 Fire drills, equipment training and evacuation procedures are carried out at least annually for all staff, and attendance logs and records are kept.
- 5.6 Exits, with illuminated exit signs, are available for egress, either at all times, or the door hardware releases on fire alarm or power failure.
- 5.7 Fire hydrants and fire exit doors are:
 - 5.7.1 clearly marked
 - 5.7.2 easily accessible
 - 5.7.3 free from clutter or equipment.
- 5.8 Fire equipment, including extinguishers and hose reels, is ready for immediate use and tested six monthly as evidenced by a current service tag.
- 5.9 Flammable rubbish is managed in a way that does not pose a fire risk.
- 5.10 A smoking policy is readily available to all staff, patients, and visitors.

- 5.11 Functioning smoke and fire alarm and detection systems are in place, are tested in accordance with Australian Standards, and service and maintenance records are kept.
- 5.12 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 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 Governance of information management includes:
 - 6.1.1 oversight by a governance committee - dependent on the size and complexity of services, this may be a stand-alone committee or a standing item on a general governance committee.
 - 6.1.2 coordination by a designated staff member - dependent on the size and complexity of services, this may be a dedicated position or included in a broader role.
 - 6.1.3 the support of policies, procedures and audit
- 6.2 Patient confidentiality is protected and managed in accordance with documented processes.
- 6.3 Every patient is to be registered once in the appropriate patient administration system with a unique identification number allocated, to be used for all health record documentation related to that patient.
- 6.4 Where required, inpatient data is provided to the Department of Health.
- 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 a daily account of the patient's care
 - 6.5.2 date, time, name, designation and signature of persons making the entries.
- 6.6 Medical record keeping complies with appropriate legislation, Australian Standards, and the facility's medical record policies.
- 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 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 legislation and the facility's policies and:
 - 6.9.1 if medical records are scanned, an adequate system exists to ensure that all paper records have been saved prior to the disposal of paper records.
- 6.10 If medical records are electronic, a system exists for 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

- 7.1 Governance of non-clinical services includes:
 - 7.1.1 oversight by a governance committee - dependent on the size and complexity of services, this may be a stand-alone committee or a standing item on a general governance committee.
 - 7.1.2 coordination by a designated staff member - dependent on the size and complexity of services, this may be a dedicated position or included in a broader role
 - 7.1.3 the support of policies, procedures and audit

Food and drink

- 7.2 Patients' nutrition and hydration needs are identified, documented and met, ensuring timely provision of the correct meals, fluids, and prescribed supplements to support recovery, prevent malnutrition, and maintain safety and quality of care.
- 7.3 Patients on therapeutic diets, special diets, enteral feeding or with cultural or religious preferences, are provided with appropriate food. Where a pureed diet is required, components are served as individual food items.
- 7.4 Food and drink services, either on site or contracted, comply with the relevant food standards. Where outsourced, food and drink services comply with the service agreement.
- 7.5 The service complies with the Hazard Analysis and Critical Control Points (HACCP) Program and Local Council Regulations as required.
- 7.6 Staff who are involved in food handling must complete food safety training.
- 7.7 Refrigerators and freezers used for storing food products operate at the temperature range outlined in the applicable standards, are monitored for temperature control daily and appropriate actions are taken when temperatures are outside the recommended temperature range.

Laundry

- 7.8 Laundry services, either onsite or contracted, comply with the relevant standards. Where outsourced, laundry services comply with the service agreement.
- 7.9 Where outsourced, there is a current contract in place that includes key performance indicators.
- 7.10 The supply of laundry is adequate to meet the function and throughput of the facility.
- 7.11 Transport and storage of laundry comply with applicable Australian Standards for storage of laundry including:
 - 7.11.1 clean and soiled laundry are stored in separate areas

7.11.2 storage areas are ventilated to minimise air contamination

7.11.3 designated laundry drop off / pickup areas are provided.

7.12 Where patients wear their own clothes, a laundry facility is available for their, or their carers/family to use.

Cleaning and waste management

7.13 Cleaning services, either onsite or contracted, comply with the applicable standards.

7.14 If environmental cleaning is outsourced, there is a current contract in place that includes key performance indicators and evidence of relevant education for contracted cleaners. Compliance monitoring of key performance indicators is undertaken.

7.15 Cleaning equipment is well maintained and complies with the applicable standards.

7.16 Detailed cleaning schedules and audits of compliance are in place to monitor and maintain the facility in a clean and hygienic manner for patients, staff and visitors.

7.17 All waste is managed in accordance with the relevant guidelines, state and national regulatory requirements.

7.18 A current contract is in place with the waste service provider that complies with the relevant guidelines, state and national regulatory requirements which includes key performance indicators.

7.19 The management and use of sharp devices and sharps disposal containers must comply with the relevant guidelines, state and national regulatory requirements.

7.20 All staff are provided with education in correct waste segregation and management to maintain staff and patient safety and comply with work health and safety regulations

Standard 8: Facility design, function and management

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

Mandatory criteria

- 8.1 Governance of the design, function and management of the facility includes:
 - 8.1.1 oversight by a governance committee - dependent on the size and complexity of services, this may be a stand-alone committee or a standing item on a general governance committee.
 - 8.1.2 coordination by a designated staff member - dependent on the size and complexity of services, this may be a dedicated position or included in a broader role.
 - 8.1.3 the support of policies, procedures and audit
- 8.2 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.
- 8.3 All rooms comply with relevant building guidelines and are adequate in size and function, to ensure that:
 - 8.3.1 patient and staff safety is maximised
 - 8.3.2 staff are able to fulfil their duties
 - 8.3.3 privacy and confidentiality is maintained.
- 8.4 Configuration, layout and workflows meet the requirements for facility operations ensuring separation of “clean” and “dirty”.
- 8.5 In addition to patient areas and patient treatment spaces, the facility also provides:
 - 8.5.1 a reception area which protects patient confidentiality
 - 8.5.2 designated separate clean and dirty utilities
 - 8.5.3 separate and sufficient storage areas for equipment and general stores
 - 8.5.4 staff toilets, showers, change rooms, secure lockers and staff dining areas
- 8.6 All areas of the facility are used for the intended purpose, and any changes of function have gone through the LARU Building approval process.
- 8.7 Signage and wayfinding throughout the facility enables safe passage for patients, staff, and visitors.
- 8.8 Systems performance, monitoring and testing of all critical systems are in accordance with the relevant codes, guidelines, and standards.
- 8.9 Documented operational and maintenance records are in place for each critical

system including:

- 8.9.1 a water risk quality management program is in place
- 8.9.2 maintenance and testing of ventilation systems in accordance with relevant standards
- 8.10 Preventative and managed breakdown maintenance is carried out in accordance with a documented program for the physical facility, furniture, building services systems, and biomedical and surgical equipment.
- 8.11 Record management systems are in place to record assets, current 'as constructed' drawings and maintenance management.
- 8.12 A back-up generator and/or UPS is readily available in the event of a power failure which is tested regularly as evidenced by onsite service maintenance records.
- 8.13 Chemicals, detergents, and gases are stored in a safe and secure manner with appropriate signage in place.

Standard 9: Sub-acute Ward

The sub-acute ward is governed by systems and processes which promote optimal patient care and a safe environment for patients and staff.

Mandatory criteria

- 9.1 The unit manager is a registered nurse with qualifications and/or clinical experience in running a sub-acute unit, responsible for the nursing care of patients at all times.
- 9.2 A system of medical governance ensures the safe clinical management of sub-acute patients.
- 9.3 Staffing arrangements, including access to allied health professionals, meet the sub-acute needs (acuity and functional) of the patient cohort.
- 9.4 The facility uses a validated functional measure at admission and discharge to assess functional capacity and whether clinical objectives have been met.
- 9.5 Equipment is available to support the services provided and to promote the delivery of safe and quality health care at the facility.
- 9.6 Equipment is located and stored in a way that ensures safe and effective use and is compliant with Work Health Safety principles.
- 9.7 Equipment is clean and maintained in a safe working condition, including exhibiting a current service sticker where appropriate.
- 9.8 Mobile resuscitation trolleys are available (Where applicable, paediatric equipment and medications are also available) and are ready for use at all times and:
 - 9.8.1 there is evidence of daily trolley checks and checks after use
 - 9.8.2 all medication and equipment must be within the “expiry date”
 - 9.8.3 a written list of contents must be attached to each trolley
- 9.9 Defibrillators are ready for use at all times
- 9.10 An emergency call system is in place throughout the facility, and a testing system is in place.
- 9.11 Consumables are safely stored and monitored, in accordance with appropriate standards.
- 9.12 Oxygen and suction outlets are available and adjacent to each bed.
- 9.13 Portable oxygen and suction cylinders are safely stored and restrained and are accessible for resuscitation with readily available emergency backup.

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