Report of the ACHS National Safety and Quality Health Service (NSQHS) Standards Survey

Griffith Rehabilitation Hospital

Hove, SA

Organisation Code: 32 50 73

Survey Date: 6-7 June 2017

ACHS Accreditation Status: **ACCREDITED**

Disclaimer:
The information contained in this report is based on the evidence provided by the participating organisation at the time of the accreditation survey and information that the organisation supplied through the reporting and editing process. Accreditation issued by ACHS/ACHSI does not guarantee the safety, quality or acceptability of an organisation or its services or programs, or that legislative and funding requirements are being met, or will be met.

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About The Australian Council on Healthcare Standards

The Australian Council on Healthcare Standards (ACHS) is an independent, not-for-profit organisation, dedicated to improving the quality of health care in Australia through the continual review of performance, assessment and accreditation. The ACHS was established in 1974 and is the leading independent authority on the measurement and implementation of quality improvement systems for Australian health care organisations.

The ACHS mission is to 'improve the quality and safety of health care' and its vision is 'to be recognised nationally and internationally as the leading Australian organisation that independently assesses performance and promotes and improves the quality and safety of health care.'

The principles upon which all ACHS programs are developed and the characteristics displayed by an improving organisation are:

- a customer focus
- strong leadership
- a culture of improving
- evidence of outcomes
- striving for best practice.

These principles can be applied to every aspect of service within an organisation.

What is Accreditation?

Accreditation is a formal process to assist in the delivery of safe, high quality health care based on standards and processes devised and developed by health care professionals for health care services. It is public recognition of achievement of accreditation standards by a health care organisation, demonstrated through an independent external peer assessment of that organisation's level of performance in relation to the standards.

How to Use this Survey Report

The ACHS survey report provides an overview of quality and performance and should be used to:

- provide feedback to staff
- identify where improvements are needed
- compare the organisation's performance over time
- evaluate existing quality management procedures
- assist risk management monitoring
- highlight strengths and opportunities for improvement
- demonstrate evidence of achievement to stakeholders.

This report provides guidance for ACHS members for future quality improvement initiatives by documenting the findings from the organisation's accreditation survey. This report is divided into five main sections.

1 Survey Team Summary Report
2 Actions Rating Summary Report
3 Recommendations from Current Survey
4 Recommendations from Previous Survey
5 Standards Rating Summary Report

1 Survey Team Summary Report

Consists of the following:

Standard Summaries - A Standard Summary provides a critical analysis for organisations to understand how they are performing and what is needed to improve. It provides an overview of performance for that Standard and comments are made on activities that are performed well and indicating areas for improvement.

Ratings

Each action within a Standard is rated by the organisation and the survey team with one of the following ratings. The survey team also provides an overall rating for the Standard. If one core action is Not Met the overall rating for that Standard is Not Met.

The report will identify individual actions that have recommendations and/or comments.

The rating levels are:

NM – Not Met

The actions required have not been achieved

SM – Satisfactorily Met

The actions required have been achieved

MM - Met with Merit

In addition to achieving the actions required, measures of good quality and a higher level of achievement are evident. This would mean a culture of safety, evaluation and improvement is evident throughout the hospital in relation to the action or standard under review.

Action Recommendations

Recommendations are highlighted areas for improvement due to a need to improve performance under an action. Surveyors are required to make a recommendation where an action is rated as Not Met to provide guidance and to provide an organisation with the maximum opportunity to improve. Recommendations in the survey report need to be reviewed and prioritised for prompt action and will be reviewed by the survey team at the next on-site survey.

Risk ratings and risk comments will be included where applicable. Risk ratings are applied to recommendations where the action rating is Not Met to show the level of risk associated with the particular action. A risk comment will be given if the risk is rated greater than low.

Risk ratings could be:

- E: extreme risk; immediate action required.
- H: high risk; senior management attention needed.
- M: moderate risk; management responsibility must be specified.
- L: low risk; manage by routine procedures

2 Actions Rating Summary Report

This section summarises the ratings for each action allocated by an organisation and also by the survey team.

3 Recommendations from Current Survey

Recommendations are highlighted areas for improvement due to a need to improve performance under a particular action.

Recommendations are structured as follows:

The action numbering relates to the Standard, Item and Action.

4 Recommendations from Previous Survey

This section details the recommendations from the previous onsite survey. The actions taken by the organisation and comments from the survey team regarding progress in relation to those recommendations are also recorded.

The action numbering relates to the month and year of survey and the action number. For example, recommendation number NSQHSS0613. 1.1.1 is a recommendation from a NSQHS Standards Survey conducted in June 2013 with an action number of 1.1.1.

5 Standards Rating Summary Report

This section summarises the ratings for each Standard allocated by the survey team.

Organisation : Griffith Rehabilitation Hospital
Orgcode : 325073

Survey Report

Survey Overview

Griffith Rehabilitation Hospital (GRH) is a 64-bed facility providing inpatient and outpatient rehabilitation services to residents of Adelaide and a wider catchment area including interstate as required. The hospital is owned and operated by Healthscope Ltd (HSP). The HSP National team provides support to the GRH workforce through policies, guidelines and frameworks and opportunities to participate in benchmarking with facilities in the HSP Group.

This Organisation-Wide Survey against the National Safety and Quality Health Service (NSQHS) Standards was undertaken on the 6th and 7th June 2017 and included an on-site visit by two surveyors.

The survey team was impressed with the progress made by the organisation in the implementation of the NSQHSS and development of services since the previous survey in 2014. It is evident that the Executive and staff are continuing to strive for excellence in the standard of healthcare provided. A distinct focus is evident throughout the organisation on the engagement of the hospital's workforce to ensure safe and quality care is provided for consumers and in fostering partnerships with consumers and carers. The organisation reported that there has been a substantial increase in attendances at the Day Patients Rehabilitation programs.

GRH has achieved the following Met with Merit ratings:

2.1.1- Consumers and/or carers are involved in the governance of the health service organisation;
2.6.1- Clinical leaders, senior managers and the workforce access training on patient-centred care and the engagement of individuals in their care;
3.5.1- Workforce compliance with current national hand hygiene guidelines is regularly audited;
3.5.2- Compliance rates from hand hygiene audits are regularly reported to the highest level of governance in the organisation;
3.5.3- Action is taken to address non-compliance, or the inability to comply, with the requirements of the current national hand hygiene guidelines; and
3.6.1- A workforce immunisation program that complies with current national guidelines is in use.

All other Core and all of the Developmental actions are assessed as Satisfactorily Met (SM). Core actions 3.10.1 and 9.6.1 are assessed as fully met.

The Executive and staff are congratulated on their enthusiasm demonstrated during the survey and their achievements in embedding the NSQHSS into the hospital's safety and quality program.

STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

The Healthscope Corporate Document Controller is responsible for the management of the corporate and clinical policy under which the Griffith Rehabilitation Hospital (GRH) operate. Systems are structured and effective to ensure the GRH receives information on the development of new policy and of changes resulting from the review process. Monthly reports identify content changes with updates communicated to staff via email and with a paper copy placed in the Staff Communication Book. Staff can access policy and procedures on the Healthscope Intranet “HINT” with a hard copy kept in the GRH Administration Area. The system for policy and procedure development and review is both effective and consultative with GRH responsible for compliance of both Healthscope Corporate and GRH local policy and procedure. Orientation of new staff includes a component on how to access policy and procedure information on the HINT.

Actions to address safety and quality across the GRH was evident at all levels with extensive work undertaken on developing the knowledge and ability of staff in implementing projects. A GRH Safety and Quality Plan 2016/2017 states the requirements and expectations for good clinical governance with a hospital-wide Working Plan documenting activity and outcomes.

Quality and Safety is a standing agenda item on all committees. Staff could describe their understanding and participation in the identification and reporting of risk, and their involvement in risk mitigation and processes for the implementation of quality improvements. Quality improvement initiatives, risk analysis, reviewing of performance data and consumer engagement are components of the organisation’s business decision making processes.

The Quality Manager is responsible for the management of audit and survey information. This information forms the basis for the reporting of key performance indicator data sets which are submitted for benchmarking through Healthscope. The audit schedule is aligned with the requirements of the national standards. For each National Clinical Standard GRH has appointed a staff member to Champion the implementation of the intent of the standard, support staff in systems for compliance and improvements and identifying staff learning needs. This is a great initiative and has demonstrated quality improvements across all the standards.

Position Descriptions identify staff roles and responsibilities with awareness of safety and quality beginning at orientation. Annual training requirements are scheduled with a completion rate of above 92% recorded in ELMO.

The detailed Integrated Risk Register is managed on RiskMan and incorporates both corporate and local risks. GRH currently has nil risks rated as High. Risk is an agenda item on all Committees and it is indicative of the safe operating environment of the GRH that only three new local risks have been identified over a two-year period. The RiskMan Incident Management System captures all incidents, complaints and compliments and tracks actions, progress and outcomes.

The survey team identified some areas of concern with staff during the survey and encourage the completion of risk minimisation actions. These refer to - Securing Access to the Hydrotherapy Pool when not in use – Medical Records Room storage of records consistent with WHS guidelines – installation of a back-up generator.

A culture of safety and quality was evident across the Health Service with quality management systems linked to the risk framework.

Clinical practice

Very well-developed rehabilitation models of care supported by clinical guidelines are incorporated in inpatient and day programs. These include completion of multidisciplinary assessments, goal setting, care planning and case reviews and commencement of discharge planning in the pre-admission phase. Length of stay of all patients and variances against expected ALOS, mortality and morbidity data and AROC and ACHS clinical indicator data are subject to regular review by clinicians, the Clinical Committee, and the Executive.

The use of risk assessment tools is incorporated in the pre-admission assessments completed by Rehabilitation Assessment Nurses and in admission processes. Risk assessments include falls, malnutrition, pressure injury, and infection and cognitive status, allergies, VTE and medication and discharge risks. The criteria detailing patients who may be admitted to the hospital GRH are very clearly articulated in the GRH guidelines for admissions. Management plans are developed for patients identified at risk and alerts are documented in the patient clinical record, the electronic administration information system, and in other communication tools. Audit results show good compliance with documentation of risk assessments and implementation of appropriate management plans.

An effective system for escalating care is established and discussed more fully in Standard 9.

Hard copy integrated records and electronic pathology results are available at the point of care. A suite of policies provides the framework for management and documentation of patient clinical records.

Processes are well- developed for checking for timely retrieval and tracking of records. Audit results show very high compliance with clinical record documentation requirements. The sample of records checked by the survey team were well-documented.

Performance and skills management

Systems for the employment and ongoing monitoring of the clinical workforce, inclusive of professional registration, the scope of clinical practice and the credentialling process are systematic and appropriate. The Medical Advisory Committee reviews the Visiting Medical Officer Credentialling and Scope of Practice prior to recommending credentialing approval.

The eCredentialing database records the details for all VMOs with an audit confirming 100% compliance. Other clinical staff registrations are reviewed monthly via AHPRA.

All staff participate in an annual Performance Appraisal where learning needs and goals are identified.

Professional development, clinical and non-clinical mandatory training compliance is well supported with the example of the eight Enrolled Nurses completing the Medication Administration Competency Program presented to the surveyors.

The 2016 Employee Engagement Survey resulted in 84% of staff agreeing that they received adequate training for the work they do.

Incident and complaints management

Structured systems exist for the reporting, investigation and analysis of incidents within the RiskMan database. There are aligned processes for the tracking and trending of incidents and complaints and with quarterly trended reporting to Healthscope. The organisation was able to describe the highest categories of patient incidents and the mechanisms in place to reduce these incidents and to reduce the risk of harm to patients. The number of patient incidents is low as is the severity rating.

The complaints process is well managed, with staff trained as first responders for informal dialogue, and formal complaints achieving the key performance indicators (KPI) for timely acknowledgement and resolution.

There has been a positive response from consumers in providing feedback via the twice-yearly Consumer Forums and an increase in knowledge and awareness of the GRH from open health forums and the consumer consultant communication with patients and families.

The GRH refers to The Healthscope Open Disclosure Policy for direction in the management and reporting of an open disclosure event. Open Disclosure events are entered in to RiskMan. Open Disclosure Training compliance exceeded the KPI achieving above 92%. Staff surveyed in 2017 resulted in 100% of respondents aware that Open Disclosure is practiced at the GRH.

The medical workforce participates in an eLearning Open Disclosure program and via the Medical Advisory Committee. Open Disclosure educational material is available via the intranet.

Patient rights and engagement

The Australian Charter on Healthcare Rights is displayed throughout the health service and given to every patient on admission. Systems are in place to support consumers who do not easily understand their health care rights or the services available. Interpreter services are available.

The collective of healthcare information available to patients (13 brochures) was reviewed by the consumer consultant with suggestions documented.

The Patient Information Guide (DVD) looped to all TVs in all rooms, contains information on hospital services including the Charter on Healthcare Rights.

The Healthscope's Rights and Responsibilities brochure is available on request in languages other than English.

The engaging of the patient in the planning of their care commences at admission, identifies assistance required, documents programs and goals and is signed by the patient. Goals are reviewed as part of a weekly case conference which may be multidisciplinary and involve the family/carer.

A patient's Advance Care Directive and Treatment Limiting Order will form part of the medical record if applicable and is discussed at the time of pre-admission, filed in the bedside folder and added to the clinical handover sheet.

VMOs are responsible for discussing Not-for-Resuscitation status with patients on admission and again as appropriate throughout their admission. Nurses receive education regarding Advance Care Directive practice by the Clinical Manager.

Healthscope Policy support staff for the process of obtaining informed consent. The occasions when consent for procedures is required are few at the Griffith Rehabilitation Hospital. The obtaining of consent for blood transfusion is the most common and an audit resulted in 100% compliance.

The GRH refers to Healthscope's policy for direction for the management of the clinical record. The clinical record is available at the point of care. It is evident that staff are well resourced in managing current, internal and externally stored clinical records. The medical records staff are commended on the quality of the care and maintenance of the clinical records. There have been no reported breaches of confidentiality of information.

There are a number of patient surveys undertaken by Healthscope Corporate. Rehabilitation specific and Patient-Centred Care Surveys are collated and benchmarked with reports available for individual sites. GRH has a Staff and Consumer "Praise/Suggestions/Feedback" process.

Complaints are recorded on RiskMan and followed up with annual trending reported. Suggestions and feedback are reported monthly to the Management Committee with outcomes posted on noticeboards.

NSQHSS Survey

Organisation : Griffith Rehabilitation Hospital
Orgcode : 325073

Governance and quality improvement systems

Ratings

Action	Organisation	Surveyor
1.1.1	SM	SM
1.1.2	SM	SM
1.2.1	SM	SM
1.2.2	SM	SM
1.3.1	SM	SM
1.3.2	SM	SM
1.3.3	SM	SM
1.4.1	SM	SM
1.4.2	SM	SM
1.4.3	SM	SM
1.4.4	SM	SM
1.5.1	SM	SM
1.5.2	SM	SM
1.6.1	SM	SM
1.6.2	SM	SM

Clinical practice

Ratings

Action	Organisation	Surveyor
1.7.1	SM	SM
1.7.2	SM	SM
1.8.1	SM	SM
1.8.2	SM	SM
1.8.3	SM	SM
1.9.1	SM	SM
1.9.2	SM	SM

Performance and skills management

Ratings

Action	Organisation	Surveyor
1.10.1	SM	SM
1.10.2	SM	SM
1.10.3	SM	SM

1.10.4	SM	SM
1.10.5	SM	SM
1.11.1	SM	SM
1.11.2	SM	SM
1.12.1	SM	SM
1.13.1	SM	SM
1.13.2	SM	SM

Incident and complaints management

Ratings

Action	Organisation	Surveyor
1.14.1	SM	SM
1.14.2	SM	SM
1.14.3	SM	SM
1.14.4	SM	SM
1.14.5	SM	SM
1.15.1	SM	SM
1.15.2	SM	SM
1.15.3	SM	SM
1.15.4	SM	SM
1.16.1	SM	SM
1.16.2	SM	SM

Patient rights and engagement

Ratings

Action	Organisation	Surveyor
1.17.1	SM	SM
1.17.2	SM	SM
1.17.3	SM	SM
1.18.1	SM	SM
1.18.2	SM	SM
1.18.3	SM	SM
1.18.4	SM	SM
1.19.1	SM	SM
1.19.2	SM	SM
1.20.1	SM	SM

STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

Aligned with the Healthscope Consumer Engagement Plan 2016-2019 and the Griffith Rehabilitation Hospital Consumer Partnering Plan 2016-2018 models were developed for consumer engagement in the operational and strategic planning for the organisation. The Consumer Consultant (CC) was an active partner in the development of the GRH Consumer Partnering Plan. The GRH convenes two Consumer Forums per year with the outcomes considered for inclusion in-service planning and development of the health service. The Clinical Committee of the health service has consumer membership and the consultant is representative of the diversity of the patient population and provides a conduit for feedback from the consumers to the health service. The consumer consultant not only provides a conduit for information and communication between the public and the hospital but has been proactive in identifying areas for future improvements in health services, reviewing patient information brochures and folders and reviewing hospital notice boards. The consumer consultant is skilled at applying health literacy assessments and feedback confirms that patient friendly hospital information is valued by the consumers.

The involvement of consumers/carers at the Griffith Rehabilitation Hospital is embedded, routine and demonstrated as making a difference through inclusion in the committee structure of the organisation. Action 2.1.1 fully meets the intent of this developmental action and is rated as Met with Merit.

Consumer partnership in designing care

It was evident that consumer engagement and partnerships are an integral part of the organisation corporate and clinical governance and examples of patient/consumer's consultation occurring include: - the review of 13 health information brochures - Feedback on patient diets - Patio & garden design - Clinical Handover scenario, patient lounge re-design – survey of patient room furniture to name a few. The organisation has collected consumer stories to be used as an education tool for clinical staff. Patient-centred care is a core component of the organisation's safety culture and staff training strengthens this culture. The involvement of consumers is evident across the health service and their commitment to quality and safety improvement was obvious to the survey team.

GRH recognised the need to present Patient-Centred Care Training to all staff in a format that was understood and appropriate to meet the needs of both clinical and non-clinical staff. This has been achieved with an increase in attendance/completion from 94.5% to 98.2% since 2014.

Clinical staff participate in a Patient-Centred Care Familiarisation as part of their Orientation on commencement and complete the updated eLearning module annually.

Non-clinical staff participate in an on-site education session which is rated as more appropriate and beneficial. The Medical Advisory Committee managed the delivery of Patient-Centred Care Training to the VMOs.

The collection of "Patient Stories" available to all staff further demonstrates a commitment to the delivery of best practice patient-centred care.

The Quality Cycle for the training of staff in patient-centred care is highly developed and inclusive of all staff with improvements to practice and patient outcomes observed by the survey team.

The GRH is commended on their achievements in embedding processes for effective, inclusive and sustained consumer engagement in the delivery of patient-centred care to the workforce of the organisation. Action 2.6.1 has been rated as Met with Merit.

Consumer partnership in service measurement and evaluation

The organisation informs the community of performance inpatient safety and quality via MyHealthscope Website and includes Rehab Health Outcomes, Infection rates, Hand Hygiene compliance, Falls, Pressure Injuries, Blood Transfusions and Unplanned Re-admissions. The Marketing Committee is involved in local activities, submits information to the local Messenger Newspaper which reaches consumers of the hospital catchment area.

The GRH holds two Consumer Forums per year attended by past patients/community members with a report on the outcomes disseminated to attendees.

The reception area, patient lounge and service areas have information boards which include results of audit data, feedback and improvements. The role of the consumer consultant at GRH and the Consumer Forums provides excellent opportunities to engage consumers in the evaluation of the service.

The Consumer Consultant has participated in the formal review of Patient-Centred Care and patient Impressions survey results, reviews of patient complaints, feedback and satisfaction reports. The CC was proactive in initiating feedback relating to bedside handover, in what patients expect from VMOs and nurses in medication management. These examples demonstrate the transparency of communication between the patient, consumer consultant, clinical staff and the management.

Consumer partnership in service planning

Ratings

Action	Organisation	Surveyor
2.1.1	SM	MM
2.1.2	SM	SM
2.2.1	SM	SM
2.2.2	SM	SM
2.3.1	SM	SM
2.4.1	SM	SM
2.4.2	SM	SM

Action 2.1.1 Developmental

Organisation's Self Rating: SM **Surveyor Rating:** MM

Surveyor Comment:

Corporate policy describes and supports a structure for the engagement of consumers to engage, participate and partners in the governance of the Griffith Rehabilitation Hospital (GRH). GRH has appointed and worked with Consumer Consultants (CC) since 2012 with the consumer engaged at committee level. The Consumer Consultant is a member of the Clinical Committee, with Consumer Participation a Standing Agenda Item and with a formal report tabled monthly. The CC is a valued member of the volunteer workforce, has scheduled working roster, committee responsibilities and obtains feedback from patients/carers which has resulted in environmental and safety improvement in patient areas. The Consumer Consultant of the GRH formally engages with patients/carers and staff to ensure that feedback and the consumer perspective and perception of care and the environment are considered in the everyday management of the hospital and in changed and improved service delivery.

The involvement of consumers/carers at the Griffith Rehabilitation Hospital is embedded, routine and demonstrated as making a difference through inclusion in the committee structure of the organisation.

This action is rated as Met with Merit.

Surveyor's Recommendation:

No recommendation

Consumer partnership in designing care

Ratings

Action	Organisation	Surveyor
2.5.1	SM	SM
2.6.1	SM	MM
2.6.2	SM	SM

Action 2.6.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** MM

Surveyor Comment:

The Griffith Rehabilitation Hospital has continued to strengthen their systems for educating staff in the importance of the delivery of Patient-Centred Care.

GRH recognised the need to present Patient-Centred Care Training to all staff in a format that was understood and appropriate to meet the needs of both clinical and non-clinical staff. This has been achieved with an increase in attendance/completion from 94.5% to 98.2% since 2014.

Clinical staff participate in a Patient-Centred Care Familiarisation as part of their Orientation on commencement and complete the updated eLearning module annually.

Non-clinical staff participate in an on-site education session which is rated as more appropriate and beneficial. The Medical Advisory Committee managed the delivery of Patient-Centred Care Training to the VMOs.

The collection of “Patient Stories” available to all staff further demonstrates a commitment to the delivery of best practice patient-centred care.

The Quality Cycle for the training of staff in patient-centred care is highly developed and inclusive of all staff with improvements to practice and patient outcomes observed by the survey team. The GRH is commended on their commitment to addressing the requirements of this action and a rating of Met with Merit is applied.

Surveyor's Recommendation:

No recommendation

Consumer partnership in service measurement and evaluation

Ratings

Action	Organisation	Surveyor
2.7.1	SM	SM
2.8.1	SM	SM
2.8.2	SM	SM
2.9.1	SM	SM
2.9.2	SM	SM

STANDARD 3
PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Surveyor Summary

Governance and systems for infection prevention, control and surveillance

GRH infection prevention and control activities are overseen by the Clinical Committee and are supported by a (0.2) part time infection control nurse and Healthcare Infection Control Management Resources (HICMR).

HSP, HICMR and local policies and procedures are available via the intranet and show evidence of ongoing review and currency. There are comprehensively documented Infection Control Plans and well-developed audit and surveillance programs. Performance monitoring and review is undertaken by the Clinical Committee and Medical Advisory Committee (MAC) and via the organisation's Quality and Safety Reports which are submitted quarterly to Healthscope Corporate. The incidence of hospital-acquired infections (HAIs) is consistently low. Results of internal infection control audits show high levels of compliance, and there is evidence of follow-up actions for areas identified as requiring improvement.

Infection prevention and control strategies

The hand hygiene education and auditing programs are very well-established. Hand washing basins, hand rub solutions and hand hygiene posters are readily available throughout the hospital. Results of audits show the overall compliance rate has been consistently above the national benchmark for the period 2014 -2017. A compliance rate greater than 90% has been sustained for the audit period 1 2015 - audit period 2017 across the clinical and non-clinical workforce, including medical officers.

There is evidence of substantial work being undertaken to ensure the GRH immunisation program complies with the national guidelines. Rigorous processes are established for pre-employment screening and for the collection of data on the information status of all employees and maintenance of records. Evidence provided shows, following Implementation of serology testing and provision of vaccinations, 98% of the Category A workforce had evidence of Hepatitis vaccination and immunity in December 2016, improving from 32% April 2014/15. Evidence provided also shows continuous improvement in the workforce uptake of influenza vaccinations since 2007, with 85% achieved in 2017.

Appropriate equipment and processes for prevention and management of occupational health and safety are in place. These includes the availability of personal protective equipment (PPE) and staff education programs. The surveyors noted that a low level of incidents of occupational exposures was reported and that processes for follow-up and counselling are well-developed. Staff who are required to perform procedures with invasive devices and aseptic technique participate in competency-based education programs. Training records show that 90% nursing staff have completed aseptic technique training in 2017. Action 3.10.1 is assessed as fully met. Audit results of IV cannula sites and indwelling urinary catheters show high levels of compliance with required standard/policy for management.

Managing patients with infections or colonisations

Guidelines for standard precautions and transmission-based precautions are available for all clinical and non-clinical staff. Staff training and monitoring of compliance with both standard and transmission based precautions are evident. Audit results show high compliance. Completion of the pre-admission patient information ensures that patients with an infection or colonisation are identified and appropriate patient placement occurs on admission. Information is documented as a clinical alert in the clinical record and in the electronic information system. Processes are well-developed for communicating a patient's infectious status whenever responsibility of care is transferred between service providers and facilities.

Antimicrobial stewardship

The antimicrobial stewardship program is overseen by the GRH Clinical Committee and the MAC. Membership of the Clinical Committee includes the HPS clinical pharmacist. Access to an infectious disease consultation is available. Healthscope and HICMR policies, restricted antimicrobial traffic light information and therapeutic guidelines are available in all clinical areas. The clinical pharmacist and the infection control nurse monitor antibiotic usage, appropriateness of antibiotic prescribing and resistance. Evidence provided showed regular reports are submitted to the clinical and medical advisory committees. Reports on GRH participation by in the National Antibiotic Prescribing Surveys (NAPS) in 2015 and 2016 show there has been improvement regarding the appropriateness of prescribing and cessation of drugs within the prescribed timeframes.

Cleaning, disinfection and sterilisation

HICMR, Healthscope and GRH policies and procedures provide the framework to ensure the principles of infection prevention and control are practiced in environmental cleaning, waste, laundry and linen management. There is access to material safety data sheets. Environmental cleaning schedules are used in all areas of the hospital, including the kitchen. A schedule also exists for monitoring temperature and bacteria levels of hot water systems, ice machines, and the hydrotherapy pool. An annual schedule of environmental audits is documented for the facility. Linen and waste management is undertaken by external contractors and is very well managed. Environmental cleaning and linen management audit results show very high compliance. Patient satisfaction survey results show very high levels of satisfaction with the cleanliness of the hospital.

No reprocessing of critical reusable medical devices is undertaken. Single use items are in use. GRH Infection Control Procedures provides the framework for cleaning of semi-critical reusable medical devices such as nebulisers. Detergent wipes have been introduced for use in clinical and storage areas. A GRH policy Traceability of Single Use Devices provides the framework for documentation in the medical record of type, site of device batch number and date of insertion. Audit results show improvement in medical record documentation.

Audits results show very high levels of compliance in storage and maintenance of integrity of sterile stock.

A gap analysis for compliance with AS4187:14 has been completed and a plan to address areas requiring upgrade has been developed.

Communicating with patients and carers

MyHealthscope website provides consumer specific information in the reduction of healthcare associated infections and GRH performance data. Infection prevention and control information is also provided in brochures, and electronically via the TV screens installed throughout the organisation. These are subject to evaluation in consultation with consumers to ensure that they meet the needs of the targeted audience.

Governance and systems for infection prevention, control and surveillance

Ratings

Action	Organisation	Surveyor
3.1.1	SM	SM
3.1.2	SM	SM
3.1.3	SM	SM
3.1.4	SM	SM
3.2.1	SM	SM
3.2.2	SM	SM
3.3.1	SM	SM
3.3.2	SM	SM
3.4.1	SM	SM
3.4.2	SM	SM
3.4.3	SM	SM

Infection prevention and control strategies

Ratings

Action	Organisation	Surveyor
3.5.1	SM	MM
3.5.2	SM	MM
3.5.3	SM	MM
3.6.1	SM	MM
3.7.1	SM	SM
3.8.1	SM	SM
3.9.1	SM	SM
3.10.1	SM	SM
3.10.2	SM	SM
3.10.3	SM	SM

Action 3.5.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** MM

Surveyor Comment:

Evidence provided showed that GRH workforce compliance with the national hand hygiene guidelines had been audited as per the HSP Hand Hygiene Policy and the national hand hygiene initiative requirements and that the overall compliance rate has been consistently above the national benchmark for the period 2014 -2017.

A compliance rate greater than 90% has been sustained for the audit period 1 2015- audit period 1 2017 across the clinical and non-clinical workforce, including medical officers. The surveyors agree there is a sustained approach in compliance auditing and the action is rated MM.

Surveyor's Recommendation:

No recommendation

Action 3.5.2 Core

Organisation's Self Rating: SM **Surveyor Rating:** MM

Surveyor Comment:

Evidence provided showed that GRH hand hygiene compliance rates are reported monthly to the GRH Clinical Committee and Executive and quarterly to HSP Corporate where performance is monitored against HSP targets, benchmarked with other HSP hospitals and reviewed by the National Safety and Quality Committee. The current HSP National Benchmark target is 80%. GRH has consistently performed above the HSP targets which are above the National benchmark and reviewed annually. The surveyors agree there is evidence of a sustained approach to reporting and review of hand hygiene compliance rates at the GRH and HSP Corporate levels and the action be rated MM.

Surveyor's Recommendation:

No recommendation

Action 3.5.3 Core

Organisation's Self Rating: SM **Surveyor Rating:** MM

Surveyor Comment:

There is a very well-established and comprehensive organisation-wide approach to improving compliance with hand hygiene and for minimisation of risks to patient safety and quality of care. This includes risk management plans, very high levels of participation in mandatory hand hygiene education by the workforce and widespread availability of hand gels and display of posters and information on workforce hand hygiene compliance rates throughout the organisation. The organisation-wide compliance performance in hand hygiene demonstrates continuous improvement and is supported with the achievement of very high compliance rates and low levels of infections. The surveyors agree that there is a very well-developed organisation wide system which is subject to ongoing review and strengthening for improving and maintaining workforce compliance with the national hand hygiene guidelines and concur that rating of the action is increased to MM.

Surveyor's Recommendation:

No recommendation

Action 3.6.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** MM

Surveyor Comment:

There is evidence of substantial work being undertaken to ensure the GRH immunisation program complies with the national guidelines. Rigorous processes are established for pre-employment screening and for the collection of data on the information status of all employees and maintenance of records. Evidence provided shows, following Implementation of serology testing and provision of vaccinations, 98% of the Category A workforce had evidence of Hepatitis vaccination and immunity in December 2016, improving from 32% April 2014/2015. Evidence provided also shows continuous improvement in the workforce uptake of influenza vaccinations since 2007, with 85% achieved in 2017. The surveyors agree that the GRH workforce immunisation program is very well-developed and is subject to ongoing review and strengthening and concur that the rating is increased to MM.

Surveyor's Recommendation:

No recommendation

Action 3.10.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

Training records show that 90% nursing staff have completed aseptic technique training in 2017. The action is fully met.

Surveyor's Recommendation:

No recommendation

Managing patients with infections or colonisations

Ratings

Action	Organisation	Surveyor
3.11.1	SM	SM
3.11.2	SM	SM
3.11.3	SM	SM
3.11.4	SM	SM
3.11.5	SM	SM
3.12.1	SM	SM
3.13.1	SM	SM
3.13.2	SM	SM

Antimicrobial stewardship

Ratings

Action	Organisation	Surveyor
3.14.1	SM	SM
3.14.2	SM	SM
3.14.3	SM	SM
3.14.4	SM	SM

Cleaning, disinfection and sterilisation

Ratings

Action	Organisation	Surveyor
3.15.1	SM	SM
3.15.2	SM	SM
3.15.3	SM	SM
3.16.1	SM	SM
3.17.1	SM	SM
3.18.1	SM	SM

Action 3.16.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

A gap analysis for compliance with AS4187:2014 has been completed and a plan to address areas requiring upgrade has been developed.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
3.19.1	SM	SM
3.19.2	SM	SM

Organisation : Griffith Rehabilitation Hospital
Orgcode : 325073

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

The GRH Clinical Committee is responsible for overseeing drug and therapeutic activities. Related committees are the Medical Advisory Committee and HSP Medication Cluster Committee. The GRH clinical committee meets monthly and membership includes a pharmacist from hospital pharmacy supplies (HPS) which is the organisation contracted to provide pharmacy services at GRH. This includes management of prescriptions and imprest medications, and medication reviews. HSP and GRH policies/ guidelines are available to support safe medication management and show evidence of ongoing review. The medication authority system is well established and subject to ongoing monitoring. Drug register audits show 100% compliance with documentation requirements. NIMC chart audits have shown improvement in legibility of prescriber signatures. No medication incidents relating to breach of the authorisation system were reported.

Evidence showed 98% of the nursing staff completed mandatory eLearning medication safety in 20015/2016. The recent introduction of a HSP ‘Med-Safe’ eLearning education program has been associated with 68% completion by the nursing workforce at the time of the survey. Completion of the program by the remainder of the nursing workforce is targeted to occur during “Medication Month” which is scheduled to occur in July 2017. Completion of appropriate education by all Enrolled nurses and medication endorsement has resulted in improved efficiency in the administration of medications by the nursing workforce.

Results of the MSSA conducted in 2016 showed 95% compliance. Incident data shows there has been a substantial decrease in medication incidents, and the omission of medications continues to be the highest category of incidents. Policies and procedures are established for recording and reporting adverse drug reactions, including notification of the Therapeutic Goods Administration (TGA). Nil significant adverse reaction events and nil sentinel events were reported. Learnings from incident investigations and from the HSP Medication Cluster Committee are communicated to GRH clinical staff.

Documentation of patient information

HSP and GRH policies and procedures are available to support the clinical workforce in documenting accurate patient medication records. NIMC audit results show improved compliance with recording patient medication histories and allergies Medication reconciliation occurs on admission and on separation of patients and is undertaken by nurses and medical officers and oversighted by clinical pharmacists. GP medication summaries for patients are obtained from GPs on admission and has improved medication reconciliation. An increase in the clinical pharmacist hours was reported to have increased the clinical review of medications by the pharmacist to 70% of all patients.

Medication management processes

Electronic and hard copy references are available to support medication practice. HPS Pharmacy staff supports the medical and nursing workforce, assisting with education in response to particular needs as well as in the provision of ongoing programs as part of the contract arrangements. Storage and distribution systems are well managed with appropriate storage of high risk and temperature-sensitive drugs and disposal of unwanted, unused and expired medications. Patients’ own medications including drugs of dependence (DDs) brought into hospital are stored, used, accounted for or disposed of with their permission. Bedside lockable cupboards are available for storage of patient medications, excluding DDs which are stored in secure drug cupboards.

Management of APINCH medications is supported with posters and TallMan lettering and use of alerts to notify pharmacist when high-risk medication reviews are required. Results of audits of Dangerous Drug registers show good compliance with required documentation. Results of audits of daily temperature monitoring of medication fridge show excellent compliance.

Continuity of medication management

Medications on patient admission, internal transfer and on discharge are well managed and are supported with specific policies. A clinical handover tool is used to communicate high-risk medications and, changes to medications during the clinical handover of patients. Reconciliation of medications is undertaken by the discharge coordinator and clinical pharmacist. Medication profiles are prepared by the clinical pharmacist and are comprehensively documented. Medication charts are copied and forwarded with patients transferred to another facility.

Communicating with patients and carers

Medication management plans are developed in consultation with patients. The clinical pharmacist provided patients with specific medication education, documentation and counselling. Information on medication management is available for patients and carers via a DVD included in the in-house TV network. Patient-centred survey results show evidence of improvement in the provision of medication information to patients. Feedback from consumers regarding the suitability of medications information is obtained via consumer forums and surveys. Results of consumer consultant survey in 2016 showed high levels of patient satisfaction with medication management.

Governance and systems for medication safety

Ratings

Action	Organisation	Surveyor
4.1.1	SM	SM
4.1.2	SM	SM
4.2.1	SM	SM
4.2.2	SM	SM
4.3.1	SM	SM
4.3.2	SM	SM
4.3.3	SM	SM
4.4.1	SM	SM
4.4.2	SM	SM
4.5.1	SM	SM
4.5.2	SM	SM

Documentation of patient information

Ratings

Action	Organisation	Surveyor
4.6.1	SM	SM
4.6.2	SM	SM
4.7.1	SM	SM
4.7.2	SM	SM
4.7.3	SM	SM
4.8.1	SM	SM

Medication management processes

Ratings

Action	Organisation	Surveyor
4.9.1	SM	SM
4.9.2	SM	SM
4.9.3	SM	SM
4.10.1	SM	SM
4.10.2	SM	SM
4.10.3	SM	SM
4.10.4	SM	SM
4.10.5	SM	SM

4.10.6	SM	SM
4.11.1	SM	SM
4.11.2	SM	SM

Continuity of medication management

Ratings

Action	Organisation	Surveyor
4.12.1	SM	SM
4.12.2	SM	SM
4.12.3	SM	SM
4.12.4	SM	SM

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
4.13.1	SM	SM
4.13.2	SM	SM
4.14.1	SM	SM
4.15.1	SM	SM
4.15.2	SM	SM

STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

The Griffith Rehabilitation Hospital has systems in place for patient identification and procedure matching consistent the Healthscope Policy. Patients wear one identification band consistent with the national standard with four agreed patient identifiers. Every patient has an arm band applied on admission to the service. Day patients presenting to the hydrotherapy pool have their identification confirmed on arrival and a removable ID Band applied for the duration of their stay. Staff confirmed their knowledge of compliance with the use of the one identification arm band protocol. Audits confirm compliance with the application and checking of patient arm bands at admission, clinical handover, medication management, minor procedures, blood product management and discharge/transfer. The catering department checks the patient's identity when delivering meals to ensure the correct patient receives the correct dietary meal at the right time. Training on Patient Identification has been provided to the Patient Services Assistant's. Incidents are reported in the electronic RiskMan system with risk identification, evaluation and investigation consistent with best practice.

Planned and scheduled patient identification audits are undertaken six-monthly. Twenty-five (25) patients are checked for compliance with having an arm band in place, four identifiers and with legible text. Staff are observed identifying patients confirming three identifiers. Patient Identification is checked throughout the patient journey. Audit results confirm high compliance with patient personal identification and with medical record identification labels. Patient ID Band compliance has been 100% for a three-year period.

The Focus Month for Patient ID and Procedure Matching is scheduled for June 2017.

Processes to transfer care

Patient identification is checked throughout the continuum of the patient journey and this applies to all occasions where care is transferred. Patient Identification and Clinical Handover policies include procedures for patient identification. Patient identification and matching of documentation information at discharge is regularly reviewed using both documentation and observational audits.

Clinical Handover includes confirmation of the patient ID for the admitted patient. On the occasion of a patient transferred out to another facility for ongoing treatment, to another service, medical appointment, or discharged to home, the patient's identification is checked on the patient ID band and on the transfer of care documentation. This could be the patient Discharge Summary, Referral Letter, Request forms etc.

Compliance with The GRH Patient Transport/Appointments Policy aims to ensure the correct patient has appropriate clinical handover and transport for transfer between facilities.

Processes to match patients and their care

Procedures and auditing systems are in place to confirm compliance with correct patient identification and treatment matching for medications, blood and blood products, and other non-surgical interventions. Both documentation and observation audits demonstrated good levels of compliance. It was evident at the time of survey that patient identification and procedure matching is compliant and aligned with policy, scheduled auditing occurs, formal reporting and evaluation is structured and staff are knowledgeable and informed in relation to the requirements of the standard.

The surveyors observed that confirmation of the patient's identification is not noted as checked on the Clinical Handover documentation. Auditing compliance with this patient ID check should be added to the audit tool.

The GRH has observed that there is a risk of incorrect ID when patients have similar names. A coloured alert card is placed in the ward nursing notes that flags patients with like names and this is also highlighted at clinical handover an/cd there have no incidents of a patient receiving incorrect treatment/care.

Identification of individual patients

Ratings

Action	Organisation	Surveyor
5.1.1	SM	SM
5.1.2	SM	SM
5.2.1	SM	SM
5.2.2	SM	SM
5.3.1	SM	SM

Processes to transfer care

Ratings

Action	Organisation	Surveyor
5.4.1	SM	SM

Processes to match patients and their care

Ratings

Action	Organisation	Surveyor
5.5.1	SM	SM
5.5.2	SM	SM
5.5.3	SM	SM

Organisation : Griffith Rehabilitation Hospital
Orgcode : 325073

STANDARD 6
CLINICAL HANDOVER

Surveyor Summary

Governance and leadership for effective clinical handover

Clinical handover is overseen by the GRH Clinical Committee and is supported by HSP and GRH policies/ procedures and guidelines and tools. Workforce education sessions on clinical handover are provided via eLearning and face-to-face presentations. Actions taken to strengthen the implementation of clinical handover include the appointment of a GRH clinical champion, increase in the hours of the Discharge Coordinator, participation in the HSP Corporate Discharge Planning Working Party by the GRH Discharge Coordinator and an occupational therapist, revision of the nursing handover tool, and establishment of an annual Clinical Handover Focus month. All clinical handover incidents are entered in RiskMan and reported to the Executive and Clinical Committee. The organisation reported a low level of clinical handover incidents.

Clinical handover processes

Processes and procedures are in place for the implementation of a structured handover between shifts, when transferring between units and between VMOs when one is going on leave etc. and are supported with the use of the ISOBAR tool. Mechanisms are well developed for handover of patients to other health providers when patients are discharged or transferred to other facilities. Comprehensive discharge summaries are completed by medical officers, nursing and allied health staff. Evidence was provided showing that GRH consistently exceeds the HSP KPI of 85% of discharges sent to ongoing providers within 48 hrs. Results of audits of bedside clinical handover show improvement with compliance in requirements with an increase from 74% in 2015 to 80% 2017. The organisation is encouraged to include checking of patient identification in the audit as this aspect is not currently incorporated in the audit tool.

Patient and carer involvement in clinical handover

There are mechanisms to facilitate the involvement of patients and/or carers in clinical handover such as the use of bedside patient whiteboards and the provision of patient written information on handover and the in-house TV system. The surveyors observed clinical handover at GRH and noted that it was undertaken in a professional manner. There was good interaction with patients, in that they were included in the discussion about their current and ongoing care. Reconciliation of identification and medicines occurred at this time. Results of patient satisfaction surveys show very high levels of satisfaction regarding the bedside handover processes.

NSQHSS Survey

Organisation : Griffith Rehabilitation Hospital
Orgcode : 325073

Governance and leadership for effective clinical handover

Ratings

Action	Organisation	Surveyor
6.1.1	SM	SM
6.1.2	SM	SM
6.1.3	SM	SM

Clinical handover processes

Ratings

Action	Organisation	Surveyor
6.2.1	SM	SM
6.3.1	SM	SM
6.3.2	SM	SM
6.3.3	SM	SM
6.3.4	SM	SM
6.4.1	SM	SM
6.4.2	SM	SM

Patient and carer involvement in clinical handover

Ratings

Action	Organisation	Surveyor
6.5.1	SM	SM

Organisation : Griffith Rehabilitation Hospital
Orgcode : 325073

STANDARD 7
BLOOD AND BLOOD PRODUCTS

Surveyor Summary

Governance and systems for blood and blood product prescribing and clinical use

The GRH Clinical Committee oversees blood transfusion management activities. HSP policies and a GRH Cold Chain procedure that are consistent with national evidence-based guidelines provide the framework to support safe transfusion practices and management of storage and transport of blood and blood products. Provision of onsite education programs, BloodSafe eLearning packages, and BloodSafe educational resource materials are also used to support safe transfusion practices and management of blood and blood products. Training records show 92% of nursing staff completed mandatory BloodSafe eLearning programs in 2015/2016. The organisation is encouraged to increase uptake of medical officers in the completion of the BloodSafe eLearning as currently, this is very low. There is evidence of internal audits, collection and review of ACHS clinical indicator data and incident monitoring. Performance review is undertaken by the GRH clinical and the medical advisory committees and via GRH quality and safety reports that are submitted quarterly to HSP corporate office. Follow-up action plans are developed for areas identified for improvement. Systems are established for reporting of transfusion-related adverse events to pathology service providers. ACHS clinical indicator report 2016 showed no significant adverse transfusion events were reported.

Results of a Blood Transfusion audit completed February 2017 for the period February 2016- January 2017 show improved adherence to best practice protocol with single units prescribed in 55% of the transfusions audited (N=11), improved assessment following transfusion of first unit with completion of a clinical assessment increasing from 27% to 73%, and completion of a haemoglobin review increasing from 13%-50%. The organisation is encouraged to implement commencement of blood transfusions earlier in the day rather than the current practice where 80% of transfusions are commenced in the afternoon/evening when a VMO is not onsite.

Documenting patient information

Results of the 2017 audit showed generally good compliance in clinical record documentation of all required information for patients undergoing blood transfusion, including documentation of a history of blood transfusions for individual patients. A new HSP transfusion form was introduced in May 2017 with increased provision for all of the required documentation.

Managing blood and blood product safety

Systems are established for the safe management of blood and blood products and monitoring of wastage. GRH reported very low wastage levels. A maximum of one unit is delivered from pathology service provider in temperature controlled containers immediately prior to the commencement of transfusions. Results of the 2017 Blood transfusion audit showed that there was variable compliance in the completion of required documentation in the blood register and resulted in the reconfiguration of the register with a view to improving documentation and monitoring of compliance. The organisation reported that two incidents had recently occurred where the temperature within the blood shippers was not within the required parameters and had resulted in wastage of two units of blood. Action was taken during the survey to formally notify the pathology services provider of the incidents and the resultant wastage of units. Inspection of the blood register by the survey team showed evidence of improved documentation had occurred since upgrading of the register, however, it was noted that there was no provision for the documentation of the signature of the nurse indicating receipt of the blood unit on delivery to the hospital. Action was taken during the survey to address this aspect.

Communicating with patients and carers

Resources relating to blood and blood products, including risks benefits and alternatives, are available in clinical areas for distribution to patients/carers by clinicians. These are available in multiple languages from the BloodSafe website if required. Results of clinical record audits indicate that there were high levels of completion of the consent form.

Governance and systems for blood and blood product prescribing and clinical use

Ratings

Action	Organisation	Surveyor
7.1.1	SM	SM
7.1.2	SM	SM
7.1.3	SM	SM
7.2.1	SM	SM
7.2.2	SM	SM
7.3.1	SM	SM
7.3.2	SM	SM
7.3.3	SM	SM
7.4.1	SM	SM

Documenting patient information

Ratings

Action	Organisation	Surveyor
7.5.1	SM	SM
7.5.2	SM	SM
7.5.3	SM	SM
7.6.1	SM	SM
7.6.2	SM	SM
7.6.3	SM	SM

Managing blood and blood product safety

Ratings

Action	Organisation	Surveyor
7.7.1	SM	SM
7.7.2	SM	SM
7.8.1	SM	SM
7.8.2	SM	SM

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
7.9.1	SM	SM
7.9.2	SM	SM
7.10.1	SM	SM
7.11.1	SM	SM

Organisation : Griffith Rehabilitation Hospital
Orgcode : 325073

STANDARD 8
PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and Systems for the prevention and management of pressure injuries

Policies, procedures and protocols consistent with best practice guidelines are available to GRH staff. The GRH Clinical Committee is responsible for overseeing pressure injuries and for managing pressure injuries. Data on pressure injuries incidents, clinical indicators and audit results tabled at the Clinical Committee GRH Management Committee. Quarterly KPI reports are submitted to the HSP Board via the Safety and Quality Committee.

GRH has appointed a staff member to champion the implementation of the intent of the standard, support staff in systems for compliance and improvements and identifying staff learning needs. A number of quality activities are undertaken in relation to pressure injury management and prevention. These include staff education, inclusion in ISOBAR clinical handover tool provision for checking that a review of pressure injury documentation has occurred, increase in hourly rounding activities, maintenance of register of pressure reliving devices, increased provision of patient education activities and resources related to pressure injury prevention.

There was evidence of very high level of compliance in completion of risk assessment for high risk patients within 24 hours of admission. Equipment and devices are available to staff to effectively implement prevention strategies for patients at risk and plans for the management of patients with pressure injuries.

Incidences of pressure injuries are reported through RiskMan. It is noted that clinical indicator data show there were 50% reduction in hospital acquired pressure injuries in 2016, which is an excellent result.

Preventing pressure injuries

There is a systematic approach taken to the prevention and management of pressure injuries with policies and procedures including the use of screening and assessment tools. The Clinical Committee monitors compliance with policies and procedures, results of audits, along with actions taken via RiskMan reporting system. Information on pressure injuries is regularly reported to the highest level of governance. Action is taken to reduce the frequency and severity of pressure injuries with quality activities undertaken to prevent pressure injuries or improve their management. All pressure injuries are entered into RiskMan and it is noted that few are hospital acquired.

Equipment and devices are available to effectively implement prevention strategies for patients at risk. There is evidence of plans developed and utilised for the management of patients with pressure injuries.

A key quality improvement activity is the Pressure Injury Focus Month. Staff participate in a Question and Answer Sheet, with evaluation identifying learning needs.

The Allied Health staff ensure that equipment and devices are catalogued and that staff are trained in correct application and placing of the aids.

Managing pressure injuries

The organisation uses the Waterlow adopted risk assessment tool. An audit of pressure injury compliance resulted in 100% of patients screened within eight hours of admission, 100% had daily reassessment. Patient clinical documentation audits confirm that every admitted patient had a pressure injury prevention plan.

Allied Health staff assess admitted patients, provide pressure injury management advice, and fit any pressure relieving devices. 100% of hospital mattresses are pressure relieving.

The Healthscope Shared Learnings report is reviewed quarterly with any new learnings considered for adoption at GRH. Staff identify issues during the auditing process with actions taken documented. Education of staff is conducted and action plans developed to increase compliance with preventing and managing pressure injuries. Hydrotherapy pool Allied Health staff check the skin integrity of patients daily and advise nursing staff of any changes. Patients are dried as soon as possible on exiting the pool.

The Discharge Planner extracts pressure injury information from the clinical record, requests re-assessment prior to discharge, documents transfer details and includes information on pressure injury management and wound care.

Communicating with patients and carers

The Rehabilitation Program booklet has information on Pressure Injury Prevention and is given to all patients on admission and the TV information channel also has a segment on Pressure Injury Prevention and awareness. The Patient Services Assistant explains the information in the Rehabilitation Program booklet to patients on admission. The Consumer Consultant reviewed the Rehabilitation Program Booklet to provide comment and input from the patient perspective.

Carers may be involved in the development of the patient pressure injury management plan with extensive notes provided on discharge.

The Occupational therapist explains positioning of relieving devices and the Rehabilitation Assessment Nurse undertakes a malnutrition screening on at-risk patients and provides information and referrals to the dietitian.

Governance and systems for the prevention and management of pressure injuries

Ratings

Action	Organisation	Surveyor
8.1.1	SM	SM
8.1.2	SM	SM
8.2.1	SM	SM
8.2.2	SM	SM
8.2.3	SM	SM
8.2.4	SM	SM
8.3.1	SM	SM
8.4.1	SM	SM

Preventing pressure injuries

Ratings

Action	Organisation	Surveyor
8.5.1	SM	SM
8.5.2	SM	SM
8.5.3	SM	SM
8.6.1	SM	SM
8.6.2	SM	SM
8.6.3	SM	SM
8.7.1	SM	SM
8.7.2	SM	SM
8.7.3	SM	SM
8.7.4	SM	SM

Managing pressure injuries

Ratings

Action	Organisation	Surveyor
8.8.1	SM	SM
8.8.2	SM	SM
8.8.3	SM	SM
8.8.4	SM	SM

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
8.9.1	SM	SM
8.10.1	SM	SM

STANDARD 9
RECOGNISING AND RESPONDING TO CLINICAL DETERIORATION IN ACUTE HEALTH CARE

Surveyor Summary

Establishing recognition and response systems

The systems for recognising and responding to clinical deterioration are very well-developed. Comprehensively documented policies/procedures provide the framework for implementation of measurement and documentation of observations, escalation of care, the rapid response system and communication processes. Implementation and monitoring of performance is overseen by the Clinical Committee and the MAC. All deaths and cardiac arrests and the use of the recognition and response systems and any failures in these systems are subject to review.

Recognising clinical deterioration and escalating care

Colour coded adult observations charts are used for measurement and documentation of observations and incorporate a track and trigger system which is designed on human factors principles and includes trigger ranges for vital signs. Results of audits of the observation charts show improved levels of compliance with completion of observations as per patient prescribed management plans and initiation of clinical reviews if indicated. Improving documentation of the initiation of clinical reviews requires ongoing work.

Responding to clinical deterioration

The adult observation chart is designed on human factor principles and comprises trigger ranges for vital signs that are used to escalate concern when observation parameters are outside normal ranges. Clinical reviews are initiated when an assessment falls into the rapid response range or there is serious concern regarding the patient condition. The visiting medical officer (VMO) attends for review and initiation of clinical care or directs a management plan per telephone that may include transfer to secondary hospital for assessment and treatment. An emergency team operates within the hospital with well-identified criteria for code blue calls. All of the nursing and allied health workforce have completed basic life support (BLS) training. No advanced life support (ALS) training is undertaken by staff. South Australia Ambulance Services provide advanced life support and undertake transfer of patients to external facilities as required. Action 9.6.1 is assessed as fully met and rated SM.

Communicating with patients and carers

Mechanisms are in place to support patients/carers in the documentation of advance care directives and development of treatment-limiting orders and for incorporation of documentation and alerts are in the clinical records. A patient and carer escalation system (PACE) is in place to support patients/carers in escalating concerns regarding changes in clinical status. Information regarding how to communicate concerns is provided in posters, the patient information booklet in the DVD used in the in-house TV system. A patient call system is available at the bedside. Results of a survey undertaken by the consumer consultant in 2016 indicated that patients had good levels of knowledge regarding the escalation processes. Results of a review of RiskMan incidents involving PACE activations for the period 2014-2016 indicate that the patient call bell is used in the majority of incidents to alert staff of deterioration concerns.

Establishing recognition and response systems

Ratings

Action	Organisation	Surveyor
9.1.1	SM	SM
9.1.2	SM	SM
9.2.1	SM	SM
9.2.2	SM	SM
9.2.3	SM	SM
9.2.4	SM	SM

Recognising clinical deterioration and escalating care

Ratings

Action	Organisation	Surveyor
9.3.1	SM	SM
9.3.2	SM	SM
9.3.3	SM	SM
9.4.1	SM	SM
9.4.2	SM	SM
9.4.3	SM	SM

Responding to clinical deterioration

Ratings

Action	Organisation	Surveyor
9.5.1	SM	SM
9.5.2	SM	SM
9.6.1	SM	SM
9.6.2	SM	SM

Action 9.6.1 Core

Organisation's Self Rating: SM **Surveyor Rating:** SM

Surveyor Comment:

Training records show 100% of the nursing and allied health workforce have completed BLS training. The action is fully met.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
9.7.1	SM	SM
9.8.1	SM	SM
9.8.2	SM	SM
9.9.1	SM	SM
9.9.2	SM	SM
9.9.3	SM	SM
9.9.4	SM	SM

STANDARD 10
PREVENTING FALLS AND HARM FROM FALLS

Surveyor Summary

Governance and systems for the prevention of fall

Governance structures and systems are in place and a well-developed audit schedule with performance indicators reported to the Clinical Committee followed by the Corporate Safety and Quality KPI quarterly report. Policies and procedures are in place and there are screening and assessment tools in use. All falls, near misses and risks are reported into RiskMan.

A falls alert is entered on the patients Care Plan and written on the Physiotherapists Board with high falls risk patients reassessed every day.

Clinical Indicator data shows a reduction in falls over a four-year period despite a change in patient mix and an increase in admissions and a reduced length of stay. This outcome clearly demonstrates a commitment to the actions taken to reduce the frequency and severity of falls at the GRH.

Falls incidents are recorded and summary reports are reviewed by the Clinical Committee. The organisation monitors the rates of falls resulting in injury for admitted patients via the incident summary reports. A Healthscope Shared Learnings report identified that the safety of left handed patients be considered when allocating their room and setting up equipment. This was reviewed at the GRH and an increase in staff awareness was promoted.

The number of patients falling between the hours of 8 and 10am was trending higher. The implementation of nursing “hourly rounding” has contributed to a significant reduction of falls during this time period and combined with the introduction of Grip Sox, beds with alarm functions, low beds and out of room alarms supports action taken to reduce the frequency and severity of falls.

Screening and assessing risks of falls and harm from falling

A pre-admission assessment of all patients includes review of patient’s mobility and falls history as all rehabilitation patients have some risk of falling due to their health status.

The GRH uses the Healthscope Falls Risk Assessment tool (FRAT) best practice screening tool. Audits confirm that all patients are risk assessed within 24 hours of admission using the FRAT. Falls risk assessment information is entered into RiskMan. Audit data confirms that the risk assessment of patients occurs routinely, within the timeframe, is effective and with staff engaged in improvements to completing all the steps in the falls risk screening and prevention pathway.

Physiotherapists and Occupational Therapist review the falls history of a patient and discuss risks and strategies for program participation with the patient.

The FRAT is available in the nursing care folder at the patient bedside, there's a colour coded risk card to identify level of falls risk and the patient fall risk is discussed at clinical handover and when a change in the patient’s status or if moved to another ward.

Preventing Falls and harm from falling

The use of widespread falls prevention strategies was clearly evident to the survey team. Patients identified of being at risk of falling are appropriately identified and strategies for prevention implemented. Review of falls prevention strategies is embedded as being conducted daily. Multifactoral falls prevention plans based on the individual patient's needs are developed and implemented. Individualised Falls Actions Plans are developed in consultation with the patient or carer for those persons screened as high risk. Nursing clinical handover includes review of ISOBAR Handover Patient Care Plan where falls risk and strategies are documented.

A Flow Chart to use for Osteoporosis Management following a low impact fragility fracture is in use, following approval by the MAC in Feb 2016. The flow chart includes tests to be undertaken, treatment to be prescribed, education to the patient, and the medical discharge letter to include the osteoporosis treatment commenced as an inpatient. The Medical discharge letter include a prompt for this information to be included.

The use of equipment to prevent falls or minimise harm from falls is apparent. There is appropriate signage at the bed side on the patient communication board regarding patient mobility.

Communicating with patients and carers

Patient information on falls risk and prevention strategies is provided to patients and carers in a format that is appropriate. Plans are developed in partnership with patients and carers.

Falls posters and printed material on Falls Prevention are available throughout the GRH. Staff undertake training and education in patient-centred care with importance of communicating with patients a key learning. The Consumer Forums, Community Forums and Falls Events are an opportunity to promote Falls Prevention and safety to the community.

Patients are involved in the pre-admission assessment, participate in the planning of their care, liaise with the multidisciplinary team on working towards their goals at the weekly case conference and complete a falls survey prior to discharge.

The GRH is congratulated on the integrated and multidisciplinary team management approach to achieving a steady decline in falls and in the severity of falls over a six-year period.

NSQHSS Survey

Organisation : Griffith Rehabilitation Hospital
Orgcode : 325073

Governance and systems for the prevention of falls

Ratings

Action	Organisation	Surveyor
10.1.1	SM	SM
10.1.2	SM	SM
10.2.1	SM	SM
10.2.2	SM	SM
10.2.3	SM	SM
10.2.4	SM	SM
10.3.1	SM	SM
10.4.1	SM	SM

Screening and assessing risks of falls and harm from falling

Ratings

Action	Organisation	Surveyor
10.5.1	SM	SM
10.5.2	SM	SM
10.5.3	SM	SM
10.6.1	SM	SM
10.6.2	SM	SM
10.6.3	SM	SM

Preventing falls and harm from falling

Ratings

Action	Organisation	Surveyor
10.7.1	SM	SM
10.7.2	SM	SM
10.7.3	SM	SM
10.8.1	SM	SM

Organisation : Griffith Rehabilitation Hospital
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Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

Organisation : Griffith Rehabilitation Hospital
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Actions Rating Summary

Governance for Safety and Quality in Health Service Organisations

Governance and quality improvement systems

Action	Description	Organisation's self-rating	Surveyor Rating
1.1.1	An organisation-wide management system is in place for the development, implementation and regular review of policies, procedures and/or protocols	SM	SM
1.1.2	The impact on patient safety and quality of care is considered in business decision making	SM	SM
1.2.1	Regular reports on safety and quality indicators and other safety and quality performance data are monitored by the executive level of governance	SM	SM
1.2.2	Action is taken to improve the safety and quality of patient care	SM	SM
1.3.1	Workforce are aware of their delegated safety and quality roles and responsibilities	SM	SM
1.3.2	Individuals with delegated responsibilities are supported to understand and perform their roles and responsibilities, in particular to meet the requirements of these Standards	SM	SM
1.3.3	Agency or locum workforce are aware of their designated roles and responsibilities	SM	SM
1.4.1	Orientation and ongoing training programs provide the workforce with the skill and information needed to fulfil their safety and quality roles and responsibilities	SM	SM
1.4.2	Annual mandatory training programs to meet the requirements of these Standards	SM	SM
1.4.3	Locum and agency workforce have the necessary information, training and orientation to the workplace to fulfil their safety and quality roles and responsibilities	SM	SM
1.4.4	Competency-based training is provided to the clinical workforce to improve safety and quality	SM	SM
1.5.1	An organisation-wide risk register is used and regularly monitored	SM	SM
1.5.2	Actions are taken to minimise risks to patient safety and quality of care	SM	SM
1.6.1	An organisation-wide quality management system is used and regularly monitored	SM	SM
1.6.2	Actions are taken to maximise patient quality of care	SM	SM

Clinical practice

Action	Description	Organisation's self-rating	Surveyor Rating
1.7.1	Agreed and documented clinical guidelines and/or pathways are available to the clinical workforce	SM	SM
1.7.2	The use of agreed clinical guidelines by the clinical workforce is monitored	SM	SM
1.8.1	Mechanisms are in place to identify patients at increased risk of harm	SM	SM
1.8.2	Early action is taken to reduce the risks for at-risk patients	SM	SM

1.8.3	Systems exist to escalate the level of care when there is an unexpected deterioration in health status	SM	SM
1.9.1	Accurate, integrated and readily accessible patient clinical records are available to the clinical workforce at the point of care	SM	SM
1.9.2	The design of the patient clinical record allows for systematic audit of the contents against the requirements of these Standards	SM	SM

Performance and skills management

Action	Description	Organisation's self-rating	Surveyor Rating
1.10.1	A system is in place to define and regularly review the scope of practice for the clinical workforce	SM	SM
1.10.2	Mechanisms are in place to monitor that the clinical workforce are working within their agreed scope of practice	SM	SM
1.10.3	Organisational clinical service capability, planning and scope of practice is directly linked to the clinical service roles of the organisation	SM	SM
1.10.4	The system for defining the scope of practice is used whenever a new clinical service, procedure or other technology is introduced	SM	SM
1.10.5	Supervision of the clinical workforce is provided whenever it is necessary for individuals to fulfil their designated role	SM	SM
1.11.1	A valid and reliable performance review process is in place for the clinical workforce	SM	SM
1.11.2	The clinical workforce participates in regular performance reviews that support individual development and improvement	SM	SM
1.12.1	The clinical and relevant non-clinical workforce have access to ongoing safety and quality education and training for identified professional and personal development	SM	SM
1.13.1	Analyse feedback from the workforce on their understanding and use of safety and quality systems	SM	SM
1.13.2	Action is taken to increase workforce understanding and use of safety and quality systems	SM	SM

Incident and complaints management

Action	Description	Organisation's self-rating	Surveyor Rating
1.14.1	Processes are in place to support the workforce recognition and reporting of incidents and near misses	SM	SM
1.14.2	Systems are in place to analyse and report on incidents	SM	SM
1.14.3	Feedback on the analysis of reported incidents is provided to the workforce	SM	SM
1.14.4	Action is taken to reduce risks to patients identified through the incident management system	SM	SM
1.14.5	Incidents and analysis of incidents are reviewed at the highest level of governance in the organisation	SM	SM
1.15.1	Processes are in place to support the workforce to recognise and report complaints	SM	SM
1.15.2	Systems are in place to analyse and implement improvements in response to complaints	SM	SM

1.15.3	Feedback is provided to the workforce on the analysis of reported complaints	SM	SM
1.15.4	Patient feedback and complaints are reviewed at the highest level of governance in the organisation	SM	SM
1.16.1	An open disclosure program is in place and is consistent with the national open disclosure standard	SM	SM
1.16.2	The clinical workforce are trained in open disclosure processes	SM	SM

Patient rights and engagement

Action	Description	Organisation's self-rating	Surveyor Rating
1.17.1	The organisation has a charter of patient rights that is consistent with the current national charter of healthcare rights	SM	SM
1.17.2	Information on patient rights is provided and explained to patients and carers	SM	SM
1.17.3	Systems are in place to support patients who are at risk of not understanding their healthcare rights	SM	SM
1.18.1	Patients and carers are partners in the planning for their treatment	SM	SM
1.18.2	Mechanisms are in place to monitor and improve documentation of informed consent	SM	SM
1.18.3	Mechanisms are in place to align the information provided to patients with their capacity to understand	SM	SM
1.18.4	Patients and carers are supported to document clear advance care directives and/or treatment-limiting orders	SM	SM
1.19.1	Patient clinical records are available at the point of care	SM	SM
1.19.2	Systems are in place to restrict inappropriate access to and dissemination of patient clinical information	SM	SM
1.20.1	Data collected from patient feedback systems are used to measure and improve health services in the organisation	SM	SM

Partnering with Consumers

Consumer partnership in service planning

Action	Description	Organisation's self-rating	Surveyor Rating
2.1.1	Consumers and/or carers are involved in the governance of the health service organisation	SM	MM
2.1.2	Governance partnerships are reflective of the diverse range of backgrounds in the population served by the health service organisation, including those people who do not usually provide feedback	SM	SM
2.2.1	The health service organisation establishes mechanisms for engaging consumers and/or carers in the strategic and/or operational planning for the organisation	SM	SM
2.2.2	Consumers and/or carers are actively involved in decision making about safety and quality	SM	SM
2.3.1	Health service organisations provide orientation and ongoing training for consumers and/or carers to enable them to fulfil their partnership role	SM	SM

2.4.1	Consumers and/or carers provide feedback on patient information publications prepared by the health service organisation (for distribution to patients)	SM	SM
2.4.2	Action is taken to incorporate consumer and/or carers' feedback into publications prepared by the health service organisation for distribution to patients	SM	SM

Consumer partnership in designing care

Action	Description	Organisation's self-rating	Surveyor Rating
2.5.1	Consumers and/or carers participate in the design and redesign of health services	SM	SM
2.6.1	Clinical leaders, senior managers and the workforce access training on patient-centred care and the engagement of individuals in their care	SM	MM
2.6.2	Consumers and/or carers are involved in training the clinical workforce	SM	SM

Consumer partnership in service measurement and evaluation

Action	Description	Organisation's self-rating	Surveyor Rating
2.7.1	The community and consumers are provided with information that is meaningful and relevant on the organisation's safety and quality performance	SM	SM
2.8.1	Consumers and/or carers participate in the analysis of organisational safety and quality performance	SM	SM
2.8.2	Consumers and/or carers participate in the planning and implementation of quality improvements	SM	SM
2.9.1	Consumers and/or carers participate in the evaluation of patient feedback data	SM	SM
2.9.2	Consumers and/or carers participate in the implementation of quality activities relating to patient feedback data	SM	SM

Preventing and Controlling Healthcare Associated Infections

Governance and systems for infection prevention, control and surveillance

Action	Description	Organisation's self-rating	Surveyor Rating
3.1.1	A risk management approach is taken when implementing policies, procedures and/or protocols for: • standard infection control precautions • transmission-based precautions • aseptic non-touch technique • safe handling and disposal of sharps • prevention and management of occupational exposure to blood and body substances • environmental cleaning and disinfection • antimicrobial prescribing • outbreaks or unusual clusters of communicable infection • processing of reusable medical devices • single-use devices	SM	SM

	• surveillance and reporting of data where relevant • reporting of communicable and notifiable diseases • provision of risk assessment guidelines to workforce • exposure-prone procedures		
3.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
3.1.3	The effectiveness of the infection prevention and control systems is regularly reviewed at the highest level of governance in the organisation	SM	SM
3.1.4	Action is taken to improve the effectiveness of infection prevention and control policies, procedures and/or protocols	SM	SM
3.2.1	Surveillance systems for healthcare associated infections are in place	SM	SM
3.2.2	Healthcare associated infections surveillance data are regularly monitored by the delegated workforce and/or committees	SM	SM
3.3.1	Mechanisms to regularly assess the healthcare associated infection risks are in place	SM	SM
3.3.2	Action is taken to reduce the risks of healthcare associated infection	SM	SM
3.4.1	Quality improvement activities are implemented to reduce and prevent healthcare associated infections	SM	SM
3.4.2	Compliance with changes in practice are monitored	SM	SM
3.4.3	The effectiveness of changes to practice are evaluated	SM	SM

Infection prevention and control strategies

Action	Description	Organisation's self-rating	Surveyor Rating
3.5.1	Workforce compliance with current national hand hygiene guidelines is regularly audited	SM	MM
3.5.2	Compliance rates from hand hygiene audits are regularly reported to the highest level of governance in the organisation	SM	MM
3.5.3	Action is taken to address non-compliance, or the inability to comply, with the requirements of the current national hand hygiene guidelines	SM	MM
3.6.1	A workforce immunisation program that complies with current national guidelines is in use	SM	MM
3.7.1	Infection prevention and control consultation related to occupational health and safety policies, procedures and/or protocols are implemented to address: • communicable disease status • occupational management and prophylaxis • work restrictions • personal protective equipment • assessment of risk to healthcare workers for occupational allergies • evaluation of new products and procedures	SM	SM
3.8.1	Compliance with the system for the use and management of invasive devices in monitored	SM	SM
3.9.1	Education and competency-based training in invasive devices protocols and use is provided for the workforce who perform procedures with invasive devices	SM	SM
3.10.1	The clinical workforce is trained in aseptic technique	SM	SM

3.10.2	Compliance with aseptic technique is regularly audited	SM	SM
3.10.3	Action is taken to increase compliance with the aseptic technique protocols	SM	SM

Managing patients with infections or colonisations

Action	Description	Organisation's self-rating	Surveyor Rating
3.11.1	Standard precautions and transmission-based precautions consistent with the current national guidelines are in use	SM	SM
3.11.2	Compliance with standard precautions is monitored	SM	SM
3.11.3	Action is taken to improve compliance with standard precautions	SM	SM
3.11.4	Compliance with transmission-based precautions is monitored	SM	SM
3.11.5	Action is taken to improve compliance with transmission-based precautions	SM	SM
3.12.1	A risk analysis is undertaken to consider the need for transmission-based precautions including: • accommodation based on the mode of transmission • environmental controls through air flow • transportation within and outside the facility • cleaning procedures • equipment requirements	SM	SM
3.13.1	Mechanisms are in use for checking for pre-existing healthcare associated infections or communicable disease on presentation for care	SM	SM
3.13.2	A process for communicating a patient's infectious status is in place whenever responsibility for care is transferred between service providers or facilities	SM	SM

Antimicrobial stewardship

Action	Description	Organisation's self-rating	Surveyor Rating
3.14.1	An antimicrobial stewardship program is in place	SM	SM
3.14.2	The clinical workforce prescribing antimicrobials have access to current endorsed therapeutic guidelines on antibiotic usage	SM	SM
3.14.3	Monitoring of antimicrobial usage and resistance is undertaken	SM	SM
3.14.4	Action is taken to improve the effectiveness of antimicrobial stewardship	SM	SM

Cleaning, disinfection and sterilisation

Action	Description	Organisation's self-rating	Surveyor Rating
3.15.1	Policies, procedures and/or protocols for environmental cleaning that address the principles of infection prevention and control are implemented, including: • maintenance of building facilities • cleaning resources and services • risk assessment for cleaning and disinfection based on transmission-based precautions and the infectious agent involved • waste management within the clinical environment	SM	SM

• laundry and linen transportation, cleaning and storage
• appropriate use of personal protective equipment

3.15.2	Policies, procedures and/or protocols for environmental cleaning are regularly reviewed	SM	SM
3.15.3	An established environmental cleaning schedule is in place and environmental cleaning audits are undertaken regularly	SM	SM
3.16.1	Compliance with relevant national or international standards and manufacturer's instructions for cleaning, disinfection and sterilisation of reusable instruments and devices is regularly monitored	SM	SM
3.17.1	A traceability system that identifies patients who have a procedure using sterile reusable medical instruments and devices is in place	SM	SM
3.18.1	Action is taken to maximise coverage of the relevant workforce trained in a competency-based program to decontaminate reusable medical devices	SM	SM

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
3.19.1	Information on the organisation's corporate and clinical infection risks and initiatives implemented to minimise patient infection risks is provided to patients and/or carers	SM	SM
3.19.2	Patient infection prevention and control information is evaluated to determine if it meets the needs of the target audience	SM	SM

Medication Safety

Governance and systems for medication safety

Action	Description	Organisation's self-rating	Surveyor Rating
4.1.1	Governance arrangements are in place to support the development, implementation and maintenance of organisation-wide medication safety systems	SM	SM
4.1.2	Policies, procedures and/or protocols are in place that are consistent with legislative requirements, national, jurisdictional and professional guidelines	SM	SM
4.2.1	The medication management system is regularly assessed	SM	SM
4.2.2	Action is taken to reduce the risks identified in the medication management system	SM	SM
4.3.1	A system is in place to verify that the clinical workforce have medication authorities appropriate to their scope of practice	SM	SM
4.3.2	The use of the medication authorisation system is regularly monitored	SM	SM
4.3.3	Action is taken to increase the effectiveness of the medication authority system	SM	SM
4.4.1	Medication incidents are regularly monitored, reported and investigated	SM	SM
4.4.2	Action is taken to reduce the risk of adverse medication incidents	SM	SM
4.5.1	The performance of the medication management system is regularly assessed	SM	SM

4.5.2	Quality improvement activities are undertaken to reduce the risk of patient harm and increase the quality and effectiveness of medicines use	SM	SM

Documentation of patient information

Action	Description	Organisation's self-rating	Surveyor Rating
4.6.1	A best possible medication history is documented for each patient	SM	SM
4.6.2	The medication history and current clinical information is available at the point of care	SM	SM
4.7.1	Known medication allergies and adverse drug reactions are documented in the patient clinical record	SM	SM
4.7.2	Action is taken to reduce the risk of adverse reactions	SM	SM
4.7.3	Adverse drug reactions are reported within the organisation and to the Therapeutic Goods Administration	SM	SM
4.8.1	Current medicines are documented and reconciled at admission and transfer of care between healthcare settings	SM	SM

Medication management processes

Action	Description	Organisation's self-rating	Surveyor Rating
4.9.1	Information and decision support tools for medicines are available to the clinical workforce at the point of care	SM	SM
4.9.2	The use of information and decision support tools is regularly reviewed	SM	SM
4.9.3	Action is taken to improve the availability and effectiveness of information and decision support tools	SM	SM
4.10.1	Risks associated with secure storage and safe distribution of medicines are regularly reviewed	SM	SM
4.10.2	Action is taken to reduce the risks associated with storage and distribution of medicines	SM	SM
4.10.3	The storage of temperature-sensitive medicines is monitored	SM	SM
4.10.4	A system that is consistent with legislative and jurisdictional requirements for the disposal of unused, unwanted or expired medications is in place	SM	SM
4.10.5	The system for disposal of unused, unwanted or expired medications is regularly monitored	SM	SM
4.10.6	Action is taken to increase compliance with the system for storage, distribution and disposal of medications	SM	SM
4.11.1	The risks for storing, prescribing, dispensing and administration of high-risk medicines are regularly reviewed	SM	SM
4.11.2	Action is taken to reduce the risks of storing, prescribing, dispensing and administering high-risk medicines	SM	SM

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Continuity of medication management

Action	Description	Organisation's self-rating	Surveyor Rating
4.12.1	A system is in use that generates and distributes a current and comprehensive list of medicines and explanation of changes in medicines	SM	SM
4.12.2	A current and comprehensive list of medicines is provided to the patient and/or carer when concluding an episode of care	SM	SM
4.12.3	A current comprehensive list of medicines is provided to the receiving clinician during clinical handover	SM	SM
4.12.4	Action is taken to increase the proportion of patients and receiving clinicians that are provided with a current comprehensive list of medicines during clinical handover	SM	SM

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
4.13.1	The clinical workforce provides patients with patient specific medicine information, including medication treatment options, benefits and associated risks	SM	SM
4.13.2	Information that is designed for distribution to patients is readily available to the clinical workforce	SM	SM
4.14.1	An agreed medication management plan is documented and available in the patient's clinical record	SM	SM
4.15.1	Information on medicines is provided to patients and carers in a format that is understood and meaningful	SM	SM
4.15.2	Action is taken in response to patient feedback to improve medicines information distributed by the health service organisation to patients	SM	SM

Patient Identification and Procedure Matching

Identification of individual patients

Action	Description	Organisation's self-rating	Surveyor Rating
5.1.1	Use of an organisation-wide patient identification system is regularly monitored	SM	SM
5.1.2	Action is taken to improve compliance with the patient identification matching system	SM	SM
5.2.1	The system for reporting, investigating and analysis of patient care mismatching events is regularly monitored	SM	SM
5.2.2	Action is taken to reduce mismatching events	SM	SM
5.3.1	Inpatient bands are used that meet the national specifications for patient identification bands	SM	SM

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Processes to transfer care

Action	Description	Organisation's self-rating	Surveyor Rating
5.4.1	A patient identification and matching system is implemented and regularly reviewed as part of structured clinical handover, transfer and discharge processes	SM	SM

Processes to match patients and their care

Action	Description	Organisation's self-rating	Surveyor Rating
5.5.1	A documented process to match patients and their intended treatment is in use	SM	SM
5.5.2	The process to match patients to any intended procedure, treatment or investigation is regularly monitored	SM	SM
5.5.3	Action is taken to improve the effectiveness of the process for matching patients to their intended procedure, treatment or investigation	SM	SM

Clinical Handover

Governance and leadership for effective clinical handover

Action	Description	Organisation's self-rating	Surveyor Rating
6.1.1	Clinical handover policies, procedures and/or protocols are used by the workforce and regularly monitored	SM	SM
6.1.2	Action is taken to maximise the effectiveness of clinical handover policies, procedures and/or protocols	SM	SM
6.1.3	Tools and guides are periodically reviewed	SM	SM

Clinical handover processes

Action	Description	Organisation's self-rating	Surveyor Rating
6.2.1	The workforce has access to documented structured processes for clinical handover that include: • preparing for handover, including setting the location and time while maintaining continuity of patient care • organising relevant workforce members to participate • being aware of the clinical context and patient needs • participating in effective handover resulting in transfer of responsibility and accountability for care	SM	SM
6.3.1	Regular evaluation and monitoring processes for clinical handover are in place	SM	SM
6.3.2	Local processes for clinical handover are reviewed in collaboration with clinicians, patients and carers	SM	SM
6.3.3	Action is taken to increase the effectiveness of clinical handover	SM	SM
6.3.4	The actions taken and the outcomes of local clinical handover reviews are reported to the executive level of governance	SM	SM
6.4.1	Regular reporting, investigating and monitoring of clinical handover incidents is in place	SM	SM

6.4.2	Action is taken to reduce the risk of adverse clinical handover incidents	SM	SM

Patient and carer involvement in clinical handover

Action	Description	Organisation's self-rating	Surveyor Rating
6.5.1	Mechanisms to involve a patient and, where relevant, their carer in clinical handover are in use	SM	SM

Blood and Blood Products

Governance and systems for blood and blood product prescribing and clinical use

Action	Description	Organisation's self-rating	Surveyor Rating
7.1.1	Blood and blood product policies, procedures and/or protocols are consistent with national evidence-based guidelines for pre-transfusion practices, prescribing and clinical use of blood and blood products	SM	SM
7.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
7.1.3	Action is taken to increase the safety and appropriateness of prescribing and clinically using blood and blood products	SM	SM
7.2.1	The risks associated with transfusion practices and clinical use of blood and blood products are regularly assessed	SM	SM
7.2.2	Action is taken to reduce the risks associated with transfusion practices and the clinical use of blood and blood products	SM	SM
7.3.1	Reporting on blood and blood product incidents is included in regular incident reports	SM	SM
7.3.2	Adverse blood and blood product incidents are reported to and reviewed by the highest level of governance in the health service organisation	SM	SM
7.3.3	Health service organisations participate in relevant haemovigilance activities conducted by the organisation or at state or national level	SM	SM
7.4.1	Quality improvement activities are undertaken to reduce the risks of patient harm from transfusion practices and the clinical use of blood and blood products	SM	SM

Documenting patient information

Action	Description	Organisation's self-rating	Surveyor Rating
7.5.1	A best possible history of blood product usage and relevant clinical and product information is documented in the patient clinical record	SM	SM
7.5.2	The patient clinical records of transfused patients are periodically reviewed to assess the proportion of records completed	SM	SM
7.5.3	Action is taken to increase the proportion of patient clinical records of transfused patients with a complete patient clinical record	SM	SM
7.6.1	Adverse reactions to blood or blood products are documented in the patient clinical record	SM	SM
7.6.2	Action is taken to reduce the risk of adverse events from administering blood or blood products	SM	SM

7.6.3	Adverse events are reported internally to the appropriate governance level and externally to the pathology service provider, blood service or product manufacturer whenever appropriate	SM	SM

Managing blood and blood product safety

Action	Description	Organisation's self-rating	Surveyor Rating
7.7.1	Regular review of the risks associated with receipt, storage, collection and transport of blood and blood products is undertaken	SM	SM
7.7.2	Action is taken to reduce the risk of incidents arising from the use of blood and blood product control systems	SM	SM
7.8.1	Blood and blood product wastage is regularly monitored	SM	SM
7.8.2	Action is taken to minimise wastage of blood and blood products	SM	SM

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
7.9.1	Patient information relating to blood and blood products, including risks, benefits and alternatives, is available for distribution by the clinical workforce	SM	SM
7.9.2	Plans for care that include the use of blood and blood products are developed in partnership with patients and carers	SM	SM
7.10.1	Information on blood and blood products is provided to patients and their carers in a format that is understood and meaningful	SM	SM
7.11.1	Informed consent is undertaken and documented for all transfusions of blood or blood products in accordance with the informed consent policy of the health service organisation	SM	SM

Preventing and Managing Pressure Injuries

Governance and systems for the prevention and management of pressure injuries

Action	Description	Organisation's self-rating	Surveyor Rating
8.1.1	Policies, procedures and/or protocols are in use that are consistent with best practice guidelines and incorporate screening and assessment tools	SM	SM
8.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
8.2.1	An organisation-wide system for reporting pressure injuries is in use	SM	SM
8.2.2	Administrative and clinical data are used to regularly monitor and investigate the frequency and severity of pressure injuries	SM	SM
8.2.3	Information on pressure injuries is regularly reported to the highest level of governance in the health service organisation	SM	SM
8.2.4	Action is taken to reduce the frequency and severity of pressure injuries	SM	SM
8.3.1	Quality improvement activities are undertaken to prevent pressure injuries and/or improve the management of pressure injuries	SM	SM
8.4.1	Equipment and devices are available to effectively implement prevention strategies for patients at risk and plans for the management of patients with pressure injuries	SM	SM

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Preventing pressure injuries

Action	Description	Organisation's self-rating	Surveyor Rating
8.5.1	An agreed tool to screen for pressure injury risk is used by the clinical workforce to identify patients at risk of a pressure injury	SM	SM
8.5.2	The use of the screening tool is monitored to identify the proportion of at-risk patients that are screened for pressure injuries on presentation	SM	SM
8.5.3	Action is taken to maximise the proportion of patients who are screened for pressure injury on presentation	SM	SM
8.6.1	Comprehensive skin inspections are undertaken and documented in the patient clinical record for patients at risk of pressure injuries	SM	SM
8.6.2	Patient clinical records, transfer and discharge documentation are periodically audited to identify at-risk patients with documented skin assessments	SM	SM
8.6.3	Action is taken to increase the proportion of skin assessments documented on patients at risk of pressure injuries	SM	SM
8.7.1	Prevention plans for all patients at risk of a pressure injury are consistent with best practice guidelines and are documented in the patient clinical record	SM	SM
8.7.2	The effectiveness and appropriateness of pressure injury prevention plans are regularly reviewed	SM	SM
8.7.3	Patient clinical records are monitored to determine the proportion of at-risk patients that have an implemented pressure injury prevention plan	SM	SM
8.7.4	Action is taken to increase the proportion of patients at risk of pressure injuries who have an implemented prevention plan	SM	SM

Managing pressure injuries

Action	Description	Organisation's self-rating	Surveyor Rating
8.8.1	An evidence-based wound management system is in place within the health service organisation	SM	SM
8.8.2	Management plans for patients with pressure injuries are consistent with best practice and documented in the patient clinical record	SM	SM
8.8.3	Patient clinical records are monitored to determine compliance with evidence-based pressure injury management plans	SM	SM
8.8.4	Action is taken to increase compliance with evidence-based pressure injury management plans	SM	SM

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
8.9.1	Patient information on prevention and management of pressure injuries is provided to patients and carers in a format that is understood and is meaningful	SM	SM
8.10.1	Pressure injury management plans are developed in partnership	SM	SM

	with patients and carers

Recognising and Responding to Clinical Deterioration in Acute Health Care

Establishing recognition and response systems

Action	Description	Organisation's self-rating	Surveyor Rating
9.1.1	Governance arrangements are in place to support the development, implementation, and maintenance of organisation-wide recognition and response systems	SM	SM
9.1.2	Policies, procedures and/or protocols for the organisation are implemented in areas such as: • measurement and documentation of observations • escalation of care • establishment of a rapid response system • communication about clinical deterioration	SM	SM
9.2.1	Feedback is actively sought from the clinical workforce on the responsiveness of the recognition and response systems	SM	SM
9.2.2	Deaths or cardiac arrests for a patient without an agreed treatment-limiting order (such as not for resuscitation or do not resuscitate) are reviewed to identify the use of the recognition and response systems, and any failures in these systems	SM	SM
9.2.3	Data collected about recognition and response systems are provided to the clinical workforce as soon as practicable	SM	SM
9.2.4	Action is taken to improve the responsiveness and effectiveness of the recognition and response systems	SM	SM

Recognising clinical deterioration and escalating care

Action	Description	Organisation's self-rating	Surveyor Rating
9.3.1	When using a general observation chart, ensure that it: • is designed according to human factors principles • includes the capacity to record information about respiratory rate, oxygen saturation, heart rate, blood pressure, temperature and level of consciousness graphically over time • includes thresholds for each physiological parameter or combination of parameters that indicate abnormality • specifies the physiological abnormalities and other factors that trigger the escalation of care • includes actions required when care is escalated	SM	SM
9.3.2	Mechanisms for recording physiological observations are regularly audited to determine the proportion of patients that have complete sets of observations recorded in agreement with their monitoring plan	SM	SM
9.3.3	Action is taken to increase the proportion of patients with complete sets of recorded observations, as specified in the patient's monitoring plan	SM	SM
9.4.1	Mechanisms are in place to escalate care and call for emergency assistance	SM	SM
9.4.2	Use of escalation processes, including failure to act on triggers for seeking emergency assistance, are regularly audited	SM	SM
9.4.3	Action is taken to maximise the appropriate use of escalation	SM	SM

	processes

Responding to clinical deterioration

Action	Description	Organisation's self-rating	Surveyor Rating
9.5.1	Criteria for triggering a call for emergency assistance are included in the escalation policies, procedures and/or protocols	SM	SM
9.5.2	The circumstances and outcome of calls for emergency assistance are regularly reviewed	SM	SM
9.6.1	The clinical workforce is trained and proficient in basic life support	SM	SM
9.6.2	A system is in place for ensuring access at all times to at least one clinician, either on-site or in close proximity, who can practise advanced life support	SM	SM

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
9.7.1	Information is provided to patients, families and carers in a format that is understood and meaningful. The information should include: • the importance of communicating concerns and signs/symptoms of deterioration, which are relevant to the patient's condition, to the clinical workforce • local systems for responding to clinical deterioration, including how they can raise concerns about potential deterioration	SM	SM
9.8.1	A system is in place for preparing and/or receiving advance care plans in partnership with patients, families and carers	SM	SM
9.8.2	Advance care plans and other treatment-limiting orders are documented in the patient clinical record	SM	SM
9.9.1	Mechanisms are in place for a patient, family member or carer to initiate an escalation of care response	SM	SM
9.9.2	Information about the system for family escalation of care is provided to patients, families and carers	SM	SM
9.9.3	The performance and effectiveness of the system for family escalation of care is periodically reviewed	SM	SM
9.9.4	Action is taken to improve the system performance for family escalation of care	SM	SM

Preventing Falls and Harm from Falls

Governance and systems for the prevention of falls

Action	Description	Organisation's self-rating	Surveyor Rating
10.1.1	Policies, procedures and/or protocols are in use that are consistent with best practice guidelines (where available) and incorporate screening and assessment tools	SM	SM
10.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
10.2.1	Regular reporting, investigating and monitoring of falls incidents is in place	SM	SM
10.2.2	Administrative and clinical data are used to monitor and investigate	SM	SM

	regularly the frequency and severity of falls in the health service organisation		
10.2.3	Information on falls is reported to the highest level of governance in the health service organisation	SM	SM
10.2.4	Action is taken to reduce the frequency and severity of falls in the health service organisation	SM	SM
10.3.1	Quality improvement activities are undertaken to prevent falls and minimise patient harm	SM	SM
10.4.1	Equipment and devices are available to implement prevention strategies for patients at risk of falling and management plans to reduce the harm from falls	SM	SM

Screening and assessing risks of falls and harm from falling

Action	Description	Organisation's self-rating	Surveyor Rating
10.5.1	A best practice screening tool is used by the clinical workforce to identify the risk of falls	SM	SM
10.5.2	Use of the screening tool is monitored to identify the proportion of at-risk patients that were screened for falls	SM	SM
10.5.3	Action is taken to increase the proportion of at-risk patients who are screened for falls upon presentation and during admission	SM	SM
10.6.1	A best practice assessment tool is used by the clinical workforce to assess patients at risk of falling	SM	SM
10.6.2	The use of the assessment tool is monitored to identify the proportion of at-risk patients with a completed falls assessment	SM	SM
10.6.3	Action is taken to increase the proportion of at-risk patients undergoing a comprehensive falls risk assessment	SM	SM

Preventing falls and harm from falling

Action	Description	Organisation's self-rating	Surveyor Rating
10.7.1	Use of best practice multifactorial falls prevention and harm minimisation plans is documented in the patient clinical record	SM	SM
10.7.2	The effectiveness and appropriateness of the falls prevention and harm minimisation plan are regularly monitored	SM	SM
10.7.3	Action is taken to reduce falls and minimise harm for at-risk patients	SM	SM
10.8.1	Discharge planning includes referral to appropriate services, where available	SM	SM

Communicating with patients and carers

Action	Description	Organisation's self-rating	Surveyor Rating
10.9.1	Patient information on falls risks and prevention strategies is provided to patients and their carers in a format that is understood and meaningful	SM	SM
10.10.1	Falls prevention plans are developed in partnership with patients and carers	SM	SM

Organisation : Griffith Rehabilitation Hospital
Orgcode : 325073

Recommendations from Current Survey

Not applicable.

Organisation : Griffith Rehabilitation Hospital
Orgcode : 325073

Recommendations from Previous Survey

Not applicable.

NSQHSS Survey

Organisation : Griffith Rehabilitation Hospital
Orgcode : 325073

Standards Rating Summary

Organisation - NSQHSS V01

Core

Standard	Not Met	Met	N/A	Total
Standard 1	0	44	0	44
Standard 2	0	4	0	4
Standard 3	0	39	0	39
Standard 4	0	31	0	31
Standard 5	0	9	0	9
Standard 6	0	9	0	9
Standard 7	0	20	0	20
Standard 8	0	20	0	20
Standard 9	0	15	0	15
Standard 10	0	18	0	18
Total	**0**	**209**	**0**	**209**

Developmental

Standard	Not Met	Met	N/A	Total
Standard 1	0	9	0	9
Standard 2	0	11	0	11
Standard 3	0	2	0	2
Standard 4	0	6	0	6
Standard 5	0	0	0	0
Standard 6	0	2	0	2
Standard 7	0	3	0	3
Standard 8	0	4	0	4
Standard 9	0	8	0	8
Standard 10	0	2	0	2
Total	**0**	**47**	**0**	**47**

NSQHSS Survey

Organisation : Griffith Rehabilitation Hospital
Orgcode : 325073

Standard	SM	MM	Total
Standard 1	44	0	44
Standard 2	4	0	4
Standard 3	39	0	39
Standard 4	31	0	31
Standard 5	9	0	9
Standard 6	9	0	9
Standard 7	20	0	20
Standard 8	20	0	20
Standard 9	15	0	15
Standard 10	18	0	18
Total	**209**	**0**	**209**

Standard	SM	MM	Total
Standard 1	9	0	9
Standard 2	11	0	11
Standard 3	2	0	2
Standard 4	6	0	6
Standard 5	0	0	0
Standard 6	2	0	2
Standard 7	3	0	3
Standard 8	4	0	4
Standard 9	8	0	8
Standard 10	2	0	2
Total	**47**	**0**	**47**

NSQHSS Survey

Organisation : Griffith Rehabilitation Hospital
Orgcode : 325073

Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 1	0	53	0	53	Met
Standard 2	0	15	0	15	Met
Standard 3	0	41	0	41	Met
Standard 4	0	37	0	37	Met
Standard 5	0	9	0	9	Met
Standard 6	0	11	0	11	Met
Standard 7	0	23	0	23	Met
Standard 8	0	24	0	24	Met
Standard 9	0	23	0	23	Met
Standard 10	0	20	0	20	Met
Total	**0**	**256**	**0**	**256**	**Met**

Standard	SM	MM	Total	Overall
Standard 1	53	0	53	Met
Standard 2	15	0	15	Met
Standard 3	41	0	41	Met
Standard 4	37	0	37	Met
Standard 5	9	0	9	Met
Standard 6	11	0	11	Met
Standard 7	23	0	23	Met
Standard 8	24	0	24	Met
Standard 9	23	0	23	Met
Standard 10	20	0	20	Met
Total	**256**	**0**	**256**	**Met**

NSQHSS Survey

Organisation : Griffith Rehabilitation Hospital
Orgcode : 325073

Surveyor - NSQHSS V01

Core

Standard	Not Met	Met	N/A	Total
Standard 1	0	44	0	44
Standard 2	0	4	0	4
Standard 3	0	39	0	39
Standard 4	0	31	0	31
Standard 5	0	9	0	9
Standard 6	0	9	0	9
Standard 7	0	20	0	20
Standard 8	0	20	0	20
Standard 9	0	15	0	15
Standard 10	0	18	0	18
Total	**0**	**209**	**0**	**209**

Standard	SM	MM	Total
Standard 1	44	0	44
Standard 2	3	1	4
Standard 3	35	4	39
Standard 4	31	0	31
Standard 5	9	0	9
Standard 6	9	0	9
Standard 7	20	0	20
Standard 8	20	0	20
Standard 9	15	0	15
Standard 10	18	0	18
Total	**204**	**5**	**209**

Developmental

Standard	Not Met	Met	N/A	Total
Standard 1	0	9	0	9
Standard 2	0	11	0	11
Standard 3	0	2	0	2
Standard 4	0	6	0	6
Standard 5	0	0	0	0
Standard 6	0	2	0	2
Standard 7	0	3	0	3
Standard 8	0	4	0	4
Standard 9	0	8	0	8
Standard 10	0	2	0	2
Total	**0**	**47**	**0**	**47**

Standard	SM	MM	Total
Standard 1	9	0	9
Standard 2	10	1	11
Standard 3	2	0	2
Standard 4	6	0	6
Standard 5	0	0	0
Standard 6	2	0	2
Standard 7	3	0	3
Standard 8	4	0	4
Standard 9	8	0	8
Standard 10	2	0	2
Total	**46**	**1**	**47**

NSQHSS Survey

Organisation : Griffith Rehabilitation Hospital
Orgcode : 325073

Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 1	0	53	0	53	Met
Standard 2	0	15	0	15	Met
Standard 3	0	41	0	41	Met
Standard 4	0	37	0	37	Met
Standard 5	0	9	0	9	Met
Standard 6	0	11	0	11	Met
Standard 7	0	23	0	23	Met
Standard 8	0	24	0	24	Met
Standard 9	0	23	0	23	Met
Standard 10	0	20	0	20	Met
Total	**0**	**256**	**0**	**256**	**Met**

Standard	SM	MM	Total	Overall
Standard 1	53	0	53	Met
Standard 2	13	2	15	Met
Standard 3	37	4	41	Met
Standard 4	37	0	37	Met
Standard 5	9	0	9	Met
Standard 6	11	0	11	Met
Standard 7	23	0	23	Met
Standard 8	24	0	24	Met
Standard 9	23	0	23	Met
Standard 10	20	0	20	Met
Total	**250**	**6**	**256**	**Met**