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

North Eastern Rehabilitation Centre

Ivanhoe, VIC

Organisation Code: 22 51 66

Survey Date: 1-2 August 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 organisations 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: North Eastern Rehabilitation Centre
Orgcode: 225166

Survey Report

Survey Overview

North Eastern Rehabilitation Centre (NERC) is a 46 bed private rehabilitation health service providing supportive services for a range of case mixes: trauma, spinal injuries, neurological/stroke, orthopaedic, cancer, respiratory, chronic pain management, cardiac, neurosurgical and restorative /reconditioning care. New services have been introduced since the last event and now include rehabilitation services for cancer and cardiac patients. NERC is part of Healthscope (HSP) and is well supported by HSP Corporate Office.

Management and staff of NERC were well prepared for their review against the ten National Standards during the accreditation survey held from 1st and 2nd August 2017. They were able to demonstrate significant evidence of their achievements in improving care and services for patients.

Appropriate governance oversight of services is in place and supported by HSP Corporate Office. A well-structured Safety and Quality Plan is in place that aligns with the HSP Strategic Plan. Quality KPIs are reported to HSP quarterly and benchmarking reports are provided Nationally to rehabilitation peer groups. A committee structure is in place that links NERC with the wider HSP group to ensure effective communication links are in place.

Incidents and complaints are captured on RiskMan and reported locally to HSP Corporate Office. NERC receives very few complaints, with only two being recorded in the last 12 months. This is partly due to effective communication systems, bedside handover and patient rounding processes that attempt to address issues as they arise rather than waiting for a complaint to be lodged. Incidents on falls, pressure injuries, medication etc are actively monitored to reduce further incidents. Shared Learning Reports are used across all HSP facilities to raise awareness of incidents and to learn from the findings following Root Cause Analysis and Clinical Reviews.

All patients at risk of deterioration are appropriately transferred to other acute care hospitals locally. Management of the deteriorating patient is well managed.

The NERC site appeared well maintained and made appropriate use of space. HSP and NERC have a suite of policy and procedure protocols in place and there was strong evidence of consultation processes in place for updating policies and procedures to ensure they reflect local requirements. The Healthscope Clinical Governance, Safety and Quality and Risk Frameworks underpin governance processes to ensure organisational and clinical effectiveness, risk and safety management for staff and patients and consumer engagement.

Significant work has been completed under the leadership of the executive team to ensure the hospital's systems and processes meet the requirements of the ten National Standards. NERC governance of credentialing and scope of practice for visiting medical offices and consultants is secure and supports clinical safety and minimises risk.

Management and staff demonstrated commitment to the increasing involvement of consumers through a network of consumer representatives both at HSP Corporate office, locally and via cluster consumer representative groups to ensure the diverse needs of the community are considered when planning services. Patient focus groups commenced in May 2017 to gather informal feedback from patients on a range of topics. Numerous pathways are in use to collect information from patients and families to continuously improve services, including patient feedback and satisfaction surveys. Information gathered is proactively used to continually drive improvements across all areas of the hospital.

Visiting medical officers are also involved in strategic planning processes to ensure their needs are also considered.

Over all, the health service infection incidence is very low. Clinical and non-clinical staff demonstrated their awareness of infection control processes that ensure patient safety.

Information gathered is proactively used to continually drive improvements across all areas of the hospital. Care is of high quality with a strong focus on evidence-based, patient-centred care using numerous tools to screen, assess and monitor care and reduce patient risk. Patients are actively encouraged to participate in their care and a number of improvements have been implemented, such as the introduction of bedside clinical handover and communication boards in patients' rooms.

A system for patient identification and procedure matching is in place that complies with the national standards. The system is overseen by the Quality and Clinical Review Committee that ensure audits and system reviews findings are acted upon to improve patient safety. Patient Identification and Procedure Matching is part of the mandatory training program for all staff. A new eLearning NERC Patient Identification Process has been introduced and at the time of survey 92% of nursing staff had completed the training. Sentinel event shared learnings are used to raise awareness and outcomes arising from incidents across HSP facilities.

Audits are conducted extensively across NERC and individual departments have action plans with quality improvement projects to address their individual issues. Incidents are addressed and reported through RiskMan.

Blood and blood products are not used in the facility.

On admission patients are asked if they have an advanced care plan in place, and advanced care directives and not for resuscitation information is recorded on the HSP alert sheet in the front of the patients, bedside folder. An appropriate suite of HSP policies and procedures is in place to support advanced care directives. Nursing staff hand over directives during clinical handover to ensure staff are aware of patients' wishes.

Information is available on the NERC website on services available to the community. The information is easy to access and provides an extensive range of information and key performance information for consumers and their families.

Patients provide informed consent on a range of clinical and administrative parameters with audits showing good rates of compliance.

An effective Medication Safety Management program is in place across NERC with a suite of evidence-based organisation-wide policies and procedures relating to medication management, with the organisation utilising the National Inpatient Medication Chart. Oversight of the system is provided by pharmacy, nursing and quality committees along with further support from an HSP Medication Safety Clinical Cluster. These groups meet regularly to review medication safety KPIs, audit data and incident reports generated to identify areas for improvement. Pharmacy Services are provided by a contracted HSP pharmacy service.

Clinical handover is governed by comprehensive policies and procedures that effectively link patient identification, procedure matching and clinical handover.

NERC response to the deteriorating patient is done well, being supported by comprehensive policies and procedures and regular auditing to identify any areas for ongoing improvement.

The 2014 transitional requirements for Actions 3.10.1 and 9.6.1 are both fully met at the Satisfactorily Met level and the 2016 requirements are met for action 3.16.1. No reprocessing of reusable medical devices in health service organisations are in use; only single use items are used.

NERC performed very well at survey and staff are congratulated on their enthusiasm and achievements demonstrated during the National Standards survey. Core actions in all Standards are Satisfactorily Met. All developmental actions have been Satisfactorily Met. The survey team has changed the ratings of the following 33 Actions from Satisfactorily Met (SM) to Met with Merit (MM):

- 1.1.1, 1.1.2, 1.5.1, 1.5.2, 1.6.1, 1.9.1, 1.10.2, 1.10.4, 1.12.1, 1.14.2, 1.14.4,
- 2.1.1, 2.4.1, 2.4.2, 2.6.1, 2.6.2,
- 3.1.3, 3.1.4,
- 4.1.1, 4.12.1, 4.12.2, 4.15.1
- 5.1.1,
- 6.1.1,
- 8.1.1, 8.2.1, 8.2.2, 8.2.3,
- 10.1.1, 10.2.2, 10.2.3, 10.5.1 and 10.5.2

in recognition of the extensive work completed in this area.

The previous recommendations have been closed.

STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

NERC is part of the Healthscope group (HSP) that owns and operates hospitals and health services both throughout Australia and internationally. Being a private-for-profit organisation there is no local Board with governance provided by the Board of Healthscope. The Corporate Office of HSP holds ACHS EQuIPNational Corporate Health Services accreditation.

HSP and NERC have well established organisational-wide processes in place for the development, implementation and regular review of policies and procedures via HSP Corporate Office. A dedicated HSP Document Controller provides oversight of general, administration and hospital policies and procedures and ensures they are distributed across the organisation. During the survey, staff were able to demonstrate to the survey team their ability to access required policies and procedures, which are readily available to staff either in hard copy or on a local hard drive. These are reviewed every three years or as required if there are changes to legislation. Evidence was noted of document control, evidence of reviews, consultations, changes and endorsements of policies and procedures that includes the date the changes came into effect.

The Board of HSP provides leadership and enhances governance by providing a comprehensive policy framework for NERC and monitoring performance in line with the Australian Commission on Safety and Quality in Healthcare and key standards set by various industry peak bodies. These standards are reflected in the HSP Safety and Quality Plan and the Clinical Governance Framework 2016/2017 that enables monitoring, reviewing and enhancing safety, clinical risk management and quality initiatives across HSP.

At the local level NERC has its own Quality and Safety Plan linked to the National Plan supported by a quarterly reporting system to HSP. Organisational committees have clear and concise lines of reporting and communication and are supported by appropriate terms of reference. Minutes of meetings are captured and clearly identify actions, who is responsible for the action, and when they need to be actioned.

HSP integrated risk management framework and risk registers are well established and overseen by relevant committees. RiskMan is used to ensure a comprehensive collection and classification of risk rated data, which is available to corporate office and NERC executive staff. The local NERC register is aligned with the HSP Corporate risk register and is used to monitor and reduce the level of risk at the local level. All risks have a clearly identified owner and the tracking of risks is transparent.

Clinical practice

The hospital has a suite of clinical pathways that guides the multidisciplinary healthcare team. Pathways such as Restorative Management (9/14), Orthopaedic Rehabilitation (9/14), Reconditioning (9/14), Neurological (9/14) and cardia (9/14) were viewed by the surveyor. An annual Rehabilitation Comparative Documentation audit is undertaken with the following results viewed: August 2016 site average was 94.97% against Healthscope National average of 89% and in August 2015 site average was 96% against Healthscope National average of 89%.

Prior to admission, each patient is seen by the pre-admission nurse and has a full pre-admission assessment undertaken. A series of risk assessments are undertaken on admission and each patient is reassessed according to their risk rating and or other events/incidents.

As part of the medial records each patient has a FRAT, pressure injury assessment, and malnutrition risk assessment. Allied health staff undertake hydrotherapy risk assessments, psychology risk assessments and OT home assessments.

Based on the results of the risk assessments, relevant equipment is provided to each patient, and an alert is placed on the front page of the medical record. Any incidents or near misses are recorded and managed via RiskMan.

A well-established MET call system is in place with any deteriorating patient transferred out to an acute hospital for further management. The hospital transfers 1 to 2 patients / month. All clinical staff undertake mandatory education on emergency code blue. Code blue mock exercises are also undertaken as are visitor initiated emergency call systems.

Patient records are readily available at the point of care; all records are securely stored and maintained as per record management standards. WebPas electronic system is in use to track all medical records and can be used to request patient records. All medical records are stored onsite for a period of 1 year and are then stored off site at nearby La Trobe Private Hospital, so therefore can easily be retrieved. Annual documentation audits are undertaken with the more recent results being the August 2016 site average of 94.97% against the Healthscope National average of 89% and the August 2015 site average of the 96% against Healthscope National average of 89%.

There is a system of reporting on safety and quality indicators that is reviewed by the executive level of governance. For example, the quarterly KPI summary compares indicators to HSP targets, with the NERC required to investigate and report on all adverse trends including a comparison to ACHS targets.

RiskMan and the Risk Register are utilised to capture clinical and non-clinical risks, incidents and feedback. Data is regularly reviewed and used to enhance quality and safety systems at the NERC.

Actions implemented over the past two years to enhance quality and safety include the introduction of patient rounding by nursing staff, increased patient involvement in clinical handover, purchase of new equipment such as hoists and bariatric mobility aids and the installation of wall protection at the bedhead of all Waratah patient beds.

Performance and skills management

The policy framework for Performance and Skills Management is provided by HSP. HSP also provides a centralised Human Resource Management service.

An organisation chart, position descriptions detailing clinical governance reporting lines and relationships, and a comprehensive Mandatory Training and Orientation Program are in place at NERC.

New procedures are managed in line with the HSP Safe Introduction of New Interventional Procedures. An example noted of a recent change was the introduction of new Ketamine Therapy Administration Pumps. All relevant staff completed assessments, training and competencies prior to the use of the new pumps. The introduction of the pumps has seen a significant reduction in the number of medication incidents and has been actively embraced by staff.

A register of credentialed healthcare medical practitioners is maintained on WebPas with files stored on a Credentialling Internet program. Oversight of the system is provided by HSP and the local MAC committee that ensures all medical staff have the appropriate qualifications and training requirements prior to granting of clinical privileges.

A new system for performance appraisal reviews has been introduced since the last ACHS event. Completion rates of performance appraisal reviews are monitored quarterly by the leadership team and department managers to ensure that they meet the HSP's expected KPI. There is an Education Plan in place linked to performance reviews.

A contract is in place with the provider of Nursing Agency staff that specifies the qualifications, experience and training required for employment at NERC. Agency staff represent a very low percentage of total nurse staffing.

Incident and complaints management

The policy framework for incident and complaints management is provided by HSP.

Incidents and complaints are very well managed. RiskMan with RiskMan extensions are in use and guided by HSP incident management policy, procedures, protocols and tools, incident management reporting and escalation tools, incident severity assessment tools (RiskMan Profiler), and there is a committee structure responsible for assessing severe and trended incidents. Complaint response times are monitored by HSP KPIs with NERC demonstrating a 100% compliance rate with the Health Services Commission's timeframes.

This is supported by sessions on Risk Management and RiskMan in the Orientation and Mandatory Training Programs. The information from RiskMan and the Risk Register is referred to the National Risk Manager. Interviews with staff confirmed an awareness of their responsibilities in reporting risk and knowledge of how to use RiskMan.

The hospital has had only two complaints in the past year. Both were investigated via the RiskMan system. One complaint was tracked by the surveyor to confirm that it had been managed satisfactorily.

Initiatives for improving and strengthening the system include the introduction of patient rounding, bedside clinical handover, installation of patient boards in patients' rooms and inpatient focus groups.

All staff receive education and training on RiskMan at orientation and have regular updates on outcomes arising from sentinel and adverse events via the quarterly Shared Learning Report.

Complaint staff training is available from the Corporate National Quality Manager.

Patient rights and engagement

HSP policy 2.16 Rights and Responsibilities - Patients and HSP brochure- Rights and Responsibilities are available and also in the bedside compendium (both viewed by surveyor). This brochure is placed in an admission pack for all patients.

In 2017, a new information channel for all patient TVs was been introduced and has been evaluated and readily accepted by patients. The patient brochure on Rights and Responsibilities has been translated into several languages (all three viewed by surveyor).

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Patients' understanding of their rights and responsibilities is measured through patient satisfaction surveys. A review of completed surveys from October 2016 - March 2017 indicated that 100% of patients understood their rights and responsibilities.

Patients are assessed for cognitive or communication difficulties prior to being deemed appropriate for admission – Pre-admission Assessment HMR 4.5B.

The Mandatory Training Program includes Open Disclosure, Patients' Rights and Customer Focus. Patients are provided with a brochure on Advance Care Planning and Enduring Power of Attorney, where appropriate.

Governance and quality improvement systems

Ratings

Action	Organisation	Surveyor
1.1.1	SM	MM
1.1.2	SM	MM
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	MM
1.5.2	SM	MM
1.6.1	SM	MM
1.6.2	SM	SM

Action 1.1.1 Core

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

Surveyor Comment:

An excellent system is in place for the management and continual review of policies and procedures, this is fully supported by Healthscope Corporate office and aligned with local needs at NERC. An extensive suite is readily available to all staff, all changes to policies and procedures are communicated to staff and inform them of what has altered in updates to ensure staff are aware of the implications. Local clinical cluster groups also provide input to ensure they meet local needs.

It was evident that NERC ensure that safety and quality indicators are regularly reported and monitored by the executive and corporate office. Safety and quality indicators are collected from all areas of the organisation and are used to continually drive further improvement. Indicators are regularly evaluated and refreshed as a part of day-to-day operations.

Examples of improvements to policies and procedures were noted in areas such as the HSC Pressure Injury Prevention policy following an in-depth review by the National Pressure Injury Working Party. The information collected is continually used to analyse and improve policies and procedures such as changes to the pressure injury policy and procedure.

A met with merit is supported.

Surveyor's Recommendation:

No recommendation

Action 1.1.2 Core

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

Surveyor Comment:

NERC business planning processes explicitly capture safety and quality strategies and initiatives. Business planning processes are aligned with the wider Healthscope; this alignment ensures that the organisation has clear direction and accountability for safety and quality activities that match those of the wider group.

Improvements since the last ACHS event include the appointment of a Professor of Clinical and Rehabilitation Practice and A Professor of Nursing – Research. These appointments now ensure clinical practice changes are based on up to date research outcomes.

All the requirements of satisfactory performance were met; improvements were noted in all relevant parts of NERC. They are sustainable and part of day to day operations.

A met with merit rating is supported.

Surveyor's Recommendation:

No recommendation

Action 1.5.1 Core

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

Surveyor Comment:

A Healthscope organisational-wide risk register is in use, NERC aligns with the register and also captures and monitors local risks on RiskMan. All the requirements of satisfactory performance are met and the management of risk and risk registers are apparent in all areas of the organisation and subject to regular review and updates. Risk and incident data are trended and benchmarked with a peer group within Healthscope.

A met with merit rating is supported.

Surveyor's Recommendation:

No recommendation

Action 1.5.2 Core

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

Surveyor Comment:

Significant effort is taken to ensure that risks to patients, visitors and staff are minimised and actively addressed. Quality action reports contain actions plans aligned with relevant risks and are subject to regular review and updates. It was evident that this is the culture of NERC as it was noted to be embedded into all parts of the organisation and has been sustained over a long period of time.

Examples of improvements taken since the last ACHS event include the appointment of a new Rehabilitation Physician that enhances the care of patients while rehabilitating by helping them to achieve an optimal level of performance and improve their overall quality of life.

A met with merit rating is supported.

Surveyor's Recommendation:

No recommendation

Action 1.6.1 Core

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

Surveyor Comment:

The organisation-wide quality management system is used and regularly monitored and meets all the requirements for satisfactory performance. Improvements are evident across all areas of the health service, are sustainable and built into day-to-day operations. It was evident to the survey team that a strong culture of striving to continually improve is well embedded and enhances patient safety and quality of care.

A met with merit rating is supported for 1.6.1.

Surveyor's Recommendation:

No recommendation

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	MM
1.9.2	SM	SM

Action 1.9.1 Core

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

Surveyor Comment:

It was observed by the surveyor that the patient medical records are readily accessible for the workforce at the nurse's station, with active medical records available at the bedside. All medical records are stored onsite for a period of 1 year and are then stored off site at nearby La Trobe University hospital, so therefore can easily be retrieved. Annual documentation audits are undertaken with the more recent results being:

- August 2016 site average was 94.97% against Healthscope National average of 89%.
- August 2015 site average was 96% against Healthscope National average of 89%.
- In 2014 site average was 95% against Healthscope National average of 88%.
- In 2013 site average was 93% against Healthscope National average of 89%.

Based on these excellent sustainable results a met with merit has been granted.

Surveyor's Recommendation:

No recommendation

Performance and skills management

Ratings

Action	Organisation	Surveyor
1.10.1	SM	SM
1.10.2	SM	MM
1.10.3	SM	SM
1.10.4	SM	MM
1.10.5	SM	SM
1.11.1	SM	SM
1.11.2	SM	SM
1.12.1	SM	MM
1.13.1	SM	SM
1.13.2	SM	SM

Action 1.10.2 Core

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

Surveyor Comment:

Mechanisms are well embedded into practice that ensure clinical staff are working within their scope of practice. Examples noted on survey include new competencies for nursing staff following the introduction of new Ketamine Therapy Administration Pumps.

These have been evaluated, are evident across the organisation and are part of day-to-day operations to warrant a met with merit rating.

Surveyor's Recommendation:

No recommendation

Action 1.10.4 Core

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

Surveyor Comment:

An effective system is in place for defining the scope of practice and is evident whenever a new clinical service, procedure or other technology is introduced. The most recent example was the introduction of new Ketamine Infusions that improved patient satisfaction and had a positive impact on the number of medication incidents.

The process is evident across the service, has been evaluated and is part of day-to-day operations.

Surveyor's Recommendation:

No recommendation

Action 1.12.1 Core

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

Surveyor Comment:

The clinical and non-clinical workforce have ready access to education and training. There is an extensive suite of educational material available to all staff and is continually evaluated and updated to reflect changing needs and staff requirements. An example of this noted by the survey team include the introduction of a ‘dry needling’ course for physiotherapists, the course was fully evaluated post implementation.

A met with merit rating is supported.

Surveyor's Recommendation:

No recommendation

Incident and complaints management

Ratings

Action	Organisation	Surveyor
1.14.1	SM	SM
1.14.2	SM	MM
1.14.3	SM	SM
1.14.4	SM	MM
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

Action 1.14.2 Core

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

Surveyor Comment:

Systems are in place to analyse and report incidents such as Committee meeting minutes (Quality) that demonstrated that incidents are discussed, analysed and trended. Any national safety and quality KPI outliers have an action plan put in place with learnings shared within the organisation. Risk management and controls are reviewed following all incidents and near misses.

Met with merit is supported.

Surveyor's Recommendation:

No recommendation

Action 1.14.4 Core

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

Surveyor Comment:

Following a review of incidents, they are investigated with corrective action implemented and following analysis and trending, preventative action is put in place with changes to practice introduced, if necessary. An example of recent changes to practice being made following review of incident trends is the introduction of CADD pumps for subcutaneous Ketamine infusions.
Met with merit is supported.

Surveyor's Recommendation:

No recommendation

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

The policy framework provided by HSP is supported by the NERC Consumer Representative Meeting and Standard 2 local champion (Quality Manager). NERC Consumers have also been part of the HSP Corporate Consumer Group for the past two years and they attend local HSP Consumer Participation Cluster Groups.

NERC Community Representatives are members of a number of local initiatives. The representatives are involved in reviewing outcomes of patient satisfaction surveys, patient focus groups and other patient related feedback. Feedback from the committee is used to inform quality improvement across the organisation.

Consumers are actively involved in the planning of their individual rehabilitation goals and care planning. Audit data arising from a National Stroke survey indicated that 'Goals set with input from team and patient' was 100%, which exceeds the national benchmark average.

The team met with some consumer representatives, who were well informed about the organisation's safety, quality and management initiatives, and confirmed their involvement at all levels. Consumer representatives tend to have had wide-ranging backgrounds.

Publications such as the NERC Internet site and local TV channel have been reviewed by consumers to ensure they meet HSP literacy requirements.

All new consumers are supported on appointment with a comprehensive orientation program and are supported by a key person while in their roles. The HSP Corporate Office provide a comprehensive training package that includes information on patient-centred care.

Consumer partnership in designing care

Consumers are regularly invited to forums to discuss care delivery and their experiences. Recent forums include the newly introduced consumer inpatient focus groups where feedback is informally sought over a cup of tea.

Consumers were consulted prior to the refurbishment of the Manor House gym area and day room to ensure they aligned with their needs. Notices have been removed from some walls ready for the introduction of art work that will make the facility more 'home like' and rehabilitation programs have been reviewed and changed as a result of patient satisfaction surveys.

Staff receive training on consumer engagement as part of the mandatory online training, and NERC Consumer Representatives attend new staff orientation. A Corporate Consumer Representative was involved in the review of the content and training package for staff on Patient-Centred Care.

Consumer involvement in service measurement and evaluation

The survey team noted consumer involvement in a range of quality activities such as: planning for the introduction of iCook, the evaluation of bedside clinical handover, the development of open charts and patient journeys.

As an outcome of the work of the organisation in engaging consumers via committees, forums and survey, changes have been made to publications, patient whiteboards, electronic feedback surveys and open patient charts.

Further detail at the action level is provided to support the elevation of Action 2.1.1 to MM rating.

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	MM
2.4.2	SM	MM

Action 2.1.1 Developmental

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

Surveyor Comment:

Significant work has been completed to ensure consumers are involved in the governance of the service, including HSP Corporate Consumer Representatives and local Consumer Representatives. There are distinct links between the NERC consumers and HSP Corporate.

It was evident that partnering with consumers is well embedded into practice, is part of day-to-day activities and that the framework is sustainable.

A met with merit is supported.

Surveyor's Recommendation:

No recommendation

Action 2.4.1 Core

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

Surveyor Comment:

A systematic process for engaging and gathering consumer feedback in the development of consumer publications and HSP website was evident. The engagement strategy has been evaluated and has been in practice for a period of time and is sufficiently embedded into practice to support a met with merit rating.

Surveyor's Recommendation:

No recommendation

Action 2.4.2 Core

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

Surveyor Comment:

Evidence was noted by the survey team of the effectiveness of consumer feedback into publications and the website. This was further confirmed with consumers during face-to-face meetings. Numerous changes have been implemented as a result of consumer input, these include updates to written information for patients on the new CADD pumps.

A met with merit is supported.

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	MM

Action 2.6.1 Core

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

Surveyor Comment:

It is evident in all education material developed for clinical and non-clinical staff that there is a focus on ensuring that a patient centred approach is always considered. This is further supported by regular shared learning reports that highlight outcomes of sentinel and adverse events across HSP facilities to raise awareness of impacts to patient safety and quality.

Improvements noted by the survey team include the strategies for improving pain management for patients that included staff education and training and the introduction of Tai Chi. Evaluations completed post implementation support the positive effect of the changes.

A met with merit is supported.

Surveyor's Recommendation:

No recommendation

Action 2.6.2 Developmental

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

Surveyor Comment:

Consumers and/or carers are involved in training of the clinical workforce at NERC. This is evident both at HSP Corporate Office and locally, and has been well embedded into practice and evaluated to support a met with merit rating.

Improvements noted since the last ACHS event include the addition of patient journeys and 'mystery shoppers'. Mystery shoppers provide honest feedback on the patient experience as a method of improving services. Evaluations to date indicate the effectiveness of the process that have led to further positive outcomes for patients and their families. This information is used for staff education and trainings and to raise awareness.

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

There is an effective governance framework for the collection and reporting of infection prevention, control and surveillance data through to the Infection Control, MAC, Leadership and Quality Committees for their discussion, action and feedback.

The organisation is supported by Healthcare Infection Control Management Resources (HICMR) which provide best practice and evidence-based policy and practice guidelines along with on-site consultancy. This platform of support and resources provides guidance to the clinical staff in the updating of action plans and the introduction of changes to practice; for example, changes with AS4187 that support the management of preventing and controlling healthcare-associated infections. However, there is no sterilisation of reusable instruments at NERC, only single use items are used.

The hospital aligns its local policies with HSP Corporate policies and procedures and has its own Infection Control Coordinator who works one day per fortnight.

ACHS and HSP clinical indicator data are collected and benchmarked. The ACHS indicators include VRE infection rates within non-ICU, with infection rates showing 0% in the second half of 2016 as per the ACHS Peer Group Comparison Report.

NERC has a comprehensive Infection Prevention & Control program in place with all elements of the core and developmental actions of this standard met.

HICMR delivers a risk assessment plan (which is reviewed annually) that addresses all areas of the hospital, such as the clinical ward, catering, cleaning, allied health, staff health, maintenance, hydrotherapy and clinical waste. The following audit tools are also utilised: admission screening, staff health, hand hygiene, clinical waste, AMS, linen management, cleaning, ANTT, and invasive devices.

All audit results and risk assessment results are reported to the IPC Committee and Quality Committee and escalated to Leadership and MAC when necessary. The risk assessments are reviewed by the GM and sent to the relevant departments where an action plan is developed and implemented. Risk assessment results are rated and repeated if lower than optional compliance is noted.

Infection prevention and control strategies

Infection prevention is a standard agenda item on both ward-based and other relevant committee meetings and staff are regularly updated on outcomes and updated policies. Evidence was provided of staff being informed of changes to policy.

Risk assessments are completed in each department to assess compliance with infection control guidelines. These are further supported through regular auditing and where less than favourable outcomes are noted, action plans are developed and implemented to improve outcomes.

Compliance with Hand Hygiene guidelines is monitored regularly and reported on the hospital website and benchmarked with HSP hospitals. All staff complete hand hygiene eLearning. Hand hygiene audit results are submitted quarterly to HHA. The hospital has two gold star auditors.

AMS is included in the IPC committee with an ID physician and pharmacist available for consultation as required.

All IC incidents are reported, monitored and reviewed using RiskMan. All Blood and Body Fluid Exposure Incidents (BBFEI) are reported to HICMR, who are available 24/7 for counselling and advice. There have been only 3 BBFEI since 2014-2017.

The hydrotherapy pool has water testing and microbial analysis undertaken, and results are discussed at the IPC.

Monthly surveillance reports are reviewed by the HICMR consultant and IC coordinator and outcomes reported to IPC. Results indicate that an effective program is in place with just one surgical site and one CDiff infection from 2015-2017.

HH audits are conducted quarterly, and data reviewed for each department and actioned in areas of poor compliance. For example, a medical practitioner with poor compliance was reported to MAC.

There is a workforce immunisation program in place.

A review of the ward area indicated that there is an ample supply of PPE with a transmission based precautions pack also available.

The only invasive devices used in the hospital are the occasional IDC and IV cannula. Invasive device mandatory education is undertaken by all staff. Invasive device audits for 2017 indicate 100% compliance.

All clinical staff undertake ANTT competency based training. Competency based training for ANTT peripheral IV and Central lines, IDC insertions and simple wound dressings is in place.

Cannulation is undertaken by the medical staff while pathology services undertake venepuncture procedures. A risk assessment of medical staff has been undertaken with an action plan developed to audit medical staff using the ANTT tool.

Managing patients with infections or colonisations

The management of patients with infections or colonisations, or patients identified as high risk, commences as part of the pre-admission procedure ensuring that appropriate accommodation and management plans are put in place. HICMR assist in ensuring compliance and strategies to improve compliance when required. The organisation has a range of education material for patients and visitors on infection control principles and how they can assist the organisation to maintain these.

There are policies and procedures for standard and transmission based precautions available to the workforce. Compliance with these precautions is monitored via risk assessments, for example results of a recent PPE audit demonstrated an 82% compliance rate in 2017, while a waste and sharps audit demonstrated an 86% compliance rate in June 2017.

Robust systems and processes are in place for the admission of patients: all patients undergo a pre-admission assessment to determine the presence of any known infections prior to admission that enable suitable plans to be developed based on the patients' needs. A patient's infection status is also discussed at clinical handover and documented on the clinical handover sheet.

Action is taken where necessary; for instance, a delivery of linen audit in February 2017 indicated 30% compliance, and an action plan has been implemented with ongoing monitoring being undertaken.

Any patient with an infection who is transferred to another facility would have it documented on the transfer documentation.

Antimicrobial stewardship

The organisation has appropriate systems and processes to comply with the antibiotic stewardship requirement. HICMR policies are in place to support antimicrobial stewardship and HSP policies. Prescribing guidelines, policies and procedures are in place, and records of antibiotic consumption are reviewed by Pharmacy.

Regular IPC meetings are held and are attended by the Antimicrobial Team (ID physician, pharmacist and HICMR representative) and has appropriate terms of reference in place. AMS is a standing agenda item at all meetings.

Staff have ready access to therapeutic guidelines and there is a list of restrictive antibiotics included in the hospital policy. HICMR undertake annual audits with the results for 2015 being 93%, May 93% and April 97%.

Educational programs address antimicrobial usage, development of resistance, and judicious prescribing. Improvements noted in 2017 included the addition of the ID physician to the AMS team and staff access to AMS education modules.

Cleaning, disinfection and sterilisation

No sterilisation or reprocessing of instruments takes place in the hospital. Only single use items are used; this was verified through visits to sterile store areas. Reusable equipment audits are undertaken with data showing 70% compliance in Dec 2016 and 80% compliance in 2017.

A significant overhaul of the environmental cleaning program took place in 2016 due to poor cleaning audit results (35%). As a result, a number of improvements have been implemented such as changes to rubbish collection, employment of new staff, the introduction of new cleaning trolleys and new cleaning schedules. Compliance in cleaning compliance continues to rise and is currently between 75% and 83%, and staff are encouraged to continue this upward trend.

Communicating with patients and carers

The organisation communicates information on the prevention and control of healthcare associated infections through its website, brochures, pamphlets and clinical handover. Patient fact sheets are available on subjects such as VREM, CDiff and MRSA infection control. The patient bedside compendium includes information on infection control.

The consumer representatives are involved in reviewing the information provided to patients and carers. International Infection Prevention Week is held annually to raise awareness for patients, families and staff.

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	MM
3.1.4	SM	MM
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

Action 3.1.3 Core

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

Surveyor Comment:

All HICMR risk assessments are reported to IPC & Quality Committee and escalated to Leadership, if necessary.

All risk assessments are reviewed and signed off by the GM.

Risk reports are sent to the relevant department and actioned when necessary. The results will determine when reassessment is deemed necessary 90 – 100% assess annually; 80 – 89% six monthly; 70 – 79% four monthly and <70% every two months.

A met with merit rating is supported.

Surveyor's Recommendation:

No recommendation

Action 3.1.4 Core

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

Surveyor Comment:

All HICMR assessments are conducted by HICMR IC Consultant. All risk assessments are reviewed by the IC Coordinator GM and relevant departments. An action plan is completed by the department and sent back to the ICC with the results discussed at relevant meetings.

A review of the risk assessments undertaken for all areas demonstrate an improvement in compliance overall for 2015 data and 2016 data.

Clinical 2015 – 90% and in 2016 90%.
Allied Health 2015 – 94% and in 2016 96%.
Environmental 2015 – 89% and in 2016 90%.
Food Services 2015- 90% and in 2016 89% (action plan sighted and implemented).
Clinical waste 2015 – 90% and in 2016 90%.
Hydrotherapy 2015 – 94% and in 2016 92% (action plan sighted and implemented).
Facility wide 2015 – 95% and in 2016 94% (action plan sighted).

A met with merit rating is supported.

Surveyor's Recommendation:

No recommendation

Infection prevention and control strategies

Ratings

Action	Organisation	Surveyor
3.5.1	SM	SM
3.5.2	SM	SM
3.5.3	SM	SM
3.6.1	SM	SM
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 3.10.1 Core

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

Surveyor Comment:

All clinical staff undertake ANTT competency based training.

Competency based training for ANTT peripheral IV and Central lines, IDC insertions and simple would dressings is undertaken.

Cannulation is undertaken by the medical staff. Pathology services undertake venepuncture procedures.

A risk assessment of medical staff has been undertaken with an action plan developed to audit medical staff using ANTT tool.

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:

No sterilisation/reprocessing is done at this hospital. All instruments used are single use, therefore are disposable. This equipment was observed by the auditor in the sterile stock room; reusable equipment such as BP cuffs have a cleaning schedule in place.

Audit results for this reusable equipment are as follows:
- May 2015 - 42%;
- December 2015 - 62%;
- December 2016 - 70%; and
- June 2016 - 80%.

The surveyor also observed that alcohol wipes and alcohol rub was stored with each BP machine.

Surveyor's Recommendation:

No recommendation

Action 3.17.1 Core

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

Surveyor Comment:

No sterilisation of instruments/reprocessing is undertaken in the hospital.

Only single use disposable equipment is used such as nurse’s scissors and staple removers, which were observed in the sterile store room.

Surveyor's Recommendation:

No recommendation

Action 3.18.1 Core

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

Surveyor Comment:

As no sterilisation of instruments takes place, it is not necessary that staff are trained in decontamination and sterilisation processes.

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: North Eastern Rehabilitation Centre
Orgcode: 225166

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

Across NERC there was evidence of governance processes through a well-led multidisciplinary pharmacy committee and a Medication Safety Cluster Committee. Both groups understand their roles and responsibilities and it was apparent that there are appropriate reporting lines to the Leadership team and Medical Advisory Group. The HSP Safety and Quality KPI program includes indicators for medication safety. All medication safety alerts are reviewed by the pharmacy committee.

All medication incidents are captured, monitored and reviewed to identify areas for improvement. Staff demonstrated their awareness of the process for reporting incidents on RiskMan. Senior staff and nurse unit managers are informed via email when incidents are logged on RiskMan and regular medication incidents reports and trends are provided to the pharmacy committee.

The Hospital Pharmacy Service (HPS) is a contracted onsite service that provides a well-monitored service and oversight through the Healthscope cluster meetings.

Education is provided to all levels of staff and includes annual mandatory competency training and in-service by the NERC Quality Manager, Educators and HSP staff. All staff complete an online medication safety program (Medsafe) and attendance is captured on ELMO.

There is a suite of evidence-based policies and procedures in relation to medication management that is consistent with national and jurisdictional legislative requirements. The policies cover medication management and the organisation uses the national inpatient medication chart (NIMC) with medication allergies documented on the NIMC, and on the alert sheet at the front of the record.

A range of tools is used for assessing the medication management system including audits, RiskMan incident reporting, HSP shared learnings and ACHS Clinical Indicators.

Medication is prescribed and administered within the recognised scope of practice for all levels of staff and this includes enrolled nurses.

Improvements since the last ACHS event include the introduction of tamper proof Ketamine infusion pumps along with updates to policies and procedures and the introduction of a medication incident reflective reporting tool. Improvements were also noted in ensuring that medical practitioner phone orders are signed within 24 hours. Compliance in April and June 2017 was 100%, which is an excellent result.

Documentation of patient information

It is evident that staff work diligently to ensure that the best possible medication history is documented for all patients. A Clinical Pharmacist undertakes reconciliation processes for all patients; DVA and patients on high risk medications are given priority.

A medication management plan is kept with the National Inpatient Medication Chart and it is readily available at the point of care in a bedside folder. Two audits completed in late 2016 indicated that 100% of patients had a completed Medication Management Plan (MMP) in place (where appropriate) and 100% of patients had all pre-admission medications listed on the MMP.

Any adverse drug reactions are reported to the Therapeutic Goods Administration.

All patients requiring medications on discharge are provided with a medication discharge profile, this outlines the current medications that they are taking, side effects and how to take them. GPs are also give information on patients' medications on discharge.

Regular education and training is provided for clinical staff; this includes staff education following the introduction of the new CADD pumps, a pain program for medication management and the use of the National Inpatient Medication Chart.

Medication management processes

Information and decision support tools are readily available for staff and are regularly reviewed and updated. Staff have ready access to educational resources such as Mims, eMims, therapeutic guidelines, Dynamed and HICMA.

Storage of medications is compliant with required standards and temperature sensitive medicines are monitored appropriately. Regular auditing and testing of fridges occur to ensure that they working properly and an alert system is in place should a system failure occur.

Destruction of dangerous drugs is carefully managed through strict protocols and the audit book for destruction of these drugs provides evidence that this is done well. The discarding of out of date stock in appropriate bins is safe and meets the required standards. Wastage is monitored through impress reviews and medicines that are close to their expiry date are clearly labelled. Regular audits of Schedule 4 & 8 medications are undertaken.

TallMan lettering is used and medications with similar names are not stored next to each other in the ward medication room.

Continuity of medication management

A medication management plan is available and a current list of medications is provided to the patient by staff with explanations as appropriate at handover and via discharge documentation.

Medications are reviewed during clinical handovers at the patient's bedside using the ISOBAR system as a prompt. Audits of clinical/bedside handovers in June 2017 demonstrated a 98% compliance rate - an excellent result. Patients and carers are provided with a currant medicine list on discharge and a process is in place if there is a risk that patients may not understand the information being provided. Carers or family members are included in discharge planning processes where appropriate to reduce medication incidents on discharge.

Communicating with patients and carers

A clinical pharmacist provides patients with verbal and written information on medications to enhance patients' understanding of their medications and answers any queries that they may have. Additionally, if the pharmacist provides education on warfarin to a patient and/or their family, they will document this in the medical record.

Patient information is regularly reviewed, and this includes a patient and carer educational brochure on medication safety.

NSQHSS Survey

Organisation: North Eastern Rehabilitation Centre
Orgcode: 225166

Patients participate in patient satisfaction surveys and are asked a couple of questions related to their medications. Results of surveys indicated that 100% of patients were satisfied with the explanation of their condition, medication and treatment and 100% were satisfied with information provided to them on discharge on their medication.

Governance and systems for medication safety

Ratings

Action	Organisation	Surveyor
4.1.1	SM	MM
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

Action 4.1.1 Core

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

Surveyor Comment:

Excellent governance processes are in place to support the development, implementation and maintenance of medication safety systems. Systems are well managed with appropriate oversight. Key performance indicators are used to benchmark with HSP peer groups, and Medication Cluster Committee meetings are in place to ensure the sustainability of the system.

A number of improvements have been implemented following analysis of the data, these include the separation of intravenous and intramuscular medication to reduce the risk of administering via the wrong route. Evaluation of the system has indicated the effectiveness of the change.

A met with merit rating is supported.

Surveyor's Recommendation:

No recommendation

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	MM
4.12.2	SM	MM
4.12.3	SM	SM
4.12.4	SM	SM

Action 4.12.1 Core

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

Surveyor Comment:

An excellent system is in place to support and generate accurate and comprehensive medicines lists for patients when being transferred. The pharmacy oversees the system and ensures that relevant information is readily available for all patients and that the information is recorded on the Medication Management Plan.

The system is well embedded into practice, is sustainable and has been evaluated and adjusted according to the findings.

A met with merit is supported.

Surveyor's Recommendation:

No recommendation

Action 4.12.2 Core

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

Surveyor Comment:

An excellent system has been implemented that provides accurate and comprehensive medicine lists to patients on discharge. The pharmacy is responsible for ensuring all relevant patients are provided with information that is in a format that is understandable and includes information on alternative drug names, risks and side effects.

The system is across all areas, is sustainable and has been evaluated with consumer input. Outcomes of the evaluation indicate that patients are very satisfied with the system and that it provides clear instructions regarding their medications.

A met with merit rating is supported.

Surveyor's Recommendation:

No recommendation

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	MM
4.15.2	SM	SM

Action 4.15.1 Developmental

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

Surveyor Comment:

Information is readily available in a format that is understandable and meaningful. Consumers are involved in the development of all written patient information to ensure it is appropriate and in line with HSP guidelines. Regular evaluations that include audits and surveys are used to ensure literacy requirements are continuously met.

A met with merit rating is supported.

Surveyor's Recommendation:

No recommendation

Organisation: North Eastern Rehabilitation Centre
Orgcode: 225166

STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

The hospital has a suite of HSP policies to guide clinical practice. All policies were current and referenced. The hospital uses 4 identifiers instead of the Standard 3 and has added this to the risk register to ensure regular oversight of the system is provided. Annual audits are undertaken with the most recent audits in 2017 and 2016 both showing 98% compliance.

The patient identification process was observed by the surveyor to be consistently correct during the bedside clinical handover process. HSP has introduced a standardised labelling system for patient arms bands which is now completed using WebPas using 4 identifiers. An audit of compliance following the introduction of WebPas shows a 100% compliance rate.

Outpatients are also appropriately identified and this process was observed in the hydrotherapy area.

Processes to transfer care

If a patient is transferred to another facility an inter-hospital transfer form is completed which includes the patient identification process.

Regular audits of patient identification processes are in place and include; bedside clinical handover, medication administration, attendance at hydrotherapy and for patients being transferred.

Processes to match patients and their care

A medication administration process according to the seven rights of medication administration including the "correct patient" indicated 98% compliance in a June 2017 audit.

Any incidents are managed via the RiskMan system, investigated, trended, actioned, and reported to the Quality committee for analysis, discussion and any resultant changes to practice are communicated to staff.

The hospital meets all core and developmental actions for this standard.

Identification of individual patients

Ratings

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

Action 5.1.1 Core

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

Surveyor Comment:

A suite of current, referenced HSP policies are available to guide staff in relation to correct patient identification. These policies were reviewed between 2015-2016. Any incidents in relation to patient identification would be managed via RiskMan system.

Audits are undertaken with 98% compliance achieved in 2016 and in 2017.

WebPas allocates each patient a UR number. The hospital has 4 identifiers as its policy, name; UR; DOB and gender.

Due to the recent introduction of the PSA role, a PSA ID audit has also been undertaken with 100% compliance.

Based on the excellent audit results consistently achieved a met with merit rating is supported.

Surveyor's Recommendation:

No recommendation

Processes to transfer care

Ratings

Action	Organisation	Surveyor
5.4.1	SM	SM

NSQHSS Survey

Organisation: North Eastern Rehabilitation Centre
Orgcode: 225166

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

STANDARD 6
CLINICAL HANDOVER

Surveyor Summary

Governance and leadership for effective clinical handover

Policies, audit reports and minutes indicate that the clinical handover of patients across the service meets required actions and national specifications.

A NERC nursing handover report is generated from WebPas for all patients. This is an up to date working document with all staff including allied health staff able to update patient information as it happens.

WebPas has been a new improvement to the handover process; it provides information using ISOBAR such as clinical diagnosis, relevant past history, current clinical history, risks, investigations and discharge plan.

Nursing discharge summaries are also generated from WebPas, with monthly "dashboard" reports that demonstrate levels of compliance with policies and procedures. The reports are reviewed by the management team and reported to committee meetings.

Clinical handover processes

Staff have ready access to documented structured processes for clinical handover as per the HSP Clinical Handover Framework. The surveyor observed the clinical handover process in the ward area between AM and PM nursing staff and noted that staff followed the processes correctly. This includes an additional handover from one manager to another to ensure they are fully informed of changes in patients' conditions.

Quarterly clinical handover audits are used to check staff compliance; the most recent report noted in June 2017 demonstrating a 79% compliance rate, which is slightly less than optimal.

An action plan has been developed and further education of staff planned.

All clinical handover incidents are registered on RiskMan, however there have been no incidents to date.

Nurse discharge summaries are provided to patients at discharge and also sent to the patient's General Practitioner. Incident reports are reviewed and trended by Leadership staff, quality and Clinical Review and departmental committees.

Patient and carer involvement in clinical handover

The team attended one handover, with the patient's consent. A structured process was followed, with appropriate interaction between staff and patient. Staff utilise communication boards for clarity and to inform patients, visitors and staff of arrangements and appointments. The large boards have been well received, and the team noted they are utilised appropriately.

Patient satisfaction surveys indicate that they are 100% "involved in decisions about their care and treatment".

The hospital meets all core and developmental actions for this standard.

Governance and leadership for effective clinical handover

Ratings

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

Action 6.1.1 Core

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

Surveyor Comment:

A suite of current (dated 2014 - 2016) referenced policies guides staff practices in relation to the clinical handover process.

NERC nursing handover report generated from WebPas.

This is an up-to-date working document with all staff able to update patient information as it happens, including allied health staff.

At 9am each day, a multidisciplinary clinical handover is undertaken with all nursing and allied health members of the team. During this clinical handover, progress is monitored and the discharge plan reviewed.

Nursing discharge summaries are generated from WebPas, with monthly "dashboard" reports obtained that demonstrates compliance, which are monitored by the management team and reported to committee meetings.

A quarterly clinical handover audit is undertaken.

Improvements added to clinical handover since the last ACHS event include, updating staff education, displaying of audits results across areas of the hospital for patients staff, the introduction of a bedside clinical handover video for patients and the introduction of a new eLearning clinical handover program for staff.

Due to the consistent approach to the clinical handover process and the improvements made to the handover report with the introduction of WebPas, a met with merit is supported.

Surveyor's Recommendation:

No recommendation

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: North Eastern Rehabilitation Centre
Orgcode: 225166

STANDARD 7
BLOOD AND BLOOD PRODUCTS

Surveyor Summary

This standard is not applicable to North Eastern Rehabilitation Centre.

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

Ratings

Action	Organisation	Surveyor
7.1.1	N/A	N/A
7.1.2	N/A	N/A
7.1.3	N/A	N/A
7.2.1	N/A	N/A
7.2.2	N/A	N/A
7.3.1	N/A	N/A
7.3.2	N/A	N/A
7.3.3	N/A	N/A
7.4.1	N/A	N/A

Documenting patient information

Ratings

Action	Organisation	Surveyor
7.5.1	N/A	N/A
7.5.2	N/A	N/A
7.5.3	N/A	N/A
7.6.1	N/A	N/A
7.6.2	N/A	N/A
7.6.3	N/A	N/A

Managing blood and blood product safety

Ratings

Action	Organisation	Surveyor
7.7.1	N/A	N/A
7.7.2	N/A	N/A
7.8.1	N/A	N/A
7.8.2	N/A	N/A

Organisation: North Eastern Rehabilitation Centre
Orgcode: 225166

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
7.9.1	N/A	N/A
7.9.2	N/A	N/A
7.10.1	N/A	N/A
7.11.1	N/A	N/A

STANDARD 8
PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and systems for the prevention and management of pressure injuries

The governance and systems for the prevention and management of pressure injuries are underpinned by Healthscope policy for 'Pressure Injury, preventing, identification and management of' that is referenced to the Australian Wound Management Association and the 2012 Pan Pacific Clinical Practice Guidelines.

Pressure injury management is regularly reviewed by the local NERC clinical nurse champion and Clinical Review Committee to ensure that appropriate oversight of the program is maintained. The clinical nurse champion also attends a Cluster Pressure Injury Prevention Group to ensure a consistent approach to pressure management and to share innovations in pressure management. This group reports quarterly to the National Quality Committee.

HSP National KPIs and ACHS clinical indicators (inpatients who develop more than one pressure injury) are collected and benchmarked, and available to all staff via the HSP intranet. ACHS Clinical Indicators are collected for Inpatients who develop one or more pressure injuries with excellent results. There was a small spike in injuries towards the end of 2016 that led to improvements in the management of pressure injuries, particularly those acquired in hospital.

All new patients are risk assessed on admission using the standard HSP Pressure Injury Risk Assessment and Management Plan. Compliance with policy is regularly undertaken to ensure all risk assessments are completed within given timelines.

All incidents are entered onto RiskMan, including those patients admitted with existing pressure injuries and those that sustain injuries.

Staff have ready access to appropriate pressure relieving devices such as mattresses and Roho cushions.

Preventing pressure injuries

All patients are screened for existing pressure injuries and risk rated for potential pressure injuries at time of admission and daily thereafter. The modified Waterlow pressure risk assessment is used.

Regular auditing of compliance is undertaken and includes the appropriate use of pressure relieving devices and documentation. Auditing against the timing of pressure injury risk assessment compliance is routinely undertaken with results demonstrating that 100% of patients have been assessed within 8 hours of admission to NERC over the past 12 months.

Comprehensive skin inspections are undertaken and documented in clinical records. Patients identified at risk are proactively managed; this includes information recorded on communication boards located in patients' rooms, the provision of written information for patients and families, staff education, and staff access to appropriate dressing supplies.

Staff are provided with excellent resources on pressure injury prevention and management including in-service education, presentations and support from the clinical nurse pressure injury management champion.

Managing pressure injuries

The Quality Committee monitors the management of pressure injuries along with the HSP Clinical Cluster - Pressure Area Prevention Committee.

A Victorian Quality Council brochure 'Move, move, move' is placed in patients' bedside compendium and staff discuss how patients and families can assist with pressure injury management.

The Pressure Injury Clinical Nurse Champion undertakes regular clinical record audits to ensure that staff are following best practice guidelines and HSP policies. Outcomes of audits are subject to regular review and areas for improvement identified and managed.

All pressure injuries are captured on RiskMan which records where the injury occurred; this includes injuries that are hospital acquired or injuries sustained elsewhere such as in the home. Pressure injuries are trended as per relevant stages and information is shared with all clinical staff.

A wound management plan is used for the prevention and management of pressure injuries. Staff have ready access to pressure relieving devices such as electronic beds, lifting devices, Roho cushions and pressure relieving mattresses.

Communicating with patients and carers

Brochures on prevention and management of pressure injuries are made available to patients and their families along with evidence that the information provided has been reviewed with consumers. Evidence was noted that care plans are developed in partnership with patients.

The organisation's website contains information on pressure injury rates for the past four years for NERC and includes information on strategies the hospital uses to reduce the risk of injuries for patients. Patients and carers are communicated with daily as part of the clinical handover process. Patients and carers have access to education material including brochures and the NERC patient TV channel on pressure injury prevention and management.

Consumers have been involved in the development of the information provided to patients and staff educational programs**.**

Governance and systems for the prevention and management of pressure injuries

Ratings

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

Action 8.1.1 Core

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

Surveyor Comment:

All policies and procedures are up to date and subject to regular review by HSP Corporate Office, these include input and from the cluster Pressure Injury Prevention group and from Pressure Injury Campion's at NERC.

Best practice assessment tools are in use and regularly audited to ensure compliance with policy. The practice is well embedded into practice and is part of day-to-day operations.

A met with merit rating is supported.

Surveyor's Recommendation:

No recommendation

Action 8.2.1 Core

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

Surveyor Comment:

The organisation system for the reporting and monitoring of pressure injuries is effectively embedded into practice. All incidents are captured on RiskMan and actively addressed to reduce incidents. KPIs are in use across NERC and HSP to ensure that the system continues to be effective and that shared learning is used to improve practice.

NERC demonstrated that they actively use information collected on pressure injuries to identify improvements in the system. These include improvements made to the NERC Patient Information Guide, improvements in staff documentation and treatment and the introduction of Pressure Injury Champions. These initiatives demonstrated a reduction in the number of pressure injuries over time.

A met with merit rating is supported.

Surveyor's Recommendation:

No recommendation

Action 8.2.2 Core

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

Surveyor Comment:

Data is used across NERC and HSP, and it is regularly reviewed at a number of committees. RiskMan extensions provide comprehensive reports that enable trending of incident information. ACHS Clinical Indicators are collected for benchmarking nationally and internally.

As a result of analysing the data a number of improvements to the system since the last ACHS event, this includes the introduction of Roho cushions and other pressure relieving devices for patients in rehabilitation settings. As a result a reduction in pressure injuries has been noted.

A met with merit rating is supported.

Surveyor's Recommendation:

No recommendation

Action 8.2.3 Core

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

Surveyor Comment:

There was ample evidence to support a met with merit rating for the reporting of pressure injury information to the highest level of governance. This occurs both at NERC and HSP Corporate Office. Safety and Quality KPIs are in use and regularly used by committees that provide oversight of the system.

A met with merit rating is supported.

Surveyor's Recommendation:

No recommendation

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

All actions are fully met for this standard.

A number of governance processes are in place to ensure appropriate actions take place should a patient deteriorate. The process is guided by the HSP Governance Framework, suite of policies and procedures that align with the NERC Clinical Governance Framework.

The Clinical Deterioration Clinical Cluster is responsible for aligning the NERC process with the wider HSP policies and procedures and has a direct reporting line to the HSP National Quality Committee. Terms of reference are in place and are designed to provide a communication network, provide leadership and support, monitor KPIs and develop a central repository of information to support all HSP sites.

The original PACE system has been reviewed and a MET call system introduced which brings the hospital into line with the same processes in other Healthscope hospitals.

All code blue and patient transfers as a result of clinical deterioration are recorded on RiskMan and investigated. Reports are regularly reviewed and reported at MAC meetings, with an analysis of each event including the age of patient, time of admission and the outcome for the patient. This also states whether or not the patient was readmitted back into the rehabilitation program. Sentinel events/mortality reviews are reported to the National Clinical Risk Manager, MAC and Leadership Team.

Mechanisms are in place for receiving Advance Care Directives (ACD) and Medical Power of Attorney.

Recognition clinical deterioration and escalating care

NERC uses a number of visual observation charts with escalation triggers that are appropriate for the ages of patients. Regular audits are undertaken to ensure staff compliance with policy and procedure, with audit data from January 2017 and April 2017 indicating a 90-100% compliance rate of staff completing observations and documenting findings in patients' records. An example of actions taken following audits includes the development of an educational package on steps to take using track and trigger charts to ensure staff are fully aware of actions to take in the case of a patient with observations that fall within the MET call criteria and required transfer to an acute hospital. As there is not a resident doctor on staff it is important that staff are fully aware of how to manage these patients.

Inspection of a cross-section of both medical and surgical files revealed appropriate charting of observations within designated clinical parameters. Discussion with staff on the wards indicated their knowledge of when and how escalation was required.

An Adult General Observation Chart HMR 6.1A with rapid response track and trigger instructions and criteria are used for all patients. This chart is regularly audited for completeness and it was noted that there have been significant improvements to the management of MET calls since this process was introduced.

Staff involved in code blue calls are offered a debriefing session post cardiac arrests.

Responding to clinical deterioration

Appropriate tools and protocols are in place with which to respond to unexpected deterioration, including NERC policy Medical Emergency Team (MET) Call and Code Blue. An emergency call bell is available in each patient room, bathroom and other relevant areas to ensure ready access to assistance if required.

As there is no resident doctor on site 24/7, when a patient's observations fall within the MET call criteria of the chart, 000 is called and a MICA team transfers the patient to an acute hospital for further management.

A number of educational processes are in place to increase staff awareness of how to manage clinical deterioration. For example, all clinical staff complete an eLearning package at orientation, annual mandatory Basic Life Support and mock arrests are conducted in areas such as the hydrotherapy pool area.

Quarterly audit are conducted and results used to improve systems and processes, recent improvements include the installation of a new emergency buzzer in the Manor gym and alterations to the volume of announcements made over the PA system.

Communicating with patients and carers

All patients and their families are informed on admission how to escalate their concerns and are further supported through the brochure on ‘Escalation of Care’ located in bedside compendiums. Observation within the wards and in discussion with patients and relatives confirmed their awareness of the ability to escalate concerns to NERC staff. Families also have access to the NERC patient TV channel that provides information on how to escalate any concerns that they may have. NERC have recently changed brochures, signage and information on the TV channel in line with other HSP facilities.

Patient care boards and bedside clinical handover are also used to communicate any concerns.

As part of the pre-admission process all patients are asked if they have ACD and if so to provide it to the hospital. HSP NFR forms are available and completed if necessary and HSP - Medical Orders for Life Sustaining treatment is also available for medical staff to complete with the patient and family.

If ACD/NFR is in place, an alert is placed in the medical record and indicated on the clinical handover sheet.

Family members are involved with mock codes and included in debriefing post events.

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:

A comprehensive organisational risk analysis of basic life support training needs has been undertaken and a plan is place to ensure that the clinical workforce can initiate appropriate early interventions and respond to life-sustaining measures when needed.

Annual mandatory training competency is in place for Basic Life Support for all clinical staff and records were sighted during the survey.

The organisation fully meets the requirements of action 9.6.1.

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 Falls

A Healthscope policy, along with site specific policies and procedures, provides effective governance and systems in the prevention of falls. ACHS and HSP clinical indicators are collected, trended, severity rated and benchmarked. The ACHS indicators include 'Inpatient falls' and 'Inpatient falls resulting in fracture or closed head injury'. Data used to compare with peer groups indicates 0.52% for inpatient falls and 0% for falls resulting in a fracture or closed head injury, demonstrating staff commitment to ensuring the safety of patients in the rehabilitation setting.

National safety and quality KPI data is reported quarterly to the Healthscope Board and to the Corporate Quality and Risk Team, NERC Quality Committee, NERC Leadership and MAC Committees.

NERC has a staff representative on the Corporate Falls Clinical Cluster who ensures that staff are kept up to date with organisational changes and KPI benchmarking outcomes. Falls prevention audits are regularly conducted and data is used to identify areas for improvement. Recent audit results demonstrated that 100% of Falls Risk Assessment Tools (FRAT) are completed within 24 hours, 92-96% of patients that required a FRAT had one completed and 92-100% of patients with falls risks had appropriate interventions documented in the medical record.

A NERC Falls Party was commenced in April 2017 that will focus on falls trends, prevention strategies and staff and patient education on falls prevention strategies. Early indications are that the strategies are beginning to have a positive result in reducing falls rates and staff are encouraged to continue with this work.

NERC has two Falls Champions (nursing and allied health); both are involved in auditing, reporting and monitoring falls incidents.

A number of quality improvements have been implemented since the last ACHS event, including the appointment of Professor Meg Morris to the role of joint Healthscope Professor of Clinical and Rehabilitation Practice. Meg has been located at NERC since January 2017 and is working in close partnership with the allied health team and patients undergoing rehabilitation and identifying areas that will reduce falls rates.

Screening and assessing risks of falls and harm from falling

All patients are screened for falls on admission to the facility and subsequently if there are any changes to their conditions. A Falls Risk Assessment Tool is in use across the service and includes inpatient and outpatient/day patients. In addition, a pre-admission assessment of patients is completed by the Rehabilitation Liaison Coordinator or Pain Program Coordinator.

Information on patients at risk of falling is also discussed at casemix, team and clinical handover meetings.

A number of audits are completed, including the use of the screening and risk assessment tool, development of falls prevention plans and involving patients in their falls prevention plans. Audit results demonstrate relatively high compliance rates and staff are encouraged to continue ensuring that falls risks and prevention plans are in place.

Preventing falls and harm from falling

There is a multidisciplinary team approach to the prevention of falls. This is complemented with a broad inventory of equipment including walking aids and non-slip socks. All falls incidents are captured on the incident reporting database and reviewed by the Nurse Unit Managers with feedback to the clinical staff.

All patients are automatically referred to physiotherapy, occupational therapy and the rehabilitation specialist. These are further complimented by referrals to exercise physiologists, dieticians, psychologists, podiatrists and hydrotherapy if required.

All patients identified as a falls risk have comprehensive falls prevention plans documented in their records. The effectiveness of these plans is regularly audited and results reported via a number of committees (compliance with protocol) and by a review of incidents entered on RiskMan.

Regular case conferences are held for all patients to plan and monitor multidisciplinary approaches to safety and discharge planning. The case conference may include the patient's family if needed or if requested by families or carers.

Clinical handover and patient bed boards are used to communicate falls risks using a traffic light system. Different falls prevention strategies are implemented as per falls risk category, for example high risk patients are placed closer to the nurses' station, are supervised when using the bathroom, and are provided with low beds and grip socks.

All staff receive regular education and training on falls prevention strategies.

The HSP shared learning report is used to identify areas for improvement across all sites, including falls prevention strategies.

Communicating with patients and carers

NERC appears very well aware of the risk of falls to its patients and provides a range of information on falls risks and falls reduction techniques. A range of brochures and educational information is available for patients and carers in three languages and the TV Patient Information channel includes information on falls prevention.

The NERC internet site contains information on fall rates for the past five years along with suggestions for falls prevention while in hospital. Bedside clinical handover allows the patient and carer to be involved in the management of falls prevention and the rational behind the management plan.

Evidence was noted that care plans are developed in partnership with patients; this includes involving patients in care planning and developing rehabilitation goals.

Governance and systems for the prevention of falls

Ratings

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

Action 10.1.1 Core

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

Surveyor Comment:

All policies and procedures are up-to-date and subject to regular review by HSP Corporate Office, these include input and from the Cluster Falls Prevention group and NERC staff.

Best practices assessment tools are in use and staff use is regularly audited to ensure compliance with policy. The practice is well embedded into practice and is part of day-to-day operations.

Improvements to policies and procedures include changes added following the introduction of RiskMan extensions for falls incidents and the introduction of low, medium and high falls intervention strategies. This has resulted in a lower number of falls occurring at NERC.

A met with merit rating is supported.

Surveyor's Recommendation:

No recommendation

Action 10.2.2 Core

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

Surveyor Comment:

Data is used across NERC and HSP, and it is regularly reviewed at a number of committees. RiskMan extensions provide comprehensive reports that enable trending of falls incident information. ACHS Clinical Indicators are collected for benchmarking nationally and internally.

Improvements noted since the last ACHS event include, improved staff education and training following the appointment of Professor Meg Morris, the introduction of strength based training for patients and updates to patients admission information. Evaluation of these initiatives indicated, for example, that 100% of patients attending Tai Chi classes found the exercise information helpful at home.

A met with merit rating is supported.

Surveyor's Recommendation:

No recommendation

Action 10.2.3 Core

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

Surveyor Comment:

There was ample evidence to support a met with merit rating for the reporting of falls information to the highest level of governance. This occurs both at NERC and HSP Corporate Office. Safety and Quality KPIs are in use and regularly used by committees that provide oversight of the system.

A met with merit rating is supported.

Surveyor's Recommendation:

No recommendation

Screening and assessing risks of falls and harm from falling

Ratings

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

Action 10.5.1 Core

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

Surveyor Comment:

A best practice tool is used by the clinical workforce to identify the risk of falls across NERC and HSP. The use of the best practice tool is subject to regular auditing where areas for improvement are identified and action plans developed to enhance the safety of patients during their episode of care.

A met with merit rating is supported.

Surveyor's Recommendation:

No recommendation

Action 10.5.2 Core

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

Surveyor Comment:

Regular auditing of clinical records occurs to ensure compliance with policy and procedures. Results are reviewed by relevant committees to ensure falls risks are actively addressed. Falls risks are discussed during clinical handover and clinical rounding. Excellent audit results were viewed and it was noted that they were actively used in day-to-day operations to improve patient safety.

A met with merit rating is supported.

Surveyor's Recommendation:

No recommendation

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

NSQHSS Survey

Organisation: North Eastern Rehabilitation Centre
Orgcode: 225166

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

Organisation: North Eastern Rehabilitation Centre
Orgcode: 225166

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	MM
1.1.2	The impact on patient safety and quality of care is considered in business decision making	SM	MM
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	MM
1.5.2	Actions are taken to minimise risks to patient safety and quality of care	SM	MM
1.6.1	An organisation-wide quality management system is used and regularly monitored	SM	MM
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	MM
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	MM
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	MM
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	MM
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	MM
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	MM
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	SM	SM

	response to complaints		
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	SM	SM

	role		
2.4.1	Consumers and/or carers provide feedback on patient information publications prepared by the health service organisation (for distribution to patients)	SM	MM
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	MM

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	MM

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	SM	SM

	• single-use devices • 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	MM
3.1.4	Action is taken to improve the effectiveness of infection prevention and control policies, procedures and/or protocols	SM	MM
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	SM
3.5.2	Compliance rates from hand hygiene audits are regularly reported to the highest level of governance in the organisation	SM	SM
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	SM
3.6.1	A workforce immunisation program that complies with current national guidelines is in use	SM	SM
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	SM	SM

- waste management within the clinical environment
- 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	MM
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

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	SM	MM

	comprehensive list of medicines and explanation of changes in medicines		
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	MM
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	MM
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	MM
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

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	MM
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	SM	SM

carer in clinical handover are in use

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	N/A	N/A
7.1.2	The use of policies, procedures and/or protocols is regularly monitored	N/A	N/A
7.1.3	Action is taken to increase the safety and appropriateness of prescribing and clinically using blood and blood products	N/A	N/A
7.2.1	The risks associated with transfusion practices and clinical use of blood and blood products are regularly assessed	N/A	N/A
7.2.2	Action is taken to reduce the risks associated with transfusion practices and the clinical use of blood and blood products	N/A	N/A
7.3.1	Reporting on blood and blood product incidents is included in regular incident reports	N/A	N/A
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	N/A	N/A
7.3.3	Health service organisations participate in relevant haemovigilance activities conducted by the organisation or at state or national level	N/A	N/A
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	N/A	N/A

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	N/A	N/A
7.5.2	The patient clinical records of transfused patients are periodically reviewed to assess the proportion of records completed	N/A	N/A
7.5.3	Action is taken to increase the proportion of patient clinical records of transfused patients with a complete patient clinical record	N/A	N/A
7.6.1	Adverse reactions to blood or blood products are documented in the patient clinical record	N/A	N/A
7.6.2	Action is taken to reduce the risk of adverse events from administering blood or blood products	N/A	N/A
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	N/A	N/A

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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	N/A	N/A
7.7.2	Action is taken to reduce the risk of incidents arising from the use of blood and blood product control systems	N/A	N/A
7.8.1	Blood and blood product wastage is regularly monitored	N/A	N/A
7.8.2	Action is taken to minimise wastage of blood and blood products	N/A	N/A

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	N/A	N/A
7.9.2	Plans for care that include the use of blood and blood products are developed in partnership with patients and carers	N/A	N/A
7.10.1	Information on blood and blood products is provided to patients and their carers in a format that is understood and meaningful	N/A	N/A
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	N/A	N/A

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	MM
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	MM
8.2.2	Administrative and clinical data are used to regularly monitor and investigate the frequency and severity of pressure injuries	SM	MM
8.2.3	Information on pressure injuries is regularly reported to the highest level of governance in the health service organisation	SM	MM
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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Orgcode: 225166

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	MM
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	MM

	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	MM
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	MM
10.5.2	Use of the screening tool is monitored to identify the proportion of at-risk patients that were screened for falls	SM	MM
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: North Eastern Rehabilitation Centre
Orgcode: 225166

Recommendations from Current Survey

Not applicable

Organisation: North Eastern Rehabilitation Centre
Orgcode: 225166

Recommendations from Previous Survey

Standard: Governance for Safety and Quality in Health Service Organisations
Criterion: Incident and complaints management
Action: 1.16.2 The clinical workforce are trained in open disclosure processes

Recommendation: NSQHSS Survey 0914.1.16.2

Recommendation:

Provide training on open disclosure for clinical staff.

Action:

The Open Disclosure elearning module has been allocated to clinical staff (GM/DON NUM'S, Nurses, Allied staff) to ensure everyone working or interacting with our patients, families and visitors.
2017 staff completion of open disclosure on line training was 90% on 23/3/2017
2017 Staff completion of open disclosure on line training was 91% on 28/6/2017

- HSP policy 2.30 Open Disclosure
- Open disclosure reporting on RiskMan with reports available
- Sentinel Event shared learning reports (Healthscope wide review and learnings)
- 100% of senior management have completed the Open Disclosure elearning training module
- Open Disclosure process and responsibilities discussed at MAC
- Department Managers awareness of open disclosure - would activate as required and seek input from Executive.

Completion Due By: 30/06/2017

Responsibility: Allison Carr

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

The survey team viewed the following evidence:
- 2017 staff completion of open disclosure on line training was 90% on 23/3/2017;
- 2017 Staff completion of open disclosure on line training was 91% on 28/6/2017; and
- 100% of senior management have completed the Open Disclosure e-training modules.

Therefore, this recommendation is closed.

NSQHSS Survey

Organisation: North Eastern Rehabilitation Centre
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Standard: Governance for Safety and Quality in Health Service Organisations
Criterion: Patient rights and engagement
Action: 1.17.3 Systems are in place to support patients who are at risk of not understanding their healthcare rights

Recommendation: NSQHSS Survey 0914.1.17.3

Recommendation:

Provide evidence to demonstrate that systems are in place to support patients who are at risk of not understanding their healthcare rights.

Action:

Information regarding rights and responsibilities is provided as a brochure in all pre/admission information, as well as in the patient bed-side compendium.
The rights and responsibilities brochure is currently being translated into a number of languages by Healthscope Corporate Quality Team.

Evaluation of our patients understanding of their rights and responsibilities is measured quarterly using the HSP Patient Satisfaction Survey Tool.
Patient Satisfaction Survey results Question: "How well you understood your rights and responsibilities" reached 100% between October 2016 to March 2017
Following a spot audit May 2017 - 3 patients responded that they did not understand Eg: 1 was non English speaking, 1 was not interested in reading the material, 1 had no alternative suggestions when asked how we can help them to know about and understand their R&R's.

Patients are also assessed for cognitive and or communication difficulties prior to being deemed appropriate for admission to North Eastern - Preadmission assessment HMR 4.5B.

Occupational Therapy Informed Decision Making Capacity Risk Assessment and Management Tool is now completed for all admissions to NERC.
Where Outcomes of the completion of this tool result in identification of a patient having communication or cognitive capacity issues this is communicated to the multidisciplinary team.

- documentation of any strategies or interventions implemented in the progress notes
- handover between the OT to the Nurse in Charge
- included on clinical handover sheets and included as part of the clinical handover
- included in Care Plans - also communicated to the Healthscope Clinical Cluster to request an additional dedicated space within the HMR 6.13 Care Plan

August 2016: Audit 30 files revealed 86.6% compliance which is a decline from the previous 93%. Mar 17: Audit of 30 files completed - 93.5% compliance with form being completed and filed.

HSP policy 2.36 Interpreter Services
Potential for interpreter service requirement is assessed at the pre admission assessment to allow forward planning
On call Interpreter and Translator service phone number available to staff - although seldom needed at NERC

NSQHSS Survey

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HSP website has information - Aboriginal and Torres Strait Islanders link
Use of family members, or staff to assist with interpretation, if assessed appropriate.

Completion Due By: 30/6/2017

Responsibility: Sarah Murphy

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

The survey team reviewed the following evidence:

- Information regarding rights and responsibilities is provided as a brochure in all pre/admission information, as well as in the patient bed-side compendium (sighted by the surveyor).
- Evaluation of our patients understanding of their rights and responsibilities is measured quarterly using the HSP Patient Satisfaction Survey Tool.
- Patient Satisfaction Survey results Question: "How well you understood your rights and responsibilities" achieved 100% between October 2016 to March 2017.
- Following a spot audit May 2017 - 3 patients responded that they did not understand e.g. 1 was non-English speaking, 1 was not interested in reading the material, 1 had no alternative suggestions when asked how we can help them to know about and understand their R&Rs. This data was viewed by the surveyor.
- Patients are also assessed for cognitive and or communication difficulties prior to being deemed appropriate for admission to North Eastern - Preadmission assessment HMR 4.5B (sighted by surveyor).
- August 2016: Audit 30 files revealed 86.6% compliance which is a decline from the previous 93%. Mar 17: Audit of 30 files completed - 93.5% compliance with form being completed and filed (data viewed by the auditor).
- HSP policy 2.36 Interpreter Services.
- Potential for interpreter service requirement is assessed at the pre-admission assessment to allow forward planning.
- On call Interpreter and Translator service phone number available to staff - although seldom needed at NERC.
- HSP website has information - Aboriginal and Torres Strait Islanders link.
- Use of family members, or staff to assist with interpretation, if assessed appropriate.

Therefore, this recommendation is met.

Standard: Governance for Safety and Quality in Health Service Organisations
Criterion: Patient rights and engagement
Action: 1.18.3 Mechanisms are in place to align the information provided to patients with their capacity to understand

Recommendation: NSQHSS Survey 0914.1.18.3

Recommendation:

Provide evidence that indicates the information provided to patients is aligned to their capacity to understand.

Action:

This recommendation has been coupled together with the previous recommendation.

Information regarding rights and responsibilities is provided as a brochure in all pre/admission information, as well as in the patient bed-side compendium.
The rights and responsibilities brochure is currently being translated into a number of languages by Healthscope Corporate Quality Team.

Evaluation of our patients understanding of their rights and responsibilities is measured quarterly using the HSP Patient Satisfaction Survey Tool.
Patient Satisfaction Survey results Question: "How well you understood your rights and responsibilities" reached 100% between October 2016 to March 2017
Following a spot audit May 2017 - 3 patients responded that they did not understand Eg: 1 was non English speaking, 1 was not interested in reading the material, 1 had no alternative suggestions when asked how we can help them to know about and understand their R&R's.

Patients are also assessed for cognitive and or communication difficulties prior to being deemed appropriate for admission to North Eastern - Preadmission assessment HMR 4.5B.

Occupational Therapy Informed Decision Making Capacity Risk Assessment and Management Tool is now completed for all admissions to NERC.
Where Outcomes of the completion of this tool result in identification of a patient having communication or cognitive capacity issues this is communicated to the multidisciplinary team.

- documentation of any strategies or interventions implemented in the progress notes
- handover between the OT to the Nurse in Charge
- included on clinical handover sheets and included as part of the clinical handover
- included in Care Plans - also communicated to the Healthscope Clinical Cluster to request an additional dedicated space within the HMR 6.13 Care Plan

August2016: Audit 30 files revealed 86.6% compliance which is a decline from theprevious 93%. Mar 17: Audit of 30 filescompleted - 93.5% compliance with form being completed and filed.

HSP policy 2.36 Interpreter Services

Potential for interpreter service requirement is assessed at the pre admission assessment to allow forward planning
On call Interpreter and Translator service phone number available to staff - although seldom needed at NERC
HSP website has information - Aboriginal and Torres Strait Islanders link
Use of family members, or staff to assist with interpretation, if assessed appropriate.

- HSP policy 1.05 Consumers, Partnering with
- HSP policy 2.14 Ten Tips for Safer Healthcare
- Staff awareness to use of interpreting services if required - seldom required because of the demographic
- Potential for use of interpreting service is identified at pre admission assessment
- Hospital management awareness of ethnicity and demographics of our patients - majority are English speaking as shown by WebPas reports
- Consumer Consultants review of patient handouts, brochures and information leaflets - changes made following analysis of suggestions / comments
- The consumer tested logo is placed on all new and revised publications that meet the requirements. There is a formal corporate process to ensure integrity of the intent for use of the Consumer logo
- Corporate Office has corporate consumers input and review of policies, feedback surveys, brochures during the development stage and NERC utilize site specific consumers similarly
- Information provided to patients is assessed during patient Centred Care survey and Patient Satisfaction surveys, and results analysed and feedback is given to staff and consumer representatives
- Quality and Risk Committee agendas have a standard agenda item - Consumers
- Consumer Committee commenced 2016 includes review of patient information

1 patient during a recent spot audit clearly understood her R&R's and made comment that due to her poor vision she had not read the brochure/compendium but that staff provided her verbally the information on admission.

Completion Due By: 30/06/2017

Responsibility: Sarah Murphy

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

As stated by the hospital, this recommendation has been coupled together with the previous recommendation.

Information regarding rights and responsibilities is provided as a brochure in all pre/admission information, as well as in the patient bed-side compendium (sighed by surveyor).

The rights and responsibilities brochure is currently being translated into a number of languages by Healthscope Corporate Quality Team, (work in progress).

Evaluation of the patients' understanding of their rights and responsibilities is measured quarterly using the HSP Patient Satisfaction Survey Tool.

Patient Satisfaction Survey Results Question: "How well you understood your rights and responsibilities" reached 100% between October 2016 to March 2017.

NSQHSS Survey

Organisation: North Eastern Rehabilitation Centre
Orgcode: 225166

Following a spot audit May 2017 - 3 patients responded that they did not understand Eg: 1 was non English speaking, 1 was not interested in reading the material, 1 had no alternative suggestions when asked how we can help them to know about and understand their R&R's.

Patients are also assessed for cognitive and or communication difficulties prior to being deemed appropriate for admission to North Eastern - Preadmission assessment HMR 4.5B (sighted by surveyor).

Occupational Therapy Informed Decision Making Capacity Risk Assessment and Management Tool is now completed for all admissions to NERC.
Where Outcomes of the completion of this tool result in identification of a patient having communication or cognitive capacity issues this is communicated to the multidisciplinary team.

- documentation of any strategies or interventions implemented in the progress notes
- handover between the OT to the Nurse in Charge
- included on clinical handover sheets and included as part of the clinical handover
- included in Care Plans - also communicated to the Healthscope Clinical Cluster to request an additional dedicated space within the HMR 6.13 Care Plan

In August 2016: An audit of 30 files demonstrated 86.6% compliance ; in Mar 17: Audit demonstrated 93.5% compliance with form being completed and filed. (viewed by the surveyor).

The hospital has systems and processes in place for patients who do not speak English, such as:-

HSP policy 2.36 Interpreter Services
On call Interpreter and Translator service phone number available to staff - although seldom needed at NERC
HSP website has information - Aboriginal and Torres Strait Islanders link
Use of family members, or staff to assist with interpretation, if assessed appropriate.

- HSP policy 1.05 Consumers, Partnering with
- HSP policy 2.14 Ten Tips for Safer Healthcare
- Staff awareness to use of interpreting services if required - seldom required because of the patient demographic of the area
- Potential for use of interpreting service is identified at pre admission assessment
- Hospital management awareness of ethnicity and demographics of our patients - majority are English speaking as shown by WebPas reports
- Consumer Consultants review of patient handouts, brochures and information leaflets - changes made following analysis of suggestions / comments
- The consumer tested logo is placed on all new and revised publications that meet the requirements. There is a formal corporate process to ensure integrity of the intent for use of the Consumer logo
- Corporate Office has corporate consumers input and review of policies, feedback surveys, brochures during the development stage and NERC utilize site specific consumers similarly
- Information provided to patients is assessed during patient Centred Care survey and Patient Satisfaction surveys, and results analysed and feedback is given to staff and consumer representatives
- Quality and Risk Committee agendas have a standard agenda item - Consumers
- Consumer Committee commenced 2016 includes review of patient information

Due to the great initiatives that have been implemented by the hospital in relation to this recommendation, it is now closed.

NSQHSS Survey

Organisation: North Eastern Rehabilitation Centre
Orgcode: 225166

Standard: Governance for Safety and Quality in Health Service Organisations
Criterion: Patient rights and engagement
Action: 1.18.4 Patients and carers are supported to document clear advance care directives and/or treatment-limiting orders

Recommendation: NSQHSS Survey 0914.1.18.4

Recommendation:

Provide evidence to demonstrate that patients and carers are supported to document clear advance care directives and/or treatment limiting orders.

Action:

North Eastern has allocated the responsibility for overseeing the matter of advanced care directives to the social worker.
This position is backed up by the GM / DON to ensure the facility has the resources necessary to manage advanced care directives.
Training has also been attended by the Social Worker.

In April 2016, it was decided the North Eastern Social Worker was the best person to attend intensive training in relation to Advanced Care Directives.
This course was attended and the Social Worker has been able to assist as required and has provided staff with updates.

HSP policy 2.56 - "It is not the role of hospital staff to assist with patients formulating an Advance Care Directive"

HSP policy 2.56 Advance Care Directive
NERC policy 1.52 Advance Care Directive
HSP policy 8.14 Not for Cardiopulmonary Resuscitation (NFR) Withdrawal of Treatment

- Patient Admission Assessment contains a question of patient re current Advance Care Directive in place / or not
- HMR 1.1 Medical orders for life sustaining treatment form
- Advance Care Directives are not prepared specifically for NERC but resources are available at NERC
- New alert sheets now incorporate a tick box for ACD and NFR

- **Completion Due By:** 30/6/2017

Responsibility: Anna Goden/Naiseel D'Souza

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

The following policies provide guidance for the hospital in relation to advanced care directives and were viewed by the surveyor:

HSP policy 2.56 - "It is not the role of hospital staff to assist with patients formulating an Advance Care Directive".

HSP policy 2.56 Advance Care Directive.
NERC policy 1.52 Advance Care Directive.
HSP policy 8.14 Not for Cardiopulmonary Resuscitation (NFR) Withdrawal of Treatment.

- Patient Admission Assessment contains a question of patient re current Advance Care Directive in place / or not.
- HMR 1.1 Medical orders for life sustaining treatment form.
- Advance Care Directives are not prepared specifically for NERC but resources are available at NERC.
- New alert sheets now incorporate a tick box for ACD and NFR.

The North Eastern Social Worker has been allocated the Advanced Care Directives role for the hospital and has attended intensive training in relation to Advanced Care Directives.

As a result, the Social Worker has been able to assist as required and has provided staff with updates.

Standard: Medication Safety
Criterion: Communicating with patients and carers
Action: 4.14.1 An agreed medication management plan is documented and available in the patient's clinical record

Recommendation: NSQHSS Survey 0914.4.14.1

Recommendation:

Ensure that an agreed medication management plan is documented and available in the clinical record for relevant patients.

Action:

On admission all patients have a Risk Assessment completed which alerts Nursing Staff of the need for a Medication Management Plan
Nursing Staff notify the pharmacist and commence the Medication Management Plan where required.

At time of discharge all patients are provided with a medication profile and a nursing discharge summary. This is also faxed to the treating General Practitioner.
As part of the nursing discharge summary, medication information and education is provided on an individual basis by the discharging nurse.
The pharmacist reviews all patient medication charts prior to discharge to clarify and respond to any queries regarding discharge medication.

As of June 2016 satisfaction with patient / carer involvement in medication management sits at 97%.

- HSP Medication management Plan (MMP) HMR 10.5 Risk Assessment completed on all patients.
- HSP Policy 8.75 Medication Management Plan.
- HSP Policy 18.85 Best Possible Medication History - Obtaining of
- Risk Assessment and MMP (if applicable) kept at point of care.
- Medication safety audit (MMP & ADR)
- Clinical Pharmacist also includes patients in reconciliation of medications throughout admission
- Patient Satisfaction Survey - Responses re: satisfaction with *The explanation of condition, medication & treatment* = 100% Quarter 2 Oct-Dec 2016, and 100% Quarter 3 March 2017. Response re: satisfaction with *Information provided at Discharge regarding your medication* = 96% rated Very good or good (Quarter 2 2016) 90% ticked "Very Good, or Good" and 10% "Fair" in Quarter 3 March 2017.

Completion Due By: 30/6/2017

Responsibility: Naiseel D'Souza (NUM)

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

An agreed medication management plan is documented and available in the clinical record for relevant patients.

An evaluation has been completed with patients indicating a 97% satisfaction rate in their involvement in medication management planning.

The intent of the recommendation has been met and is now closed.

An agreed management plan is documented and readily available in the clinical record.
An evaluation has been completed indicating a 97% satisfaction rate from patients in their involvement in their medication management.

The intent of the recommendation has been met and is now closed.

Standard: Preventing and Managing Pressure Injuries
Criterion: Communicating with patients and carers
Action: 8.10.1 Pressure injury management plans are developed in partnership with patients and carers

Recommendation: NSQHSS Survey 0914.8.10.1

Recommendation:

Provide evidence to demonstrate that pressure injury management plans are developed in partnership with patients and carers.

Action:

A number of initiatives have been implemented to ensure the patient is included in the management and prevention of pressure injury.

1. Patient information on admission includes PI prevention brochure - NERC "Prevention of pressure injuries - Time to move". Given to every patient on admission & explained by nursing staff.
2. Patient bedside compendium - page on pressure injury prevention -"Move move move!"
3. TV channel - Patient information channel provides slides on pressure injury prevention for patients and their carers / visitors.
4. Changes made to NERC's Pressure Injury Prevention brochure - content review, addition of nutritional information post discussion with Healthscope Clinical cluster and dietician, consumer approved publication (CAP).
5. HMR 7.6B Screening your patient for Malnutrition completed for all admissions
6. If relevant the patient is referred to a Dietitian who consults with the patient to discuss their dietary needs.
7. All admissions are assessed by a Physiotherapist and an Occupational Therapist who discusses with the patient their limitations and goals for improving their mobility. The physiotherapist/occupational therapist also guides the patient with ways to avoid pressure injuries.
8. HMR 7.5 Pressure Injury Risk Assessment/Management Plan is completed at the bedside together with the patient, ensuring the patient is aware of what pressure injury risk rating they have and what strategies can be used to prevent pressure injuries
9. Nursing staff seek assistance of the PSA team to increase patient mobility where assistance is required
10. Pressure injury prevention education of all staff by the Pressure Injury Prevention Champion that cover the importance of developing PIP plans in consultation with patients/ carers
11. Pressure Injury Prevention audits in place
12. Results of most recent audit June 2017 - "Is there evidence that the interventions have been discussed with the patient carer" - 89%, "Have you received information on your risk of pressure injury?" - 100%
13. Results of audits discussed at Nursing meetings, handovers, memos and staff noticeboards - indicates areas for improvement with the focus on patient information and patient education
14. Healthscope Policy 8.05 Pressure Injury - Prevention, Identification and Management of
15. Recruitment of further two nursing Pressure Injury Champions - one on evening shifts, to assist with promotion of best practice in pressure injury prevention and management.
16. Purposeful Patient Rounding in place at NERC - HMR 7.19. Form Includes Position section - ask the patient if they are comfortable and complete turning as required (if necessary commence patient turn chart)
17. Conduction of "World Stop Pressure Day" - displays for patients/ carers, staff education / information. Held in November annually, organised by NERC pressure champion and OT

Completion Due By: 30/6/17

Responsibility: Patricia Booth S8 Champion

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

Evidence was viewed during the survey that demonstrated that pressure injury management plans are developed in partnership with patients and carers.

Evaluations have been undertaken that demonstrate patient satisfaction in their involvement.

The intent of the recommendation has been met and the recommendation closed.

Standard: Recognising and Responding to Clinical Deterioration in Acute Health Care
Criterion: Communicating with patients and carers
Action: 9.9.3 The performance and effectiveness of the system for family escalation of care is periodically reviewed

Recommendation: NSQHSS Survey 0914.9.9.3

Recommendation:

Periodically review the effectiveness and performance of the system for family escalation of care.

Action:

NERC has undergone a change in our response system to align with other Healthscope hospitals within the North Eastern Cluster.

A number of our staff work across the Cluster and other Healthscope sites so we have adopted a consistent approach.

The MET system has been implemented at NERC:

1. NERC Escalation of care brochure - revised in 2017 & is a consumer approved publication. (Approved by NERC Consumer Representatives). Every patient now receives one of these brochures on admission.
2. Bedside patient compendium / patient information guide provides information relating to escalation of care process.
3. NERC TV Information channel - revised content 2017, including information for patients / carers on escalation of care / how to call for an emergency response if they are worried
4. New wall signs placed in all patients' rooms & other areas around hospital in 2017 re: escalation of care / emergency buzzer.
5. New NERC 6.2.2 policy - MET Call outlines family, patient, visitor ability to initiate escalation of care
6. New MET Call procedure identified as part of the Emergency Codes Charts that are placed throughout the facility - outlines patient and or family can raise alarm

NSQHSS Survey

Organisation: North Eastern Rehabilitation Centre
Orgcode: 225166

Auditing, reporting and reviewing.

1. Review of information brochures provided to all patients in 2017. Escalation of Care brochure included in nursing admission packs.
2. Patient survey conducted both pre & post changes being made to the Escalation of Care information that is provided to patients. Refer to evidence folder.
3. Results of Riskman reports, Audit results and Surveys reported to relevant committees Eg: MAC, Clinical Care Review Committee
4. Riskman Incident documentation and review / evaluation of individual incidents (records who activated the escalation of care response)
5. Riskman incident reports relating to clinical deterioration to Clinical Review and MAC Committees.
6. Patient Rounding: HSP Policy 2.63 Purposeful Patient Rounding & Purposeful Patient Rounding form HMR 7.19. Rounding includes ensuring patients call bell is within reach, letting the patient know nurse is available and asking if there is anything that can be done for the patient.
7. Bedside handover including patients occurs each day between morning and afternoon shift. Clinical Handover audits - June result for involving patient and / or family / carer = 100% compliance.
8. New Emergency Procedures Policies including MET Call Policy altered to staff via E Learning tool
9. New MET Call Policy assessed via Mock Code system

Completion Due By: 30/6/17

Responsibility: Naiseel D'Souza (NUM)

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

The hospital has reviewed its original PCE call system and has adapted and implanted a MET system to bring it in line with other Healthscope hospitals. The following evidence was viewed by the survey team:

- NERC Escalation of care brochure - revised in 2017 & is a consumer approved publication. (Approved by NERC Consumer Representatives). Every patient now receives one of these brochures on admission. (viewed by the surveyor).
- Bedside patient compendium / patient information guide provides information relating to escalation of care process. (viewed by surveyor)
- NERC TV Information channel - revised content 2017, including information for patients / carers on escalation of care / how to call for an emergency response if they are worried
- New wall signs placed in all patients' rooms & other areas around hospital in 2017 re: escalation of care / emergency buzzer. (viewed by surveyor)
- New NERC 6.2.2 policy - MET Call outlines family, patient, visitor ability to initiate escalation of care (reviewed by surveyor)
- New MET Call procedure identified as part of the Emergency Codes Charts that are placed throughout the facility - outlines patient and or family can raise alarm.

All MET calls have a RiskMan raised and the incident is reviewed, analysed, trended and discussed at Quality, Clinical Review, MAC and staff meetings.

NSQHSS Survey

Organisation: North Eastern Rehabilitation Centre
Orgcode: 225166

Standard: Recognising and Responding to Clinical Deterioration in Acute Health Care
Criterion: Communicating with patients and carers
Action: 9.9.4 Action is taken to improve the system performance for family escalation of care

Recommendation: NSQHSS Survey 0914.9.9.4

Recommendation:

Ensure that action is taken to improve the system for family escalation of care.

Action:

NERC has undergone a change in our response system to align with other Healthscope hospitals within the North Eastern Cluster.

A number of our staff work across the Cluster and other Healthscope sites so we have adopted a consistent approach.

The MET system has been implemented at NERC:

1. NERC Escalation of care brochure - revised in 2017 & is a consumer approved publication. (Approved by NERC Consumer Representatives). Every patient now receives one of these brochures on admission.
2. Bedside patient compendium / patient information guide provides information relating to escalation of care process.
3. NERC TV Information channel - revised content 2017, including information for patients / carers on escalation of care / how to call for an emergency response if they are worried
4. New wall signs placed in all patients' rooms & other areas around hospital in 2017 re: escalation of care / emergency buzzer.
5. New NERC 6.2.2 policy - MET Call outlines family, patient, visitor ability to initiate escalation of care
6. New MET Call procedure identified as part of the Emergency Codes Charts that are placed throughout the facility - outlines patient and or family can raise alarm

Auditing, reporting and reviewing.

1. Review of information brochures provided to all patients in 2017. Escalation of Care brochure included in nursing admission packs.
2. Patient survey conducted both pre & post changes being made to the Escalation of Care information that is provided to patients. Refer to evidence folder.
3. Results of Riskman reports, Audit results and Surveys reported to relevant committees Eg: MAC, Clinical Care Review Committee
4. Riskman Incident documentation and review / evaluation of individual incidents (records who activated the escalation of care response)
5. Riskman incident reports relating to clinical deterioration to Clinical Review and MAC Committees.
6. Patient Rounding: HSP Policy 2.63 Purposeful Patient Rounding & Purposeful Patient Rounding form HMR 7.19. Rounding includes ensuring patients call bell is within reach, letting the patient know nurse is available and asking if there is anything that can be done for the patient.

7. Bedside handover including patients occurs each day between morning and afternoon shift. Clinical Handover audits - June result for involving patient and / or family / carer = 100% compliance.
8. New Emergency Procedures Policies including MET Call Policy altered to staff via E Learning tool
9. New MET Call Policy assessed via Mock Code system

Completion Due By: 30/6/17

Responsibility: Naiseel d'Souza (NUM)

Organisation Completed: Yes

Surveyor's Comments: **Recomm. Closed:** Yes

The hospital has a number of systems and processes in place to measure the effectiveness of the MET call system such as clinical handover audits, patient rounding, staff education, patient satisfaction surveys, mock exercises and analysis of RiskMan incidents and patient satisfaction surveys. All data which is analysed for trends and reported to executive level and at departmental level.

NSQHSS Survey

Organisation: North Eastern Rehabilitation Centre
Orgcode: 225166

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	0	20	20
Standard 8	0	20	0	20
Standard 9	0	15	0	15
Standard 10	0	18	0	18
Total	**0**	**189**	**20**	**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	0	3	3
Standard 8	0	4	0	4
Standard 9	0	8	0	8
Standard 10	0	2	0	2
Total	**0**	**44**	**3**	**47**

NSQHSS Survey

Organisation: North Eastern Rehabilitation Centre
Orgcode: 225166

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	0	0	0
Standard 8	20	0	20
Standard 9	15	0	15
Standard 10	18	0	18
Total	**189**	**0**	**189**

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	0	0	0
Standard 8	4	0	4
Standard 9	8	0	8
Standard 10	2	0	2
Total	**44**	**0**	**44**

NSQHSS Survey

Organisation: North Eastern Rehabilitation Centre
Orgcode: 225166

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	0	23	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**	**233**	**23**	**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	0	0	0	Met
Standard 8	24	0	24	Met
Standard 9	23	0	23	Met
Standard 10	20	0	20	Met
Total	**233**	**0**	**233**	**Met**

NSQHSS Survey

Organisation: North Eastern Rehabilitation Centre
Orgcode: 225166

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	0	20	20
Standard 8	0	20	0	20
Standard 9	0	15	0	15
Standard 10	0	18	0	18
Total	**0**	**189**	**20**	**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	0	3	3
Standard 8	0	4	0	4
Standard 9	0	8	0	8
Standard 10	0	2	0	2
Total	**0**	**44**	**3**	**47**

Standard	SM	MM	Total
Standard 1	33	11	44
Standard 2	1	3	4
Standard 3	37	2	39
Standard 4	28	3	31
Standard 5	8	1	9
Standard 6	8	1	9
Standard 7	0	0	0
Standard 8	16	4	20
Standard 9	15	0	15
Standard 10	13	5	18
Total	**159**	**30**	**189**

Standard	SM	MM	Total
Standard 1	9	0	9
Standard 2	9	2	11
Standard 3	2	0	2
Standard 4	5	1	6
Standard 5	0	0	0
Standard 6	2	0	2
Standard 7	0	0	0
Standard 8	4	0	4
Standard 9	8	0	8
Standard 10	2	0	2
Total	**41**	**3**	**44**

NSQHSS Survey

Organisation: North Eastern Rehabilitation Centre
Orgcode: 225166

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	0	23	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**	**233**	**23**	**256**	**Met**

Standard	SM	MM	Total	Overall
Standard 1	42	11	53	Met
Standard 2	10	5	15	Met
Standard 3	39	2	41	Met
Standard 4	33	4	37	Met
Standard 5	8	1	9	Met
Standard 6	10	1	11	Met
Standard 7	0	0	0	Met
Standard 8	20	4	24	Met
Standard 9	23	0	23	Met
Standard 10	15	5	20	Met
Total	**200**	**33**	**233**	**Met**