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

Dorset Rehabilitation Centre

Pascoe Vale, VIC

Organisation Code: 22 01 81

Survey Date: 4-5 December 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 : Dorset Rehabilitation Centre
Orgcode : 220181

Survey Report

Survey Overview

Dorset Rehabilitation Centre (DRC) provides specialist rehabilitation care for both admitted and non-admitted private clients, as part of the Healthscope group. Servicing the northern suburbs of Melbourne primarily, it provides comprehensive allied health services for orthopaedic, neurological and cardiac rehabilitation. It also provides a range of pain rehabilitation and pulmonary rehabilitation. Increasingly, it also provides care to clients in need of restorative care including for falls and arthritis. Clients have a comprehensive assessment prior to their planned admission.

There has been a particularly strong focus on involving consumers in the development of services at Dorset and impressive consumer consultants work closely with the management team to ensure consumer focused care is in place. The multidisciplinary approach to care was well demonstrated.

The buildings at Dorset do have limitations and the layout is somewhat dated. However, staff make best use of the design available. The recent addition of an outdoor area which doubles as a mobility garden has been a welcome enhancement to the facilities.

Good care outcomes are achieved with over 99% of discharged clients going to accommodation with either the same or a higher level of independence. The survey team was impressed with the care provided and in particular the focus on falls prevention.

STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

Healthscope (HSP) provides the overarching corporate framework and governance structures that are adopted by Dorset Rehabilitation Centre (DRC) for best practice. DRC has a local policy and procedure system in place that aligns with the HSP governance, safety and quality framework and is supported by a committee structure that actively manages and communicates the development, implementation and review of policies, procedures/protocols and guidelines. Documentation control has been improved with the implementation of the electronic system LEX that provides staff access to current best practice guidelines.

The senior management team provides strong leadership that is reflected in the alignment with the organisational values of safety and embed a quality culture through interdisciplinary teamwork for the provision of quality care and services. There is an organisational Risk Register and Quality Plan that links with the National Standards for a systematic approach for all activities and demonstrates a high level of commitment at all levels for the provision of safe quality care and services. A hospital wide audit schedule has been introduced and reviewed annually. All staff are allocated roles and responsibilities within the quality framework that ensures there is consistent reporting of data that reflects the safety and quality culture of DRC. The recent upgrade of RiskMan to RiskMan Extension links with the national standards to provide a robust method for monitoring legislative compliance and the impact on clinical and non-clinical services. RiskMan Extensions provide the framework for a range of learning opportunities including the shared learning reports that are used to improve clinical practice and patient outcomes

Staff training and orientation programs are contemporary and the annual mandatory training programs support staff in their roles for the provision of safe, quality care. Locum and agency staff are provided with an orientation package that includes detailed information on safety and quality roles and responsibilities. The eLearning platform for staff mandatory education has been improved with the addition of a Med-Safe module (ELMO that has been introduced that includes a self-reflective tool in medication management that staff has found to be an invaluable learning tool to support their clinical practice).

Clinical practice

Clinical guidelines and care plans are in place with an annual audit documentation schedule that reflects alignment with the national standards with results to staff tabled through the Quality Improvement committee and staff meetings. There are a range of assessment tools that align with best practice as well as practices such as purposeful patient hourly rounding. ISOBAR provides the framework to support the early identification, and escalation of care when required. At-risk patients are identified and strategies are incorporated into the care plans and identified at clinical handovers. Clinical records are accurate, integrated and available at the point of care.

There is a rapid response system in place to escalate the level of care that is underpinned by a new way of thinking that includes an increased understanding by staff of the “worried or concerned” patient or carer when there is an unexpected clinical deterioration. The redesign of the Patient Care Boards provides a visual guide for patients and carers to follow in the event of the need to initiate the rapid response system.

Performance and skills management

Comprehensive policy, procedures and protocols support the credentialling and defining scope of practice for all clinicians.

Healthscope By-Laws are used for credentialling of Visiting Medical Officers (VMO) and Allied Health staff. Medical, Nursing and Allied Health registration is audited annually with consistent compliance. Annual audits are conducted to ensure scope of practice is defined and credentialling compliance is adhered to. Position descriptions are reviewed annually and used during the performance review process.

Performance reviews are conducted annually with a consistent 99% compliance rate. Staff training and education needs are identified through this process and an annual educational analysis is completed providing a comprehensive education program for all staff. Mandatory training has been improved with the addition of ELMO to the eLearning platform. A positive outcome of the Staff Engagement survey has been the introduction of the Staff Engagement Plan 2017 that promotes a safety culture, staff wellness and alignment with the organisational values through the STAR recognition and awards program.

Incident and complaints management

There is an incident and complaints management system in place supported by organisational policy and procedures. Analysis of incidents and trending of complaints is completed monthly and tabled at the relevant committees and is linked to the shared learning's and cluster groups. There is a comprehensive education program in place for all staff in incident reporting and complaints management.

The introduction of Champions for National Standards is an innovative strategy to engage staff and encourage their participation in completing incident reviews and improvements related to their standard.

Complaints are actively managed and used as a learning opportunity to improve systems with a focus on customer service. Recent environmental improvements include the replacement of larger television screens in patient rooms and the installation of air conditioners in the waiting rooms to provide a greater level of patient comfort. Mandatory training in Open Disclosure is in place for all staff supported by corporate policies and procedures aligning with the national open disclosure standards.

Patient rights and engagement

The Patient Charter of Rights is displayed in patient areas and in the compendium at the patient bedside. Following feedback from consumers the compendium has been updated to include information on the potential transfer by ambulance to another hospital if you become unwell during your stay. The Patient Satisfaction Surveys are used to assess the patient's understanding of their rights and responsibilities with 95% of patients understanding and actively being involved in decision making about their care and treatment. Informed consent is obtained on admission and for all procedures. Advance Care Directives are documented in the patient history and is a standard inclusion in the admission pack. Medical record storage onsite is secure, with policy and procedures and protocols in place to protect the confidentiality and privacy of all patient clinical information.

NSQHSS Survey

Organisation : Dorset Rehabilitation Centre
Orgcode : 220181

Governance and quality improvement systems

Ratings

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

Clinical practice

Ratings

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

Performance and skills management

Ratings

Action	Organisation	Surveyor
1.10.1	SM	SM
1.10.2	SM	SM

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

Incident and complaints management

Ratings

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

Patient rights and engagement

Ratings

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

STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

A range of policy documents encourages the involvement of consumers in the service and also supports the requirements for cultural diversity. DRC has developed a structure incorporating Consumer consultants who provide representation on various governance committees including the quality and safety committee. Consumers also provide representation on the Healthscope cluster committee and there is an explicit link between the local and cluster representation.

A number of the consumer consultants have extensive community links and these are used to publicise and support events held within the community or at DRC.

Various community forums have been held in which feedback on services and or service/health information is provided to consumers. The planning for these has included consumer consultants.

Consumer partnership in designing care

DRC has used consumers for a number of its educational videos, including a recently developed one on the “patient journey”. As part of the overall Healthscope initiative, consumers have been used as actors in a locally produced video on client handover. This is an excellent tool for staff training.

Consumer consultants have been actively involved in reviewing publications. They are able to provide generic feedback. The plan to also involve clients of the specific service streams reviewing publications as they are developed is encouraged. Consumers have also been actively involved in reviewing the website. Displays of quality data throughout the service have had consumer feedback regarding location and display type.

Consumer partnership in service measurement and evaluation

The service has developed a specific consumer toolkit which is used to guide consumers in developing their roles. Consumers are actively involved in seeking client feedback. There is a strong link with the management team and clear evidence that the feedback provided by consumers results in quality improvement plans. Consumer involvement is widely publicised throughout the organisation, including display boards featuring the individual consumers at the entrance to the DRC.

Consumer partnership in service planning

Ratings

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

Consumer partnership in designing care

Ratings

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

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

DRC uses a private consultancy service to oversee its infection control program. HICMR Pty Ltd has been providing this service for 25 years. A 24-hour consultancy is available and this is complemented by a local Infection Control Coordinator (IFC), who also takes on the role of coordinator for hand hygiene, aseptic technique and antimicrobial stewardship. Monitoring and reporting is undertaken locally as well as in the Healthscope cluster.

Infection prevention and control strategies

A comprehensive infection control plan is in place, which details planned activities, measurements and timetabling against all the requirements of the National Standards. The plan also clearly identifies the responsibilities of HICMR and the local staff. There is a compressive policy manual in place.

Compliance auditing is undertaken by HICMR and also the local IFC. Risk assessments are undertaken for key activity areas and a Dorset Infection Control Risk Management Plan is in place. Internal audits are undertaken on aseptic technique, antibiotic usage, clinical waste, linen use, environmental services, food services and staff health. Staff vaccinations are offered.

Managing patients with infections or colonisations

All clients of Dorset are planned admissions and while a few are admitted with resolving infections e.g. post joint replacement, this is relatively uncommon. Any client who develops an infection is transferred to a higher care\acute facility. Aseptic technique is monitored and a practical competency is in place with most satisfactory results for nurses. Hand Hygiene rates are monitored with most recent results indicating an overall compliance rate of greater than 82%. This result included medical officers.

Antimicrobial stewardship

Almost all clients who are on an antibiotic have arrived at Dorset with this already prescribed. Discussions with medical staff revealed that they were very aware of the antibiotic stewardship issues and received regular reports on antibiotic use. The medical team reported that medications, including antibiotics, were included in the regular file reviews and results were used to inform practice. As a rehabilitation facility, the service does not keep clients with active infection, and rarely prescribes antibiotics.

Cleaning, disinfection and sterilisation

The facility is clean and well maintained. The hydrotherapy pool has a comprehensive cleaning routine in place. Water quality is tested regularly for pH and microbiological testing is also undertaken. There are strict guidelines in place for clients to be eligible to use the hydrotherapy pool.

There are no instruments reused at DRC and no invasive procedural work undertaken with the exception of wound management. Disposable instruments are used for this.

There was evidence that reusable patient equipment e.g. sphygmomanometer cuffs were cleaned regularly and audits of compliance were undertaken.

Communicating with patients and carers

There is considerable information about hand hygiene and respiratory etiquette available for clients, visitors and carers. This includes information in the patient compendium, brochures and posters. Hand Hygiene products were available in public and ward areas.

Governance and systems for infection prevention, control and surveillance

Ratings

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

Infection prevention and control strategies

Ratings

Action	Organisation	Surveyor
3.5.1	SM	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:

Noting that Dorset does not undertake any interventional work, appropriate training and implementation of aseptic technique takes place.

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:

Dorset does not use any reusable instruments or devices, noting also that appropriate cleaning is undertaken for any equipment (e.g. sphygmo BP cuffs) that comes into contact with the patient.

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 : Dorset Rehabilitation Centre
Orgcode : 220181

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

The current contracted pharmacy services provide a complete service supported by the internal governance structure in place that is consistent with the national and legislative requirements, policies and procedures for pharmacy services and aligns with DRC governance structure for the management of organisational wide medication safety systems.

There is an audit framework in place, and audit results are presented at Medication Safety, Quality and MAC committee meetings. The effectiveness of the medication authority system is regularly monitored in line with staff scope of practice and annual credentialling process.

Medication incidents are reported through RiskMan Extension and are a shared learning opportunity for staff. All medication incidents are reviewed by the Quality Manager, NUM, GM/DON and forwarded to the pharmacist. To support staff learning the Med-Safe eLearning module (ELMO) has been introduced and includes a self-reflective tool in medication management. Staff feedback was positive identifying it as an invaluable learning tool to support their clinical practice. Quality improvement activities are continuously undertaken and audited to reduce the risk of patient harm and increase the quality and effectiveness of medicine with regular Pharmacy newsletters with updates on drug profiles, education sessions, mandatory training in medication management as well as the trialling of an updated medication incident reflection tool.

Documentation of patient information

A best possible medication history is documented for every patient with identified medication allergies and any adverse drug reactions documented in the clinical record. Every patient has a medication plan and includes a risk assessment with a scoring system that determines the need for a referral to the Pharmacist. This information is available at the point of care. Clinical reviews are completed by the pharmacist to reduce the risk of adverse reactions and are documented in the medical record. Current medications are documented and reconciled at admission and on discharge with audits identifying 100% compliance. The pharmacist completes medication discharge profiles for all patients.

Medication management processes

There are a range of support tools available for staff to access to ensure safe medication practices including eMIMMS and Therapeutic Guidelines available online and access to a range of other supports including Injectable Handbook, Don't Rush to Crush Handbook and the Healthscope Library service EBSCO database package that includes MEDLINE.

DRC medication safety policies cover the range of legislative requirements for the storage and distribution of medications; disposal of unused, unwanted or expired medications. There is a register of high risk medicines which is relevant to the organisation and the Tallman lettering system is used.

Continuity of medication management

Medication management is a multidisciplinary approach with the Pharmacist providing reviews and medication reconciliation throughout the admission and on discharge. The medication management plan is supported by the pharmacist that provides a medication profile and updates for clinical hand overs using ISOBAR for patient care.

On discharge a complete and comprehensive medication management plan and profile is provided to the patient/carer and faxed to the local GP as well as a copy filed in the medical record. The medication profiles are an excellent communication tool for patients and carers as well as other health professionals for the safe continuity of medication management.

Communicating with patients and carers

The clinical staff provides patients with information regarding medication management options, benefits and associated risks and are documented in the medical record. The bedside handover also provides an opportunity for communicating with patients and carers about their medications. All patients are provided with a comprehensive medication profile on discharge that provides information that is in a format that is meaningful in relation to their current medication management plan. A range of brochures, pamphlets and fact sheets are available for patients. On discharge the nursing discharge summary is completed in partnership with the patient/carer who completes the process by signing indicating that they have been involved in the discharge planning process

Governance and systems for medication safety

Ratings

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

Documentation of patient information

Ratings

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

Medication management processes

Ratings

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

4.10.6	SM	SM
4.11.1	SM	SM
4.11.2	SM	SM

Continuity of medication management

Ratings

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

Communicating with patients and carers

Ratings

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

Organisation : Dorset Rehabilitation Centre
Orgcode : 220181

STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

In line with the HSP and local policy and procedure guidelines DRC uses four core identifiers on name bands in all patient identification processes and comply with the national specifications. A comprehensive checking process is in place and is regularly audited. A quality improvement initiative introduced has improved the safety for outpatients attending hydrotherapy sessions with the introduction of name badges to ensure patient identification at all times when on site. There is a mechanism in place to capture any mismatching events and no mismatching events reported.

Processes to transfer care

Patient identification and matching systems are well integrated throughout the patient journey including at handover, transfer to another facility as well as on discharge. ISOBAR is well established and is a consistent tool for communication across all disciplines for safe practice. RiskMan is used to collect information on any incidents associated with patient identification and inform the Shared Learning reports and discussed at the Quality/Consumer Improvement Committee. Regular audits are conducted with a change in practice noted for the medication reconciliation process on discharge and the development of consumer information on the importance of identification checks throughout stay and as an outpatient.

Processes to match patients and their care

There are specific processes in place to correctly match patients for intended procedures, treatments and care for both inpatient and outpatient services. To improve the effectiveness of the process for matching patients for care and services the medical records are available for the programs that they participate in both as an inpatient and outpatient. Regular audits are conducted and benchmarked within the Healthscope group. DRC through their Consumer Consultants have surveyed patients on their experience with patient identification procedures and have provided feedback to staff to assist their practice.

NSQHSS Survey

Organisation : Dorset Rehabilitation Centre
Orgcode : 220181

Identification of individual patients

Ratings

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

Processes to transfer care

Ratings

Action	Organisation	Surveyor
5.4.1	SM	SM

Processes to match patients and their care

Ratings

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

STANDARD 6
CLINICAL HANDOVER

Surveyor Summary

Governance and leadership for effective clinical handover

HSP Clinical Handover policies and local DRC policies and procedures are in place providing a standardised process for the transfer of patient information between clinicians.

ISOBAR provides the framework for a structured handover process with a consistent standard of communication and transfer of information between staff and external services. This is supported by a comprehensive education program for staff that includes education on bedside handover, use of the ISOBAR tool and a Clinical Handover DVD for staff education.

Regular auditing and review of the clinical handover processes has resulted in the redesign of the patient bedside folders structure and content to assist with accurate procedures and communication at handover.

Clinical handover processes

There is a structured handover process in place for clinical handover with all staff understanding their roles and responsibilities. The bedside handover is embedded into daily practices with regular audits identifying the timeliness of the handover process has improved communication between clinicians and provided open transparent communication with patients and carers. The effectiveness of the clinical handover has been evaluated and has a continuous improvement focus with the redesign of the Patient Care Boards; the electronic patient boards in the nurses' station; redesign of the handover documentation including the discharge summary; and changes to handover practices to provide more time for staff to participate in the bedside handover process. Communication between disciplines is framed by ISOBAR and supported by the clinical handover process in place; it is multidisciplinary and links the inpatient and outpatient services. Incidents related to handover are reported through RiskMan Extensions and discussed at the Quality Committee, Executive and MAC.

Patient and carer involvement in clinical handover

On admission, all patients/carers are provided information on the handover process through the Consumer Brochure and information on the internal TV channel. There was evidence of patient carer involvement in the clinical handover processes with staff introducing themselves, involving them in the handover process and updating the Patient Care Boards providing a visual prompt for patients and carers. Regular audits are conducted by the Consumer Consultants who provide feedback on the patients/carers experience with the clinical handover and this feedback is included in staff education programs.

Governance and leadership for effective clinical handover

Ratings

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

Clinical handover processes

Ratings

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

Patient and carer involvement in clinical handover

Ratings

Action	Organisation	Surveyor
6.5.1	SM	SM

Organisation : Dorset Rehabilitation Centre
Orgcode : 220181

STANDARD 7
BLOOD AND BLOOD PRODUCTS

Surveyor Summary

Approved as not applicable by ACHS.

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

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

Organisation : Dorset Rehabilitation Centre
Orgcode : 220181

STANDARD 8
PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and systems for the prevention and management of pressure injuries

The governance of pressure injury management is undertaken by an enthusiastic, multidisciplinary team.

While there are very few pressure injuries that develop in clients at Dorset, some clients are transferred with wounds and the occasional skin break down. All pressure injuries are recorded and analysed, using the RiskMan program. The service also uses ACHS clinical indicators as a benchmark tool.

Preventing pressure injuries

All clients admitted to Dorset have a pressure injury risk assessment undertaken, using the Waterlow screening tool. A range of pressure preventing equipment is available including pressure relieving mattresses and slide sheets. As a rehabilitation facility, there is a strong focus on client movement and encouraging clients to change position.

Managing pressure injuries

The service has access to expert advice in margining wounds and pressure areas, with some staff having expert knowledge in this area. The service actively involves consumers in the process of preventing pressure injuries.

Communicating with patients and carers

The bedside compendiums at Dorset contain information about the importance of avoiding pressure injuries. Prevention is also highlighted at bedside clinical handover. Regular audits are undertaken which confirm that documentation of screening has occurred and information has been provided to the client and where appropriate the carer. At the time of survey, the issue of how to display actual rates of pressure injuries was discussed and it is suggested that a rate per bed day has limited value for clients, particularly given the very low number of pressure injuries. It is suggested that the service look at displaying this as a “days since last pressure injury ….”, which is more meaningful to clients and many staff.

Governance and systems for the prevention and management of pressure injuries

Ratings

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

Preventing pressure injuries

Ratings

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

Managing pressure injuries

Ratings

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
8.9.1	SM	SM
8.10.1	SM	SM

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

Surveyor Summary

Establishing recognition and response systems

HSP policy on deteriorating patient is on HINT and the public database as is DRC's local policies and procedures. There is an established system in place with all rapid response calls reported on the RiskMan Clinical Deterioration Extension. All RiskMan entries trigger an alert email to the Executive team, Quality Manager and relevant staff for review. Critical Systems Review (CSR) are conducted on all rapid responses, followed by staff debriefing sessions as a learning opportunity and how to improve current practices. Follow up review of all incidents are an opportunity for shared learnings and are discussed at the Quality Committee and peer review by the MAC. Improvements include the development of an outpatient policy for the rapid response systems for cardiac rehabilitation outpatients and the redesign of the Patient Care boards visual display of how to initiate a rapid response. Rapid Response inpatient mock codes have been introduced as a learning tool to support escalation of care with a no blame approach and to increase staff understanding of the worried or concerned.

Recognising clinical deterioration and escalating care

Track and trigger observation charts are in use with clearly defined reporting parameters. Audits have been undertaken regarding compliance with charting requirements and reportable ranges are reviewed by the Quality Improvement Committee. Critical Systems Review (CSRs) are conducted on all failures to call rapid response calls as well as delay in responses against track and trigger guidelines.

Recent improvements include the installation of a new call bell system which includes a new emergency call system.

Responding to clinical deterioration

There is a rapid response system in place. Rapid Response inpatient mock codes have been introduced as a learning tool to support escalation of care with a no blame approach and staff understanding of the worried or concerned. CSR's are conducted on all rapid responses called. The clinical workforce are trained in basic life support with a staff completion rate of 95%. Train-the-Trainor concept has been introduced with four staff completing the training to ensure access at all times to a trained practitioner in advanced life support.

Communicating with patients and carers

On admission, there is a range of information provided to patients, families and carers on how to access assistance if concerned about clinical deterioration and how to initiate a rapid response. The compendium at the bedside provides information and has been updated to include that if they become unwell DRC may have to call an ambulance and be transferred to another hospital. The Patient Care Boards provides a visual display and guide on how to initiate the rapid response system that is easily read and followed.

Regular audits are conducted to ensure that the patients and carers understand the rapid response system. One hundred percent (100%) of respondents who used the rapid response system during their admission stated that they found the process clear and easy to follow. Patient stories are a learning tool for staff education to increase their understanding of the worried or concerned patient/carer.

Advance Care Planning and policies are in place with an increased uptake of advanced directives documented in the medical history following the introduction of the observation charts section for Altered Calling criteria.

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:

The surveyors noted appropriate levels of training were in place.

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

Healthscope policies and procedures are used as guiding documents for falls prevention. A very active multidisciplinary team oversee the falls prevention program locally. Falls are recorded using the RiskMan incident reporting database. Local KPIs are in place and benchmarking occurs with both the ACHS Clinical Indicator program and other healthscope services. The service has a very low falls rate. An eLearning program is in place for staff training.

Screening and assessing risks of falls and harm from falling

All clients are assessed for falls risks on admission and when there is a change in client status, following a fall or room change.

The Falls Risk Assessment Tool (FRAT) is used to screen clients. Identified risks are then included in a management plan for the clients. Regular audits are undertaken to confirm that assessments are being undertaken, the audit undertake in 2016 confirmed that all risk screening, re-assessment and development of a risk management plan all had 100% compliance.

Preventing falls and harm from falling

Range of equipment is available for those clients identified as a falls risk. This includes non-slip socks, lift off sensor mats, and low-low beds. For inpatients, active nurse "rounding" occurs and a review of medications (by the pharmacist) occurs for all clients deemed high risk. There is active involvement of the allied health clinicians and falls prevention becomes a focus for these rehabilitation clients. The nature of the service is such that walking aids are progressively changed as the client's mobility improves. Balance retraining is considered part of the rehabilitation interventions. Clients have access to a six-week Better Balance program, which covers all aspects of general mobility improvement, including the impact of diet. The team also uses fear of falling measures as part of this program and can demonstrate improvement at the conclusion of the six weeks.

Recently, there has been a focus on involving non-clinical staff in how they can contribute to falls prevention.

Communicating with patients and carers

The multidisciplinary team has used a number of innovative ways to communicate with both clients and other staff on the importance of falls prevention. This has included activities during falls week, including a high tea and various educational activities. Staff have been involved in skits to demonstrate the importance of avoiding a fall. A falls prevention crossword was included on meal trays during this week.

Falls prevention and management is included in the rehabilitation goals for clients and this has been confirmed by audit review of patient documentation. A range of Healthscope brochures on falls prevention are actively promoted, and consumer signage was noted throughout the service.

Governance and systems for the prevention of falls

Ratings

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

Screening and assessing risks of falls and harm from falling

Ratings

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

Preventing falls and harm from falling

Ratings

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

Organisation : Dorset Rehabilitation Centre
Orgcode : 220181

Actions Rating Summary

Governance for Safety and Quality in Health Service Organisations

Governance and quality improvement systems

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

Clinical practice

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

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

Performance and skills management

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

Incident and complaints management

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

	reported complaints		
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	SM
2.1.2	Governance partnerships are reflective of the diverse range of backgrounds in the population served by the health service organisation, including those people who do not usually provide feedback	SM	SM
2.2.1	The health service organisation establishes mechanisms for engaging consumers and/or carers in the strategic and/or operational planning for the organisation	SM	SM
2.2.2	Consumers and/or carers are actively involved in decision making about safety and quality	SM	SM
2.3.1	Health service organisations provide orientation and ongoing training for consumers and/or carers to enable them to fulfil their partnership role	SM	SM
2.4.1	Consumers and/or carers provide feedback on patient information	SM	SM

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

Consumer partnership in designing care

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

Consumer partnership in service measurement and evaluation

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

Preventing and Controlling Healthcare Associated Infections

Governance and systems for infection prevention, control and surveillance

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

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

Infection prevention and control strategies

Action	Description	Organisation's self-rating	Surveyor Rating
3.5.1	Workforce compliance with current national hand hygiene guidelines is regularly audited	SM	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 • waste management within the clinical environment • laundry and linen transportation, cleaning and storage • appropriate use of personal protective equipment	SM	SM

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

Communicating with patients and carers

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

Medication Safety

Governance and systems for medication safety

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

NSQHSS Survey

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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 comprehensive list of medicines and explanation of changes in medicines	SM	SM
4.12.2	A current and comprehensive list of medicines is provided to the patient and/or carer when concluding an episode of care	SM	SM

4.12.3	A current comprehensive list of medicines is provided to the receiving clinician during clinical handover	SM	SM
4.12.4	Action is taken to increase the proportion of patients and receiving clinicians that are provided with a current comprehensive list of medicines during clinical handover	SM	SM

Communicating with patients and carers

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

Patient Identification and Procedure Matching

Identification of individual patients

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

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,	SM	SM

	treatment or investigation is regularly monitored		
5.5.3	Action is taken to improve the effectiveness of the process for matching patients to their intended procedure, treatment or investigation	SM	SM

Clinical Handover

Governance and leadership for effective clinical handover

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

Clinical handover processes

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

Patient and carer involvement in clinical handover

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

Blood and Blood Products

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

Action	Description	Organisation's self-rating	Surveyor Rating
7.1.1	Blood and blood product policies, procedures and/or protocols are	N/A	N/A

	consistent with national evidence-based guidelines for pre-transfusion practices, prescribing and clinical use of blood and blood products		
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

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

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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	SM
8.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
8.2.1	An organisation-wide system for reporting pressure injuries is in use	SM	SM
8.2.2	Administrative and clinical data are used to regularly monitor and investigate the frequency and severity of pressure injuries	SM	SM
8.2.3	Information on pressure injuries is regularly reported to the highest level of governance in the health service organisation	SM	SM
8.2.4	Action is taken to reduce the frequency and severity of pressure injuries	SM	SM
8.3.1	Quality improvement activities are undertaken to prevent pressure injuries and/or improve the management of pressure injuries	SM	SM
8.4.1	Equipment and devices are available to effectively implement prevention strategies for patients at risk and plans for the management of patients with pressure injuries	SM	SM

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	SM	SM

	periodically audited to identify at-risk patients with documented skin assessments		
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 with patients and carers	SM	SM

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	SM	SM

	• communication about clinical deterioration		
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 processes	SM	SM

Responding to clinical deterioration

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

Communicating with patients and carers

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

Preventing Falls and Harm from Falls

Governance and systems for the prevention of falls

Action	Description	Organisation's self-rating	Surveyor Rating
10.1.1	Policies, procedures and/or protocols are in use that are consistent with best practice guidelines (where available) and incorporate screening and assessment tools	SM	SM
10.1.2	The use of policies, procedures and/or protocols is regularly monitored	SM	SM
10.2.1	Regular reporting, investigating and monitoring of falls incidents is in place	SM	SM
10.2.2	Administrative and clinical data are used to monitor and investigate regularly the frequency and severity of falls in the health service organisation	SM	SM
10.2.3	Information on falls is reported to the highest level of governance in the health service organisation	SM	SM
10.2.4	Action is taken to reduce the frequency and severity of falls in the health service organisation	SM	SM
10.3.1	Quality improvement activities are undertaken to prevent falls and minimise patient harm	SM	SM
10.4.1	Equipment and devices are available to implement prevention strategies for patients at risk of falling and management plans to reduce the harm from falls	SM	SM

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Screening and assessing risks of falls and harm from falling

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

Preventing falls and harm from falling

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

Communicating with patients and carers

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

Organisation : Dorset Rehabilitation Centre
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Recommendations from Current Survey

Not applicable.

Organisation : Dorset Rehabilitation Centre
Orgcode : 220181

Recommendations from Previous Survey

Standard: Partnering with Consumers
Criterion: Consumer partnership in service planning
Action: 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

Recommendation: NSQHSS Survey 1214.2.2.1

Recommendation:

Identify and implement a mechanism for involving consumers and/or carers in strategic and operational planning.

Action:

Development of consumer involvement quality plan for 2015-2016.

Introduction of Structured Consumer Consultant Program in 2017 to strengthen their involvement in ongoing involvement with hospital strategic planning by providing feedback on consumer programs and projects and patient/carer satisfaction

Redesign of patient care boards
Design of hospital signage
Design of patient and visitor 'Quality Information Board'
Conduct outpatient group forums and provide suggestions
Conduct Inpatient Surveys based on Patient Survey Feedback and policies, rapid response, falls
Review and share patient feedback at relevant committee meetings
Revision of current consumer publications
Consumer Consultant Participation in HSP Forums.

Completion Due By: March 2015

Responsibility: Amelia Watkins

Organisation Completed: Yes

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

Dorset has significantly strengthened the involvement of consumers in its operations and this has included involvement in strategic and operational planning. The consumer consultants are actively involved in the various programs and committees as well as health service forums.

NSQHSS Survey

Organisation : Dorset Rehabilitation Centre
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Standard: Partnering with Consumers
Criterion: Consumer partnership in designing care
Action: 2.6.2 Consumers and/or carers are involved in training the clinical workforce

Recommendation: NSQHSS Survey 1214.2.6.2

Recommendation:

Identify and implement a mechanism for the involving of consumers and/or carers in the training of the clinical workforce.

Action:

Consumer Consultant Project -Sharing of patient journey in rehabilitation -Consumer consultants are providing recommendations and participating in the project 'My Journey' where patients are provided the opportunity after discharge to share their experiences of rehabilitation at DRC so to provide the consumer experience for staff education and patient information

Use of patient Feedback at relevant committee meetings.

Consumers participate in compliance auditing and patient surveys and provide feedback of patient experience through local meetings.

Patient forum questions developed by Consumer Consultants from review of complaints and surveys requiring action.

Patient forum responses and action plans documented and distributed to relevant staff

Consumer Consultants share their experience of being a patient or carer with staff during committee meetings

Consumer Consultants attend surveys and observational auditing to provide feedback at meetings on rapid response systems, medication safety, patient identification, clinical handover practices and contribute to hospital quality projects such as

Falls prevention week
Pressure Risk Prevention Week
Patient information displays

The DVD 'through our eyes' produced in 2013 is part of staff orientation requirements and shown to patients during pre-admission process and available on my Healthscope.

Bedside handover DVD was produced with assistance of Consumer Consultants to provide education to staff on their bedside handover practices.

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Completion Due By: June 2017

Responsibility: Amelia Watkins

Organisation Completed: Yes

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

Consumers have been actively involved in staff training. The clinical handover video features role playing by consumers and has been used extensively for staff training. In addition, consumers have undertaken a project to "share the client journey", and the video produced is used for staff education. There is also regular informal sharing of client experiences at committee meetings.

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 1214.9.9.3

Recommendation:

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

Action:

Mock drills conducted annually to assist with staff education and policy review.

Update of local Policy and procedures.

Redesign of patient care boards from patient/carer feedback which includes rapid response.

Consumer audits of patient/carer understanding of use rapid response systems.

Medical Advisory Committee peer review of deteriorating patient incidents at DRC.

Audit and review of all deteriorating patients at DRC.

RiskMan reports show patient/carer escalation of care and outcomes.

Implementation of Emergency data collection tool to assist with commencing audit on documentation and compliance.

NSQHSS Survey

Organisation : Dorset Rehabilitation Centre
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CSR conducted on carer feedback relating to rapid response systems.

Completion Due By: December 2016

Responsibility: Amelia Watkins

Organisation Completed: Yes

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

There have been several reviews conducted of the effectiveness and performance of the system for the family escalation of care.

The actions implemented are underpinned by a new way of thinking that includes a no-blame approach and understanding of the “worried or concerned” to improve the effectiveness and performance of the current system to support family escalation of care. The intent of the recommendation has been met and the recommendation is closed.

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 1214.9.9.4

Recommendation:

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

Action:

Annual audit scheduled of care boards and families understanding of the escalation process is now undertaken.

Results discussed at the quality, MAC and EMT meeting closest to the completion of the audit.

Action Plan associated with 2015 audit where admission and nursing staff where reminded to orientate inpatients and carers to DRC escalation in care procedure including the emergency buzzer and the care board during their admission process.

A review of inpatient care boards undertaken by consumer consultants.

Redesign of patient care boards.

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Promoting nursing staff to remind patients of the emergency buzzer during bedside handover processes during the first 72 hours following admission.

Addition to bedside handover observational tool to ensure staff orientate patients and carers to their care boards and rapid response systems.

Installation and checking of new call bell system which includes a new emergency call system.

Documentation of inpatient and outpatient Mock Codes outcomes include revision of local policy and procedure guidelines, staff survey to assist with education, communication and training for both clinical and non-clinical staff, implementation of the emergency data collection tool to assist with documentation.

Completion Due By: Dec 16

Responsibility: Amelia Watkins

Organisation Completed: Yes

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

Following the reviews significant actions have been introduced to improve the system for family escalation of care. A range of improvements include local policy and procedure review, improvement to the clinical handover to include education of patients and carers, education and training for all staff, new equipment purchased and redesign of the patient care boards implemented to support family escalation of care. The intent of the recommendation has been met and the recommendation is closed.

NSQHSS Survey

Organisation : Dorset Rehabilitation Centre
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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**

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**

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Organisation : Dorset Rehabilitation Centre
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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

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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	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 : Dorset Rehabilitation Centre
Orgcode : 220181

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**