NSQHS Standards 2nd Edition Assessment Healthscope - Dorset Rehabilitation Centre 101064

Accreditation Status	*Accredited*
Date(s) of Assessment	*27/11/2024 - 28/11/2024 (Initial)* *24/02/2025 - 24/02/2025 (Final)*
Site	*146 Derby Street Pascoe Vale VIC 3044*
Scope of certification	*The provision of rehabilitation and medical services within the following case mix: cardiac, neurological, orthopaedic, respiratory and trauma rehabilitation*

Details and Registration of the Health Service
Facility #2366 *Specialist rehabilitation services* *Department of Health Victoria (12/07/2024)*

Note: The information provided in this report is based on the information provided by the Health Service Organisation at the time of the accreditation assessment. Accreditation issued by Global-Mark does not guarantee the ongoing safety or quality of an organisation or its services or programs, or that legislative requirements are being met, or will be met.

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ABOUT THE COMMISSION

The Australian Commission on Safety and Quality in Health Care (Commission) leads and coordinates national improvements in healthcare safety and quality. It works in partnership with patients, carers, clinicians, the Australian, state and territory health systems, the private sector, managers and healthcare organisations to achieve a safe, high-quality and sustainable health system.
Key functions of the Commission include developing national safety and quality standards, developing clinical care standards to improve the implementation of evidence-based health care, coordinating work in specific areas to improve outcomes for patients, and providing information, publications and resources about safety and quality.
The Commission works in four priority areas:

1. Safe delivery of health care
2. Partnering with consumers
3. Partnering with healthcare professionals
4. Quality, value and outcomes.

THE AHSSQA SCHEME

Under the National Health Reform Act 2011, the Commission is responsible for the formulation of standards relating to health care safety and quality matters. This includes formulating and coordinating the Australian Health Service Safety and Quality Accreditation Scheme (the AHSSQA Scheme), which provides for the national coordination of accreditation processes.
The AHSSQA Scheme sets out the responsibilities of accrediting agencies in relation to implementation of the following safety and quality standards:

- National Safety and Quality Health Service (NSQHS) Standards including the Multi-Purpose Services Aged Care (MPS) Module
- National Safety and Quality Digital Mental Health (NSQDMH) Standards
- National Safety and Quality Primary and Community Healthcare (NSQPCH) Standards, once approved and
- Any other set of standards that may be developed by the Commission from time to time.

The National Safety and Quality Health Service (NSQHS) Standards were developed by the Commission in collaboration with the Australian Government, states and territories, the private sector, clinical experts, patients and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met.
There are eight NSQHS Standards, which cover high-prevalence adverse events, healthcare associated infections, medication safety, comprehensive care, clinical communication, the prevention and management of pressure injuries, the prevention of falls, and responding to clinical deterioration. Importantly, the NSQHS Standards have provided a nationally consistent statement about the standard of care consumers can expect from their health service organisations.

RATING SCALE DEFINITION

Whenever the NSQHS Standards (2nd ed.) are assessed, actions are to be rated using the revised rating scale outline below:

Rating	Definition of rating
MET	All requirements are fully met
MET WITH RECOMMENDATIONS	The requirements of an action are largely met across the health service organisation, with the exception of a minor part of the action in a specific service or location in the organisation, where the additional implementation is required. If there are no not met actions across the health service organisation, actions rated met with recommendations will be assessed during the next assessment cycle. Met with recommendations may not be awarded at two consecutive assessments where the recommendation is made about the same service or location and the same action. In this case an action should be rated not met.
NOT MET	Part or all of the requirements of the action have not been met.
NOT APPLICABLE	The action is not relevant in the service context being assessed. The Commission's advisory relating to not applicable actions for the health sector need to be taken into consideration when awarding a not applicable rating and assessors must confirm the action is not relevant in the service context during the assessment visit.
NOT ASSESSED	Actions that are not part of the current assessment process and therefore not reviewed.
For further information, see Fact Sheet 4: Rating scale for assessment.	

Suggestions for Improvement

The assessment team may provide suggestions for improvement for the health service to consider implementing. They are not required to be implemented for an action to achieve a met rating.

Repeat Assessment

If a health service organisation has 16 or more percent of assessed actions not met or more than 8 actions from the Clinical Governance Standard not met at initial assessment and is subsequently awarded accreditation, the organisation is required to undertake a further assessment within six months of the assessment being finalised. All actions rated not met or met with recommendations from the initial assessment will be reassessed.
The aim of the reassessment is to ensure the organisation has fully embedded the necessary improvements in their safety and quality systems to maintain compliance with the NSQHS Standards. This is a one off assessment with no remediation period. All actions must be met for the organisation to retain its accreditation.
For further information, see Fact Sheet 3: Repeat assessment of health service organisations.

Safety and Quality Advice Centre and Resources

The Advice Centre provides support for health service organisations, assessors and accrediting agencies on NSQHS Standards implementation, the National Safety and Quality Primary and Community Healthcare Standards, the National General Practice Accreditation (NGPA) Scheme, the National Pathology Accreditation Scheme and the National Diagnostic Imaging Accreditation Scheme.
Telephone: 1800 304 056 | Email: AdviceCentre@safetyandquality.gov.au
Further information can be found online at the Commission's Advice Centre

ACCREDITING AGENCY

I, Kelly Gillen declare that Global-Mark Pty Ltd has the approval from the Australian Commission on Safety and Quality in Health Care to conduct assessment to the National Safety and Quality Health Service / National Safety and Quality Primary and Community Healthcare Standard(s). This approval is current until 31/12/2024.

Under this authority, Global-Mark Pty Ltd is authorised to assess health service organisations against the Australian Health Service Safety and Quality Accreditation Scheme.

Conflicts of Interest

I, Kelly Gillen declare that Global-Mark Pty Ltd has complied with Australian Commission on Safety and Quality in Health Care policy on minimising and managing conflicts of interest.

The following conflicts of interest were identified, and management of these conflicts have declared to the relevant regulator and the Australian Commission on Safety and Quality in Health Care:
NO REAL OR PERCEIVED CONFLICTS OF INTEREST IDENTIFIED
Further information can be found on the Factsheet 9: Managing conflicts of interest in accreditation

Is this the first assessment of this health service organisation by Global-Mark?	Yes
If yes, has the final report of the last assessment completed by the HSO been provided to Global-Mark?	Yes
Matters that arose during the assessment that may have impacted on the assessment outcome	Not Applicable

Health Service Organisation and Assessment Determination

Global-Mark Pty Ltd has reviewed and verified the assessment report for	Healthscope - Dorset Rehabilitation Centre
The outcome for this assessment is	Accredited
Date of accrediting agency determination	26/03/2025
Date health service organisation notified	26/03/2025
Date regulator / Commission notified where accreditation not awarded	NA

ASSESSMENT DETAILS

Not Applicable Actions

All actions rated not applicable complied with Advisory 18/01: Advice on not applicable actions. Not applicable actions below:

5.36, 7.01, 7.02, 7.03, 7.04, 7.05, 7.06, 7.07, 7.08, 7.09, 7.10

Has the assessor verified actions were not applicable during the assessment	Yes
Have any actions not complying with Advisory 18/01 been approved by the Commission	NA

Actions not complying with Advisory 18/01	Details of verification (Name and Date)
-	-

Mandatory Reporting

The management system includes an adequate process to identify the organisation's key systems and determine their controls.	Yes
The system provides an adequate description of the organisation and its onsite processes.	Yes
The system includes an overview of the applicable regulations (including licenses and permits) and agreements with authorities, and that any licenses necessary for the relevant activities of the organisation are in place.	Yes
The management system is effective in achieving the organisation's objective.	Yes
High risk scenarios have been tested by the auditors during the review.	Yes
Safety and quality consultants have been declared at the opening meeting, and where applicable, have met the requirements of Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme Requirements for managing conflicts of interest in accreditation.	NA
The governing body's attestation statement is current and has been submitted to Global-Mark	Yes
Consumers were involved in the review in a meaningful way.	Yes
Has there been any critical incidents/accidents?	No
Has there been any inspections/audits by regulators?	No

Additional Assessment Details

Requirement	Assessment Outcome	Complies
Use of Certificate, Mark(s) and Advertising Material	Evidence has been sighted during the review to verify that the health service organisation uses their certificate, marks and advertising materials in accordance with certification requirements.	Yes
Patient Episode	During the assessment the assessment team had the opportunity to visit and spend time in the clinical area observing various aspects of patient care and held discussions with the clinical staff regarding the NSQHSS. · Patient discharge MRN #215009 and #012543 · Clinical Handover from morning to afternoon staff MRN #215063;#215062; #15050; #206720; #215055 and #215058 · Ward huddle between morning staff and afternoon staff · Group clinical handover from night duty staff to morning staff · Completion of medication management plan by the Pharmacist MRN # 211626	Yes

Requirement	Assessment Outcome	Complies
	· Administration of oral medication MRN #214998 · Multidisciplinary Team (MDT) Meeting 27/11/24 attendance include the Rehabilitation Specialist, Nurse Unit Manager, Physiotherapist x 2 and Occupational Therapist x 1. Discussion of patients MRN #211626; #214057 and #215061 The assessors also observed patient related processes including: · Support services inclusive of catering, cleaning, waste and linen management · Pharmacy services including inventory management, discharge medications and education A sample of medical records were reviewed to further verify documentation of processes (n=10) Day patient program MRN #214649; #211592; and #214314; Inpatient MRN #215009; #012543; #13263; #211616; #214943; #214970 and #214965.	
Consumer Interview	During the assessment, the assessor had an opportunity to speak with a number of patients. The patients confirmed that adequate information had been provided throughout their episode of care and were happy with the care received and felt that their individual needs were met. They did not have any suggestion for improvement and felt safe and supported during their stay.	Yes

Attendance to Opening and Closing Meeting

Name and Designation	Opening	Closing
Matthew Knight, General Manager - Initial only	Yes	Yes
Linda Shelley, Director of Clinical Services (The Victorian Rehabilitation Centre) - Initial and final	Yes	Yes
Danielle Jones, Director of Clinical Services (Dorset) - Initial and final	Yes	Yes
Dana Rowe, Global Mark - Initial only	Yes	Yes
Susan Dunn, Global Mark - Initial and final	Yes	Yes
Sarah Campbell, Acting Quality Manager- final	Yes	Yes

High Risk Scenario

At least one high risk scenario was reviewed during this assessment	Yes
Summary of high-risk scenarios	Disruptions to essential utilities Gaps in the workforce Intakes of new staff

Shared and Contracted Services

List organisational relationships relevant to the assessment of this health service organisation. For e.g., the HSO: - Shares a campus, pharmacy service, biomedical, food and linen service - Is part of *other HSO* - Is affiliated with *other HSO*	Part of Healthscope Hospitals
List contracted services relevant to the assessment of this health service organisation. For e.g., the HSO maintains a contract for provision of: - Sterilising - Laundry services - Food preparation - Theatre Services	Laundry, pharmacy and waste

Declared shared and contracted services were verified during this assessment	Yes
These agreements have been reviewed in the past three years	Yes
Consultants or Third Party participated in the assessment	NA

ASSESSMENT TEAM AND RECOMMENDATION

Assessment Team Details			
Assessor Role	**Name**	**NSQHS ID**	**Declaration of independence signed**
Lead Auditor	Susan Dunn	A1318	Yes
Auditor	Dana Rowe	A1074	Yes
**Note: Assessments should have a minimum of two assessors.*			

ACCREDITATION OUTCOME RESULTS

Assessment Team Recommendation

The assessment team recommends to Global-Mark Pty Ltd, based on the information provided, that Healthscope - Dorset Rehabilitation Centre be Accredited. This has been confirmed by Global-Mark's Chief Executive Officer or delegate.

Executive Summary

Dorset Rehabilitation Centre (DRC) provides specialist inpatient and outpatient rehabilitation care. Evidence based care is provided to assist with improved function following recent illness, injury or surgery. DRC is part of Healthscope Hospitals that provide overarching corporate supports including policies, procedures, frameworks and guidelines for the provision of a safe high quality healthcare service. A Short Notice Assessment has been conducted with four Met with Recommendation findings identified. The service in remediation with a final review due in 60 business working days

Final Review
A remote review of the identified findings from the initial assessment was conducted, resulting in the successful resolution of all issues. The service has demonstrated a strong commitment to the NSQHSS assessment process, ensuring continuous adherence to high standards of quality and safety in healthcare delivery.
We believe that the health service organisation has the capacity to systematically meet the requirements of the NSQHSS against the activities identified within the scope of certification. The auditor team would like to thank the health service organisation for their openness, transparency and hospitality during the review.

Recommendations from Previous Assessments

Action	Gaps in implementation identified	Recommendation(s)	Rating
1.07	Action not fully implemented	Documenting of clinical care pathways for outpatient care is not yet fully implemented	Met with Recommendations
1.22	Action not fully implemented	At the time of review processes to ensure that performance reviews are routinely undertaken is not yet fully implemented]	Met with Recommendations
1.27	Action not fully implemented	Documenting of clinical care pathways for outpatient care is not yet fully implemented	Met with Recommendations
5.07	Action not fully implemented	Processes for risk screening for outpatients is not fully implemented	Met with Recommendations

Summary of Recommendations from the Current Assessment

Action	Gaps in implementation identified	Recommendation(s)	Rating

DETAILED REPORT FOR STANDARDS ASSESSED

Action 1.01
The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews, reports and monitors the organisation's progress on safety and quality performance
Evidence Reviewed
Dorset Rehabilitation Centre (DRC) is part of Healthscope Hospitals and sister hospital within the Victorian Rehabilitation Hospitals (VRH). Corporate oversight and support are provided to governance and operational management processes within the facility. The Health Service Organisation (HSO) has determined the Medical Advisory Committee (MAC) as its local governing body (GB). The governing body leads the development of a culture centred on safety and quality improvement, ensuring its presence throughout the organisation. It provides leadership to facilitate effective partnerships with patients, carers, and consumers, while also establishing priorities and strategic directions for delivering safe and high-quality clinical care, ensuring these are effectively communicated to the workforce and the community. Additionally, the governing body endorses the clinical governance framework, ensures that roles and responsibilities are clearly defined for all stakeholders, monitors actions taken in response to clinical incident analyses, and reviews, reports, and monitors the organization's progress in achieving safety and quality performance objectives. National Clinical Governance Plan 2024- 2025 is used nationally to describe the safety and quality systems and processes including their relationship to the organisational strategic plan. It describes how key objectives of patient care, clinical outcomes are operationalised and monitored Healthscope By Laws (03/07/2024) which promotes quality healthcare and the safety of patients as being central to the services provided by Healthscope facilities. This supports the clinical governance framework for medical practitioners through the credentialing process The following evidence supports and confirms the statements above: - Victorian Rehabilitation Hospitals aligned to OneHealthscope Strategic Plan 2025 - Victoria Rehabilitation Hospitals Consumer Engagement Plan 2024 – 2025 - Victorian Rehabilitation Hospitals Organisational Chart (11/2024) - Victorian Rehabilitation Hospitals Committee Structure (06/2024) Healthscope Risk Management Framework outlines risk culture, appetite, methodology includes risk identification, analysis, evaluation , treatment, monitoring and review, risk reporting, key risk indicators, roles and responsibilities. There is a suite of Healthscope Clinical and Non-Clinical Policies and Procedures and a Risk Register with clinical and non-clinical risks

Incident Management framework accessible through RiskMan software for the reporting of feedback and incidents

The Quality Action Plans register is housed in RiskMan

Meeting minutes reviewed and consistently demonstrated evaluation, monitoring and management of all clinical safety and quality data:

- MAC Meetings (21/05/2024 & 27/08/2024)
- Executive Management Meeting (21/11/2024)
- Quality and Risk (4/06/24; 13/08/24 & 1/10/24)
- Consumer Committee (16/07/2024 & 24/09/24)
- Nursing Team Meeting (23/04/2024, 19/11/2024 & 5/12/2024)
- Allied Health (25/09/2024; 23/10/2024)
- Medication Safety (22/05/2024 & 28/08/2024)
- Work, Health & Safety Committee (08/08/24 & 10/10/24)
- National Standards Committee (19/11/2024)
- Infection Prevention & Control Committee (30/10/2024)

Rating

Met

Findings

-

Action 1.02

The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people

Evidence Reviewed

The governing body ensures that the organisation's safety and quality priorities are aligned with and address the specific health needs of Aboriginal and Torres Strait Islander people.

The following evidence supports and confirms the statements above:

- Healthscope Policy 1.03 Acknowledgement of Country
- Healthscope Reconciliation Action Plan Jan 2024 – Dec 2025
- Healthscope ATSI Rights Poster acknowledges Aunty Peggy Tidyman who assisted with wording and includes artwork commissioned by Karen Lee Mungarrja

- Australian Hospital Patient Experience Question Set (AHPEQS) Comparison Data Review 2024 – total survey responses 269 (2024) 0.37% respondents identified as Aboriginal or Torres Strait Islander
- Expression of interest with Wurundjeri Cultural Heritage Unit for all Victorian Rehabilitation sites
- Local Aboriginal Health and Wellbeing Services with information related to culturally based services and contact details
- Victorian Rehabilitation Hospitals Indigenous Engagement Plan 2024 - 2026

Rating

Met

Findings

-

Action 1.03

The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality

Evidence Reviewed

The health service organisation establishes and maintains a clinical governance framework and utilises the processes within this framework to drive safety and quality improvements.

The following evidence supports and confirms the statements above:

Healthscope Clinical Governance Plan 2024 – 2025 is used nationally to describe the safety and quality systems and processes including their relationship to the organisational strategic plan. It describes how key objectives of patient care, clinical outcomes are operationalised and monitored. The plan references the ACSQHC National Model of Clinical Governance. Review of schedules for operational documentation is described in Healthscope Policy 1.01 Policy Governance states the National Document Controller oversees all policy creation, review, authorisation and distribution processes reporting to the Quality and Risk Governance Committee. All polices must reflect current best practice guidelines and the appropriate standards or legislation which should be included in the references. Interviews conducted with management verified that the HSO conducts triennial reviews of policies or as required.

A risk management framework runs clinical quality and safety and is articulated in a number of governing documents and processes

- Healthscope Policy 2.29 Risk Management- Clinical
- Healthscope Policy 2.13 Incident Management
- RiskMan software is the operational platform for entering incidents, feedback and quality data
- Quality Action Plans 2023 – 2024
- Clinical Indicators Policy 2.33
- Clinical indicators submitted to ACHS and AROC for benchmarking (ACHS Second Half 2023 - hospital wide; infection control; medication safety and rehabilitation medicine and AROC July 2023 – June 2024)

- Safety and quality performance data regularly tabled through the committee frameworks. Sampled outcome data from quality activities included the following: Clinical Governance Audit first quarter 2024 89%, Medical Record Documentation (Rehab) – 07/24 96%, Practitioner credentialing – 08/24 100%, VMO scope of practice – 11/24 100%, Nursing and allied health registration – 06/24 100%, Consumer programs – 10/24 96%, AMS audit – 11/23 72%, NAPS 2023– Compliance with Guidelines 93.3%; Appropriateness Documentation of indication 96.7%; review or stop date documented 60%, NHHI – period 3 - 113 moments out 218 moments 82.3 % compliance rate, Transmission based precautions & PPE – 07/24 100%, Environment cleaning/linen and laundry - 08/24 82%, Sharps and waste handling – 09/24 96%, Reusable equipment – 08/24 92%, High risk medication and controlled drugs – 08/24 78%, Comprehensive care – 08/24 82 and Clinical handover – 07/24 90% & Observation chart – 48% 08/24; 10/24 67%.

Interviews with management and staff verified the HSO's commitment to calendared safety and quality activities to drive improvements.

Rating

Met

Findings

-

Action 1.04

The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people

Evidence Reviewed

The health service organisation implements and monitors strategies to achieve its safety and quality priorities for Aboriginal and Torres Strait Islander people.

The following evidence supports and confirms the statements above:

- Healthscope Policy 1.03 Acknowledgement of Country
- Healthscope Reconciliation Action Plan Jan 2024 – Dec 2025
- Healthscope ATSI Rights Poster acknowledges Aunty Peggy Tidyman who assisted with wording and includes artwork commissioned by Karen Lee Mungarrja
- Australian Hospital Patient Experience Question Set (AHPEQS) Comparison Data Review 2024 – total survey responses 269 (2024) 0.37% respondents identified as Aboriginal or Torres Strait Islander
- Expression of interest with Wurundjeri Cultural Heritage Unit for all Victorian Rehabilitation sites
- Local Aboriginal Health and Wellbeing Services with information related to culturally based services and contact details
- Victorian Rehabilitation Hospitals Indigenous Engagement Plan 2024 - 2026

Rating

Met

Findings
-

Action 1.05
The health service organisation considers the safety and quality of health care for patients in its business decision-making
Evidence Reviewed
The health service organisation uses it clinical governance framework to ensure organisation-wide awareness of safety and quality data. The following evidence were verified during the assessment: State Licencing, Clinical Indicator Reporting and Benchmarking, Patient Satisfaction Survey, Risk Register and Risk Management System, Credentialing and scope of practice process for all VMO's, Nurses and VMO's registration with AHPRA. Interviews with management confirmed safety and quality data was a driver for continuous improvement and business decision making.
Rating
Met
Findings
-

Action 1.06
Clinical leaders support clinicians to: a. Understand and perform their delegated safety and quality roles and responsibilities b. Operate within the clinical governance framework to improve the safety and quality of health care for patients
Evidence Reviewed
Clinical leaders at the HSO support clinicians in understanding and performing their delegated safety and quality roles and responsibilities by: - Clear role definition contained in each workers position description which outlines the workers scope of practice, key responsibilities inclusive of safety and quality requirements of their role - There is a hierarchy of reporting responsibilities and performance outcome monitoring which ensures the clinical workforce operates within the clinical governance framework. This process was well understood by Management and Staff interviewed during the assessment confirmed the following. - Training and education which is provided at all levels to help staff understand their roles in safety and quality and how their individual contributions impact overall healthcare quality - Performance reviews for identification of training needs of the worker

- Information systems, such as, Measurement, Analysis and Reporting System (MARS) and Data Analytics Service Hub (DASH)

- Clinical Governance Framework supports workers in addressing their responsibilities and is monitored and reported for effectiveness with changes made as required

Rating

Met

Findings

-

Action 1.07

The health service organisation uses a risk management approach to:

a. Set out, review, and maintain the currency and effectiveness of policies, procedures and protocols

b. Monitor and take action to improve adherence to policies, procedures and protocols

c. Review compliance with legislation, regulation and jurisdictional requirements

Evidence Reviewed

The health service organisation employs a risk management approach to establish, review, and maintain the relevance and effectiveness of policies, procedures, and protocols; monitor and take action to improve adherence to these policies, procedures, and protocols; and review compliance with legislation, regulations, and jurisdictional requirements.

The following evidence supports and confirms the statements above:

- Policy Management is articulated in Healthscope Policy 1.01 Policy Governance and states the National Document Controller oversees all policy creation , review , authorisation and distribution processes reporting to the Quality and Risk Governance Committee; defined as national policies, take precedence over any existing policies, must reflect current best practice guidelines and the appropriate standards or legislation which are included in references

- Monitoring compliance through incident reporting and identifiable trends guide revision and updates

- Risk Management assists with the scheduled revision of key documents to ensure their ongoing currency in managing corporate and clinical risks

However, while there are documented processes for inpatient clinical care and associated pathways. Documenting of clinical care pathways for outpatient care is not yet fully implemented

Final Review

Evidence reviewed at the Final Review confirms the establishment of documented clinical pathways for outpatient care. The following evidence was sighted:

- Establishment of local working Multidisciplinary Team (MDT) party commenced with meeting minutes provided (13/01/2025, 29/01/2025 & 12/02/2025). Focus of the working party on Outpatient/Day patient Program services processes.

- Committee meeting minutes review of SNA findings (Quality & Risk 03/12/2024, Medical Advisory Committee 11/02/2025, Consumer Committee Meeting 17/12/2024, Allied Health Department Meeting 25/02/2025 & Forms Committee 05/02/205)
- Utilisation of Pain pathway as initial reference point for further clinical pathway refinement (pain) and development of new clinical pathway (joint)
- Noted correspondence from Allied Health Manager to team outlining the documentation and setting up of outpatient clinical pathways, outpatient risk screening and implementation of outpatient centred goals of care (23/01/2025)
- Network Pain Management Program Pathway flowchart updated v2 01/2025. Outlining patient pathway through outpatient service from referral to discharge
- Establishment of Day Rehab (Non-Pain) Pathway 14/02/2025. Outlining patient pathway through outpatient service from referral to discharge
- Working party to continue throughout 1H 2025
- Development of Healthscope Day Rehabilitation/Outpatient Risk Screening Form inclusive of infection screening, mental health, substance use and behaviour, cognition, mental health, malnutrition, falls.
- Roll out of revised pathways evidenced in Allied Health Department Meetings 25/02/2025

Rating

Met

Findings

-

Action 1.08

The health service organisation uses organisation-wide quality improvement systems that:

a. Identify safety and quality measures, and monitor and report performance and outcomes

b. Identify areas for improvement in safety and quality

c. Implement and monitor safety and quality improvement strategies

d. Involve consumers and the workforce in the review of safety and quality performance and systems

Evidence Reviewed

The organisation maintains a quality improvement program by identifying areas for improvement. Inputs to the process include but are not limited to the incident management and reporting system, internal audit program, patient, staff and doctor feedback and clinical indicator reporting. Sampled safety and quality performance data from quality activities included: Clinical Governance Audit first quarter 2024 89%, Medical Record Documentation (Rehab) – 07/24 96%, Practitioner credentialing – 08/24 100%, VMO scope of practice – 11/24 100%, Nursing and allied health registration – 06/24 100%, Consumer programs – 10/24 96%, AMS audit – 11/23 72%, NAPS 2023– Compliance with Guidelines 93.3%; Appropriateness Documentation of indication 96.7%; review or stop date documented 60%, NHHI – period 3 - 113 moments out 218 moments 82.3 % compliance rate, Transmission based precautions & PPE – 07/24 100%, Environment cleaning/linen and laundry - 08/24 82%, Sharps and waste handling – 09/24 96%, Reusable equipment – 08/24 92%, High

risk medication and controlled drugs – 08/24 78%, Comprehensive care – 08/24 82%, Clinical handover – 07/24 90% & Observation chart – 48% 08/24; 10/24 67%. Review of committee meeting minutes verified regular tabling of safety and quality performance data for analysis and management. Outputs include reviews of the risk register, continuous improvement suggestions and key performance indicator reporting. Consumers are involved in the reviews of safety and quality improvement through their membership to the Quality and Risk Committee and Consumer Committee. Interview conducted with management confirmed the regular review of safety and quality data with consumer consultant representation on the Quality and Risk committee (4/06/24; 13/08/24 and 1/10/24) and Consumer Committee (16/07/2024; 24/09/24).

Rating

Met

Findings

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Action 1.09

The health service organisation ensures that timely reports on safety and quality systems and performance are provided to:

a. The governing body

b. The workforce

c. Consumers and the local community

d. Other relevant health service organisations

Evidence Reviewed

The health service organisation ensures that timely reports on safety and quality systems and performance are provided to the governing body, the workforce, consumers and the local community, and other relevant health service organisations. These processes were verified through review of committee meeting minutes:

- MAC (21/05/2024 & 27/08/2024)
- Executive Management (21/11/2024)
- Quality and Risk (4/06/24; 13/08/24 & 1/10/24)
- Consumer Committee (16/07/2024 & 24/09/24)
- Nursing Team Meeting (23/04/2024, 19/11/2024 & 5/12/2024)
- Allied Health (25/09/2024; 23/10/2024)
- Medication Safety (22/05/2024 & 28/08/2024)
- Work, Health & Safety Committee (08/08/24 & 10/10/24)
- National Standards Committee (19/11/2024)

- Infection Prevention & Control Committee (30/10/2024)

Rating

Met

Findings

-

Action 1.10

The health service organisation:

a. Identifies and documents organisational risks

b. Uses clinical and other data collections to support risk assessments

c. Acts to reduce risks

d. Regularly reviews and acts to improve the effectiveness of the risk management system

e. Reports on risks to the workforce and consumers

f. Plans for, and manages, internal and external emergencies and disasters

Evidence Reviewed

The HSO have developed and implemented risk management processes articulated in corporate document Healthscope Policy 0.17 Risk Management and Healthscope Policy 1.18 Quality Management. Review of the Risk Register maintained in RiskMan demonstrated the inclusion of clinical and non-clinical risks that are aligned to the NSQHS standards with risk ratings, risk mitigation strategies, and review dates. Risks remain flexible to the dynamic nature of healthcare provision by being regularly monitored and reviewed as needed through MAC and Quality and Risk Committees to ensure that current controls remain effective. Evidence of plans was sighted for the management of internal and external emergencies and disasters and included Pandemic acute respiratory infection health care facility preparedness/business continuity toolkit (HICMR) 2023, Annual Essential Safety Measures Report 27/11/2024 and HSO Disaster Management & Recovery Plan

Rating

Met

Findings

-

Action 1.11
The health service organisation has organisation-wide incident management and investigation systems, and: a. Supports the workforce to recognise and report incidents b. Supports patients, carers and families to communicate concerns or incidents c. Involves the workforce and consumers in the review of incidents d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems
Evidence Reviewed
The HSO has organisation-wide incident management and investigation systems and supports the workforce in recognising and reporting incidents. It also supports patients, carers, and families in communicating concerns or incidents, involves the workforce and consumers in the review of incidents, and provides timely feedback on incident analyses to the governing body, the workforce, and consumers. Furthermore, the organisation uses the information from incident analyses to improve safety and quality, incorporates risks identified in these analyses into the risk management system, and regularly reviews and acts to enhance the effectiveness of the incident management and investigation systems. Sampling of incidents from August 2024 to November 2024 demonstrated a strong reporting culture. It was noted that there have been no critical system reviews conducted. Sampling of incidents was undertaken #2165106 clinical deterioration of 82 year old female with transfer, #2163626 clinical deterioration 83 year old female with transfer, #2169552 clinical deterioration 72 year old female with transfer use of open disclosure, #2162492 clinical deterioration 88 year old female with transfer and use of open disclosure, # 2161351 witnessed fall of 80 year old female with transfer and use of open disclosure, # 2161008 clinical deterioration 92year old female with transfer and use of open disclosure. All incidents were noted to be consistently managed as stated in Healthscope Policy 2.13 Incident Management.
Rating
Met
Findings
-

Action 1.12
The health service organisation: a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework b. Monitors and acts to improve the effectiveness of open disclosure processes

Evidence Reviewed
The health service organisation utilises an open disclosure program that aligns with the Australian Open Disclosure Framework and continuously monitors and takes action to improve the effectiveness of open disclosure processes. Staff complete Open Disclosure training as part of their mandatory training requirements with a 100% completion rate at the time of review. Review of incidents #2161351 (witnessed fall 80 year old female with transfer and use of open disclosure, # 2161008 clinical deterioration 92 year old female with transfer and use of open disclosure, #2161051clinical deterioration 88 year old female with transfer and use of open disclosure. All incidents, demonstrated actions undertaken by the HSO, were consistent with corporate direction in Healthscope Policy 2.30 Open Disclosure Policy.
Rating
Met
Findings
-

Action 1.13
The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems
Evidence Reviewed
The health service organisation has established processes to regularly seek feedback from patients, carers, and families regarding their experiences and outcomes of care, as well as from the workforce on their understanding and use of safety and quality systems. Evidence sighted in MAC and Quality & Risk Committee of review of Qualtrics Patient Satisfaction Surveys on Quality of Treatment & Care with Net Promotor Score (4/06/24; 13/08/24 and 1/10/24). Interviews with management verified that feedback information is regularly used to enhance and improve safety and quality systems. The use of the 'Patient Story' within the committee meeting minutes is developed from rounding by managers and consumer consultants. This supports the organisation in capturing feedback from the service users for the purposes of continuous improvement and reflective practice at a management level.
Rating
Met
Findings
-

Action 1.14
The health service organisation has an organisation-wide complaints management system, and: a. Encourages and supports patients, carers and families, and the workforce to report complaints b. Involves the workforce and consumers in the review of complaints c. Resolves complaints in a timely way d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e. Uses information from the analysis of complaints to inform improvements in safety and quality systems f. Records the risks identified from the analysis of complaints in the risk management system g. Regularly reviews and acts to improve the effectiveness of the complaints management system
Evidence Reviewed
The health service organisation has an organisation-wide complaints management system that encourages and supports patients, carers, families, and the workforce to report complaints. It involves the workforce and consumers in the review of complaints, resolves complaints in a timely manner, and provides timely feedback to the governing body, the workforce, and consumers on the analysis of complaints and the actions taken. The organisation uses information from the analysis of complaints to inform improvements in safety and quality systems, records risks identified from complaints in the risk management system, and regularly reviews and acts to improve the effectiveness of the complaints management system. The following evidence supports and confirms the statements above: - Healthscope Policy 1.08 Complaints Management - Healthscope Policy 1.05 Partnering with Consumers - Risk Register #16078 Inadequate Complaints Management - Meeting minutes with Compliments and Complaints being a standing agenda item. (Quality and Risk 4/06/24; 13/08/24 and 1/10/24 , MAC 21/05/2024 and 27/08/2024 and Consumer Committee 16/07/2024 and 24/09/24) - Review of complaints on RiskMan from January 2024 – November 2024 n23. Sampling of Complaints (#78544, # 76880, #74434 and # 74627) verified management of complaints consistent with policy direction - Interviews with workers, consumer consultants and management demonstrated a sound understanding of patient rights and the HSO complaints management processes.
Rating
Met
Findings
-

Action 1.15
The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher- risk groups into the planning and delivery of care
Evidence Reviewed
The health service organisation identifies the diversity of the consumers using its services and recognises groups of patients who are at higher risk of harm. It incorporates this information on consumer diversity and higher-risk groups into the planning and delivery of care. The following evidence supports and confirms the statements above: - Healthscope Policy 0.12 Diversity and Inclusion - The facilities utilise information from their patient information software system and census data to identify the diversity of its consumers. - HSO Demographic Analysis for 2023 – 2024 By age largest group 75-79 total count of admissions 3016, By language largest group English, By gender F 1869 M 1147, Not indigenous 2651; unable to be asked 364; declined to answer 1 - Interviews with staff verified the use of Interpreters when necessary and at times the use of family members for interpreting - Patients are identified on admission if they are ATSI – included in Admission documentation - Healthscope training for staff includes Asking the Question: “Are you of Aboriginal or Torres Strait Island descent?” with 100% compliance at the time of review and Cultural Diversity and Sensitivity in Healthcare 94% compliance at the time of review.
Rating
Met
Findings
-

Action 1.16
The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used

Evidence Reviewed
Healthcare records are managed and maintained as per jurisdictional requirements. Medical records were sampled at the point of care and included consent, demographic data, traceability, national inpatient medication charts, observation and response charts, discharge processes, operative notes, assessment data, clinical pathways and Multidisciplinary team meetings Healthcare records are part of the audit schedule for review of their completeness.
Rating
Met
Findings
-

Action 1.17
The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that: a. Are designed to optimise the safety and quality of health care for patients b. Use national patient and provider identifiers c. Use standard national terminologies
Evidence Reviewed
The health service organisation is working towards implementing systems that can provide clinical information into the My Health Record system. These systems are designed to optimise the safety and quality of healthcare for patients, utilise national patient and provider identifiers, and employ standard national terminologies. The following evidence supports and confirms the statements above: - Healthscope Policy 1.14 Document Control states that a document control system is maintained at corporate level and at all sites which ensure that policies, procedure, forms and brochures are current and are reviewed and approved by the appropriate parties - Healthscope Policy 2.66 My Health Record System - Healthscope Medical Record – Documentation Audit 2.27 - HSO Medical Record Documentation (Rehab) Audit 07/2024 with 96% compliance - Confidentiality included in staff position descriptions - Computers are password protected - Health records available at point of care - Secure onsite and off-site storage of medical records - Use of unique patient identifiers for their medical records

- Medical Record Tracking System

Rating

Met

Findings

-

Action 1.18

The health service organisation providing clinical information into the My Health Record system has processes that:

a. Describe access to the system by the workforce, to comply with legislative requirements

b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system

Evidence Reviewed

The health service organisation that provides clinical information into the My Health Record system has processes in place that define workforce access to the system in compliance with legislative requirements and ensure the accuracy and completeness of the clinical information uploaded by the organisation. My Health Record is currently in use by the facility. Accuracy is internally audited.

Rating

Met

Findings

-

Action 1.19

The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for:

a. Members of the governing body

b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation

Evidence Reviewed

The HSO maintains a stable workforce to meet the service's scheduling needs. Orientation is provided to all onboarding workforce members through the HSO learning platform eLearning. All workers are provided with position descriptions which outline their roles and responsibilities and include safety and

quality requirements. This was verified with the sampling of worker files n=6. The MAC members are provided with access to relevant information on their roles and responsibilities through the Healthscope by Laws and confirmed during an interview with the HSO Medical Director.

Rating

Met

Findings

-

Action 1.20

The health service organisation uses its training systems to:

a. Assess the competency and training needs of its workforce

b. Implement a mandatory training program to meet its requirements arising from these standards

c. Provide access to training to meet its safety and quality training needs

d. Monitor the workforce's participation in training

Evidence Reviewed

The health service organisation utilises its training systems to assess the competency and training needs of its workforce, implement a mandatory training program to meet the requirements of these standards, provide access to training that addresses safety and quality needs, and monitor workforce participation in training.

The following evidence supports and confirms the statements above:

- Healthscope Policy 4.10 Mandatory Training
- Review of Mandatory Training records for with stated 90.79% current compliance rate for staff
- Interviews with staff confirmed training is accessible to them through the learning platform eLearning and formed part of their individual KPI's
- Mandatory training was noted to include, but not limited to Manual Handling, Standard Precautions, Transmission Based Precautions, Infection Prevention & Control; Hand Hygiene, AMS, Aseptic technique, Cultural Diversity, Fire Safety & BLS)
- Visiting Medical Practitioner mandatory training requirements have been determined and at the time of review showed a 93% compliance rate
- Interviews with management confirmed training is monitored and reported through the committee frameworks for their completeness (Quality and Risk Committee 4/06/24; 13/08/24 & 1/10/24 , MAC 21/05/24; 20/08/24 & 19/11/24)
- Interviews with management confirmed that training is facilitated by the requirements of each staff members role and scope of practice
- Quality improvements to related to training were sighted in the HSO Quality Action Plan housed in RiskMan with the following sampled #11877 Anaphylaxis Clinical Care Standard to support staff with ongoing education and #12076 Promotion National Hand Hygiene Day #16049 mandatory training compliance rates

Rating
Met
Findings
-

Action 1.21
The health service organisation has strategies to improve the cultural safety and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients
Evidence Reviewed
The health service organisation has strategies in place to enhance the cultural safety and cultural competency of its workforce to better meet the needs of its Aboriginal and Torres Strait Islander patients. Healthscope training for staff includes Asking the Question: “Are you of Aboriginal or Torres Strait Island descent?” 100% compliance at the time of review) and Cultural Diversity and Sensitivity in Healthcare (94% compliance at the time of review).
Rating
Met
Findings
-

Action 1.22
The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system
Evidence Reviewed
The health service organisation has valid performance review processes that require members of the workforce to participate in performance reviews, identify training and development needs related to safety and quality, and incorporate information on these training requirements into the organisation's training system. However, at the time of review processes to ensure that performance reviews are routinely undertaken is not yet fully implemented Final Review

Evidence reviewed at the Final Review confirms the establishment of consistent processes to ensure staff performance reviews are routinely completed

- Establishment of local working Multidisciplinary Team (MDT) party commenced with meeting minutes provided (13/01/2025, 29/01/2025 & 12/02/2025). Focus of the working party on Outpatient/Day patient Program services processes.
- Committee meeting minutes review of SNA findings (Quality & Risk 03/12/2024, Medical Advisory Committee 11/02/2025, Consumer Committee Meeting 17/12/2024, Allied Health Department Meeting 25/02/2025 & Forms Committee 05/02/205)
- eQuaMS ID #17045 action plan for review of current practices of annual performance appraisals with position description, their storage and for the ongoing management
- Development and implementation of Department Manager Performance Appraisal & Position Description Flowchart v2 (02/2025)
- Development and implementation of standardised set up of personnel files (hard copy)
- Implementation of Healthscope Personnel File Checklist
- Evidence of communication between DoN to team leaders outlining the management requirements related to appraisal and position description processes (20/02/205)
- Healthscope Course Status Report for VRH – Dorset completion rate for performance appraisal @ 81.91% for 94 enrolments (21/02/2025)
- Dorset Rehabilitation Centre Performance Appraisal Recompletion Report

Rating

Met

Findings

-

Action 1.23

The health service organisation has processes to:

a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan

b. Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice

c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered

Evidence Reviewed

The health service organisation has processes in place to define the scope of clinical practice for clinicians, considering the organisation's clinical service capacity and clinical services plan. It also monitors clinicians to ensure they are operating within their designated scope of clinical practice and periodically reviews this scope, particularly when a new clinical service, procedure, or technology is introduced or substantially altered.

The following evidence supports and confirms the statements above:

- Healthscope By Laws (03/07/2024) outline processes to define the scope of clinical practice for clinicians, monitor practices to ensure they are operating within their designated scope of practice and review the scope of practices of clinicians
- Inclusion of Visiting Medical Officer (VMO) Scope of Practice in the National Audit Schedule 2024 with outcome data conducted by the HSO 11/2024 with compliance rate 100%
- Sampling of VMO files through Cgov verified all relevant credentialing documentation required by the HSO. This includes the practitioner's scope of practice.
- Review of MAC Meeting Minutes (21/05/2024 & 27/08/2024) verified the inclusion of credentialing as standing agenda item
- Interview with HSO Medical Director confirming credentialing processes include the medical practitioner's scope of practice and consistent with the requirements as set out in Healthscope By Laws

Rating

Met

Findings

-

Action 1.24

The health service organisation:

a. Conducts processes to ensure that clinicians are credentialed, where relevant

b. Monitors and improves the effectiveness of the credentialing process

Evidence Reviewed

There is a formal credentialling process for clinicians designed to reflect their scope of practice. AHPRA registration is monitored annually for nursing and allied health staff. Credentialling of medical officers is described in the Healthscope By Laws (03/07/2024). The Medical Advisory Committee (MAC) review and approve all new visiting medical officers. Scope of practice is defined in the approval letters sent following MAC approval. Credentialling is completed every three years as specified in the Healthscope By Laws. A review of VMO files was undertaken during the assessment with sampling of VMO files held in Cgov and verified evidence of, but not limited to the practitioners qualifications, AHPRA registration and insurances. The effectiveness of the credentialling process is monitored via scheduled quality activities that include Practitioner Credentialing audit– 08/24 100% and VMO Scope of Practice audit– 04/24 100%

Rating

Met

Findings

-

Action 1.25
The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff
Evidence Reviewed
Discussion held with management verified all employed workers are provided with position descriptions that outline their role, responsibilities, and accountabilities. Review of position descriptions confirmed the inclusion of safety and quality requirements of staff to their role. Sampling of the following position descriptions verified above processes Occupational Therapist, Registered Nurse, Social Worker and Physiotherapist. Agency staff are used infrequently but when used are provided orientation to their role by senior clinicians.
Rating
Met
Findings
-

Action 1.26
The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate
Evidence Reviewed
Supervision is provided in the facility by appropriately qualified staff. Rostering ensures that there is suitable skill mix to support service provision.
Rating
Met
Findings
-

Action 1.27
The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care
Evidence Reviewed
Sufficient tools and information are available to clinicians at the point of care. Tools include but are not limited to Clinical Care Standards register, Injectable Handbooks, AMS prescribing guidance, and Therapeutic Guidelines. However, while there are documented processes for inpatient clinical care and associated pathways. Documenting of clinical care pathways for outpatient care is not yet fully implemented. Final Review Evidence reviewed at the Final Review confirms the establishment of documented clinical pathways for outpatient care. The following evidence was sighted: - Establishment of local working Multidisciplinary Team (MDT) party commenced with meeting minutes provided (13/01/2025, 29/01/2025 & 12/02/2025). Focus of the working party on Outpatient/Day patient Program services processes. - Committee meeting minutes review of SNA findings (Quality & Risk 03/12/2024, Medical Advisory Committee 11/02/2025, Consumer Committee Meeting 17/12/2024, Allied Health Department Meeting 25/02/2025 & Forms Committee 05/02/205) - Utilisation of Pain pathway as initial reference point for further clinical pathway refinement (pain) and development of new clinical pathway (joint) - Noted correspondence from Allied Health Manager to team outlining the documentation and setting up of outpatient clinical pathways, outpatient risk screening and implementation of outpatient centred goals of care (23/01/2025) - Network Pain Management Program Pathway flowchart updated v2 01/2025. Outlining patient pathway through outpatient service from referral to discharge - Establishment of Day Rehab (Non-Pain) Pathway 14/02/2025. Outlining patient pathway through outpatient service from referral to discharge
Rating
Met
Findings
-

Action 1.28
The health service organisation has systems to:

a. Monitor variation in practice against expected health outcomes

b. Provide feedback to clinicians on variation in practice and health outcomes

c. Review performance against external measures

d. Support clinicians to take part in clinical review of their practice

e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems

f. Record the risks identified from unwarranted clinical variation in the risk management system

Evidence Reviewed

Variation in practice is monitored through the organisation submitting their outcomes to clinical indicator data sets (Sighted ACHS Second Half 2023 & AROC July 2023 – June 2024). Data from these bodies enables feedback to clinicians and benchmarking activity. Data is reconciled with the incident and complaint management systems to ensure any individual variation is identified and discussed at MAC. Review of MAC (21/05/2024; 27/08/2024) and Quality and Risk Committee (4/06/24, 13/08/24 & 1/10/24) meeting minutes verified routine tabling of safety and quality data for review and management of any unwarranted variation in practice.

Rating

Met

Findings

-

Action 1.29

The health service organisation maximises safety and quality of care:

a. Through the design of the environment

b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose

Evidence Reviewed

The facility has a preventive maintenance program and a suite of policies and procedures related to Health, Safety and Wellbeing that are accessible to all staff. All biomedical equipment reviewed displayed current compliance plates. Sampling of records include TMV, monthly temperature testing , legionella testing and pool testing demonstrated calendared activities with responses to any non-compliant outcomes. There is also a reactive maintenance process for staff to quickly respond to breakages in order to minimise patient risk and ensure the facility is fit for purpose.

Rating

Met

Findings
-

Action 1.30
The health service organisation: a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required
Evidence Reviewed
There are documented policies for aggression management. Mandatory training is provided to workers in Managing Conflict & Challenging Behaviour with a completion rate of 96% at the time of review. Emergency Plans and internal phone directories are available for staff. Emergency flip charts were sighted in appropriate locations with staff confirming when they would be used. Emergency and Safety Procedures which informs patients about taking direction from staff in the event of a fire or smoke alarm activation. Emergency call and nurse call buttons are positioned throughout the facility. There is restricted entry into the hospital after hours.
Rating
Met
Findings
-

Action 1.31
The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose
Evidence Reviewed
The health service organisation facilitates access to services and facilities by providing signage and directions that are clear and fit for purpose.
Rating
Met
Findings
-

Action 1.32
The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so
Evidence Reviewed
Discussions with management and staff confirmed that the health service organisation has flexible visiting arrangements to meet patient's needs when clinically indicated. Patient Information and the facility website has information related to visiting times.
Rating
Met
Findings
-

Action 1.33
The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people
Evidence Reviewed
The health service organisation fosters a welcoming environment that acknowledges and respects the cultural beliefs and practices of Aboriginal and Torres Strait Islander people. The following evidence supports and confirms the statements above: - Healthscope Policy 1.03 Acknowledgement of Country - Healthscope Reconciliation Action Plan Jan 2024 – Dec 2025 - Healthscope ATSI Rights Poster acknowledges Aunty Peggy Tidyman who assisted with wording and includes artwork commissioned by Karen Lee Mungarrja - Australian Hospital Patient Experience Question Set (AHPEQS) Comparison Data Review 2024 – total survey responses 269 (2024) 0.37% respondents identified as Aboriginal or Torres Strait Islander - Expression of interest with Wurundjeri Cultural Heritage Unit for all Victorian Rehabilitation sites - Local Aboriginal Health and Wellbeing Services with information related to culturally based services and contact details - Victorian Rehabilitation Hospitals Indigenous Engagement Plan 2024 - 2026

Rating
Met
Findings
-

Action 2.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for partnering with consumers b. Managing risks associated with partnering with consumers c. Identifying training requirements for partnering with consumers
Evidence Reviewed
Clinicians adhere to the safety and quality systems outlined in the Clinical Governance Standard by implementing policies and procedures that foster effective partnerships with consumers, managing the associated risks to ensure these partnerships are secure and beneficial, and identifying the necessary training requirements to enhance their ability to work collaboratively with consumers. The following evidence supports and confirms the statements above: - Healthscope Policy 1.03 Partnering with Consumers - Healthscope Policy 1.08 Complaints Management - Healthscope Policy 2.60 Consumer Approved Publications - VRH Consumer Committee Terms of Reference states its role is to provide advice from the perspective of a consumer, views into the health service operation, planning and development, review of safety and quality care outcomes and activities, feedback on patient information, publications and brochures - National Clinical Governance Plan 2024- 2025 is used nationally to describe the safety and quality systems and processes including their relationship to the organisational strategic plan. It describes how key objectives of patient care, clinical outcomes are operationalised and monitored - Victorian Rehabilitation Hospitals Consumer Engagement Plan 2024 – 2025 - Interviews conducted with management and consumer consultants verified an orientation process to their role.
Rating
Met
Findings
-

Action 2.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring processes for partnering with consumers b. Implementing strategies to improve processes for partnering with consumers c. Reporting on partnering with consumers
Evidence Reviewed
The Clinical Governance Framework and Victoria Rehabilitation Hospitals Consumer Engagement Plan 2024 – 2025 outlines the organisation's processes for monitoring partnering with consumers. This mandates the consumer engagement processes for the hospital and how the outputs are reported to the highest level of governance and how improvement strategies are identified and implemented. The HSO consumer consultants have membership to both Quality and Risk Committee and Consumer Committee and was verified during interviews with management and consumer consultants. Meeting minutes confirmed regular review of safety and quality performance data. It was noted that consumer feedback and engagement is a standing agenda item at MAC and Quality and Risk Committee. The use of the 'Patient Story' within the committee meeting minutes is developed from rounding by managers and consumer consultants. This supports the organisation in capturing feedback from the service users for the purposes of continuous improvement and reflective practice at a management level.
Rating
Met
Findings
-

Action 2.03
The health service organisation uses a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights b. Easily accessible for patients, carers, families and consumers
Evidence Reviewed
Australian Charter of Healthcare Rights (ACHCR) is in use and on display throughout the facility. The facility ensures patients read and understand the Australian Charter of Healthcare Rights and Privacy Policy at pre-admission/admission or on arrival.
Rating
Met

Findings
-

Action 2.04
The health service organisation ensures that its informed consent processes comply with legislation and best practice
Evidence Reviewed
The health service organisation ensures that its informed consent processes follow relevant legislation and adhere to best practice standards. The HSO is compliant with the requirements of Advisory 18/10 Informed Financial Consent with signed financial consents routinely sighted during sampling of healthcare records. Audits on Medical Record Documentation are conducted at set intervals for review of their completeness - Medical Record Documentation (Rehab) – completed 07/24 with 96% compliance.
Rating
Met
Findings
-

Action 2.05
The health service organisation has processes to identify: a. The capacity of a patient to make decisions about their own care b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves
Evidence Reviewed
There is a documented policy Healthscope Policy 2.17 Consent to Medical/Surgical Treatment that states legal capacity/competence is assessed by the treating Medical Practitioner, who if satisfied that the patient does not have legal capacity will obtain consent in accordance with the appropriate legislation which may include the use of a substitute decision maker. Also covered within the policy is valid consent, witnessing of consent, withdrawal of consent, the role of Healthscope staff, Riskman reporting and audits. There is a process in place for checking for Enduring Power of Attorney and Advance Health Care Directives and articulated in Healthscope Policy 2.56 Advance Care Directives.
Rating
Met

Findings
-

Action 2.06
The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care
Evidence Reviewed
The health service organisation has established processes for clinicians to collaborate with patients and/or their substitute decision-makers in planning, communicating, setting goals, and making decisions about their current and future care. Clinical Handover was witnessed in several clinical areas to confirm that clinicians partner with their patients to plan, communicate and make decisions about care. White Boards are available in the majority of patient rooms.
Rating
Met
Findings
-

Action 2.07
The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care
Evidence Reviewed
Patients and Consumer Consultants interviewed during the assessment confirmed the clinical handover processes include the patient with goals of care being identified and communicated. Assessors observed full engagement of patients with appropriate information being disseminated to patients during the bedside handover. This shared decision making for ongoing care is documented in the comprehensive care plan and whiteboards in the patient's room.
Rating
Met
Findings
-

Action 2.08
The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community
Evidence Reviewed
The diversity of the population is mainly English speaking and relatively homogenous. The Australian Charter of Healthcare rights (ACHCR) is available in a number of different languages to patients and is monitored through the various bedside audits completed at unit levels. The ACHCR is displayed in patient waiting areas, in the Patient Compendiums located in each patient room and also on the website.
Rating
Met
Findings
-

Action 2.09
Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review
Evidence Reviewed
Local consumers are engaged in the review of patient information as verified during consumer consultant and management interviews. Corporate policies on consumer engagement and participation describe how information is reviewed by consumers, families and their carers. Consumer Committee Terms of Reference state that consumers will provide feedback on patient information, publications and brochures.
Rating
Met
Findings
-

Action 2.10
The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that:

a. Information is provided in a way that meets the needs of patients, carers, families and consumers

b. Information provided is easy to understand and use

c. The clinical needs of patients are addressed while they are in the health service organisation

d. Information needs for ongoing care are provided on discharge

Evidence Reviewed

Clinical areas were accessed by the assessment team to ensure the organisation supports their staff to communicate with consumers regarding their health care. If necessary, staff will arrange for an interpreter to ensure that communication with a patient is meaningful if required. The patient information booklet has been prepared to provide patients with information about the hospital's services with the booklet prepared with consumer input.

Rating

Met

Findings

-

Action 2.11

The health service organisation:

a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care

b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community

Evidence Reviewed

The health service organisation involves consumers in partnerships for the governance, design, measurement, and evaluation of healthcare and ensures that the consumers participating in these partnerships reflect the diversity of those who use the service or, where relevant, the diversity of the local community. This was confirmed during interviews conducted with consumer consultants, management and review of Consumer Committee meeting minutes (16/07/2024; 24/09/24) and information on safety and quality data is fed back to the patients via quality boards in the clinical areas. The diversity of consumers is assessed regularly with the HSO conducting demographic analysis of the patient cohort.

Rating

Met

Findings

-

Action 2.12
The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation
Evidence Reviewed
The health service organisation provides orientation, support, and education to consumers who are involved in partnering in the governance, design, measurement, and evaluation of the organisation. This was confirmed with the review of Consumer Committee meeting minutes (16/07/2024; 24/09/24) and the Consumer Committee Terms of Reference.
Rating
Met
Findings
-

Action 2.13
The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs
Evidence Reviewed
The health service organisation collaborates with Aboriginal and Torres Strait Islander communities to address their healthcare needs. The following evidence supports and confirms the statements above: - Healthscope Policy 1.03 Acknowledgement of Country - Healthscope Reconciliation Action Plan Jan 2024 – Dec 2025 - Healthscope ATSI Rights Poster acknowledges Aunty Peggy Tidyman who assisted with wording and includes artwork commissioned by Karen Lee Mungarrja - Australian Hospital Patient Experience Question Set (AHPEQS) Comparison Data Review 2024 – total survey responses 269 (2024) 0.37% respondents identified as Aboriginal or Torres Strait Islander - Expression of interest with Wurundjeri Cultural Heritage Unit for all Victorian Rehabilitation sites
Rating
Met
Findings
-

Action 2.14
The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce
Evidence Reviewed
The health service organisation collaborates with consumers to incorporate their views and experiences into workforce training and education. Interviews with Consumer Consultants confirmed their involvement in the development and delivery of Relationship Centred Caring: Reflecting on the 'Key Drivers' to a Positive Patient Experience – Insights from our Consumer Consultants delivered 19/08/2024. The use of the 'Patient Story' within the committee meeting minutes is developed from rounding by managers and consumer consultants. This supports the organisation in capturing feedback from the service users for the purposes of continuous improvement and reflective practice at a management level.
Rating
Met
Findings
-

Action 3.01
The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for infection prevention and control b. Identifying and managing risks associated with infections c. Implementing policies and procedures for antimicrobial stewardship d Identifying and managing antimicrobial stewardship risks
Evidence Reviewed
Assessors reviewed infection control procedures and processes which were consistent with the safety and quality systems from the Clinical Governance Standard. These principles underpin the implementation of policies and procedures, risk management and determining training requirements for preventing and controlling healthcare associated infections and antimicrobial stewardship. Staff were able to describe how they operationalise infection control related policies and procedures, how associated risks are managed and describe the training provided regarding antimicrobial stewardship and preventing and controlling healthcare associated infections.

Dorset Rehabilitation Centre utilises the services of an external consultant, Healthcare Infection Control Management Resources (HICMR) to ensure practices are consistent with relevant infection control standards with annual reviews conducted focusing on the following areas IPC Program, Ward area; Clinical waste and linen; Environmental Services; Food Services; Maintenance; Staff Health; Hydrotherapy and Allied Health.

Assessors sighted the following reports:

- Facility wide completed 15/11/24 with 97% compliance achieved.
- Clinical waste and linen completed 07/06/2024 with 93.4% compliance achieved.
- Environmental Services 07/06/24 with 82.9% compliance achieved.
- Hydrotherapy pool completed 21/05/24 with 89% compliance achieved.
- Clinical Ward area completed 27/08/24 with 91.9% compliance achieved.
- Staff Health completed 15/11/24 with 96.4% compliance achieved.

The facility has recruited a new Infection Prevention and Control Coordinator to work across all three sites in the network, who will commence in the next couple of weeks and will be supported by the HICMR consultant. The committee structure involves all three sites also with the Victorian Rehabilitation Hospitals Infection Prevention Committee (minutes sighted 30/10/2024) reporting up to the Quality and Risk Committee.

Risks associated with infections and antimicrobial stewardship are documented within the risk register and reviewed regularly.

- Risk ID # 17292 Antimicrobial stewardship - inappropriate management
- Risk ID # 19545 Safety of patients on Transmission based precautions
- Risk ID # 19119 Pandemic (e.g. COVID-19) affecting the community, country or greater population
- Risk # 15996 Notifiable Disease - inadequately managed

Policies are in place and are predominately managed at a Corporate level and are provided by HICMR.

Rating

Met

Findings

-

Action 3.02

The health service organisation:

a. Establishes multidisciplinary teams to identify and manage risks associated with infections using the hierarchy of controls in conjunction with infection prevention and control systems

b. Identifies requirements for, and provides the workforce with, access to training to prevent and control infections

c. Has processes to ensure that the workforce has the capacity, skills and access to equipment to implement systems to prevent and control infections

d. Establishes multidisciplinary teams, or processes, to promote effective antimicrobial stewardship

e. Identifies requirements for, and provides access to, training to support the workforce to conduct antimicrobial stewardship activities

f. Has processes to ensure that the workforce has the capacity and skills to implement antimicrobial stewardship

g. Plans for public health and pandemic risks

Evidence Reviewed

The Infection Prevention and Control Committee(IPC) which has an extensive membership across all three hospitals within the group and is inclusive of the HICMR Consultants.

There are documented terms of reference sighted- Infection Prevention and Control Committee(IPC) Terms of Reference 3/23. The IPC committee reports up to the Quality and Risk Committee.

Training requirements has been determined and is monitored by management. Education status report provided verified an overall compliance of 90.79 % (Aseptic Technique - Theory 89 % and Infection Prevention and Control 87%).

Director of Nursing receives alerts from Victorian Health which would then be reported through the IPC Meeting and noting that the recruitment of the Infection Prevention and Control Coordinator will be involved in this role once they commence.

Rating

Met

Findings

-

Action 3.03

The health service organisation applies the quality improvement system from the Clinical Governance Standard when:

a. Monitoring the performance of infection prevention and control systems

b. Implementing strategies to improve infection prevention and control systems

c. Reporting to the governance body, the workforce, patients and other relevant groups on the performance of infection prevention and control systems

d. Monitoring the effectiveness of the antimicrobial stewardship program

e. Implementing strategies to improve antimicrobial stewardship outcomes

f. Reporting to the governance body, the workforce, patients and other relevant groups on antimicrobial stewardship outcomes

g. Supporting and monitoring the safe and sustainable use of infection prevention and control resources

Evidence Reviewed

Dorset Rehabilitation Centre has a comprehensive audit schedule for infection prevention and control systems. Audits sighted include:

- Antimicrobial Stewardship (AMS) audit completed on 11/23 with 72% compliance achieved.

- National Antimicrobial Prescribing Survey (NAPS) 2023– Compliance with Guidelines 93.3%; Appropriateness Documentation of indication 96.7%; review or stop date documented 60%

- National Hand Hygiene Initiative (NHHI) – period 3, 82.3 % compliance rate achieved.

- Transmission based precautions and Personal Protective Equipment (PPE), completed 07/24 with 100% compliance achieved.

- Environment cleaning/linen and laundry, completed on 08/24 with 82% compliance achieved.

- Sharps and waste handling, completed on 09/24 with 96% compliance achieved.

- Reusable equipment, completed on 08/24 with 92% compliance achieved. There is a clinical indicators program which is monitored via The Australian Council on Healthcare Standards (ACHS) clinical Indicator program. Audit results are provided to staff and data is provided through the committee structure. Infection control and prevention including antimicrobial stewardship are discussed at staff meetings and strategies are documented to improve performance where gaps are identified.

Dorset Rehabilitation Centre utilises the services of an external consultant, Healthcare Infection Control Management Resources (HICMR)to ensure practices are consistent relevant infection control standards Infection Prevention and Control. Annual reviews conducted focusing on the following areas IPC Program, Ward; Clinical waste; Environmental Services; Food Services; Maintenance; Staff Health; Hydrotherapy and Allied Health with reports sighted.

Reporting to patients on antimicrobial stewardship outcomes occurs via a displayed AMS poster in the clinical areas.

Rating

Met

Findings

-

Action 3.04

Clinicians use organisational processes consistent with the Partnering with Consumers Standard when assessing risks and preventing and managing infections, and implementing the antimicrobial stewardship program to:

a. Actively involve patients in their own care

b. Meet the patient's information needs

c. Share decision-making

Evidence Reviewed

Patients and staff interviewed by members of the assessment team were able to describe the actions taken to involve and inform them about infection prevention and control as well as AMS measures. Information is available to patients, carers and families in a format that is easily understood.

Patient brochures are available, sighted in the clinical area include ACSQHC - "Do I really need antibiotics? "

Rating
Met
Findings
-

Action 3.05
The health service organisation has a surveillance strategy for infections, infection risk, and antimicrobial use and prescribing that: a. Incorporates national and jurisdictional information in a timely manner b. Collects data on healthcare-associated and other infections relevant to the size and scope of the organisation c. Monitors, assesses and uses surveillance data to reduce the risks associated with infections d. Reports surveillance data on infections to the workforce, the governing body, consumers and other relevant groups e. Collects data on the volume and appropriateness of antimicrobial use relevant to the size and scope of the organisation f. Monitors, assesses and uses surveillance data to support appropriate antimicrobial prescribing g. Monitors responsiveness to risks identified through surveillance h. Reports surveillance data on the volume and appropriateness of antimicrobial use to the workforce, the governing body, consumers and other relevant groups
Evidence Reviewed
Dorset Rehabilitation Centre monitors and collects data on healthcare related infections and antimicrobial used as well as broader infection control surveillance data. The collection of clinical indicators is also monitored via The Australian Council on Healthcare Standards (ACHS) clinical Indicator program. The facility contribute to the National Antimicrobial Prescribing Survey (NAPS) annually, 2023 audit results sighted with 93.3% compliance with guidelines. The program is evaluated and performance is monitored with reports provided to clinicians via the Medical Advisory Committee and also to the Victorian Rehabilitation Hospitals Infection Prevention and Control Committee Meeting minutes sighted 30/10/24 with a consumer present. Consumers are provided with data via the Consumer Committee (16/07/24 and 24/09/24).
Rating
Met
Findings
-

Action 3.06
The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare, jurisdictional requirements, and relevant jurisdictional laws and policies, including work health and safety laws
Evidence Reviewed
The review of infection control documents at Dorset Rehabilitation Centre specifically transmission based precautions indicates that processes are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare standard. Processes were observed to be consistent with the policy 15.03 Standard and Transmission-Based Precautions 06/23.
Rating
Met
Findings
-

Action 3.07
The health service organisation has: a. Collaborative and consultative processes for the assessment and communication of infection risks to patients and the workforce b. Infection prevention and control systems, in conjunction with the hierarchy of controls, in place to reduce transmission of infections so far as is reasonably practicable c. Processes for the use, training, testing and fitting of personal protective equipment by the workforce d. Processes to monitor and respond to changes in scientific and technical knowledge about infections, relevant national or jurisdictional guidance, policy and legislation e. Processes to audit compliance with standard and transmission- based precautions f. Processes to assess competence of the workforce in appropriate use of standard and transmission-based precautions g. Processes to improve compliance with standard and transmission-based precautions
Evidence Reviewed
Dorset Rehabilitation Centre has policies and processes for the management of organisms-specific risks, including prevalence in the community is in place that are consistent with jurisdictional and Public Health advice. Fit testing/checking training is undertaken and is monitored. Adequate PPE available for all staff was sighted in the clinical area.

Documentation and communication of infectious status is included with all documentation and communication is included in transfer of care and discharge processes. Dorset Rehabilitation Centre staff undertake mandatory training for the appropriate use of standard and transmission-based precautions.

Rating

Met

Findings

-

Action 3.08

Members of the workforce apply standard precautions and transmission-based precautions whenever required, and consider:

a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated during care

b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance

c. Accommodation needs and patient placement to prevent and manage infection risks

d. The risks to the wellbeing of patients in isolation

e. Environmental control measures to reduce risk, including but not limited to heating, ventilation and water systems; work flow design; facility design; surface finishes

f. Precautions required when a patient is moved within the facility or between external services

g. The need for additional environmental cleaning or disinfection processes and resources

h. The type of procedure being performed

i. Equipment required for routine care

Evidence Reviewed

Procedures are available for implementing standard and transmission-based precautions for all staff. Staff were able to confirm their use and understanding of these measures and risk screening procedures. Dorset Rehabilitation Centre is designed to effectively manage infection risks with single rooms available. Negative pressure rooms are not available, should the patient require a negative pressure room the patient would be transferred to an appropriate facility.

Environmental management and cleaning practices are consistent with policy with cleaning checklist sighted on the ward areas.

Monitoring processes occurs via the audit schedule with audit completed 7/24 Transmission based precautions and PPE with a 100% compliance achieved.

There is a transmissions precautions outbreak kit available with weekly checks conducted.

Rating

Met

Findings
-

Action 3.09
The health service organisation has processes to: a. Review data on and respond to infections in the community that may impact patients and the workforce b. Communicate details of a patient's infectious status during an episode of care, and at transitions of care c. Provide relevant information to a patient, their family and carers about their infectious status, infection risks and the nature and duration of precautions to minimise the spread of infection
Evidence Reviewed
Communication of a patient's infectious status is included at all transfer of care/handover points and compliance is monitored. Infectious status is documented on the Nursing Handover Report. Patients, carers, families and visitors are alerted to precautions that are required with posters describing the required precautions at the entry points of clinical areas. The following patient episodes of care witnessed by the assessor verified processes: - Clinical Handover from morning to afternoon staff MRN #215063; #215062; #15050; #206720; #215055 and #215058 - Ward huddle between morning staff and afternoon staff - Group clinical handover from night duty staff to morning staff
Rating
Met
Findings
-

Action 3.10
The health service organisation has a hand hygiene program that is incorporated in its overarching infection prevention and control program as part of standard precautions and: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with benchmarks and the current National Hand Hygiene Initiative

c. Provides timely reports on the results of hand hygiene compliance audits, and action in response to audits, to the workforce, the governing body, consumers and other relevant groups

d. Uses the results of audits to improve hand hygiene compliance

Evidence Reviewed

The Hand Hygiene program is consistent with the current National Hand Hygiene Initiative (NHHI) and jurisdictional requirements. The organisation has access to Hand Hygiene auditors that have undertaken the NHHI training. Good hand hygiene practices were observed during the assessment in the clinical area. Hand hygiene posters were sighted in the clinical area with a "Bare below the elbow" poster also displayed.

National Hand Hygiene Initiative (NHHI) – period 3, 82.3% compliance rate achieved.

Rating

Met

Findings

-

Action 3.11

The health service organisation has processes for aseptic technique that:

a. Identify the procedures in which aseptic technique applies

b. Assess the competence of the workforce in performing aseptic technique

c. Provide training to address gaps in competency

d. Monitor compliance with the organisation's policies on aseptic technique

Evidence Reviewed

The health service organisation has processes for aseptic technique that identify the procedures where aseptic technique is required, assess the competence of the workforce in performing these techniques, provide training to address any gaps in competency, and monitor compliance with the organisation's policies on aseptic technique. Aseptic technique is addressed in the Risk Register, Risk ID #18176 Aseptic technique training credentialed Medical Practitioners.

Rating

Met

Findings
-

Action 3.12
The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare17
Evidence Reviewed
Training and assessment for the management of invasive devices are available to staff and align with the current best practice. Noted that Healthscope are currently reviewing their Intravenous (IV) Cannulation program which was evidenced in the Healthscope VIC/TAS Educators 2024 Q4 Meeting Agenda. Monitoring of invasive devices is conducted via the peripheral intravenous catheter chart medical record HMR6 and the Central Venous Access Device (CVAD) medical record HMR6c
Rating
Met
Findings
-

Action 3.13
The health service organisation has processes to maintain a clean, safe and hygienic environment – in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare17 and jurisdictional requirements – to: a. Respond to environmental risks, including novel infections b. Require cleaning and disinfection using products listed on the Australian Register of Therapeutic Goods, consistent with manufacturers' instructions for use and recommended frequencies c. Provide access to training on cleaning processes for routine and outbreak situations, and novel infections d. Audit the effectiveness of cleaning practice and compliance with its environmental cleaning policy e. Use the results of audits to improve environmental cleaning processes and compliance with policy

Evidence Reviewed
Cleaning procedures and schedules are in place with regular auditing and reports made available through the committee structure. A sample of cleaning schedules for Dorset Rehabilitation Centre were reviewed by the assessors and staff interviewed regarding cleaning processes had a good knowledge and understanding of the cleaning requirements. It was verified that the cleaning staff have access to training on cleaning processes for routine and outbreak situations, and novel infections. The policy 1.29 Procurement 4/24 outlines that all products utilised for cleaned or disinfecting medical devices is ARTG listed. Environmental cleaning is monitored through the audit schedule with an audit conducted 08/24, Environment cleaning/linen and laundry with 82% compliance achieved.
Rating
Met
Findings
-

Action 3.14
The health service organisation has processes to evaluate and respond to infection risks for: a. New and existing equipment, devices and products used in the organisation b. Clinical and non-clinical areas, and workplace amenity areas c. Maintenance, repair and upgrade of buildings, equipment, furnishings and fittings d. Handling, transporting and storing linen e. Novel infections, and risks identified as part of a public health response or pandemic planning
Evidence Reviewed
Dorset Rehabilitation Centre has infection control processes, policies and procedures to respond to infection risks for equipment, devices, products, buildings and linen that is responsive to novel infections risks and pandemic planning. All new products are reviewed and assessed for infection related risk. Maintenance is both scheduled and responsive to failure with the facility utilising BGIS for all maintenance. Linen handling and storage was sighted and appropriate, conformance report from the external contractor dated 30/03/24 confirms compliance to AS/NZ 4146:2000. Audit completed on 08/24, Environment cleaning/linen and laundry 82% compliance achieved.
Rating
Met

Findings
-

Action 3.15
The health service organisation has a risk-based workforce vaccine- preventable diseases screening and immunisation policy and program that: a. Is consistent with the current edition of the Australian Immunisation Handbook19 b. Is consistent with jurisdictional requirements for vaccine- preventable diseases c. Addresses specific risks to the workforce, consumers and patients
Evidence Reviewed
There is a risk-based workforce vaccine-preventable disease screening and immunisation program consistent with the current edition of the Australian Immunisation Handbook in place at Dorset Rehabilitation Centre . HICMR complete an annual review which was last conducted on 11/25 with a 96.4% achieved. All Credentialled Practitioners have returned their Credentialled Practitioner Declaration Training and Vaccination forms. A Credentialled Practitioners Immunisation Data base is maintained and is monitored by the General Manager.
Rating
Met
Findings
-

Action 3.16
The health service organisation has risk-based processes for preventing and managing infections in the workforce that: a. Are consistent with the relevant state or territory work health and safety regulation and the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare17 b. Align with state and territory public health requirements for workforce screening and exclusion periods c. Manage risks to the workforce, patients and consumers, including for novel infections d. Promote non-attendance at work and avoiding visiting or volunteering when infection is suspected or actual e. Monitor and manage the movement of staff between clinical areas, care settings, amenity areas and health service organisations

f. Manage and support members of the workforce who are required to isolate and quarantine following exposure to or acquisition of an infection

g. Provide for outbreak monitoring, investigation and management

h. Plan for, and manage, ongoing service provision during outbreaks and pandemics or events in which there is increased risk of transmission of infection

Evidence Reviewed

There are policies and procedures consistent with jurisdictional regulations to prevent and manage infections in the workforce. The program for workforce screening and workplace exclusion is aligned with Victorian Health directions.

A tiered approach to outbreak and pandemic planning and management is in place.

Risks associated with novel infections is addressed through the risk register, ID # 19119 Pandemic (e.g. COVID-19) affecting the community, country or greater population.

Staff confirmed that management promote non-attendance at work when staff are sick and visitors would be restricted.

Rating

Met

Findings

-

Action 3.17

When reusable equipment and devices are used, the health service organisation has:

a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines

b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying

• the patient

• the procedure

• the reusable equipment, instruments and devices that were used for the procedure

c. Processes to plan and manage reprocessing requirements, and additional controls for novel and emerging infections

Evidence Reviewed

Evidence sighted in the clinical area that non critical reusable equipment and devices are cleaned between each patient use with a weekly reusable equipment schedule in place also with checklists maintained.

Audit results for cleaning reusable equipment/ clean in between conducted 08/24 with 92% compliance achieved.

Rating
Met
Findings
-

Action 3.18
The health service organisation has an antimicrobial stewardship program that: a. Includes an antimicrobial stewardship policy b. Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing c. Has an antimicrobial formulary that is informed by current evidence- based Australian therapeutic guidelines and resources, and includes restriction rules and approval processes d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard e. Acts on the results of antimicrobial use and appropriateness audits to promote continuous quality improvement
Evidence Reviewed
Dorset Rehabilitation Centre has established an antimicrobial stewardship program that is guided by evidenced based policy. There is a Local site policy Anti-Microbial and Management policy which is which is currently under review. Access to the current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing was evidenced through "HINT" Healthscope intranet. The facility contribute to the National Antimicrobial Prescribing Survey (NAPS) annually, 2023 audit results sighted with 93.3% compliance with guidelines. The program is evaluated and performance is monitored with reports provided to clinicians via the Medical Advisory Committee (21/05/2024) and also the Victorian Rehabilitation Hospitals Infection Control Committee meeting (minutes sighted 30/10/24). Availability of an Infectious disease physician is via the Victorian Rehabilitation Hospitals network.
Rating
Met
Findings
-

Action 3.19
The antimicrobial stewardship program will:

a. Review antimicrobial prescribing and use

b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing

c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use

d. Report to clinicians and the governing body regarding

• compliance with the antimicrobial stewardship policy and guidance

• areas of action for antimicrobial resistance

• areas of action to improve appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing

• the health service organisation's performance over time for use and appropriateness of use of antimicrobials

Evidence Reviewed

Dorset Rehabilitation Centres documentation showed that the antimicrobial stewardship program is audited to review the antimicrobial prescribing and use, including surveillance data on antimicrobial resistance. The facility contribute to the National Antimicrobial Prescribing Survey (NAPS) annually, 2023 audit results sighted with 93.3% compliance with guidelines. The program is evaluated and performance is monitored with reports provided to clinicians via the Medical Advisory Committee (21/05/2024) and also the Victorian Rehabilitation Hospitals Infection Control Committee meeting (minutes sighted 30/10/24).

Clinicians interviewed were able to describe the processes in place to evaluate antimicrobial use and how surveillance data on local antimicrobial resistance is used to support appropriate prescribing.

Patient brochures are available, sighted in the clinical area ACSQHC - "Do I really need antibiotics? "

Rating

Met

Findings

-

Action 4.01

Clinicians use the safety and quality systems from the Clinical Governance Standard when:

a. Implementing policies and procedures for medication management

b. Managing risks associated with medication management

c. Identifying training requirements for medication management

Evidence Reviewed
Dorset Rehabilitation Centre has in place a hospital-wide system for safety in the supply, storing, prescribing and administration of medication which is outlined in the following policies which are available to all staff. - 18.89 Medication Safety Governance including APINCHS 07/2023 - 18.01 Medications Orders and Administration 5/2021 - 18.75 Medication Management Plan 11/2019 - 2.45 Alerts- Documentation and Management 10/20 - 18.85 Best Possible Medication History, Obtaining of 4/21 - 18.49 Discharge Medication 4/2023 - 18.02 Enrolled Nurse - Administration of Medication 10/2021 - Drugs, Poisons and Controlled Substances Permit is displayed in the facility. Risks associated with medication management are documented within the risk register and reviewed regularly. - Risk ID # 15985 Discharge Medication - inadequate management - Risk ID # 15984 Illegible Medication Order - Risk ID # 15981 Verbal / Telephone Medication Order - non compliance - Risk ID # 15948Medication Administration – medication error - Risk ID # 15986 Narcotic (S8) medication - non compliance with legislation The HPS Pharmacist is involved in the education of the staff with at least 4 in-services completed annually. Dorset Rehabilitation Centre has identified training requirements for medication management which include Medication Calculation Quiz with a completion of 94% verified.
Rating
Met
Findings
-

Action 4.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes

c. Reporting on outcomes for medication management

Evidence Reviewed

Dorset Rehabilitation Centre applies the quality improvement system from the Clinical Governance Standard by monitoring the effectiveness and performance of medication management, implementing strategies to improve outcomes and associated processes, and reporting on medication management outcomes.

The following evidence supports and confirms the statements above:

- Audit schedule
- Medical record documentation completed 07/24 with 97% compliance achieved.
- ACHS Clinical indicator report second Half 2023 medication safety
- Quality Improvement ID #16711, safe selection and storage of medications has commenced.
- Quality Improvement ID #12391, improve S8 medication storage and administration processes- completed 10/24.
- Quality Improvement ID #16405, to have information for staff on what to do if an entry is made incorrectly in the DD medication book which was closed 10/24 with the introduction of posters.

Reporting on outcomes for medication management occurs through the committee framework, minutes sighted for the Medication Safety Committee sighted (22/05/2024 & 28/08/2024).

Rating

Met

Findings

-

Action 4.03

Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to:

a. Actively involve patients in their own care

b. Meet the patient's information needs

c. Share decision-making

Evidence Reviewed
Dorset Rehabilitation Centre has a strong focus on the involvement of consumers, carers, and patients in medication management. Every effort is made by staff to ensure that there is a clear understanding of the effects of prescribed medications and their correct use during their stay and prior to patient discharge. Patients and/or carers are encouraged to ask questions and importantly report any side effects or other reactions they may be experiencing. Patients are also be provided with information in either verbal, written form, or both to inform them on any special instructions, directions and/or precautions. This information is made available to the carers and /or families who may be monitoring the administration of a patient's prescribed medication post discharge. Staff can also organise individual sessions with the Pharmacist as required.
Rating
Met
Findings
-

Action 4.04
The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians
Evidence Reviewed
Processes are in place for ensuring that all relevant clinicians operate within their medicines scope of clinical practice. Any incidents that have been reported either as an incident or a near miss in either prescribing, dispensing and/or administration that may have occurred outside a clinician's scope of practice are subject to incident review, further reporting and when and if required further education. Monitoring of all Visiting Medical Officers, Registered Nurses Australian Health Practitioner Regulation Agency (APHRA) is monitored.
Rating
Met
Findings
-

Action 4.05
Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care

Evidence Reviewed
Clinicians take a best possible medication history on admission utilising pre-admission information provided by the patient. This may be taken and documented with input from a carer or family member. Patients, carers, and families are encouraged to be active participants if this is considered appropriate by both the patient and the clinician. Important information is documented on allergies and adverse drug reactions on the Alert Sheet. This process was verified through the witnessed patient admission MRN #138167 .
Rating
Met
Findings
-

Action 4.06
Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care
Evidence Reviewed
Discussions with the Pharmacist verified medication reconciliation is undertaken at admission with documentation of this reconciliation process documented in the Medical Records. Completion of medication management plan by the Pharmacist (MRN # 211626) was observed during the assessment.
Rating
Met
Findings
-

Action 4.07
The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation

Evidence Reviewed
The process for identifying and documenting medication allergies and adverse drug reactions is well defined and monitored. Discussion with staff and sampling of patient records verified these processes. Review of patient records confirmed appropriate processes are undertaken, MRN #215009; #012543; #13263; #211616; #214943; #214970 and #214965.
Rating
Met
Findings
-

Action 4.08
The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system
Evidence Reviewed
The medication error reporting systems (RiskMan) are maintained by a hospital-wide approach to supporting and encouraging medication adverse drug reactions reporting by both documenting in the clinical record and RiskMan. All medication incidents are reviewed by the Medication Safety Committee. This process contributes to and is a focus to manage medication risks and uses the investigation of medication error/s and near misses to improve medication safety. Minutes sighted for the Medication Safety Committee sighted (22/05/2024 & 28/08/2024).
Rating
Met
Findings
-

Action 4.09
The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements
Evidence Reviewed
Policies and guidelines are in place to report adverse drug reactions experienced by patients in their care journey to the Therapeutic Goods Administration (TGA).Discussions with the Pharmacist confirmed the reporting process to TGA.

Rating
Met
Findings
-

Action 4.10
The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result
Evidence Reviewed
Medication reviews are practised in line with best practice guidelines. Medication reviews may be based on a patient's clinical presentation, pre-admission medication prescriptions or due to a change in medication treatment.
Rating
Met
Findings
-

Action 4.11
The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks
Evidence Reviewed
Information for patients on specific medications is available to clinicians and appropriate to the patient population. The pharmacist provides education to patients with this process generally completed on a one on one basis with written information provided as required.
Rating
Met

Findings
-

Action 4.12
The health service organisation has processes to: a. Generate a current medicines list and the reasons for any changes b. Distribute the current medicines list to receiving clinicians at transitions of care c. Provide patients on discharge with a current medicines list and the reasons for any changes
Evidence Reviewed
A component of discharge documentation is the provision of a current medicines list which is given to the patient on discharge. This list is provided to the patient, which is generated by the pharmacist, education is undertaken with the Patient and their Carer as required. Verified for the patient MRN #215009 and #012543. The medication chart is utilised and discussed during the bedside clinical handover.
Rating
Met
Findings
-

Action 4.13
The health service organisation ensures that information and decision support tools for medicines are available to clinicians
Evidence Reviewed
Medication prescribing decision support tools are readily available for clinicians including the eMims, Australian Injectable Drug Book and Don’t rush to crush. All these are known to and accessible to staff. Staff have access to the pharmacist during business hours who is a valuable resource to staff and patients.
Rating
Met

Findings
-

Action 4.14
The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the: a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted or expired medicines
Evidence Reviewed
Dorset Rehabilitation Centre adheres to the jurisdictional requirements for the safe and secure storage, recording and administration of medication as evidenced by assessors in the clinical areas. The storage of temperature sensitive medicines, storage, disposal was all evidenced with records maintained. The assessors confirmed the checking of the scheduled medications between shifts with associated documentation in the registers with the staff. Appropriate management of the DD keys was also observed during the assessment.
Rating
Met
Findings
-

Action 4.15
The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely
Evidence Reviewed
Interviews with staff and supporting documents and assessor observations that high risk medications are clearly identified and that there is an appropriate management system in place for the storage, dispensing and administration of those medications. Scheduled drugs are recorded in appropriate registers and audited within the audit framework. Compliance to the policy 18.89 Medication Safety Governance including APINCH 07/23 was verified. Monitoring is conducted via the audit schedule.

Rating
Met
Findings
-

Action 5.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for comprehensive care b. Managing risks associated with comprehensive care c. Identifying training requirements to deliver comprehensive care
Evidence Reviewed
The requirements of this action are well supported by the management of Dorset Rehabilitation Centre through appropriate safety strategies. Systems and processes based on best practice guidelines and industry standards, support clinicians to deliver comprehensive care. Policies are procedure are predominately managed at a corporate level with some local site policies in place. Risks associated with associated with comprehensive care - ID # 16013 Slips, trips and falls - inadequate prevention and management of - ID # 15943 Suicide/Self Harm - inadequate assessment, prevention and management - ID # 17227 Pressure injury inadequate prevention and management Training requirements have been identified to deliver comprehensive care and available to staff via eLearning.
Rating
Met
Findings
-

Action 5.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care

b. Implementing strategies to improve the outcomes from comprehensive care and associated processes

c. Reporting on delivery of comprehensive care

Evidence Reviewed

Comprehensive care is defined and monitored with outcomes and audits reviewed at the Quality and Risk Committee meetings, minutes sighted 4/06/24; 13/08/24 and 1/10/24. Dorset Rehabilitation Centre uses feedback, data and outcomes together with evidenced based practice to support improvements in care. Submission of Clinical Indicators to the Australasian Rehabilitation Outcomes Centres (AROC) which is a benchmarking system to improve clinical rehabilitation outcomes. AROC reports July 2023 – June 2024 sighted.

Rating

Met

Findings

-

Action 5.03

Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to:

a. Actively involve patients in their own care

b. Meet the patient's information needs

c. Share decision-making

Evidence Reviewed

Processes are in place to partner with patients in their care and associated decision-making as best suits the patient. Staff were able to describe to the assessors how they actively achieve this, and patients reported that they felt actively engaged in, and informed about their care. Assessors observed staff and clinician interviews with patients throughout various patient episodes of care witnessed, that were patient centred and involved shared decision-making.

Rating

Met

Findings

-

Action 5.04
The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify, at all times, the clinician with overall accountability for a patient's care
Evidence Reviewed
Clinicians are supported by policies and procedures to establish effective comprehensive plans for patients' care and treatment. Dorset Rehabilitation Centre operates within their scope of service to provide care that best meets the patient's needs and has established protocols and processes for referral where needed. The clinician with overall accountability for a patient's care is defined as admitting VMO.
Rating
Met
Findings
-

Action 5.05
The health service organisation has processes to: a. Support multidisciplinary collaboration and teamwork b. Define the roles and responsibilities of each clinician working in a team
Evidence Reviewed
There are processes in place to support multidisciplinary collaboration and teamwork which was verified through the witnessed patient episodes of care including the Multidisciplinary Team (MDT) Meeting which occurred on 27/11/24, attendance include the Rehabilitation Specialist, Nurse Unit Manager, Physiotherapist x 2 and Occupational Therapist x 1 with discussion of patients MRN #211626; #214057 and #215061. Roles and responsibilities are clearly defined through contracts and position descriptions. A system is in place for orientation, performance review and ongoing education.
Rating
Met
Findings
-

Action 5.06
Clinicians work collaboratively to plan and deliver comprehensive care
Evidence Reviewed
The assessors witnessed collaborative engagement with patients receiving care and with family and carers, where required, to screen for risk. A range of policies and procedures are in place to support the clinical team to deliver comprehensive care. Collaboration to plan and deliver comprehensive care was evident during the Multidisciplinary Team (MDT) Meeting which occurred on 27/11/24 attendance include the Rehabilitation Specialist, Nurse Unit Manager, Physiotherapist x 2 and Occupational Therapist x 1. Discussion of patients MRN #211626; #214057 and #215061.
Rating
Met
Findings
-

Action 5.07
The health service organisation has processes relevant to the patients using the service and the services provided: a. For integrated and timely screening and assessment b. That identify the risks of harm in the ‘Minimising patient harm' criterion
Evidence Reviewed
Processes are in place to screen and assess inpatients for risks aimed at minimising preventable harm. Staff were able to describe the risk assessment process and evidence was sighted in clinical documentation. Regular audits are undertaken to support that timely and comprehensive risk screening and patient assessment is completed. A review of medical records verified the screening process for inpatients with the completion of the Comprehensive Risk Screening within the medical record HMR 6.1G MRN #215009; #012543; #13263; #211616; #214943; #214970 and #214965. Monitoring is conducted via the audit schedule with the audit on Comprehensive Care completed 08/24 with 82% compliance achieved. Processes for risk screening for outpatients is not fully implemented. Final Review Evidence reviewed at the Final Review confirms the implementation of processes for risk screening of patients receiving outpatient clinical care. The following evidence was sighted:

- Establishment of local working Multidisciplinary Team (MDT) party commenced with meeting minutes provided (13/01/2025, 29/01/2025 & 12/02/2025). Focus of the working party on Outpatient/Day patient Program services processes, in particular, the development and implementation of risk screening processes for outpatient programs.

- Committee meeting minutes review of Short Notice Assessment findings (Quality & Risk 03/12/2024, Medical Advisory Committee 11/02/2025 , Consumer Committee Meeting 17/12/2024, National Standard 4 26/02/2025 & Forms Committee 05/02/205)

- Development of Healthscope Day Rehabilitation/Outpatient Risk Screening Form inclusive of infection screening, mental health, substance use and behaviour, cognition, mental health, malnutrition, falls.

- Submitted to Healthscope National Forms Manager and National Policy & Forms Committee for approval with form allocated form identifier HMR 6.13K

- Local Working Party to continue meeting across 1H 2025 to enable roll out of form

- Now to be included as agenda item in the National Rehabilitation Committee (06/03/2025) to assist with the potential as a national project and inclusion into MARS audit tool development and Healthscope policy integration

Rating

Met

Findings

-

Action 5.08

The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems

Evidence Reviewed

Dorset Rehabilitation Centre has processes in place for identifying Aboriginal and Torres Strait Islander patients and recording this information in administrative and clinical information systems.

Rating

Met

Findings

-

Action 5.09
Patients are supported to document clear advance care plans
Evidence Reviewed
The health service organisation has processes in place to ensure patients receive support to document clear advance care plans. The following evidence supports and confirms the statements above: - 2.56 Advance Care Directives 07/22 - Rehab Assessment Form HMR 4.58
Rating
Met
Findings
-

Action 5.10
Clinicians use relevant screening processes: a. On presentation, during clinical examination and history taking, and when required during care b. To identify cognitive, behavioural, mental and physical conditions, issues, and risks of harm c. To identify social and other circumstances that may compound these risks
Evidence Reviewed
A comprehensive assessment is conducted on admission. Risk screening processes are subject to audits and reports are reviewed and reported through Dorset Rehabilitation Centre Committee structure. A review of medical records verified the screening process for inpatients with the completion of the Comprehensive Risk Screening within the medical record HMR 6.1G MRN #215009; #012543; #13263; #211616; #214943; #214970 and #214965. Monitoring is conduced via the audit schedule with the audit on Comprehensive Care completed 08/24 with 82% compliance achieved.
Rating
Met
Findings
-

Action 5.11
Clinicians comprehensively assess the conditions and risks identified through the screening process
Evidence Reviewed
Risks are identified using standardised screening tools which identify the level of risk and appropriate actions to mitigate them. A review of medical records verified the screening process for inpatients with the completion of the Comprehensive Risk Screening within the medical record HMR 6.1G MRN #215009; #012543; #13263; #211616; #214943; #214970 and #214965.
Rating
Met
Findings
-

Action 5.12
Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record
Evidence Reviewed
Documentation reviewed by the assessors demonstrated that processes are in place for implementing policies, managing risks and identifying the training required to deliver comprehensive care. The risk screening tools utilised on admission and throughout the patient journey enables effective management of risk, prevention of deterioration and the development of an individualised appropriate care plan, provision of ongoing care. The use of the Alert Form facilitates communication of the risks/alerts.
Rating
Met
Findings
-

Action 5.13
Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care

c. Identifies the support people a patient wants involved in communications and decision-making about their care

d. Commences discharge planning at the beginning of the episode of care

e. Includes a plan for referral to follow-up services, if appropriate and available

f. Is consistent with best practice and evidence

Evidence Reviewed

Clinicians and patients were able to describe the role patients, carers and families play in their care and in determining patient centred goals and how it aims to best meet their specific needs. A review of clinical documentation by the assessors reflected this and demonstrated that comprehensive discharge planning is initiated as early as possible in the patient's journey. The assessors witnessed interactions between staff, patients, their carers and families that demonstrated this partnership in care and decision making.

Witnessed patient episodes of care confirmed processes:

- Patient discharge MRN # 215009 and # 012543
- Clinical Handover from morning to afternoon staff MRN #215063;#215062; #15050; #206720; #215055 and #215058

Rating

Met

Findings

-

Action 5.14

The workforce, patients, carers and families work in partnership to:

a. Use the comprehensive care plan to deliver care

b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care

c. Review and update the comprehensive care plan if it is not effective

d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur

Evidence Reviewed

Consumers have an opportunity to be involved with the clinical care and decision-making through pre-admission, admission and discharge procedures and consumer feedback mechanisms. Evidence provided supported that the care planning process is patient centred and well documented.

Witnessed patient episodes of care confirmed processes:

- Patient discharge MRN # 215009 and # 012543

- Clinical Handover from morning to afternoon staff MRN #215063;#215062; #15050; #206720; #215055 and #215058

Rating
Met
Findings
-

Action 5.15
The health service organisation has processes to identify patients who are at the end of life that are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care
Evidence Reviewed
Dorset Rehabilitation Centre does not currently provide end of life care; however, they have the capability with determined corporate end of life care resources and clinical governance processes, consistent with the requirements of the National Consensus Statement to accommodate and manage this care in the future.
Rating
Met
Findings
-

Action 5.16
The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice
Evidence Reviewed
Dorset Rehabilitation Centre does not currently provide end of life care; however, they have the capability with determined corporate end of life care resources and clinical governance processes, consistent with the requirements of the National Consensus Statement to accommodate and manage this care in the future.
Rating
Met

Findings
-

Action 5.17
The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record
Evidence Reviewed
Advanced Care Plans received from patients are documented in the patient's medical health record HMR4.5B.
Rating
Met
Findings
-

Action 5.18
The health service organisation provides access to supervision and support for the workforce providing end-of-life care
Evidence Reviewed
Dorset Rehabilitation Centre does not currently provide end of life care; however, they have the capability with determined corporate end of life care resources and clinical governance processes, consistent with the requirements of the National Consensus Statement to accommodate and manage this care in the future.
Rating
Met
Findings
-

Action 5.19
The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care
Evidence Reviewed
Dorset Rehabilitation Centre does not currently provide end of life care; however, they have the capability with determined corporate end of life care resources and clinical governance processes, consistent with the requirements of the National Consensus Statement to accommodate and manage this care in the future.
Rating
Met
Findings
-

Action 5.20
Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care
Evidence Reviewed
Dorset Rehabilitation Centre does not currently provide end of life care; however, they have the capability with determined corporate end of life care resources and clinical governance processes, consistent with the requirements of the National Consensus Statement to accommodate and manage this care in the future.
Rating
Met
Findings
-

Action 5.21
The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines

Evidence Reviewed
There is provision for a skin assessment to be performed on admission, Comprehensive Risk Screening Tool 6.13G which is undertaken on admission and includes a skin assessment which is repeated at least every seven days. Incidents are reported and managed through RiskMan. Sampling of medical records verified processes, MRN #215009; #012543; #13263; #211616; #214943; #214970 and #214965.
Rating
Met
Findings
-

Action 5.22
Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency
Evidence Reviewed
Appropriate care and advice is given, with staff ensuring that the clinical teams are aware of any compromise to skin integrity. Any pressure injuries are recorded through RiskMan. Regular audits are built into the annual audit schedule.
Rating
Met
Findings
-

Action 5.23
The health service organisation providing services to patients at risk of pressure injuries ensures that: a. Patients, carers and families are provided with information about preventing pressure injuries b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries

Evidence Reviewed
Staff have appropriate equipment available to them to aid in managing risks to skin integrity. Equipment, products and devices, including air mattresses are available to prevent and manage pressure injuries, the assessor witness the availability of products. Noted during the review it was observed that patient MRN # 13263 was provided with a roho cushion and an air mattress.
Rating
Met
Findings
-

Action 5.24
The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: a. Falls prevention b. Minimising harm from falls c. Post-fall management
Evidence Reviewed
All patients are assessed on admission against a standardised screening tool, Comprehensive Risk Screening Tool 6.13G which is undertaken on admission and includes a Falls Risk Screen which is repeated at least every seven days. Incidents of falls are reported and managed through RiskMan. Patients at risk of falls are highlighted on the Patient Care Board and documented on the ISOBAR handover sheet. Sampling of medical records MRN #213313 and # 211867 verified the post fall huddle process with a falls alert sticker placed in the medical records.
Rating
Met
Findings
-

Action 5.25
The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls

Evidence Reviewed
Patient are assessed on admission by the physiotherapist as to the most appropriate aides required. Mobility aides are also identified and communicated on the ISOBAR handover sheet. Noted the Safe Operating Procedures for the RAIZER II Patient lifting device 05/23.
Rating
Met
Findings
-

Action 5.26
Clinicians providing care to patients at risk of falls provide patients, carers and families with information about reducing falls risks and falls prevention strategies
Evidence Reviewed
Falls prevention information is provided by the physiotherapist to patients and families. Referral pathways are available for patients on discharge if required.
Rating
Met
Findings
-

Action 5.27
The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice
Evidence Reviewed
Dorset Rehabilitation Centre has a food safety program in place which is audited by an external third party process, Blonde Rust Project, certificate of adequacy and compliance report dated 19/06/24 sighted with a follow up completed on 02/08/2024 outlining compliance with the applicable food safety standards. Registration of food premises under the Food Act 1984 expiry 31/12/2024.

Rating
Met
Findings
-

Action 5.28
The workforce uses the systems for preparation and distribution of food and fluids to: a. Meet patients' nutritional needs and requirements b. Monitor the nutritional care of patients at risk c. Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone d. Support patients who require assistance with eating and drinking
Evidence Reviewed
The workforce utilises the systems for the preparation and distribution of food and fluids to meet patients' nutritional needs and requirements, monitor the nutritional care of patients at risk, identify and provide access to nutritional support for patients who cannot meet their nutritional needs through food alone, and support patients who require assistance with eating and drinking. Referral to the dietitian is based on the outcome of the Comprehensive Risk Screening Tool 6.13G which is undertaken on admission and includes a Malnutrition Risk Screen which is repeated at least every seven days. Sampling of the patient medical record MRN # 215053 verified the referral process to the dietitian with completion of the Nutrition and Dietetics initial assessment form HMR 6.16. Malnutrition poster displayed in the clinical areas which provides information to staff on malnutrition and it associated risks. Malnutrition was noted to be the education focus of the month.
Rating
Met
Findings
-

Action 5.29
The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to:

a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard, where relevant

b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation

Evidence Reviewed

Dorset Rehabilitation Centre has systems in place to care for patients who have cognitive impairment or are at risk of developing delirium as per 8.94 Delirium and Cognitive Impairment Prevention and Management Policy 4/24.Cognitive screening of patients consistent with the hospital policy was recorded in the patient medical record. Sampling of medical records verified the presence of cognitive assessment (4AT) MRN #215058; #215009 and #012543.

A gap analysis to the clinical care standard Psychotropic medicines in cognitive disability or impairment has been developed and presented at the Medical Advisory Committee dated 27/08/2024.

Rating

Met

Findings

-

Action 5.30

Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to:

a. Recognise, prevent, treat and manage cognitive impairment

b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care

Evidence Reviewed

Clinicians providing care to patients with cognitive impairment or those at risk of developing delirium use the system for caring for these patients to recognise, prevent, treat, and manage cognitive impairment. They also collaborate with patients, carers, and families to understand the patient and implement individualised strategies that minimise anxiety or distress during care. Cognitive screening of patients consistent with the hospital policy (8.94

Delirium and Cognitive Impairment Prevention and Management Policy 04/24) was recorded in the patient medical record. Sampling of medical records verified the presence of cognitive assessment (4AT) MRN #215058; #215009 and #012543.
Rating
Met
Findings
-

Action 5.31
The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed
Evidence Reviewed
Dorset Rehabilitation Centre has systems in place to support collaboration with patients, carers and families to identify when a patient is at risk of self-harm or suicide, as per the policy 2.54 Self-Harm and Suicide (Threatened, Attempted or Completed) in a Non-Mental Health Facility 12/23. There are quiet spaces within the facility to remove the patients from the immediate acute setting and de-escalate the immediate situation.
Rating
Met
Findings
-

Action 5.32
The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts
Evidence Reviewed
The local site policy 1.1.02 Admission exclusion criteria 11/23 excludes patents requiring mental health admission for admission to Dorset Rehabilitation Centre. However in the event that a patient may harm themselves or report suicidal thoughts the policy 2.54 Self-Harm and Suicide (Threatened,

Attempted or Completed) in a Non-Mental Health Facility 12/23 sets out to guide staff to ensures that follow-up arrangements are developed, communicated and implemented.
Rating
Met
Findings
-

Action 5.33
The health service organisation has processes to identify and mitigate situations that may precipitate aggression
Evidence Reviewed
Processes are in place to guide and support staff in the identification of situations that may result in aggressive behaviour, and how to manage them. Staff were able to describe how they work with patients and others to implement these strategies effectively. Incidents of aggression are reported and managed through RiskMan. Assessors observed Emergency Procedures posters available near all phones and throughout the facility. There are quiet spaces within the facility to remove the patients from the immediate acute setting and de-escalate the immediate situation. Staff undertake Healthscope - WAVE 1 - Managing Conflict & Challenging Behaviour training and education with a 96% completion rate noted.
Rating
Met
Findings
-

Action 5.34
The health service organisation has processes to support collaboration with patients, carers and families to: a. Identify patients at risk of becoming aggressive or violent b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce

Evidence Reviewed
Processes are in place to guide and support staff in the identification of situations that may result in aggressive behaviour, and how to manage them. Staff were able to describe how they work with patients and others to implement these strategies effectively. Incidents of aggression are reported through RiskMan. Assessors observed Emergency Procedures posters available near all phones and throughout the facility. There are quiet spaces within the facility to remove the patients from the immediate acute setting and de-escalate the immediate situation. Staff undertake Healthscope - WAVE 1 - Managing Conflict & Challenging Behaviour training and education with a 96% completion rate noted.
Rating
Met
Findings
-

Action 5.35
Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of restraint b. Govern the use of restraint in accordance with legislation c. Report use of restraint to the governing body
Evidence Reviewed
Dorset Rehabilitation Centre has restrictive practices protocols documented in the policy 8.95 Restrictive Practices - Patient Restraint (Non- Mental Health Facilities) 12/23. All episodes of restraint would be documented in RiskMan and reviewed if occurred.
Rating
Met
Findings
-

Action 5.36
Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that:

a. Minimise and, where possible, eliminate the use of seclusion
b. Govern the use of seclusion in accordance with legislation
c. Report use of seclusion to the governing body

Evidence Reviewed

The HSO is not a gazetted facility

Rating

Not Applicable

Findings

-

Action 6.01

Clinicians use the safety and quality systems from the Clinical Governance Standard when:
a. Implementing policies and procedures to support effective clinical communication
b. Managing risks associated with clinical communication
c. Identifying training requirements for effective and coordinated clinical communication

Evidence Reviewed

Policies and procedures are in place to support effective clinical communication including handover.
- 2.08 Patient Identification Bands 03/24
- 2.63 Patient Rounding 08/22
- 10.03 Admission of Patient - Rehabilitation 11/21
- 10.09 Care Conference , Rehabilitation 10/22
- 2.15 Correct Patient, Correct Procedure, Correct Site 07/22
- 2.50 Discharge of a Patient 07/22

Risks are managed through the Risk Register with frequency of reviews depending on risk level.
- ID #15946 Patient Identification -failure to identify
- ID # 17262 Clinical Handover -failure

Training is completed via eLearning and is monitored by management.

Rating
Met
Findings
-

Action 6.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes
Evidence Reviewed
The health service organisation applies the quality improvement system from the Clinical Governance Standard by monitoring the effectiveness of clinical communication and associated processes, implementing strategies to improve these processes, and reporting on the effectiveness and outcomes of clinical communication. The clinical handover audit conducted 07/24 with a 90% compliance achieved with a Quality improvement ID # 16702 Post Audit Action Plan. Reporting on the effectiveness and outcomes of clinical communication processes occurs at the Quality and Risk Committee Meeting with minutes sighted for 4/06/24; 13/08/24 and 1/10/24 and more recently the National Standards Committee Meeting with minutes sighted 19/11/2024.
Rating
Met
Findings
-

Action 6.03
Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making

Evidence Reviewed
Dorset Rehabilitation Centre has procedures and policies that support the engagement of patients, their carers and families in their own care and shared decision making process. Patients are involved in clinical handover and verification of this was witnessed by the assessors. Patients who were interviewed reported being engaged in their care and that they had adequate information available to them to make informed decisions about their care. During the assessment, the assessor had an opportunity to speak with a number of patients. The patients confirmed that adequate information had been provided throughout their episode of care and were happy with the care received and felt that their individual needs were met. They did not have any suggestion for improvement and felt safe and supported during their stay.
Rating
Met
Findings
-

Action 6.04
The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes
Evidence Reviewed
Policies and processes are in place to support staff use the appropriate identifiers when procedure matching, transfer of care, handover, discharge and where changes in clinical care/patient risk profile are identified. Documentation viewed by the assessors supports the use of specified identifiers in these situations. - Patient discharge MRN #215009 and #012543 - Clinical Handover from morning to afternoon staff MRN #215063;#215062; #15050; #206720; #215055 and #215058 - Completion of medication management plan by the Pharmacist MRN # 211626 - Administration of oral medication MRN #214998 - Multidisciplinary Team (MDT) Meeting 27/11/24 attendance include the Rehabilitation Specialist, Nurse Unit Manager, Physiotherapist x 2 and Occupational Therapist x 1. Discussion of patients MRN #211626; #214057 and #215061.
Rating
Met

Findings
-

Action 6.05
The health service organisation: a. Defines approved identifiers for patients according to best-practice guidelines b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated
Evidence Reviewed
Dorset Rehabilitation Centre has policies that define the use of three approved identifiers. Staff interviewed by the assessment team were able to describe how and when these are used. Patients were also able to describe the questions asked to confirm their identity and the assessors verified this when observing clinical bedside handover, admission of the patient, discharge of a patient and administration of oral medication.
Rating
Met
Findings
-

Action 6.06
The health service organisation specifies the: a. Processes to correctly match patients to their care b. Information that should be documented about the process of correctly matching patients to their intended care
Evidence Reviewed
Dorset Rehabilitation Centre has policies that define the use of three approved identifiers. The assessors noted the use of the approved patient identifiers during the clinical bedside handover, admission of the patient, discharge of a patient and administration of oral medication as set out in the policy 2.08 Patient Identification Bands 03/24. - Patient discharge MRN #215009 and #012543 - Clinical Handover from morning to afternoon staff MRN #215063; #215062; #15050; #206720; #215055 and #215058 - Completion of medication management plan by the Pharmacist MRN # 211626

- Administration of oral medication MRN #214998
- Multidisciplinary Team (MDT) Meeting 27/11/24 attendance include the Rehabilitation Specialist, Nurse Unit Manager, Physiotherapist x 2 and Occupational Therapist x 1. Discussion of patients MRN #211626; #214057 and #215061
- Patient admission MRN # 138167 – Gardenia Ward

Rating

Met

Findings

-

Action 6.07

The health service organisation, in collaboration with clinicians, defines the:

a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines

b. Risks relevant to the service context and the particular needs of patients, carers and families

c. Clinicians who are involved in the clinical handover

Evidence Reviewed

Clinical handover documentation contains the required minimum content, relevant risk and needs of the patient as well as the clinicians involved in the handover.

The ISOBAR framework has been implemented as a standardised approach to communication which is included in the clinical handover sheet. Staff interviewed could explain their respective roles in clinical handover, the processes used to support this including the minimum information communicated at clinical handover.

Rating

Met

Findings

-

Action 6.08

Clinicians use structured clinical handover processes that include:

a. Preparing and scheduling clinical handover

b. Having the relevant information at clinical handover

c. Organising relevant clinicians and others to participate in clinical handover

d. Being aware of the patient's goals and preferences

e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient

f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care

Evidence Reviewed

Dorset Rehabilitation Centre has formalised processes in place regarding clinical handover, 8.18 Clinical Handover- Department and Intra Unit 12/23.

These include, when and where clinical handover is to occur, what information is required for adequate clinical handover and how this is documented. The assessors witnessed clinical handover that was structured and effectively engaged with patients, their carers and families. The processes in place for clinical handover ensures the relevant clinicians are actively engaged in the process. Both patients and staff were able to articulate the process of handover and provide confirmation of patients, carer and family in decision making.

An information sheet is available in the bedside folder to guide staff in clinical handover, ISOBAR Clinical Handover.

Rating

Met

Findings

-

Action 6.09

Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to:

a. Clinicians who can make decisions about care

b. Patients, carers and families, in accordance with the wishes of the patient

Evidence Reviewed

Dorset Rehabilitation Centre has policies and procedures to guide and inform staff in effective communication and handover of critical information including risks and alerts. Clinical handover involves patients, their carers and families as required. Clinical handover is audited, and incidents / feedback related to communication issues are addressed through the committee framework. There was an opportunity for the assessor to attend the Multidisciplinary Team (MDT) Meeting 27/11/24 attendance include the Rehabilitation Specialist, Nurse Unit Manager, Physiotherapist x 2 and Occupational Therapist x 1. Discussion of patients MRN #211626; #214057 and #215061.

Rating

Met

Findings
-

Action 6.10
The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians
Evidence Reviewed
Documentation reviewed verified that there are communication processes in place for patients, carers and families to directly communicate critical information and risks about care. Clinicians and patients/carers interviewed confirmed this process and the assessors observed information available to support and facilitate this process. Currently the there a number of processes in place to inform patients, carers or families to directly escalate care. These include The Dorset Rehabilitation Centre "Escalation of Care" brochure located in each patient room and the patient Care Board. Dorset Rehabilitation Centre have recently implementing the Recognise, Engage, Act, Call, Help (REACH) program with posters displayed in each patient room. Opportunities are also made available during the clinical bedside handover which was observed during the assessment.
Rating
Met
Findings
-

Action 6.11
The health service organisation has processes to contemporaneously document information in the healthcare record, including: a. Critical information, alerts and risks b. Reassessment processes and outcomes c. Changes to the care plan
Evidence Reviewed
Clinical documentation reviewed by the assessors confirmed compliance with the organisation’s process to ensure complete, accurate and up to date information and the recording of this in the patient healthcare record. Monitoring of the medical records is conducted through the MARS audit schedule. Medical record documentation audit completed 07/24 achieved a 96% compliance.

Rating
Met
Findings
-

Action 7.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management
Evidence Reviewed
Verified that Dorset Rehabilitation Centre does not use blood or blood products
Rating
Not Applicable
Findings
-

Action 7.02
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of the blood management system b. Implementing strategies to improve blood management and associated processes c. Reporting on the outcomes of blood management
Evidence Reviewed
Verified that Dorset Rehabilitation Centre does not use blood or blood products
Rating
Not Applicable

Findings
-

Action 7.03
Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Evidence Reviewed
Verified that Dorset Rehabilitation Centre does not use blood or blood products
Rating
Not Applicable
Findings
-

Action 7.04
Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products by: a. Optimising patients' own red cell mass, haemoglobin and iron stores b. Identifying and managing patients with, or at risk of, bleeding c. Determining the clinical need for blood and blood products, and related risks
Evidence Reviewed
Verified that Dorset Rehabilitation Centre does not use blood or blood products
Rating
Not Applicable
Findings
-

Action 7.05
Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record
Evidence Reviewed
Verified that Dorset Rehabilitation Centre does not use blood or blood products
Rating
Not Applicable
Findings
-

Action 7.06
The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria
Evidence Reviewed
Verified that Dorset Rehabilitation Centre does not use blood or blood products
Rating
Not Applicable
Findings
-

Action 7.07
The health service organisation uses processes for reporting transfusion- related adverse events, in accordance with national guidelines and criteria
Evidence Reviewed
Verified that Dorset Rehabilitation Centre does not use blood or blood products

Rating
Not Applicable
Findings
-

Action 7.08
The health service organisation participates in haemovigilance activities, in accordance with the national framework
Evidence Reviewed
Verified that Dorset Rehabilitation Centre does not use blood or blood products
Rating
Not Applicable
Findings
-

Action 7.09
The health service organisation has processes: a. That comply with manufacturers' directions, legislation and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer
Evidence Reviewed
Verified that Dorset Rehabilitation Centre does not use blood or blood products
Rating
Not Applicable
Findings
-

Action 7.10
The health service organisation has processes to: a. Manage the availability of blood and blood products to meet clinical need b. Eliminate avoidable wastage c. Respond in times of shortage
Evidence Reviewed
Verified that Dorset Rehabilitation Centre does not use blood or blood products
Rating
Not Applicable
Findings
-

Action 8.01
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration
Evidence Reviewed
Dorset Rehabilitation Centre has policies and procedures in place to recognise and respond to acute deterioration and staff were able to describe their role on such events. Documentation reviewed by assessors includes: - 8.45 Clinical Deterioration - Recognising and Responding 10/22 - 8.94 Delirium and Cognitive Impairment Prevention and Management 04/24 - 2.54 Self-Harm and Suicide (Threatened, Attempted or Completed) in a Non-Mental Health Facility 12/23 - 2.49 Transfer of a Patient - Inter-Hospital 07/22 - 8.88 Anaphylaxis, Management of 03/24 - 8.09 Anaphylaxis Presentations(Victoria),Mandatory Reporting of 04/23 - 8.50 Hyperglycaemia(in Adults), Management of 7/23

Local site policy Rapid Response-Escalation of care in the management of the deteriorating patient for inpatients and outpatients 09/23.
Risks are identified on the Risk Register located with RiskMan.
- ID # 15943 Suicide/Self Harm - inadequate assessment, prevention and management
- ID # 15947 Patient Transfer to another Facility- inadequate process
- ID # 15952 Code Blue - Delay or Failure to Call
- ID # 17263 Deteriorating patient inadequate management of
Training needs have been identified with Basic Life Support (BLS) compliance is currently sitting at 89% for practical and theory is at 87% completion.
Pool rescue is undertaken annually by relevant staff.

Rating

Met

Findings

-

Action 8.02

The health service organisation applies the quality improvement system from the Clinical Governance Standard when:
a. Monitoring recognition and response systems
b. Implementing strategies to improve recognition and response systems
c. Reporting on effectiveness and outcomes of recognition and response systems

Evidence Reviewed

The health service organisation applies the quality improvement system from the Clinical Governance Standard by monitoring recognition and response systems, implementing strategies to improve these systems, and reporting on their effectiveness and outcomes.
The following evidence supports and confirms the statements above:
- Quality improvement ID # 12710 - To standardize the Resuscitation Trolleys equipment across all 3 Rehab Sites which was completed in 5/24.
- Quality improvement ID # 14189 Recognise, Engage, Act, Call, Help (REACH) process roll out -consumer lead escalation of care
- Quality improvement ID # 15953 Providing all nursing staff with small cards to place on lanyards to prompt them re the signs and symptoms of sepsis and to commence the sepsis pathway implemented 10/24.
- Reporting on effectiveness and outcomes of recognition and response systems occurs at the Quality and Risk Committee Meeting with minutes sighted for 4/06/24; 13/08/24 and 1/10/24 and more recently the National Standards Committee Meeting with minutes sighted 19/11/2024.

Rating
Met
Findings
-

Action 8.03
Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making
Evidence Reviewed
Dorset Rehabilitation Centre has documents that were reviewed to show there is a process in place that supports partnering with consumers in recognising and responding to acute deterioration. The assessors observed examples of the shared decision-making process through the admission, discharge and clinical handover episodes of care, which was supported by interviews with staff and patients. - Patient discharge MRN #215009 and #012543 - Clinical Handover from morning to afternoon staff MRN #215063;#215062; #15050; #206720; #215055 and #215058 - Group clinical handover from night duty staff to morning staff
Rating
Met
Findings
-

Action 8.04
The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient

Evidence Reviewed
Dorset Rehabilitation Centre has processes in place for clinicians to detect acute physiological deterioration, including the use of track and trigger observation charts. Each patient has an individualised vital sign monitoring plan in place which is monitored by the attending staff. Sampling medical records verified that observations are graphically documented MRN #215009; #012543; #13263; #211616; #214943; #214970 and #214965.
Rating
Met
Findings
-

Action 8.05
The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d. Determine the required level of observation e. Document and communicate observed or reported changes in mental state
Evidence Reviewed
Policies and procedures support staff in identifying acute deterioration in mental state including the risk or delirium: - 8.45 Clinical Deterioration - Recognising and Responding 10/22 - 8.94 Delirium and Cognitive Impairment Prevention and Management 04/24 - 2.54 Self-Harm and Suicide (Threatened, Attempted or Completed) in a Non-Mental Health Facility 12/23 Dorset Rehabilitation Centres comprehensive risk screening and clinical pathway reviewed by assessors also supported the establishment of individualised and appropriate management plans for patients with acute mental deterioration and/or delirium. Clinical documentation is audited regularly for compliance with documentation of any acute deterioration. Processes are in place to support timely communication between members of the treating team and the patient, carers and family members.
Rating
Met

Findings
-

Action 8.06
The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration
Evidence Reviewed
Dorset Rehabilitation Centre monitors performance of the identification and management of acute physiological, mental status, pain and/or distress and concerns raised by staff, patients, carers and families through clinical documentation audits, RiskMan incident management and clinical review. Staff interviewed were aware of these processes and able to describe them to the assessors, including the process for escalation of care where needed. Documentation reviewed identified policies and procedures are in place to support clinical staff in the management and escalation of clinical deterioration and they are current and reference best-practice. - 8.54 Clinical Deterioration- Recognising and Responding 10/22 - 2.49 Transfer of a Patient - Inter-Hospital 07/22 - 8.88 Anaphylaxis, Management of 03/24 - 8.09 Anaphylaxis Presentations(Victoria),Mandatory Reporting of 04/23 - 8.50 Hyperglycaemia (in Adults), Management of 7/23 Currently the there a number of processes in place to inform patients, carers or families to directly escalate care. These include The Dorset Rehabilitation Centre "Escalation of Care" brochure located in each patient room and the patient Care Board. Dorset Rehabilitation Centre have implementing the Recognise, Engage, Act, Call, Help (REACH) program with posters displayed in each patient room.
Rating
Met
Findings
-

Action 8.07
The health service organisation has processes for patients, carers or families to directly escalate care
Evidence Reviewed
Currently the there a number of processes in place to inform patients, carers or families to directly escalate care. These include The Dorset Rehabilitation Centre "Escalation of Care" brochure located in each patient room and the patient Care Board. Dorset Rehabilitation Centre have implementing the Recognise, Engage, Act, Call, Help (REACH) program with posters displayed in each patient room.
Rating
Met
Findings
-

Action 8.08
The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance
Evidence Reviewed
Dorset Rehabilitation Centres policy for escalation of care is clear and provides direction for staff to escalate care and respond to a clinical emergency. Staff were able to describe this process and assessors were provided with documentation to support the evaluation of these processes. - Mechanisms to escalate care and call for emergency assistance include but not limited too: - Emergency buzzers and patient call bells - Emergency trolley with completed checklists - Staff mandatory BLS training - Pool rescue training undertaken annually by relevant staff - Rostering to ensure appropriate staffing mix is in place for the scope of the facility
Rating
Met
Findings
-

Action 8.09
The workforce uses the recognition and response systems to escalate care
Evidence Reviewed
Staff were able to describe the systems in place to escalate care consistent with Dorset Rehabilitation Centres policy and procedure. Observation and response charts are in use by the staff which is monitored through the audit schedule. Audit on the various aspects of the Observation Charts initially completed 08/24 achieved a 48% compliance and with education (Quality Improvement ID # 16694) increased to 67% when repeated 10/24.
Rating
Met
Findings
-

Action 8.10
The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration
Evidence Reviewed
Education is provided to clinicians to support the timely and effective management of patients who acutely deteriorate. Dorset Rehabilitation Centre provides Basic Life Support (BLS) training annually as it is a mandatory requirement for all staff. BLS compliance is currently sitting at 89% for practical and theory is at 87% completion. Staff were able to describe the process to call an ambulance if required.
Rating
Met
Findings
-

Action 8.11
The health service organisation has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support

Evidence Reviewed
Education is provided to clinicians to support the timely and effective management of patients who acutely deteriorate. Dorset Rehabilitation Centre provides Basic Life Support (BLS) training annually as it is a mandatory requirement for all staff. BLS compliance is currently sitting at 89% for practical and theory is at 87% completion. Staff were able to describe the process to call an ambulance if required.
Rating
Met
Findings
-

Action 8.12
The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated
Evidence Reviewed
Dorset Rehabilitation Centre has processes in place to ensure timely referral to the closest mental health service if a patients mental state should deteriorate. These processes were explained to the assessors by the staff which were consistent with the policy 2.49 Transfer of a Patient -Inter-Hospital 07/22 and 8.45 Clinical Deterioration - Recognising and Responding 10/22.
Rating
Met
Findings
-

Action 8.13
The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration
Evidence Reviewed
Patients who physically deteriorate are transferred by ambulance to the nearest public hospital/Private hospital in accordance with the policy 2.49 Transfer of a Patient -Inter-Hospital 07/22. These processes were explained to the assessors by the staff interviewed during the assessment process. Sampling of medical record MRN #211867 verified appropriate management for a patient transfer.

Rating
Met
Findings
-

APPENDICES / SUPPORTING DOCUMENTS

Not applicable