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

The Melbourne Clinic

Richmond, VIC

Organisation Code: 22 06 90

Survey Date: 10-12 July 2018

ACHS Accreditation Status: **ACCREDITED**

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About The Australian Council on Healthcare Standards

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

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

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

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

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

What is Accreditation?

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

How to Use this Survey Report

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

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

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

1 Survey Team Summary Report
2 Actions Rating Summary Report
3 Recommendations from Current Survey

4 Recommendations from Previous Survey
5 Standards Rating Summary Report

1 Survey Team Summary Report

Consists of the following:

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

Ratings

Each action within a Standard is rated by the organisation and the survey team with one of the following ratings. The survey team also provides an overall rating for the Standard. If one core action is Not Met the overall rating for that Standard is Not Met.
The report will identify individual actions that have recommendations and/or comments.

The rating levels are:

NM – Not Met
The actions required have not been achieved

SM – Satisfactorily Met
The actions required have been achieved

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

Action Recommendations

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

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

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

2 Actions Rating Summary Report

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

3. Recommendations from Current Survey

Recommendations are highlighted areas for improvement due to a need to improve performance under a particular action.
Recommendations are structured as follows:
The action numbering relates to the Standard, Item and Action.

4 Recommendations from Previous Survey

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

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

5. Standards Rating Summary Report

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

Organisation: Melbourne Clinic, The
Orgcode: 220690

Survey Report

Survey Overview

Throughout the survey at The Melbourne Clinic (TMC) the survey team observed a very positive adult learning culture. It was evident that the staff displayed a respectful, dignified and inclusiveness culture to colleagues, patients, carers and families.

There is a strong culture of quality improvement, staff and patient safety and consumers are involved in all aspects of the service.

TMC has a large redevelopment program underway and due to finish mid-2019. This program will see two new levels including 44 more single bedrooms and a refurbishment of level 1. Further to this a new Intake office and an extension to medical records office and storage room and a refurbishment to ICU/BMU ward. The patient dining room will also be extended and updated and four new group rooms and a new staff room be added. This will also include a new elevator which will serve all levels.

The survey team visited all services including the community outpatient areas and noted the standardisation of systems in place. There is a very strong emphasis on patient-centred care and diversity and inclusion.

The executive management team are well regarded by the staff and the patients interviewed made it clear that they trust the staff. It was evident that there was a strong multidisciplinary team effort in ensuring the standards are maintained and met.

The work the staff have done to ensure the standards are embedded into the daily practice was clearly highlighted during the survey.

STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and quality improvement systems

TMC as part of Healthscope has an effective governance framework in place, which is linked to the safety and quality plan. The business plan and risk register supports its commitment to patients and staff safety and quality.

The framework outlines detailed organisational and committee structures, with up to date policies, procedures and terms of reference. The minutes are well maintained and in an action format which ensures the safety and quality issues are considered in business decisions

The risk register and risk planning process is closely monitored and managed through the Quality, Work Health and Safety (WHS) and Infection Prevention committee.

All reviews occur via the audit, risk and compliance process.

There is a process in place to manage the development, trialing and monitoring of policies and procedures and a policy guide tool to enable and ensure timely reviews.

A signed set of hard copy policies and procedures were available to staff on site and all policies and procedures are available online.

There have been many organisation changes at TMC and feedback from the staff was that they felt these changes have had a positive impact.

The formal communication systems throughout TMC ensures quality, safety and patient information is communicated across the continuum of care.

Professional development programs are in place and all staff receive a very structured and informative orientation program. The training team also conducts one to one practical testing as part of the mandatory training approach with a high level of compliance. There is also online training available and an inclusive multidisciplinary team across all areas.

Throughout the survey the survey team observed a culture of quality, respectful and dignified care and an alignment and commitment to diversity and inclusion which has led to TMC gaining the Rainbow tick. Another component of the positive culture at TMC is their approach to the open disclosure policy and processes for ensuring staff are trained to participate in this process.

Of particular note was the strong quality improvement and research program in place, with academic appointments as part of the Processional Unit and the key partnerships with universities. This program supports a strong training, supervision and collaborative publication process which is overseen by TMC Research Ethics Committee.

A wide range of quality and safety indicators are in place throughout TMC and this can be seen in the Work Health and Safety program and through the mental health cluster.

There is a large redevelopment program currently occurring and due to be completed mid-2019. This will include an extra 44 new single rooms for In-patients across two levels along with a number of refurbishment programs, including ICU/BMU.

There is a new Intake office and staff room, four new group rooms and extension to the patient dining room. The engineering and support staff were very proactive in ensuring the noise and dust levels were kept to a minimum through this period and that staff, patients and visitors were kept informed via brochures, signage and broadcasted messages.

The wards and service areas were very clean and the food menu program and food preparation, of a high quality.

Work health and safety plans are in place as part of the Healthsafe Safety Management System and staff are well aware of their roles and responsibilities, for example, the fire training and staff appraisal systems are at 100% compliance.

A highlight of the survey was the strong commitment staff placed on quality and safety in all interviews conducted.

Clinical practice

Governance is via the executive leadership team and Medical Advisory committee.

There is a clinical governance framework in place, which is reflected in the safety and quality plan. The main focus of this plan is on prevention and improvement. Supporting this plan are clinical guidelines, which are available on the intranet and an auditing schedule is in place to ensure compliance. TMC is also represented at the Healthscope National Hospital Quality Cluster and TMC has a national leadership role in the mental health cluster.

Patient care plans include risk management strategies and there are escalation of care and advanced care planning processes available and in place.

There is an annual quality review of key performance indicators and quality and safety initiatives. A brief summary of the achievements of the previous twelve months are discussed as part of reflective practice and potential new initiatives are advised for the pending twelve months.

All new initiatives are consistent with the overarching Safety and Quality Plan.

It is worth noting the number of In-patient group programs that TMC conduct. These programs are also individually designed as part of their evidence pathway.

There is a strong clinical awareness of high risks as part of the therapeutic approach. The risk register is supported by appropriate policies and procedures which, as part of risk prevention includes an excellent process for handover through the continuum of care from in-patient treatment to outpatients.

There are a number of inpatient programs offered, such as the Living Well, Emotional Management, OCD, TMS, ECT and Eye Movement Desensitising and Reprocessing (EMDR) and an Older Persons program. Community outpatient programs are also in place. All programs have audits and reviews completed and evaluated.

As part of the strategic and business plan, a very significant clinical treatment gap was identified. This action was allocated to the Director of Nursing to follow through on, which led to the appointment of the first Nurse Practitioner and Consultation Liaison (CL) Nurse program. This is a pilot program with Holmesglen Private Hospital. In The short period that this position has been in place, there has been the development of a CL referral pathway, education packages, a focus on clinical outcomes, teaching and research. The staff within TMC have an enthusiastic respect and regard for this new position.

TMC report 19 ACHS clinical indicators and it is worthwhile noting that TMC met the Healthscope minimum data set with no outliers.

The patient records were clear in their clinical picture and well-maintained, however the service is looking forward to the pending electronic medical record.

Performance and skills management

There are well established processes in place across TMC in regard to position description development, credentialing and scope of practice. Managers and the clinical workforce have the right qualifications, skills and approach to provide, safe, high-quality health care.

A multidisciplinary competency approach is in place along with supervision arrangements and it is worth noting that all staff have completed their performance appraisal and educational needs, which are identified as part of this process.

A new legislative compliance system was introduced within the reporting tool RiskMan that provides the executive governance group with a robust method of monitoring. This system also provides the opportunity to reflect legislative changes and introduce them into policies and procedures in a timely manner.

Each department within TMC have quality plans and risk assessments. Audits are conducted and the leadership team receive feedback from programs such as WHS drills, mock evacuations and emergency code practices.

Incident and complaints management

Well-established systems and processes support the management of incidents and complaints.

All Incidents are reported on RiskMan and form part of the quarterly KPI data set reporting. Shared learnings are discussed at the mental health cluster and minutes of meetings and working parties identify and reflect actions and improvements. One recent improvement was in the ECT area and the emergency response equipment, which led to changes being made to include light weight trolleys.

Incidents are reviewed by the executive team and feedback to the staff in the respective areas is provided in a timely manner.

The complaints management system is well managed and supported by the availability of the complaints management handbook as a resource for staff. Further to this, there is a 100% compliance to complaint acknowledgement and over the past 12months between 93% -100% regarding responses.

Complaints are reviewed by consumers and feedback from this process has also provided a review of the feedback/complaints form to make it more user friendly.

TMC have systems in place to ensure the consumer and carer have the opportunity to provide feedback. There is an open disclosure policy available to staff and reports are provided to the leadership team. Educational records of staff attendance at open disclosure training are kept.

Patient rights and engagement

TMC has a patient information booklet and a patient rights and responsibilities brochure which highlights privacy as part of the privacy policy, confidentiality and the hospitals commitment to the Australian Charter of Healthcare Rights. This information is provided on admission to each patient.

The meetings the survey team had with patients confirmed that they valued TMC's approach to their safety, respect as individuals and their privacy.

TMC is undertaking a lot of work in the area of diversity and inclusiveness practice following on from their rainbow tick accreditation.

The Intensive Care Unit supports patients at risk and all other units have the ten tips for safer healthcare displayed.

A number of patient surveys have been conducted, for example the Yes survey, and a Patient Centred Care survey. The Yes survey is part of the Department of Health and Human services process, which was developed in conjunction with mental health consumers and is provided to patients post discharge. The responses are discussed at senior level and incorporated into the planning process if seen as beneficial.

The surveyors met with the consumer consultants and a selected group of in-patients who provided very good feedback to the service. The overall impression was that the consumers trust the staff and the care they provide at TMC.

There is an information brochure provided regarding advanced care planning and information provided to patients, carers, families and support persons regarding escalation of care issues and concerns.

NSQHSS Survey

Organisation: Melbourne Clinic, The
Orgcode: 220690

Governance and quality improvement systems

Ratings

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

Clinical practice

Ratings

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

Performance and skills management

Ratings

Action	Organisation	Surveyor
1.10.1	SM	SM
1.10.2	SM	SM

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

Incident and complaints management

Ratings

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

Patient rights and engagement

Ratings

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

STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer partnership in service planning

A Partnering with Consumers policy has been developed at corporate level which requires all health services to employ a consumer or carer consultant and for consumers and carers to be actively involved in service planning, operational planning, strategic planning, service design and development. This policy was itself developed with consumer input and is comprehensive and prescriptive in setting the requirements for all aspects of consumer engagement and responsiveness to consumer feedback. Gender diversity has been embraced by the organisation at corporate level through the development of relevant policies and procedures. The approach is based on principles of cultural safety and inclusiveness of consumers needs relating to sex and gender identity, including male, female, transgender, intersex, non-binary, gender questioning, gender diverse and sexual preferences. At hospital level, TMC has a Diversity, Equity and Inclusivity Committee which meets bi monthly and has developed a Diversity and Inclusivity Strategy (2016-18). Actions from the Strategy are identified in the Quality Action Plan with performance monitored through the Quality, WHS and Infection Control Committee.

TMC was the first psychiatric inpatient service in Australia to achieve Rainbow Tick accreditation. The process for review of the Diversity and Inclusiveness Strategy will be an opportunity to progress these developments further. In particular the opportunity is there to focus on Aboriginal and Torres Strait Islander health and culturally safe environments.

TMC has recently varied its lived experience input into decision making with the appointment of consumer, carer and diversity and inclusivity consultant capacity. This has enabled broader representation and input into TMC activities. All consumer related documentation including pamphlets, brochures and information sheets have recently been republished in clear, easy to read format and are subject to the Consumer Approved Publication insignia. Consumer feedback on this has also been undertaken and this information is used to inform improvements to the content and style of the publication material. Evaluation results (June 2018) indicate a high level of support for the usefulness of this information.

Consultants meet quarterly as well as attend mental health cluster meetings within the Healthscope hospitals group. A consumer consultant is a member of the Quality, WHS and Infection Control Committee.

It is clear that consumer consultants are active throughout the service including in inpatient, outreach and day program service areas. Information evenings for carers (bi-monthly) and consumer focus groups (to be recommenced) are important features of the approach adopted at TMC. Consultants are also engaged in the development of orientation, induction and mandatory training programs for clinical and non-clinical staff, including for students, agency and locum staff. This involvement extends to the design of course content to incorporate consumer perspectives in how services are provided.

A consumer participation audit is conducted annually and bench-marked at cluster level. Consumer consultants have had ongoing involvement in the design and oversight of the capital works development currently occurring at TMC.

Consumer partnership in designing care

In addition to consumer consultant engagement in the on-site training program for all staff, the training modules available online also reflect consumer and carer insights.

The Patient Centred Care online module is part of the mandatory training required for all staff.

Consumer and carer consultants have input into corporate and TMC specific planning and development activities. There is a clear line of communication within TMC for this input to occur through representation on relevant committees and working groups. Consumer consultant's report that in addition to regular meetings with senior management, they have direct access on a daily basis regarding operational issues that arise to the General Manager and Director of Nursing level.

Discussions with consumers who were current inpatients of the service confirmed that staff are accessible and open to suggestions for service improvement. The consumers reported feeling that they were respected and that their opinions were valued. Consumers are aware of the mechanisms available to provide feedback and to provide input into the programs offered within the service.

Consumer partnership in service measurement and evaluation

Healthscope has a corporate policy for Patient Satisfaction Surveys which requires all hospitals to participate. A corporate consumer survey is distributed to all consumers who were inpatients in the week following discharge. Results are reported to the Consumer and Carer Consultants Committee, Quality, WHS and Infection Control Committee and reported to the Healthscope CEO through corporate reporting structures.

The Consumer and Carer Consultant Committee reviews consumer feedback and service quality data and provides input to the Quality WHS and Infection Control Committee. Incident data is also subject to consumer consultant review. A partnership approach has been adopted by management to ensure consumer and carer perspectives are included in the analysis and response to incidents. This engagement extends to day program, outreach and inpatient services.

Quality improvement activities that have been initiated through the involvement of consumer and carer consultants include addressing waiting times for outpatient appointments, hot water and climate control systems in inpatient areas of the hospital. Through membership on the Quality, WHS and Infection Control Committee, the consumer consultant participates directly in the review of all organisational quality performance indicators and KPIs.

Your Experience Survey (YES) results are reviewed locally by the Quality Manager and issues identified followed up directly with the consumer and relevant work units as required. Unfortunately, the response rate is very low across most data items which does limit the usefulness of the data. The hospital is encouraged to consider what other approaches can be adopted to increase the level of participation in the YES survey. This would be assisted through the involvement of consumer consultants to provide input.

NSQHSS Survey

Organisation: Melbourne Clinic, The
Orgcode: 220690

Consumer partnership in service planning

Ratings

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

Consumer partnership in designing care

Ratings

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

Consumer partnership in service measurement and evaluation

Ratings

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

Organisation: Melbourne Clinic, The
Orgcode: 220690

STANDARD 3
PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Surveyor Summary

Governance and systems for infection prevention, control and surveillance

The Quality, Safety, WHS and Infection Control Management plan includes monitoring of aseptic technique, hand hygiene, antimicrobial resistance and management of standard precautions. Infection control policies and procedures are in place and referenced to the Australian guidelines. The Infection control prevention guidelines are available via the HICMR website. There is a very committed team managing staff training, support, education and monitoring in this area. Feedback utilising audits are provided to staff and to the executive team via KPI reports.

This program is firmly embedded into the safety and quality culture across TMC.

Infection prevention and control strategies

TMC has an Infection Prevention and Control Manual as part of the management plan toolkit via HICMR. Hand hygiene policy compliance is above 95% and audits are reported to the infection control committee. Information is shared at the Infection Control Cluster as part of this learning organisation.

Staff undertake the 5 moments program and audit results from this education are reported to staff via their newsletter.

There is a consumer infection control leaflet which has been endorsed by consumers which includes hand hygiene and there are a number of hand hygiene prompts at sinks and in bathrooms.

All staff at TMC are provided with a comprehensive risk based training program, which includes Occupational Health and Safety requirements, such as patient evacuation mats, personal protective equipment, gloves for patient searches, staff immunisation program and also outbreak management precautions.

There is an effective participation uptake of influenza vaccinations which is managed by the Infection Control manager and GP.

Staff health forms are completed prior to commencement. Staff refusal to participate in immunisation programs have information documented and placed on their HR file.

There is a policy for aseptic technique which is part of the mandatory training program. There is also an impressive face to face competency training module. Further to this staff complete the eLearning module.

Managing patients with infections or colonisations

All staff are provided appropriate training and supplied with equipment and the environment to enable compliance with standard and transmission based precautions.

Outbreak packs are available and TMC risk response plan provides and supports staff in managing outbreaks.

Infection control alerts are incorporated into the admission and treatment program and whenever care is transferred within or between areas, wards and departments.

Antimicrobial stewardship

A very committed and dedicated team manage the AMS program. Safe prescribing and monitoring is in place, supported by the therapeutic online guidelines and antimicrobial prescribing education programs.

The survey team received feedback from the staff regarding the support from the AMS team that their commitment to verbal communication and availability was appreciated and valued.

Cleaning, disinfection and sterilisation

TMC has a number of appropriate policies and procedures in place via the HICMR portal and work health and safety policies and procedures such as waste management, Healthsafe programs, personal and protective equipment and food service training.

Material safety data sheets were available and food and chemicals were stored in appropriate areas.

Regular audits regarding environmental risks were conducted and reviewed and cleaning schedules were in place and monitored.

Policies are in place to manage invasive devices and a policy in relation to traceability of single use devices and mandatory training is in place for relevant staff.

Communicating with patients and carers

TMC conducts patient surveys on cleanliness and a patient information brochure has been endorsed by the consumers.

TMC infection control coordinator attends the consumer committee meetings on invitation and infection control information is provided in the newsletter. The consumer consultant periodically attends the quality, safety, WHS and Infection Control committee.

The consumer consultant meets regularly with consumers and provides feedback to the leadership team.

Governance and systems for infection prevention, control and surveillance

Ratings

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

Infection prevention and control strategies

Ratings

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

Action 3.10.1 Core

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

Surveyor Comment:

TMC has a policy in place that sees aseptic technique as a mandatory training competency. There are education and training programs in place for the required workforce and education status is reported at the Work Health and Safety and Infection Control meeting.

There is also an aseptic technique training package.

Surveyor's Recommendation:

No recommendation

Managing patients with infections or colonisations

Ratings

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

Antimicrobial stewardship

Ratings

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

Cleaning, disinfection and sterilisation

Ratings

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

Action 3.16.1 Core

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

Surveyor Comment:

A recent Department of Health inspection in 2018 found Nil Infection control outliers.

Education and training schedule includes mandatory training for invasive and reusable devices.
HICMR conducts education on cleaning, disinfection and sterilisation of reusable instruments and devices for all ECT.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
3.19.1	SM	SM
3.19.2	SM	SM

STANDARD 4
MEDICATION SAFETY

Surveyor Summary

Governance and systems for medication safety

TMC demonstrated sound governance of medication safety programs and the medication safety cluster is the peak committee overseeing medication safety.

There are a large number of policies and procedures in place in relation to all aspects of medication safety and staff are provided with education around medication safety requirements.

Staff have access to MIMS and Therapeutic guidelines online and hard copies are also available. The on-site pharmacy provides support in medication management and all patients have a medication plan and there is a patient medication brochure available also.

Medication incidents are reported through RiskMan and all incidents are investigated by the nurse unit manager and reviewed and monitored by the Director of Nursing and Quality Manager. There is also the medication cluster which discusses sharing lessons learned.

All Medications are prescribed, stored, administered, dispensed and disposed of in line with professional guidelines and legislative requirements. There is a self-reflective tool as a part of reviewing medication incidents and the quality audit program includes medication safety.

A VMO credentialing process in place and the performance appraisal system addresses the scope of practice compliance.

Documentation of patient information

All patients have a medication history documented as part of intake and a medication management plan. Pharmacy completes a medication reconciliation and medication profile for patients on discharge.

Patients interviewed by the surveyors indicated a high level of trust in the staff and medication dispensing processes.

There is a documented system for known allergies and information and training is provided to food service staff regarding adverse reactions and allergies. Clinical staff have education and training on alerts as part of the Medsafe eLearning program.

Medication management processes

Medication safety is discussed at TMC Medical Advisory Committee.

Pharmacy circulate medication safety communications and wards are part of a clinical drug auditing schedule.

Pharmacy ensures patient medications are separated into individual containers.

Medication refrigeration temperatures are monitored daily and audits for medications that are no longer required or expired ensure medications are collected by pharmacy and disposed of appropriately.

Registers are kept for scheduled medications and all registers are audited.

Continuity of medication management

Each patient has a medication management plan and an explanation from nursing staff on medication information.

Medication discussions form part of the clinical handover and the bedside handover with the patient.

Each patient receives a medication profile on discharge.

Communicating with patients and carers

Pharmacy provides information for patients and carers/family members involved in the care of the patient. TMC has a number of brochure stands throughout the hospital on medication. Inpatient groups on medication are conducted by the pharmacist and the patient centred care survey also asked patients their satisfaction with the communication they received regarding medicines.

Governance and systems for medication safety

Ratings

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

Documentation of patient information

Ratings

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

Medication management processes

Ratings

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

4.10.5	SM	SM
4.10.6	SM	SM
4.11.1	SM	SM
4.11.2	SM	SM

Continuity of medication management

Ratings

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

Communicating with patients and carers

Ratings

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

STANDARD 5
PATIENT IDENTIFICATION AND PROCEDURE MATCHING

Surveyor Summary

Identification of individual patients

The inpatient identification system includes photograph identification supplemented by at least three unique identifiers. In addition, health fund insurance details are matched at intake and Bradma labels created on the consumer record. Observation of staff adherence to the policy at handover was observed at the TMS suite and ECT following treatment to ward staff in recovery.

File records confirmed that patient details are completed routinely in the consumer record and this is very clearly presented and located in the file. Wrist bands are utilised in all inpatient areas and outpatient treatment for ECT and TMS. Day program staff conduct a four point identify check (name, date of birth, medical record number and gender) at time of presentation for group. Referral details are also checked with the consumer to verify identification as well as specific group enrolment. TMS for outpatients confirms address and referring doctor upon first treatment. Patient ID bands comply with ACSQHC standards (white background) with red bands signifying allergic conditions.

ISOBAR is used to guide clinical handover and transfer of care processes. This was observed to be administered routinely across all areas with the hospital. This includes patient identification processes. Nursing discharge summaries automatically generates four unique identifiers as part of the documentation produced by the clinical record information system – WebPAS.

ECT suite safety checklist includes provision for time out and this protocol is strictly adhered to by medical and nursing staff. Audit results confirm an improvement in compliance for time out procedures (from 85% in March 2016) to 100% in June 2017. Time out and patient ID audits are scheduled for annual audit on TMC audit schedule. TMS and ECT Safety check forms are reviewed to comply with NSQHS standards. Timeout provisions included are included in the checklist.

Positive identification of inpatients was also observed to occur during medication dispensing through the overt identification of at least three unique identifiers.

Data indicated that no patient identification incidents have been reported since November 2017. RiskMan is utilised to record and report on all incidents and this data is reviewed by the Quality Manager on a daily basis with aggregated reports provided to the Quality, WHS and Infection Control Committee. Patient identification is included as part of TMC's annual audit program.

WebPAS is used at point of service delivery for confirmation of patient identification details within all treatment areas of the hospital and at the day programs facility.

Processes to transfer care

Corporate policies exist for Patient ID Bands, Correct Patient - Correct Procedure, Medication Orders and Administration, Admission of Patient to the Facility and Admissions of Patients by Ambulance.

In relation to inter-hospital transfers a transfer summary protocol includes checklist provision of unique identifiers. Audit results indicate significant improvement in time out compliance, and continued sound performance against hospital group benchmarks for patient identification and correct patient, correct procedure and correct site KPIs.

Processes to match patients and their care

The policies relevant to matching patients with their care are comprehensive, current and clearly set out. The policy suite is supported by time out procedure checklists for ECT and TMS procedures, transfer of care and handover within the service and externally. Policies include consent for medical treatment with compliance included in documentation audit processes. Audits also include Patient identification, time out and clinical handover.

All incidents and near misses are entered into RiskMan. There is a clear path of reporting, investigation, action and review to ensure continual improvement in compliance. RiskMan reports are reviewed at Quality, WHS and Infection Control Committee and at the Medical Advisory Committee. Performance is reported to quarterly as part of corporate reporting requirements.

The ECT and TMS suite of forms, including ECT Time out and TMS Safety check forms have been subject to review by the Mental Health Cluster (2016/17) ensuring compliance with corporate and NSQHSS requirements. This was finalised and circulated to TMC in March 2018.

NSQHSS Survey

Organisation: Melbourne Clinic, The
Orgcode: 220690

Identification of individual patients

Ratings

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

Processes to transfer care

Ratings

Action	Organisation	Surveyor
5.4.1	SM	SM

Processes to match patients and their care

Ratings

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

STANDARD 6
CLINICAL HANDOVER

Surveyor Summary

Governance and leadership for effective clinical handover

TMC Clinical handover policy 8.18 is used by the workforce and regularly monitored by Heathscope. It is noted that the Policy 8.18 provides generic direction in regard to the use of agreed tools and guides. It was witnessed that the standard of practice of Clinical Handover far exceeds the direction of the policy. *There is opportunity in the project 'Back to the Bedside' which commences in August 2018 and is to be completed within 6 months (Feb 2019) to ensure that the agreed tools and guides are specified for TMC.* Clinical Handover has been implemented across the organisation at all levels – community – intake; intake to inpatient units; intake to Day Therapy Program; inpatient to discharge to the community. Compliance with Clinical Handover processes are completed through observational monitoring, audit and confirmation with patients. Evaluation of the clinical handover process is assessed through patient satisfaction survey. Bedside handover occurs at a minimum of once per 24 hours between morning and afternoon shift, with utilisation of ISOBAR tool. ISOBAR education is provided to all new staff, graduate and undergraduate students. Recently the Day Programs implemented the use of ISOBAR. The Clinical Bedside Handover brochure for patients and carers was reviewed and updated in January 2018 (joint project with TVC) and endorsed by TMC and TVC consumers and consumer consultants. Handover is structured using the ISOBAR tool. ISOBAR cue/prompt cards are available and support consistency. All audit results, including peer and benchmarking reports tabled at Quality Work Health & Safety & Infection Control Committee, Medical Advisory Committee. The Risk Register is utilised track trends of clinical handover incidents These trends are analysed and communicated to the clinical workforce through newsletters and via the Nurse Unit Managers. Over a three-year period there have been 22 incidents. Quarterly Shared Learnings report includes Clinical Handover and are tabled at Quality WHS & IC Committee, MAC, circulated to Head of Department. Signed off by the General Manager, Director of Nursing, Quality Manager. TMC conducted a Nursing discharge summary (NDS) quality improvement project to improve the compliance and effectiveness of the NDS. The project has seen an increase in the compliance of NDS within the specified timeframe of 24hrs post discharge. A Clinical Handover training package has been developed and includes a detailed explanation of ISOBAR, bedside handover and transfer of information from one situation to another.

Clinical handover processes

Bedside clinical handover occurs at a minimum of once per 24 hours between morning and afternoon shift utilising the ISOBAR format. Staff have access to the prompt card if required. The Patient Inter-hospital, Facility and Service Transfer form (HMR 3.1) completed for all external hospital transfers. There is an audit schedule of bedside handover which are six monthly as well as those randomly conducted by the Nurse Unit Managers. The Education Manager provides education to all clinical staff, including Day Program staff. There is regular evaluation and monitoring processes for clinical handover. These being audits and participation in the ACHS Clinical Indicator suite and review of the Risk Register. ACHS Clinical Indicators for Mental Health: 9.1 Discharge summary/letter provided to consumer or nominated carer and 9.2 Discharge summary/letter provided to service providing ongoing care- within one working day exceed the target and lead their cohort. Benchmarking graphs from ACHS are tabled at the Quality WHS &IC Committee and MAC. All near misses and incidents related to clinical handover reported into RiskMan reviewed and investigated.

Patient and carer involvement in clinical handover

TMC has mechanisms to involve a patient and, where relevant, their carer in clinical handover. Consent is asked of the patient first and if the patient consents the carer is involved in the handover.

Carers evening sessions are provided and include discussion re the importance of carer involvement in clinical handover. The Carers Information pack includes the National Standards brochure with Clinical handover information included.

NSQHSS Survey

Organisation: Melbourne Clinic, The
Orgcode: 220690

Governance and leadership for effective clinical handover

Ratings

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

Clinical handover processes

Ratings

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

Patient and carer involvement in clinical handover

Ratings

Action	Organisation	Surveyor
6.5.1	SM	SM

Organisation: Melbourne Clinic, The
Orgcode: 220690

STANDARD 7
BLOOD AND BLOOD PRODUCTS

Surveyor Summary

Standard 7 is not applicable to The Melbourne Clinic.

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

Ratings

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

Documenting patient information

Ratings

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

Managing blood and blood product safety

Ratings

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

NSQHSS Survey

Organisation: Melbourne Clinic, The
Orgcode: 220690

Communicating with patients and carers

Ratings

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

STANDARD 8
PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and systems for the prevention and management of pressure injuries

TMC policy 8.05 Pressure Injury, Prevention and Management governs and directs the management and prevention of Pressure Injury. This policy is evidence based and linked to Safer Care Victoria's online learning module for the prevention and Management of Pressure Injuries. The use of the policy is monitored through audit three monthly and reported through the Clinical Indicator suite to TMC Quality & Safety Committee and through to Corporate – the highest level of governance. Screening for pressure injury and of skin integrity occurs at intake, on admission using the tool referenced to Pan Pacific Guidelines. The risk is identified and low risk patients are screened weekly – high risk clients screened each shift. All incidents are documented on RiskMan which tracks the investigation and frequency. Frequency of skin integrity issues is low, with one occasion in the past year. The patient was admitted with the pressure injury. Staff education is provided online and compliance is at 94%. TMC has identified a Pressure Injury Champion. Equipment is readily available through a rental agency and can be delivered within the hour. Selected bariatric equipment has been purchased. All companies are credentialed and managed through contract and compliance monitored through the Engineering department.

Preventing pressure injuries

An agreed risk assessment screening tool is available for the workforce. A Pressure area risk assessment / management plan (HMR 7.5) completed on all patients on admission. The use of the screening tool is monitored to identify the proportion of at-risk patients that are screened for pressure injuries on presentation and has demonstrated 100% compliance in the annual Quality Annual Audit - Pressure Ulcer Screening skin assessment and management plans. All patients are screened for pressure injury on presentation. Low risk patients have a weekly comprehensive skin inspection which are documented in the patient clinical record for patients at risk of pressure injuries. Prevention plans for all patients at risk of a pressure injury are consistent with best practice guidelines and are documented in the patient clinical record. All inpatient medical records reviewed by clinical coders for presence of documentation indicating pressure injuries which is reported through to the Quality & Safety Committee. Patients at risk of pressure injuries have an implemented prevention plan. The brochure Prevention of Pressure Injuries is available to patients/carers/friends in the Consumer Hub and on the units and is aimed at empowering the individuals.

Managing pressure injuries

TMC has an evidence-based wound management system in place which is guided by HSP Policy 8.05 Prevention, Identification and Management of Pressure Injury. A Wound chart is utilised to document patients at risk of developing Pressure Injury and wounds. The Annual eLearning education of Pressure Injury Prevention and Management includes wound management. Mandatory Training for Aseptic technique, competencies and audits based on ANTT guidelines and tools. ANTT Audits are completed by Infection Control Manager Management plans for patients with pressure injuries are consistent with best practice and documented in the patient clinical record. This practice is guided by HMR 7.5 Pressure Injury Risk Assessment and Management Plan in place and was developed by Clinical Cluster with Best Practice Guidelines and associated form being: Wound Management Form - HMR 7.14. Access and referral to General practitioners are available Monday through Friday. Patient clinical records are monitored to determine compliance with evidence-based pressure injury management plans by clinical coders for presence of documentation indicating pressure injuries. Action is taken to increase compliance with evidence-based pressure injury management plans through audit and monitoring of KPI non-compliance.

NSQHSS Survey

Organisation: Melbourne Clinic, The
Orgcode: 220690

Communicating with patients and carers

Patient information on prevention and management of pressure injuries is provided for patients and carers in a format that is understood and is meaningful through the publication. TMC Pressure injury management and prevention brochure. The information for patients, families and friends reviewed November 2017, with consumer input. The patient information on National Standards including Pressure Injury Prevention is included in patient information and Carers packs. Pressure injury management plans are developed in partnership with patients and carers. The Care plan is developed with and signed by the patient. Compliance is audited as part of the Documentation audit and the clinical Indicator-report. The Carer Nomination form encourages Patients to nominate a Carer to be involved in Care planning. There is an opportunity to evaluate the patient and carer experience of the pressure injury prevention and management strategy.

NSQHSS Survey

Organisation: Melbourne Clinic, The
Orgcode: 220690

Governance and systems for the prevention and management of pressure injuries

Ratings

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

Preventing pressure injuries

Ratings

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

Managing pressure injuries

Ratings

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

NSQHSS Survey

Organisation: Melbourne Clinic, The
Orgcode: 220690

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
8.9.1	SM	SM
8.10.1	SM	SM

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

Surveyor Summary

Establishing recognition and response systems

TMC had governance arrangements in place to support the development, implementation, and maintenance of organisation-wide recognition and response systems for the deteriorating patient. These Healthscope corporate policies;

1. 8.45 Clinical Deterioration, Recognising and Responding to
2. 8.42 Basic Life Support and Cardiopulmonary Resuscitation (CPR)
3. 8.13 Advanced Life Support (ALS) - Adult
4. 2.31 Exclusions - Services Not Provided
5. 2.56 Advance Care Directives

and The Melbourne Clinic policies

1. 1.1.14 Exclusion Policy
2. 1.4.21 Escalation of Care
3. 1.1.25 Advance Care Directive
4. EM 7 Emergency Manual Policy- 7 Code Blue

provide the governance and direction.

The Healthscope Shared Learnings report with recommendations relating to Standard 9 for TMC are tabled at Quality WHS & IC Meeting. TMC Emergency policy manual - Emergency response policy and procedures are place. After a review of incidents occurring frequently in the reception area an emergency response kit was developed and located in reception. All incident response teams (from Unit 3) take a defibrillator to the incident. The use of a defibrillator is part of the Basic Life Support Training. Staff training is provided in Basic Life Support and compliance with online training at 96% and the practical training 100%. The Critical Incident Response debrief team managed by the Chief Social Worker
Action is taken to improve the responsiveness and effectiveness of the recognition and response systems at TMC. This is achieved through the implementation of the online training in Clinical Deterioration which has a 97% compliance. Response to acute clinical deterioration is through calling the Ambulance. Ambulance response times are under five mins. Staff are trained in use of the Emergency Resuscitation Trolley equipment as part of mandatory BLS training.

Recognising clinical deterioration and escalating care

TMC has Implemented mechanisms for recording physiological observations that incorporates triggers to escalate care when deterioration occurs through the use of the Healthscope Track and Trigger Observation Chart (HMR 6.1A) and the implementation of the Track and Trigger protocol which indicate flagging alerts and provide staff with clear guidelines for clinical review or any intervention required. This is audited annually and compliance is high at 97%. Advance care plan for physical deterioration has a compliance of 100% although Advance Care Directives have a low take up by patients.

Emergency activation and the nurse call system are in place in all clinical departments. All call buttons are actively tested once per month. Emergency equipment is checked weekly and duress alarms are checked monthly.

TMC has developed the Escalation of Care - Information for patients, carers, family and support person's brochure. This was a joint project with The Victoria Clinic and included consumer input. The brochure describes how consumers and visitors can escalate care for any patient. The brochure is available in the Consumer Hub as well as in the units and a copy is placed in every bedroom.

Albamat - the fire removal mat with fire blanket was introduced 18 months previous and staff training provided. This is a much-improved version.

The Emergency Warden training completed annually is at 100%. All senior management are trained as controllers and attend fire training practical annually.

Responding to clinical deterioration

The MET call and Code Blue policy has documented the requirements of escalation of deteriorating patient/staff/visitor. The MET/ emergency team call criteria is included in the MET call policy. Unit 3 respond to all MET / Code Blue calls as the first responders. An emergency backpack which includes a defibrillator is included. *There is an opportunity to label the sections of the backpack to make it easier for staff to locate the equipment.* Emergency buttons are in place in all clinical areas and these are checked monthly. All clinical staff trained in Basic Life Support, through both an eLearning module and competency. Compliance rates are recorded in the Elmo training system. TMC use ambulance service/paramedics for all incidents where greater intervention than BLS is required. Response times are reported to be under 5 minutes. The circumstances and outcome of calls for emergency assistance are regularly reviewed through audit of RiskMan reviews of clinical deterioration. There is a system in place for ensuring access to at least one clinician at all times, either on site or in close proximity, who can practise advanced life support. All patients and carers receive orientation to the unit on admission including emergency response.

Recently TMC introduced the use of Dantrolene in response to Malignant Hypothermia during the ECT as it was recognised that should this occur the MICA response time would place the patient at risk.

Communicating with patients and carers

TMC complete a comprehensive plan on admission in partnership with patients, families and carers. As per TMC Advance Care Directive policy 1.1.25/ HSP Policy 2.56 Advance Care Directives advance care directives are available to all patients. This is detailed in the HSP brochure Advanced Care Directives and is included in the Mental Health Pre Admission Form. This includes a question regarding the presence of a Current Advanced Care directive and/or other treatment limiting orders. Completion of this is audited annually and compliance is at 100%. TMC has mechanisms in place for a patient, family member or carer to initiate an escalation of care response. Communication to patients/ carers/friends is achieved through the Escalation Brochure, Patient Information Booklet and in the orientation to the unit. This is also covered in TMC Escalation of Care Policy which includes carer and patient directives. All family generated escalation of care is entered into RiskMan Reporting System. To date there have been no escalation of care incidents from this source.

NSQHSS Survey

Organisation: Melbourne Clinic, The
Orgcode: 220690

Establishing recognition and response systems

Ratings

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

Recognising clinical deterioration and escalating care

Ratings

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

Responding to clinical deterioration

Ratings

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

Action 9.6.1 Core

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

Surveyor Comment:

All clinical staff trained in Basic Life Support, through both an eLearning module and competency. Compliance rates are recorded in the Elmo training system. TMC use ambulance service/paramedics for all incidents where greater intervention than BLS is required. Response times are reported to be under five minutes. The circumstances and outcome of calls for emergency assistance are regularly reviewed through audit of RiskMan reviews of clinical deterioration. There is a system in place for ensuring access to at least one clinician at all times, either on site or in close proximity, who can practice advanced life support. All patients and carers receive orientation to the unit on admission including emergency response.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

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

STANDARD 10
PREVENTING FALLS AND HARM FROM FALLS

Surveyor Summary

Governance and systems for the prevention of falls

A falls prevention clinical cluster is in place within the Healthscope group of facilities. This provides a mechanism for benchmarking performance and sharing information regarding falls risk management approaches.

Falls risk assessment is routinely addressed at time of admission and intake to the service. For inpatients, an additional assessment is undertaken on arrival at the ward and any high-risk individuals identified for completion of a falls risk management plan. Form design conforms to international best practice for the identification and management of falls. Falls risk is also screened as part of the procedure for inter-hospital transfers and transfer of care within the hospital or between hospital programs.

Practice is supported by a corporate Falls Prevention and Management – Patient – policy. Procedures are observed at ward level to identify hazards that may result in a fall occurring. Patient needs are identified in the assessment process and this is used to inform decisions concerning room allocation, proximity to the nurses' station and disability access considerations.

Audit data indicates that for the second half of 2017 TMC had no falls resulting in injury. For the same period, the frequency of falls as a proportion of total inpatient bed days was 0.193% compared with the ACHS Clinical aggregate of 0.320% across 376 hospital facilities. Falls is also compared across all Healthscope facilities as part of the half yearly benchmarking report.

Audit data for the completion of the falls risk assessment indicated 100% compliance.

Screening and assessing risks of falls and harm from falling

Falls Risk Assessment Tool (FRAT) and Falls Risk Assessment Management Plan (FRAMP) compliant forms are utilised in all service areas. A review of consumer records confirmed that risk assessments are undertaken routinely for all patients at the point of admission. Where indicated, a FRAMP is also completed and actions incorporated into the consumer care plan as required.

There is a high degree of awareness in the staff group within the hospital, day programs and importantly in the outreach service regarding the need to closely monitor and assess falls risk. It is pleasing that this responsibility extended to consumers living in the community, especially in the immediate period following discharge from hospital and where the outreach service had continued involvement in providing care.

Preventing falls and harm from falling

Falls prevention strategies include the provision of high-low beds throughout the hospital, rooms with disabled access provisions, supply of appropriate non-slip socks for consumers at high risk of a fall, positioning of consumers at risk in rooms to facilitate access to nursing assistance and duress alarms within easy reach are all strategies deployed within the hospital. Importantly, falls risk assessments are undertaken at the point of admission at each point of service delivery. The outreach program facilitates an assessment of falls risks for consumers that commence with that service. Similarly, upon enrolment in day program activities a falls risk assessment is undertaken and recorded on the consumer record.

Other preventative measures are undertaken, including the provision of exercise regimes, walking aides, physiotherapy and occupational therapy assessments. The provision of OT assessments has been increased since January 2018 for consumers identified as high risk. This has resulted on an 11% decrease in the number of falls from December to May 2018.

Staff complete mandatory training in relation to falls risk, prevention strategies and management. Mandatory training audits show a high compliance rate for learning module completions. Consumer education occurs at the point of admission and includes discussion with carers.

It was noted during survey that falls can occur as a result of difficulty in accessing the fixed bedside duress alarms, with not all rooms being fitted with a socket to enable plugging in the removable short lead duress handsets. Enabling this feature in rooms occupying consumers assessed at risk of falling would be beneficial.

There has not been a fall that has resulted in injury in the three years prior to survey and the hospital is consistently performing at below the aggregate incidence of inpatient falls for all peer hospitals in the clinical indicators program. This is a very good level of performance.

Communicating with patients and carers

TMC has a falls prevention program in place which includes the provision of consumer and carer information at the point of admission. The Keeping a Step Ahead of Falls brochure is available which provides useful information for consumers on what to be aware of during their admission and how they can mitigate the risk of a fall occurring. Discussions occur with next of kin and carers at the point of admission as well as discharge in relation to the risk of falls occurring and what preventative measures can be taken to manage this. This is also undertaken as part of commencing in the outreach program where an assessment of the home living environment may identify risks for a person transitioning from inpatient to outpatient support.

ECT discharge checklists include assessment of falls risk for day patients and discussion about management approaches. This also occurs as part of post discharge follow-up. Carers are encouraged to be part of the care planning process where falls risks are discussed.

NSQHSS Survey

Organisation: Melbourne Clinic, The
Orgcode: 220690

Governance and systems for the prevention of falls

Ratings

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

Screening and assessing risks of falls and harm from falling

Ratings

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

Preventing falls and harm from falling

Ratings

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

Organisation: Melbourne Clinic, The
Orgcode: 220690

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

Organisation: Melbourne Clinic, The
Orgcode: 220690

Actions Rating Summary

Governance for Safety and Quality in Health Service Organisations

Governance and quality improvement systems

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

Clinical practice

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

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

Performance and skills management

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

Incident and complaints management

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

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

Patient rights and engagement

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

Partnering with Consumers

Consumer partnership in service planning

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

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

Consumer partnership in designing care

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

Consumer partnership in service measurement and evaluation

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

Preventing and Controlling Healthcare Associated Infections

Governance and systems for infection prevention, control and surveillance

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

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

Infection prevention and control strategies

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

3.10.1	The clinical workforce is trained in aseptic technique	SM	SM
3.10.2	Compliance with aseptic technique is regularly audited	SM	SM
3.10.3	Action is taken to increase compliance with the aseptic technique protocols	SM	SM

Managing patients with infections or colonisations

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

Antimicrobial stewardship

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

Cleaning, disinfection and sterilisation

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

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

Communicating with patients and carers

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

Medication Safety

Governance and systems for medication safety

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

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

Documentation of patient information

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

Medication management processes

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

Continuity of medication management

Action	Description	Organisation's self-rating	Surveyor Rating
4.12.1	A system is in use that generates and distributes a current and	SM	SM

	comprehensive list of medicines and explanation of changes in medicines		
4.12.2	A current and comprehensive list of medicines is provided to the patient and/or carer when concluding an episode of care	SM	SM
4.12.3	A current comprehensive list of medicines is provided to the receiving clinician during clinical handover	SM	SM
4.12.4	Action is taken to increase the proportion of patients and receiving clinicians that are provided with a current comprehensive list of medicines during clinical handover	SM	SM

Communicating with patients and carers

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

Patient Identification and Procedure Matching

Identification of individual patients

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

Processes to transfer care

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

Processes to match patients and their care

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

Clinical Handover

Governance and leadership for effective clinical handover

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

Clinical handover processes

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

Patient and carer involvement in clinical handover

Action	Description	Organisation's self-rating	Surveyor Rating
6.5.1	Mechanisms to involve a patient and, where relevant, their	SM	SM

carer in clinical handover are in use

Blood and Blood Products

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

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

Documenting patient information

Action	Description	Organisation's self-rating	Surveyor Rating
7.5.1	A best possible history of blood product usage and relevant clinical and product information is documented in the patient clinical record	N/A	N/A
7.5.2	The patient clinical records of transfused patients are periodically reviewed to assess the proportion of records completed	N/A	N/A
7.5.3	Action is taken to increase the proportion of patient clinical records of transfused patients with a complete patient clinical record	N/A	N/A
7.6.1	Adverse reactions to blood or blood products are documented in the patient clinical record	N/A	N/A
7.6.2	Action is taken to reduce the risk of adverse events from administering blood or blood products	N/A	N/A
7.6.3	Adverse events are reported internally to the appropriate governance level and externally to the pathology service provider, blood service or product manufacturer whenever appropriate	N/A	N/A

NSQHSS Survey

Organisation: Melbourne Clinic, The
Orgcode: 220690

Managing blood and blood product safety

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

Communicating with patients and carers

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

Preventing and Managing Pressure Injuries

Governance and systems for the prevention and management of pressure injuries

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

NSQHSS Survey

Organisation: Melbourne Clinic, The
Orgcode: 220690

Preventing pressure injuries

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

Managing pressure injuries

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

Communicating with patients and carers

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

	with patients and carers

Recognising and Responding to Clinical Deterioration in Acute Health Care

Establishing recognition and response systems

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

Recognising clinical deterioration and escalating care

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

	processes

Responding to clinical deterioration

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

Communicating with patients and carers

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

Preventing Falls and Harm from Falls

Governance and systems for the prevention of falls

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

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

Screening and assessing risks of falls and harm from falling

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

Preventing falls and harm from falling

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

Communicating with patients and carers

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

Organisation: Melbourne Clinic, The
Orgcode: 220690

Recommendations from Current Survey

Nil

Organisation: Melbourne Clinic, The
Orgcode: 220690

Recommendations from Previous Survey

Nil

NSQHSS Survey

Organisation: Melbourne Clinic, The
Orgcode: 220690

Standards Rating Summary

Organisation - NSQHSS V01

Core

Standard	Not Met	Met	N/A	Total
Standard 1	0	44	0	44
Standard 2	0	4	0	4
Standard 3	0	39	0	39
Standard 4	0	31	0	31
Standard 5	0	9	0	9
Standard 6	0	9	0	9
Standard 7	0	0	20	20
Standard 8	0	20	0	20
Standard 9	0	15	0	15
Standard 10	0	18	0	18
Total	**0**	**189**	**20**	**209**

Developmental

Standard	Not Met	Met	N/A	Total
Standard 1	0	9	0	9
Standard 2	0	11	0	11
Standard 3	0	2	0	2
Standard 4	0	6	0	6
Standard 5	0	0	0	0
Standard 6	0	2	0	2
Standard 7	0	0	3	3
Standard 8	0	4	0	4
Standard 9	0	8	0	8
Standard 10	0	2	0	2
Total	**0**	**44**	**3**	**47**

NSQHSS Survey

Organisation: Melbourne Clinic, The
Orgcode: 220690

Standard	SM	MM	Total
Standard 1	44	0	44
Standard 2	4	0	4
Standard 3	39	0	39
Standard 4	31	0	31
Standard 5	9	0	9
Standard 6	9	0	9
Standard 7	0	0	0
Standard 8	20	0	20
Standard 9	15	0	15
Standard 10	18	0	18
Total	**189**	**0**	**189**

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

NSQHSS Survey

Organisation: Melbourne Clinic, The
Orgcode: 220690

Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 1	0	53	0	53	Met
Standard 2	0	15	0	15	Met
Standard 3	0	41	0	41	Met
Standard 4	0	37	0	37	Met
Standard 5	0	9	0	9	Met
Standard 6	0	11	0	11	Met
Standard 7	0	0	23	23	Met
Standard 8	0	24	0	24	Met
Standard 9	0	23	0	23	Met
Standard 10	0	20	0	20	Met
Total	**0**	**233**	**23**	**256**	**Met**

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

NSQHSS Survey

Organisation: Melbourne Clinic, The
Orgcode: 220690

Surveyor - NSQHSS V01

Core

Standard	Not Met	Met	N/A	Total
Standard 1	0	44	0	44
Standard 2	0	4	0	4
Standard 3	0	39	0	39
Standard 4	0	31	0	31
Standard 5	0	9	0	9
Standard 6	0	9	0	9
Standard 7	0	0	20	20
Standard 8	0	20	0	20
Standard 9	0	15	0	15
Standard 10	0	18	0	18
Total	**0**	**189**	**20**	**209**

Standard	SM	MM	Total
Standard 1	44	0	44
Standard 2	4	0	4
Standard 3	39	0	39
Standard 4	31	0	31
Standard 5	9	0	9
Standard 6	9	0	9
Standard 7	0	0	0
Standard 8	20	0	20
Standard 9	15	0	15
Standard 10	18	0	18
Total	**189**	**0**	**189**

Developmental

Standard	Not Met	Met	N/A	Total
Standard 1	0	9	0	9
Standard 2	0	11	0	11
Standard 3	0	2	0	2
Standard 4	0	6	0	6
Standard 5	0	0	0	0
Standard 6	0	2	0	2
Standard 7	0	0	3	3
Standard 8	0	4	0	4
Standard 9	0	8	0	8
Standard 10	0	2	0	2
Total	**0**	**44**	**3**	**47**

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

NSQHSS Survey

Organisation: Melbourne Clinic, The
Orgcode: 220690

Combined

Standard	Not Met	Met	N/A	Total	Overall
Standard 1	0	53	0	53	Met
Standard 2	0	15	0	15	Met
Standard 3	0	41	0	41	Met
Standard 4	0	37	0	37	Met
Standard 5	0	9	0	9	Met
Standard 6	0	11	0	11	Met
Standard 7	0	0	23	23	Met
Standard 8	0	24	0	24	Met
Standard 9	0	23	0	23	Met
Standard 10	0	20	0	20	Met
Total	**0**	**233**	**23**	**256**	**Met**

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