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

The Victorian Rehabilitation Centre

Glen Waverley, VIC

Organisation Code: 21 16 82

Survey Date: 31 October – 2 November 2017

ACHS Accreditation Status: **ACCREDITED**

Disclaimer:

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

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About The Australian Council on Healthcare Standards

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

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

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

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

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

What is Accreditation?

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

How to Use this Survey Report

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

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

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

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

1 Survey Team Summary Report

Consists of the following:

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

Ratings

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

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

The rating levels are:

NM – Not Met

The actions required have not been achieved

SM – Satisfactorily Met

The actions required have been achieved

MM - Met with Merit

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

Action Recommendations

Recommendations are highlighted areas for improvement due to a need to improve performance under an action. Surveyors are required to make a recommendation where an action is rated as Not Met to provide guidance and to provide an organisation with the maximum opportunity to improve.

Recommendations in the survey report need to be reviewed and prioritised for prompt action and will be reviewed by the survey team at the next on-site survey.

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

Risk ratings could be:

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

2 Actions Rating Summary Report

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

3 Recommendations from Current Survey

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

Recommendations are structured as follows:

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

4 Recommendations from Previous Survey

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

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

5 Standards Rating Summary Report

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

Organisation : Victorian Rehabilitation Centre, The
Orgcode : 211682

Survey Report

Survey Overview

The Victorian Rehabilitation Centre (TVRC) is a Healthscope facility that provides private rehabilitation services for a large range of casemix including pain management, orthopaedics, neurology, cardiac, trauma, falls and balance, and rehabilitation in the home.

One hundred and forty-three (143) inpatient beds are arranged into three main ward areas, with gymnasiums, therapy areas, and a well-maintained pool conveniently located within the building. A large outpatients' area caters for outpatient therapies, and a newly developed 'AchieveHealth' program enables therapies to be provided for those who would normally not have access.

Compounding pharmacy and sophisticated radiology services have been on-site since 2015, and have greatly enhanced the timeliness and effectiveness of these services.

An Allied Health restructure in 2016 has seen the position of Allied Health Manager that has integrated functional and physical therapies, and has enhanced communications with all disciplines. A master planning process has been conducted that has identified five possible stages of development on the site, and the Executive is working through the process with the Board.

In addition to Healthscope performance reporting and analysis, TVRC reports ACHS Clinical Indicators, and Australian Rehabilitation Outcomes Centre (AROC) data for comparison to peers, and sustains high levels of performances across all performance measures. Performance measures are transparently reported to the community via the MyHealthscope website, and within the local community and patient care areas.

TVRC was well prepared for survey and the timetable and a good balance of staff contact, ward visits and verification of evidence provided.

All Actions have been met, and a number have been met at the Met with Merit (MM) level within Standards 1, 3, 8 and 10. All the previous recommendations have been met, and none have been carried forward. The overall impression of TVRC is one of a very well maintained, clean and tidy environment, and a strong staff commitment and enthusiasm for the improvement of patient care and achievement of optimal levels of function for all patients.

STANDARD 1
GOVERNANCE FOR SAFETY AND QUALITY IN HEALTH SERVICE ORGANISATIONS

Surveyor Summary

Governance and Quality Improvement Systems

Policies, procedures and developed by Healthscope (HSP) are regularly reviewed, and demonstrate contemporary referencing. Local policies are developed to reflect the role and function of individual organisations.

Locally developed TVRC policies consistently reflect the safety and quality culture of HSP are reviewed in accordance with schedule, and referenced to contemporary practice.

A well-developed governance system is in place throughout HSP, (separately accredited by the ACHS) and The Victorian Rehabilitation Centre (TVRC).

The committee structures ensure targets set by HSP for quality and safety indicators are consistently met or exceeded.

TVRC has consistently reported all quality and safety indicators including those related to these Standards, and achieved outcomes well above the targets set by Healthscope Corporate (HC).

TVRC consumers and staff are involved with the executive in analysing quality and safety indicators, and outcomes are consistently communicated to all staff, consumers and the community through the website, newsletters, brochures and posters in ward/patient areas.

Given the consistently high performance against safety and quality indicators related to these standards over the last three years, the eagerness of staff across all departments and wards to discuss outcomes and ideas for improvement, and evaluation of the system by HSP in collaboration with TVRC the surveyors have recommended an MM rating for Action 1.2.1.

Action plans and the quality register are regularly reviewed and demonstrate that improvements to patient care are implemented and evaluated.

Orientation of new staff and locums is inclusive of delegated responsibilities and ensures all mandatory training is completed within the orientation program and required specific training is completed within three months of the start date.

Annual mandatory training programs, competency-based training and opportunistic mandatory events are consistently attended by over 95% of staff including casual staff, with non-attendees identified to ensure future attendance. The surveyors have recommended an MM rating for Action 1.4.2.

The comprehensive risk and quality registers are reviewed regularly and there is evidence throughout the minutes of meetings that action is taken to ensure all identified risks and quality improvements are addressed.

Given the consistently high performance of TVRC quality performance indicators for a number of years, the incorporation of the quality management system into day-to-day operations evidenced by the staff knowledge and enthusiasm to discuss future improvements and the regular monitoring of the system by HSC the surveyors have recommended an MM rating for 1.6.1.

The surveyors suggest that increased use of action plans throughout committee meetings would improve tracking of outcomes.

Clinical Practice

TVRC provides inpatient and outpatient services, and the recently developed "AchieveHealth" program has enabled the provision of outpatient services. This has been embraced by the community and enables the provision of outpatient allied health services to those who would previously be unable to access them.

The integrated model of care provided by TVRC utilises several best practice guidelines across all disciplines and those related to these criteria. Guidelines are reviewed by the appropriate discipline in conjunction with the relevant policy/procedure, and as evidence-based improvements in care are identified. Staff can electronically access a large range of research sites related to their discipline, and there is evidence of staff involvement in selection and use of contemporary evidence-based sites and tools available.

A range of contemporary guidelines and tools are used to identify patients at increased risk of harm. TVRC policy is to assess all patients admitted to the service for risks associated with these criteria. 100% of patients have been consistently assessed for falls and pressure injuries over the last three years, and over 92% consistently assessed for all risks. All Healthscope Corporate (HC) targets associated with patient risk assessments have achieved well over expected outcomes, and TVRC continues to strive towards 100% for completion of all assessments. The surveyors have recommended MM for Action 1.8.1.

TVRC procedures aim to have multidisciplinary risk assessment conducted within 8 hours of admission, and management plans in place within 24 hours. These targets are met during normal operations when patient admissions are planned, and largely for those unplanned admissions.

There is a well-established response and recognition system, and the recommendation associated with this Action has been closed by the surveyors.

The clinical record is well managed with the record and its clinical content regularly audited and improved as required.

Performance and Skills Management

There is a well-developed system that is effective in defining the scope of practice for all disciplines, it is facilitated through the HSP electronic system and managed by the Medical Advisory Committee. Records attest to regular annual review of insurance, registration and performance review for all relevant disciplines, and 360-degree performance management for admitting VMOs.

The KRONOS system identifies on the roster those nursing staff who are not qualified to administer medication and student nurses are supernumerary and supervised according to developing competencies.

All staff are able to access quality and safety education through the newly installed ELMO online education program as a mandatory requirement, or for their own development. Application for support to access other personal and professional development events are considered and resourced according to set criteria. All staff complete a questionnaire about their understanding of safety and quality systems, and there is evidence of identified deficits being included in once- off mandatory training.

Incident and Complaints Management

Processes to recognise and report incidents and complaints through the RiskMan system are well established and all staff are educated about the system and reporting mechanisms at orientation. Annual education addresses any issues arising from training needs analysis and knowledge deficits.

Incidents and complaints are analysed through the Executive and the Quality and Risk Management Committee (QRMC), reported to HSP and compared to their peer group.

Results are communicated to consumers, staff and the community through staff and consumer meetings and the website. Evidence of improvements in response to complaints was provided to the surveyors.

All clinical staff have been trained in open disclosure and staff interviewed were well able to articulate principles and processes associated with open disclosure.

Patient rights and engagement

Information provided to patients about their rights and responsibilities in the form of brochures and the patient information booklet is consistent with the National Charter of Healthcare Rights displayed within patient areas.

Telephone based translation services are available, Auslan services can be readily accessed and understanding is verbally assessed during initial assessment.

A video has been made that includes patient information and education described by consumers that will enhance understanding from the consumer’s perspective.

The surveyors observed that patients and carers sign all care and risk management plans to verify their partnership in planning care.

Support to document Advanced Care Directives is provided through social workers, and they are clearly identifiable within the clinical record.

Patient clinical records are available at the point of care and are protected within the nurse’s station that is accessed by electronic pass key.

Patient feedback is analysed through the Quality and Risk Management Committee with consumer membership, and there is evidence of resulting improvements.

Governance and quality improvement systems

Ratings

Action	Organisation	Surveyor
1.1.1	SM	SM
1.1.2	SM	SM
1.2.1	SM	MM
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	MM
1.4.3	SM	SM
1.4.4	SM	SM
1.5.1	SM	SM
1.5.2	SM	SM
1.6.1	SM	MM
1.6.2	SM	SM

Action 1.2.1 Core

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

Surveyor Comment:

Healthscope has a very strong framework that has been adopted readily by TVRC through which safety and quality indicators are reported.

Safety and quality indicators are collected and analysed monthly from all TVRC departments and wards and analysed by TVRC executive prior to reporting them to Healthscope Corporate. A large number of indicators are compared with peer Healthscope organisations, and those not meeting targets are required to submit an improvement action plan within a week. Evidence provided showed that TVRC exceeds their Healthscope targets consistently across all indicators and uses them in day to day operations as indicators for continuous performance improvement. All staff interviewed were knowledgeable about, and eager to discuss performance data with the surveyors, indicating the strong safety and quality culture of TVRC.

The surveyors agreed that a Met with Merit (MM) rating reflects the performance against this Action.

Surveyor's Recommendation:

No recommendation

Action 1.4.2 Developmental

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

Surveyor Comment:

Annual mandatory training is inclusive of all these Standards, and includes issues identified in audits and adverse events as they occur throughout the whole organisation. Attendance records over the last three years have consistently exceeded Healthscope benchmarks and have proven to be sustainable through systematic planning and scheduling of events.

Planned and opportunistic education also occurs through documented 'Huddles' within the ward environment and include specific patient issues, procedure/policy updates and shared learnings. During interviews, it was evident to the surveyors that staff are heavily engaged day-to-day in training and education, are using their knowledge in day to day patient care, and are eager to seek and share knowledge. Evaluation of the system has occurred and a new system has been introduced that will further enhance the efficiency in planning and recording education and training events. The surveyors agree an MM rating for this Action.

Surveyor's Recommendation:

No recommendation

Action 1.6.1 Core

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

Surveyor Comment:

Healthscope has a strong well-established framework through which safety and quality indicators are reported.

Quality indicators are collected and analysed monthly from all TVRC clinical and non-clinical groups and analysed by TVRC executive prior to reporting them through the appropriate committee structure to Healthscope Corporate. A comprehensive range of indicators are compared with peer Healthscope organisations, and those not meeting targets are required to submit an improvement action plan within a week. Evidence provided showed that TVRC exceeds Healthscope targets consistently across all indicators and uses them in day to day operations as indicators for continuous performance improvement. All staff interviewed were knowledgeable about, and eager to discuss performance data with the surveyors, indicating the strong quality culture of TVRC.

The surveyors agreed that a Met with Merit (MM) rating reflects the consistently high level of performance against this Action, and its incorporation into day to day activities. The quality management system is regularly evaluated at corporate level and the results communicated to all staff through committee and ward meetings.

Surveyor's Recommendation:

No recommendation

Clinical practice

Ratings

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

Action 1.8.1 Core

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

Surveyor Comment:

There is a robust comprehensive organisational wide approach to identifying patents at risk of harm that reflects the safety and quality culture of TVRC and achieves high performance levels beyond Healthscope targets. Over 95% of relevant multidisciplinary assessments are completed, and risks identified within the first eight hours (verified through audit) with falls and risk assessments consistently achieving 100% across the whole organisation over the last few years. Ninety-one percent (91%) of patients are given a very comprehensive medication profile that includes risks, benefits, side effects and rationale for prescribing each medication on discharge that has consistently achieved over 90%. The organisation is working to identify the reason for the 9% deficit. All patient risk assessment rates achieve well above the Healthscope target.

The surveyors are confident that the criteria for an MM rating have been met.

Surveyor's Recommendation:

No recommendation

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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

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Patient rights and engagement

Ratings

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

STANDARD 2
PARTNERING WITH CONSUMERS

Surveyor Summary

Consumer Partnership in Service Planning

The Quality and Risk Management Committee (QRMC) includes two consumer members and focus groups are used for specific input and feedback for specific diverse groups of patients. Involvement of consumers in strategic and operational planning is evident within committee meetings and related documents. The surveyors suggest the inclusion of a Consumer Advisory Group (CAG) in the Consumer Engagement Plan for 2017-2018 in order to bring together representatives of focus groups and QRMC consumer members to enhance communication and integrate diversity within all aspects of service planning.

Within committee minutes and verified with consumers, it is evident that consumers are encouraged to fully participate in decision making about safety and quality issues.

Consumers verified participation in orientation and training, and demonstrated an excellent level of knowledge about their roles.

All patient information is examined by consumers and changes relating to clarity, font, and inconsistencies in information have been identified and incorporated into publications.

Consumer Partnership in Designing Care

There are numerous examples of consumer participation is designing care that can be demonstrated, for example, staggering of allied health services over lunchtime, improvements in room temperature and noise that has greatly improved patient feedback and the use of colour coded stickers to differentiate between allied health services for patients with limited eyesight, an improvement that has been welcomed by patients.

All management and staff members have been educated in patient centred care as demonstrated in mandatory training record, and consumers have been heavily involved in advising staff and participating in the handover and patient information videos. A consumer is also involved in talking to staff about her experiences as a patient.

The recommendation related to Action 2.6.2 has been closed.

Consumer partnership in Service Measurement and Evaluation

Consumers have direct input into information provided to the community about TVRC safety and quality performance to ensure it is relevant and clearly described for distribution to the community through media, newsletters and the MyHealthscope website that reports 25 local and national indicators.

Through the QRMC surveyors could verify that consumers are involved in planning quality improvements and evaluating patient feedback data.

Consumers have participated in quality improvement through implementation of lunchtime allied health schedules to reduce patient waiting time in outpatients, participating in the rescheduling of meal deliveries to certain wards to ensure patient lunches don't go cold while in therapy, re-fashioning of patient boards to clarify information for patients and re-design of the Quality Tree.

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Consumer partnership in service planning

Ratings

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

Consumer partnership in designing care

Ratings

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

Consumer partnership in service measurement and evaluation

Ratings

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

STANDARD 3
PREVENTING AND CONTROLLING HEALTHCARE ASSOCIATED INFECTIONS

Surveyor Summary

Governance and systems for infection prevention, control and surveillance

TVRC has a well-developed governance framework that includes Executive responsibility and a risk management approach and allows for the management and reporting of prevention and control of health care associated infections. TVRC Infection Prevention and Control Committee (IPCC) provides oversight to the well- developed infection prevention and control (IPC) program which is reviewed regularly and monitored for effectiveness. This multidisciplinary committee meets regularly and reports to the TVRC Executive Committee. Policies, procedures, protocols and monitoring systems are based on risk assessment and provide direction to assist in minimising infection risks to patients, carers and staff. Healthcare Infection Control Management Resources (HICMR) and Healthscope (HSP) infection prevention and control policies/procedures show evidence of ongoing review and maintenance of currency to ensure alignment with evidence-based practice, and are available via the HICMR website and the HSP intranet.

The infection prevention and control activities are supported by a part- time Infection Prevention and Control Coordinator (IPC), link nurses and a Healthcare Infection Control Management Resources (HICMR) a Level 3 Consultancy service. Infection Control Plans are comprehensively documented and implementation of quality improvement activities and monitoring of achievements and outcomes is evident Infection and prevention and control education for the workforce occurs via orientation, eLearning and face-to-face sessions, with mandatory education programs showing very high levels of compliance.

Annual infection prevention and control facility-wide risk assessments are undertaken by HICMR to assess the effectiveness of compliance with IPC policies. Risk assessments are completed for all wards/departments, environmental services, clinical waste and linen management and food services Results for the period 2014-2017 show consistently high levels of achievement and improved performance ranging from 90% in 2014 to 98% in 2017. There is evidence of annual revision of TVRC IPC Risk Management Plan and implementation of actions to address recommendations for areas identified as requiring strengthening and monitoring of outcomes. The audit and surveillance programs are well-developed. A number of audits and a comprehensive audit schedule is utilised and implementation of follow-up actions for areas identified as requiring improvement is evident. Action 3.1.4 has been rated MM.

Performance monitoring and review is undertaken by the lPCC and Medical Advisory Committee (MAC) and via the organisation's Quality and Safety Reports which show performance against a suite of HSP Infection Control KPIs and which are submitted quarterly to HSP National Quality and Safety Committee. The incidence of hospital-acquired infections (HAIs) is consistently low.

Infection prevention and control strategies

There is a very well-developed organisation-wide hand hygiene program which is subject to ongoing review for improving and maintaining compliance with the national hand hygiene guidelines. Hand washing basins, hand rub solutions and hand hygiene posters are readily available throughout the hospital. The level of workforce compliance in the completion of the mandatory hand hygiene education programs was 98% at the time of survey. Hand hygiene audits are conducted and data is submitted to Hand Hygiene Australia (HHA). Results show the overall compliance rate has been consistently above the National benchmarks for the period 2014-2017 and HSP benchmarks. A compliance rate greater than 90% has been sustained for the audit period 2015 to 2017 across the clinical and non-clinical workforce, including medical officers. The compliance rate for the Audit period 3 2017 was 93% compliance.

Actions 3.5.1, 3.5.2 and 3.5.3 have been rated MM.

There is evidence of substantial work being undertaken to ensure the TVRC staff immunisation program complies with the national guidelines. Processes are well-developed for pre-employment screening, for the collection of data on the serology and vaccination status of all employees and maintenance of records. Records are being maintained in an electronic database which is subject to ongoing review. Pre-employment vaccination history records for new employees were reported to be 100% and very high levels of compliance in Varicella, Hep B and MMR immunity of staff were reported. Evidence provided shows continuous improvement in the workforce uptake of influenza vaccinations since 2007, with 47% achieved in 2017.

Appropriate equipment and processes for prevention and management of occupational health and safety are in place and include the availability of personal protective equipment (PPE) and staff education programs. The surveyors noted that a very low level of incidents of occupational exposures was reported and that processes for follow-up and counselling are well-developed.

Management of intravascular devices is supported with training and competency assessment of nursing staff and is well addressed. Audit results of IV cannula sites, peripherally inserted central venous catheters (PICCs) and indwelling urinary catheters show high levels of compliance with required standard /policy for management. A very low level of healthcare-associated bloodstream infections is reported.

Records showed 90% of the nursing staff had completed aseptic technique training; Action 3.10.1 is assessed as fully met and rated SM.

Managing patients with infections or colonisations

Guidelines for standard precautions and transmission-based precautions are available for all clinical and non-clinical staff. Staff education and monitoring of compliance for standard and transmission-based precautions are evident, with audit results showing very high levels of compliance. Completion of the pre-admission patient information and screening of patients assists with identification of patients with an infection or colonisation and facilitates appropriate patient placement on admission. Information on infectious status is documented as a clinical alert in the clinical record and in the electronic patient information system (WebPas). Processes are well-developed for communicating a patient's infectious status whenever responsibility of care is transferred between service providers and facilities

Antimicrobial stewardship

The antimicrobial stewardship (AMS) program is overseen by the TVRC Infection Prevention Control Committee and the MAC, and is supported by the HPS pharmacist. TVRC also participates in the Knox Group AMS Working Party which includes Knox, Ringwood & Bellbird Hospitals. Arrangements are in place for TRVC to access to infectious disease physicians through the Knox Hospital. Healthscope and HICMR policies, restricted antimicrobial traffic light information and therapeutic guidelines are available in all clinical areas.

The clinical pharmacist and the infection control nurse monitor antibiotic usage, appropriateness of antibiotic prescribing and resistance. Targeted audits include antimicrobials used for Urinary Tract infections and acquired pneumonia. Regular AMS reports are submitted to the TVRC IPC and MAC and show evidence of improvement regarding appropriateness of prescribing and cessation of drugs within the prescribed. TVRC is encouraged to participate in the National Antibiotic Prescribing Surveys (NAPS) as currently this does not occur.

Cleaning, disinfection and sterilisation

A suite of HICMR and HSP policies and procedures provide the framework to ensure the principles of infection prevention and control are practised in environmental cleaning, waste, laundry and linen management. Linen and waste management is undertaken by external contractors and is very well managed. Environmental cleaning schedules are used in all areas of the facility and are subject to ongoing review. Schedules also exists for monitoring temperature and bacteria levels of hot water systems, ice machines, and the hydrotherapy pool.

Results of HICMR risk assessments for environmental services, clinical waste and linen management show evidence of very high levels of compliance for the period 2015-2017 (95% - 98%). Environmental cleaning and linen management audits results show very high levels of sustained compliance with required standards/policies throughout the facility. Patient satisfaction survey results show very high levels of satisfaction (98%) with the cleanliness of the hospital. Action 3.15.3 has been rated MM.

Results of the external Food Safety Audits show full compliance. HICMR Risk assessments for the 2017 is 98%.

No reprocessing of critical reusable medical devices is undertaken at TVRC. Single use items are in use. A HSP Vascular Access Chart is used to record details of PICC, IV cannula insertion and management. Patients transferred from other facilities with PICC, IV Cannula & indwelling catheter have information included on the transfer form and included in TVRC patient clinical record. Equipment and single use items delivery is done by the store's manager. Batch numbers are recorded in delivery dockets which are scanned and are accessible in the event of a recall.

Storage of sterile stock storage areas have all been refurbished and appropriate wire baskets installed. Audit results October 2017 show 98% compliance in storage and maintenance of integrity of sterile stock.

A gap analysis for compliance with ASNZS 4187:2014requirements has been completed and results show a high level of compliance. A plan has been developed and actions have been taken to address all areas identified as requiring strengthening.

Communicating with patients and carers

Infection prevention and control information is provided via brochures and posters displayed throughout the hospital and via the organisation's website. Information on TVRC healthcare-associated infections and hand hygiene compliance rates is available on the MyHealthscope website. Infection prevention and control information has been included in the updated patient information directory and in the TRVC channel which is scheduled for installation in the near future. Evidence available showed that evaluation of infection control information provided to consumers had been undertaken to determine if it met the needs of the target audience. Results showed high levels of satisfaction.

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	MM
3.2.1	SM	SM
3.2.2	SM	SM
3.3.1	SM	SM
3.3.2	SM	SM
3.4.1	SM	SM
3.4.2	SM	SM
3.4.3	SM	SM

Action 3.1.4 Core

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

Surveyor Comment:

Annual infection prevention and control facility- wide risk assessments are undertaken by HICMR to assess the effectiveness of the IPC policies/procedures. Risk assessments are completed for all wards/departments, environmental services, clinical waste and linen management and food services. Results for the period 2014-2017 show improved performance and consistently high levels of facility-wide achievements (2014-90%; 2015-94%; 2016-96%, 2017-98%). There is evidence of annual revision of the TVRC IPC Risk Management Plan and implementation of actions to address recommendations for areas identified as requiring strengthening and monitoring of outcomes. The IPC education and audit programs are comprehensive and very well developed, and there is evidence of high levels of compliance reported and implementation of follow-up actions for areas identified as requiring improvement and monitoring of outcomes. The surveyors agree the Action warrants a MM rating.

Surveyor's Recommendation:

No recommendation

Infection prevention and control strategies

Ratings

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

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

Surveyor Comment:

Evidence provided showed that TVRC workforce compliance with the national hand hygiene guidelines had been audited as per the HSP Hand Hygiene Policy and the national hand hygiene initiative requirements and that the overall compliance rate has been consistently above the national benchmark for the period 2015-2017. There was a compliance rate of 93% for the audit period 3 2017 across the clinical and non-clinical workforce, including medical officers. The surveyors agree there is a sustained approach to compliance auditing and the Action is rated MM.

Surveyor's Recommendation:

No recommendation

Action 3.5.2 Core

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

Surveyor Comment:

Evidence provided showed that TVRC hand hygiene rates are reported regularly to the TVRC Quality and Risk Management Committee and quarterly to HSP Corporate where performance is monitored against HSP targets, benchmarked with other HSP hospitals and reviewed by the National Safety and Quality Committee. The current HSP National Benchmark target is 85%. TVRC has consistently performed above the HSP targets and the National Benchmark. The surveyors agree there is evidence of a sustained approach to reporting and review of hand hygiene compliance rates at the TVRC and HSP Corporate levels and the Action has been rated MM.

Surveyor's Recommendation:

No recommendation

Action 3.5.3 Core

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

Surveyor Comment:

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

Surveyor's Recommendation:

No recommendation

Action 3.10.1 Core

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

Surveyor Comment:

Education records show that 97% of the nursing staff have completed aseptic technique training. The action is fully met.

Surveyor's Recommendation:

No recommendation

Managing patients with infections or colonisations

Ratings

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

Antimicrobial stewardship

Ratings

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

Cleaning, disinfection and sterilisation

Ratings

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

Action 3.15.3 Core

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

Surveyor Comment:

There is evidence of a sustained robust organisational-wide approach to environmental services management and cleaning and ensuring compliance with standards and policies/procedures which is supported by risk assessments, a well-developed environmental cleaning schedule and auditing program. Results of HICMR risk assessments and audits for environmental services and cleaning show evidence of very high levels of compliance for the period 2015-2017 and improved performance with results ranging from 95%-100%. There is evidence of monitoring of performance, implementation of follow-up actions for areas identified as requiring improvement. The survey team agree that this Action warrants a MM rating.

Surveyor's Recommendation:

No recommendation

Action 3.16.1 Core

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

Surveyor Comment:

A gap analysis for compliance with ASNZS 4187:2014 has been completed and a plan has been developed and implemented to address all areas identified as requiring strengthening.

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

TVRC has a robust governance framework that includes executive responsibility, a risk management approach, and enables efficient reporting of medication incidents, evaluation, and the development of risk management strategies. The system is overseen by the Medication Safety Committee that reports to the Executive Management Committee. All individual incidents are reviewed at the QRMC and reported to HSP. TVRC staff are involved in quarterly cluster meetings that provide contemporary information, a venue for learning, improvement initiatives, and support in developing local policies and risk mitigation strategies.

HSP and TVRC policies are based on National legislation and professional guidelines. The surveyors verified referencing and review in accordance with HSP policy.

The medication management system is assessed in conjunction with renewal of the pharmacy contract, or if indicated by deficits within the system.

The surveyors observed within the nurse's station a list of signatures of those staff with medication authorities which is reviewed six-monthly and when clinical staff leave or are newly employed.

Incidents are recorded on the risk management system, and comparison with coding data and recorded incidents demonstrates a good reporting culture. In the case of an adverse event, immediate action is taken to review the incident and implement risk management strategies. TVRC has been under the HSP target for medication incidents (0.3%) for the last three years, and achieved 0% for the ACHS Indicator Medication error- adverse event requiring intervention since 2015.

All staff with medication authorities are required to pass medication calculations annually, and complete mandatory medication education. Tall Man lettering, documentation audits, and patient education have been demonstrated to reduce risks associated with medication use.

Documentation of Patient Information

Surveyors perused clinical records and verified that a best possible medication history is obtained on admission, and all risks such as allergies, adverse drug reactions and high-risk medications are recorded as an alert consistently throughout the clinical record which is available in the ward area. Adverse reactions are reported through the risk management system and immediately reviewed and reported to the Therapeutics Goods Administration (TGA) as relevant.

A very comprehensive medication profile is completed by the clinical pharmacist. It forms part of the discharge documentation for the General Practitioner and is given to the patient with medications on discharge. Audit indicates that 92% of complete discharge summaries are forwarded to the relevant receiving clinician.

Medication Management Processes

Contemporary information is distributed electronically or in hard copy to the clinic workforce through resources such as the Hospital Pharmacy Service (HSP) updates, Therapeutic Guidelines, MIMMS, 'Don't Rush to Crush', The Injectables Handbook, HSP intranet library service, and Anti-MIcrobial Stewardship High Alert Antibiotic medications.

The Medication Safety Committee provides a venue for clinician review of the effectiveness of the resources available including on-line access to professional research material.

Medication risks are reviewed regularly on the risk register, and these include those related to storage and safe distribution.

Storage of all medications including temperature sensitive, ensures that only those clinical staff with authorisation are able to access medications in the imprest, or on the medication trolley. Security is escalated in accordance with the level of risk associated with the medication, and includes Tall Man lettering, storage of medications that look the same (e.g. Potassium vials), high risk **a**nti-psychotics, **p**otassium, **i**nsulin, **n**arcotics and sedative agents, **c**hemotherapy and **h**eparin and other anticoagulants (APINCH) drugs and S8 drugs of dependence.

S8 drugs are registered, receipted and transported between the pharmacy and ward. There is a point of risk when returning unwanted S8 medications to the pharmacy in the care of a sole clinician, and the surveyors suggest TVRC develop a further safeguard by notifying pharmacy that the unwanted drugs have left the ward, and the person in whose care they are.

Continuity of Medication Management

The Medication Management Plan and the National Inpatient Medication Chart are used to track changes in medication administration and are audited regularly to ensure compliance with policy and procedure.

The surveyors observed that a complete list of a patient's medicines is provided within the clinical record during clinical handover and the system for providing a copy of the current list of medications on discharge with explanation of changes, the medication management plan and profile on transfer of care are audited and indicate a high level of compliance.

Communication with Patients and Carers

Patient interviews indicate that pharmacy discuss any changes of medication with them, and that is supported within clinical records. Patient information leaflets are readily available to clinical staff and are given to patients during discussion when medication is changed.

On discharge, pharmacy provides a comprehensive medication profile that includes options, benefits and associated risks to the patient/carer, and sends it to the receiving clinician on handover. Patient satisfaction surveys related to the provision and understanding of medication information is high, and the consumers have contributed to analysis of patient feedback resulting in expanded verbal discussion.

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

TVRC has well-developed systems for patient identification and procedure matching consistent with the HSP Policy. Patients wear one identification band consistent with the national standard with four agreed patient identifiers. Every patient has an arm band applied on admission to the service. Red armbands are used for alerts and replace white armbands. Day patients presenting to the outpatient services have their identification (ID) confirmed on arrival and a label is applied with 3 identifiers. Results of audits of inpatients ID compliance show continuous improvement in levels of compliance (95%-99%) for the period 2015-2017. Results of outpatient audits which commenced in September 2017 showed 100% compliance. Plans are in place for ongoing scheduling of regular audits of outpatient ID compliance. A very low level of patient identification incidents is reported.

Processes to transfer care

Patient identification is checked throughout the continuum of the patient journey and this applies to occasions where care is transferred.

A number of initiatives have been undertaken to improve patient identification processes undertaken by orderlies when transporting patients to the gym and therapy areas and medical imaging services within the hospital and include training and competency assessments on patient identification, review of portering spreadsheets to include ID checks, introduction of a Diagnostic Imaging Clinical Handover Sheet (which includes checking ID signed by orderly when the patient is handed over from the ward and when received by Diagnostic Imaging). Audit results show 19.4% improved compliance in patient identification by orderlies for the period July – September 2017.

Observation of the clinical handover process during the survey demonstrated effective use of the identification band.

Processes to match patients and their care

Procedures and auditing systems are in place to confirm compliance with correct patient identification and treatment matching for medications and other non-surgical interventions.

NSQHSS Survey

Organisation : Victorian Rehabilitation Centre, The
Orgcode : 211682

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

Clinical handover is overseen by TVRC Quality & Risk Committee and is supported by HSP policies/ procedures and guidelines and tools. Workforce education sessions on clinical handover are provided via eLearning and face-to-face presentations. Actions taken to strengthen the implementation of clinical handover include the appointment of a TVRC clinical champion, participation in the HSP Corporate Discharge Planning Working Party, and revision of the ISOBAR tool (identify–situation–observations–background–agreed plan–read back) and nursing handover tool. All clinical handover incidents are entered in RiskMan and reported to the Executive and Quality & Risk Committee. The organisation reported a low-level of clinical handover incidents.

Clinical handover processes

Processes and procedures are in place for the implementation of a structured handover between shifts, when transferring between units and between VMOs when one is going on leave etc. and are supported with the use of the ISOBAR tool. Mechanisms are well developed for handover of patients to other health providers when patients are discharged or transferred to other facilities. Comprehensive discharge summaries are completed by medical officers, nursing and allied health staff. Evidence was provided showing that TVRC consistently exceeds the HSP KPI of 85% of discharges sent to ongoing providers within 48 hours. Results of audits of bedside clinical handover show improvement in compliance with requirements, increasing from 74%in 2015 to 80% 2017.

Clinical Handover processes for patients transferring to the Marina Imaging Services have been established and include use of a Diagnostic Imaging Clinical Handover Sheet and documentation of relevant information related to the patient clinical status and treatment and fall risks etc. Other actions taken to strengthen clinical handover by nursing staff include the use of a HSP DVD on bedside clinical handover and distribution of lanyards to staff and inclusion of tools in bedside folders for reference for new staff and refresher for others. It is suggested that a DVD be developed for allied health staff clinical handover.

Patient and carer involvement in clinical handover

Mechanisms to facilitate the involvement of patients and/or carers in clinical handover include the use of bedside patient communication boards and the provision of patient written information. The surveyors observed clinical handover at TVRC and noted that it was undertaken in a professional manner. There was good interaction with patients, in that they were included in the discussion about their current and ongoing care. Results of patient satisfaction surveys show high levels of patient satisfaction regarding the bedside handover processes.

The surveyors noted that there is very small print on the bedside communication boards and not all required information was documented. The organisation is encouraged to review the content of the bedside communication boards and increase the size of the font.

NSQHSS Survey

Organisation : Victorian Rehabilitation Centre, The
Orgcode : 211682

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 : Victorian Rehabilitation Centre, The
Orgcode : 211682

STANDARD 7
BLOOD AND BLOOD PRODUCTS

Surveyor Summary

This Standard has been rated Not Applicable, and the surveyors found no evidence of the use of blood or blood products.

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

Ratings

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

Documenting patient information

Ratings

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

Managing blood and blood product safety

Ratings

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

Communicating with patients and carers

Ratings

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

STANDARD 8
PREVENTING AND MANAGING PRESSURE INJURIES

Surveyor Summary

Governance and systems for the prevention and management of pressure injuries

Governance and systems for the prevention and management of pressure injuries are well established and are supported by well documented policies and procedures that are based on the Pan Pacific Guidelines for the Prevention and Management of Pressure Injury, and use the Modified Waterlow Scale as the assessment tool. Pressure injuries are reported through the risk management system according to frequency and severity with severity scores of 3 and 4 designated 'Never Events'.

Incidents of pressure injury development in hospital or in situ on admission are reported through the Quality and Risk Management Committee (QRMC) and Executive to HSP where peer review indicates very low incidence of pressure injury development, and no incidence of levels 3 and 4 development.

Ninety-nine percent (99%) of staff have completed mandatory education on preventing and managing pressure injuries with ward based one on one and opportunistic training provided by the wound care nurse.

Laminated posters and staff education provided by the wound care nurse has facilitated the differentiation between stage 2 pressure injury and incontinence dermatitis. A low level of recognition of the difference by ward staff has improved to 80% since the bedside education and laminated posters.

Preventing pressure injuries

All patients are screened using the modified Waterlow Scale for risk of pressure injury. Audits consistently identify 100% compliance with completion of a full multidisciplinary assessment completed within eight hours of admission, and in situ wounds assessed by the wound consultant if requested within 24 hours of admission. These results have been sustained over many years, and are indicative of the quality culture of TVRC. The surveyors have advised an MM rating for Action 8.5.1.

Skin inspections are conducted on all consenting patients, not just those at risk and the rate of compliance is increasing markedly to the current high nineties percentile.

Prevention plans are clearly documented and based on best practice using multidisciplinary guidelines. The surveyors observed that plans are reviewed with the patient during bedside handover. Clinical records demonstrate review of plans should unexpected changes occur, and weekly during multidisciplinary ward meetings.

Audit of clinical records by TVRC indicate that all at-risk patients have an implemented pressure injury prevention plan.

Managing Pressure Injuries

The Pan Pacific Guidelines for the Prevention and Management of Pressure Injury are used to develop wound management protocols. Wound management plans are developed with the patient and multidisciplinary services such as the dietician, pharmacist, wound care nurse, and occupational therapist as relevant. TVRC audit of clinical records indicate a high level of compliance with the completion of pressure injury management plans.

Organisation : Victorian Rehabilitation Centre, The
Orgcode : 211682

Communicating with patients and carers

Patient information about preventing and managing pressure injuries is provided in the form of brochures, posters and verbal advice. The information has been subject to feedback from consumers to ensure it is easily understood by patients. The recently developed CD (an initiative of the consumer group) will further facilitate patient understanding.

Patients and/or carers sign all pressure injury prevention and management plans to indicate their participation.

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	MM
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

Action 8.5.1 Core

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

Surveyor Comment:

The management of pressure injuries is guided by the Pan Pacific Clinical Practice Guidelines for the Prevention and Management of Pressure Injuries and the Modified Waterlow Scale. Audits of the multidisciplinary use of this tool to identify patient risk of pressure injury across all wards and departments within 8 hours of admission has consistently achieved 100% over the last few years. The surveyors observed that the risk for each patient is reviewed daily during clinical handover, and the nurse consultant is involved as requested within 24 hours of admission or by phone at any time. There is evidence of a sustained approach to reporting and review by TVRC and Healthscope Corporate. The surveyors agreed on an MM rating for this Action.

Surveyor's Recommendation:

No recommendation

Managing pressure injuries

Ratings

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
8.9.1	SM	SM
8.10.1	SM	SM

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

Surveyor Summary

Establishing recognition and response systems

The systems for recognising and responding to clinical deterioration are well-developed and show evidence of review and strengthening. Actions taken to strengthen the implementation include the appointment of a TVRC clinical champion, participation in the HSP Clinical Deterioration Cluster, development and implementation of a medical emergency team (MET) Call System supported with a MET policy, education of staff and patients and enhancement of data collection to evaluate performance. Comprehensively documented policies/procedures provide the framework for implementation of measurement and documentation of observations, escalation of care, the rapid response system and communication processes.

Implementation and monitoring of performance is overseen by the Quality & Risk Management Committee and the MAC.

All deaths and cardiac arrests and the use of the recognition and response systems and any failures in these systems are subject to review.

Recognising clinical deterioration and escalating care

Colour coded adult observations charts are used for measurement and documentation of observations and incorporate trigger ranges for vital signs. Results of audits of the observation charts show improved levels of compliance with completion of observations as per patient prescribed management plans and initiation of clinical reviews if indicated. Ongoing work is planned to further increase compliance in documentation.

Responding to clinical deterioration

The adult observation chart is designed on human factor principles and trigger ranges for vital signs that are used to escalate concern when observation parameters are outside normal ranges. Clinical reviews are initiated when an assessment falls into the rapid response range or there is serious concern regarding the patient condition. The visiting medical officer (VMO) attends for review and initiation of clinical care or directs a management plan per telephone that may include transfer to secondary hospital for assessment and treatment. When on duty, the TVRC Rehabilitation Registrar may undertake a clinical review and communicates with the VMO.

The medical emergency team (MET) operates within the hospital with well-identified criteria for calls. All the nursing and allied health workforce has completed basic life support (BLS) training. No advanced life support (ALS) training is undertaken by staff. Victoria Ambulance is called and Mobile Intensive Care Ambulance (MICA) Services provide advanced life support and undertake transfer of patients to external facilities as required. Action 9.6.1 is assessed as fully met and rated SM.

Mechanisms are well-developed for review of MET calls and monitoring of processes and outcomes and feedback to the workforce.

Results of a May 2017 survey showed very high levels of staff knowledge of the rapid response system and how to make a MET call and perceived high levels of support provided post MET call. ACHS clinical indicator data for 2016-2017 shows rates of rapid response attendance within five minutes was 98.5% and 100% respectively. HSP Clinical Safety and quality reports show 100% compliance in completion of Mortality reviews.

Communicating with patients and carers

Mechanisms are in place to support patients/carers in the documentation of advanced care directives and development of treatment-limiting orders and is supported with an Advanced Care Directive brochure which is available for patients and carers. Documentation of plans and alerts is incorporated in the clinical records.

A patient and carer escalation system is established to support patients/carers in escalating concerns regarding changes in clinical status. Information regarding how to communicate concerns is provided via admission procedures, a brochure, the patient information booklet which have been subject to review and bedside communication boards. A patient call system is available at the bedside and is subject to regular testing. Results of a surveys undertaken in 2016 and 2017 indicated that patients had good levels of knowledge regarding the escalation processes. Results of a review of RiskMan incidents involving escalation of care show increasing activations by patients/carers. The organisation is strongly encouraged to install bedside posters detailing the steps for escalation of care by patients and carers as the font of information contained in the bedside communication boards is extremely small.

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:

Education records show that 99% of the nursing and allied health workforce have completed BLS training. The action is fully met.

Surveyor's Recommendation:

No recommendation

Communicating with patients and carers

Ratings

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

STANDARD 10
PREVENTING FALLS AND HARM FROM FALLS

Surveyor Summary

Governance and Systems for Preventing Falls

Governance and systems for preventing falls and harm from falls are well established and supported by well documented policies and procedures that are based on best practice and use Falls Risk Assessment Tool (FRAT) as the assessment tool. Falls are reported through the risk management system according to frequency and severity of injury, and there have been no falls causing harm during the last year.

Falls incidents are reported through the QRMC and Executive to HSP where peer review indicates a higher incidence of falls causing no harm than their peer group. TVRC is reviewing all their data and definition of falls to attempt to identify the cause of the seemingly high incidence.

All staff have completed mandatory education on preventing and minimising harm from falls.

“April Falls Week” consists of activities, education sessions and community involvement that highlights the importance of preventing falls.

Staff experience is planned that will emulate patient situations and give staff insight in trying to move with catheters, infusions and poor eyesight.

Equipment designed to prevent falls such as lifting machines, mobility aids, pressure mats, are readily available and staff report that whatever equipment is needed will be purchased or hired within a short period of time.

Signs within the patient area remind patients to ask before they move. Patient information boards within the ward area inform staff and the patient of their level of risk and mobility aids indicate to staff the level of falls risk of the patient using them.

Screening and Assessing Risks of Falls and Harm from Falling

The FRAT is used to screen all patients on admission for the risk of falls. The use of the screening tool is monitored and the proportion of all patients screened and appropriately assessed has been 100% for the last three years. Given the sustained high performance level associated with Action 10.5.2 the surveyors have awarded an MM rating. All risk assessments are reviewed by physiotherapy and nursing in the case of an unexpected change, during their daily morning meetings, with the patient during bedside handover, and during weekly multidisciplinary ward meetings.

Preventing Falls and Harm From Falling

Falls prevention and harm minimisation plans are documented in the clinical record and their effectiveness and appropriateness are regularly monitored in conjunction as change occurs, at bedside handover, and weekly multidisciplinary ward meetings. TVRC takes their falls incidents very seriously and have striven to reduce them and balance the need to encourage patient mobility with the associated risks through patient therapy, equipment purchase and rental, staff and patient education, and the provision of a safe environment.

On or before discharge, patients are referred to appropriate services such as home safety assessment, home care services, GP services, the community based Better Balance group, and outpatient therapy services. The patient and family are educated prior to discharge about falls prevention and minimising the harm from falls.

Communication with Patients and Carers

Patient and family education is provided through information brochures, leaflets and verbal discussion that is documented in clinical notes. The consumer group has perused the patient education information and changes have been made to clarify information through some re-wording and reformatting: Patients and/or carers sign all falls prevention plans to denote their understanding and participation in falls preventions plans.

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	MM
10.5.3	SM	SM
10.6.1	SM	SM
10.6.2	SM	SM
10.6.3	SM	SM

Action 10.5.2 Core

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

Surveyor Comment:

The management of falls is guided by policies and procedures based on the evidence based FRAT. Audits of the multidisciplinary use of this tool to identify patient risk of falls across all wards and departments within eight hours of admission has consistently achieved 100% over the last few years. The surveyors noted that the risk for each patient is reviewed daily during the morning nursing and allied health handover, and discussed with the patient during clinical handover. There is evidence of a sustained approach to reporting and review by TVRC and Healthscope Corporate. Given also the sustainable 100% daily application of the action and regular evaluation by Healthscope Corporate the surveyors have rated this Action MM.

Surveyor's Recommendation:

No recommendation

Preventing falls and harm from falling

Ratings

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

Communicating with patients and carers

Ratings

Action	Organisation	Surveyor
10.9.1	SM	SM
10.10.1	SM	SM

Organisation : Victorian Rehabilitation Centre, The
Orgcode : 211682

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	MM
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	MM
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	MM
1.6.2	Actions are taken to maximise patient quality of care	SM	SM

Clinical practice

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

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

Performance and skills management

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

Incident and complaints management

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

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

Patient rights and engagement

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

Partnering with Consumers

Consumer partnership in service planning

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

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

Consumer partnership in designing care

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

Consumer partnership in service measurement and evaluation

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

Preventing and Controlling Healthcare Associated Infections

Governance and systems for infection prevention, control and surveillance

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

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

Infection prevention and control strategies

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

3.10.3	Action is taken to increase compliance with the aseptic technique protocols	SM	SM

Managing patients with infections or colonisations

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

Antimicrobial stewardship

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

Cleaning, disinfection and sterilisation

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

3.15.2	Policies, procedures and/or protocols for environmental cleaning are regularly reviewed	SM	SM
3.15.3	An established environmental cleaning schedule is in place and environmental cleaning audits are undertaken regularly	SM	MM
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

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Documentation of patient information

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

Medication management processes

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

Continuity of medication management

Action	Description	Organisation's self-rating	Surveyor Rating
4.12.1	A system is in use that generates and distributes a current and comprehensive list of medicines and explanation of changes in medicines	SM	SM
4.12.2	A current and comprehensive list of medicines is provided to the patient and/or carer when concluding an episode of care	SM	SM

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

Communicating with patients and carers

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

Patient Identification and Procedure Matching

Identification of individual patients

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

Processes to transfer care

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

Processes to match patients and their care

Action	Description	Organisation's self-rating	Surveyor Rating
5.5.1	A documented process to match patients and their intended treatment is in use	SM	SM
5.5.2	The process to match patients to any intended procedure,	SM	SM

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

Clinical Handover

Governance and leadership for effective clinical handover

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

Clinical handover processes

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

Patient and carer involvement in clinical handover

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

Blood and Blood Products

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

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

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

Documenting patient information

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

Managing blood and blood product safety

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

Communicating with patients and carers

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

Preventing and Managing Pressure Injuries

Governance and systems for the prevention and management of pressure injuries

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

Preventing pressure injuries

Action	Description	Organisation's self-rating	Surveyor Rating
8.5.1	An agreed tool to screen for pressure injury risk is used by the clinical workforce to identify patients at risk of a pressure injury	SM	MM
8.5.2	The use of the screening tool is monitored to identify the proportion of at-risk patients that are screened for pressure injuries on presentation	SM	SM
8.5.3	Action is taken to maximise the proportion of patients who are screened for pressure injury on presentation	SM	SM
8.6.1	Comprehensive skin inspections are undertaken and documented in the patient clinical record for patients at risk of pressure injuries	SM	SM
8.6.2	Patient clinical records, transfer and discharge documentation are	SM	SM

	periodically audited to identify at-risk patients with documented skin assessments		
8.6.3	Action is taken to increase the proportion of skin assessments documented on patients at risk of pressure injuries	SM	SM
8.7.1	Prevention plans for all patients at risk of a pressure injury are consistent with best practice guidelines and are documented in the patient clinical record	SM	SM
8.7.2	The effectiveness and appropriateness of pressure injury prevention plans are regularly reviewed	SM	SM
8.7.3	Patient clinical records are monitored to determine the proportion of at-risk patients that have an implemented pressure injury prevention plan	SM	SM
8.7.4	Action is taken to increase the proportion of patients at risk of pressure injuries who have an implemented prevention plan	SM	SM

Managing pressure injuries

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

Communicating with patients and carers

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

Recognising and Responding to Clinical Deterioration in Acute Health Care

Establishing recognition and response systems

Action	Description	Organisation's self-rating	Surveyor Rating
9.1.1	Governance arrangements are in place to support the development, implementation, and maintenance of organisation-wide recognition and response systems	SM	SM
9.1.2	Policies, procedures and/or protocols for the organisation are implemented in areas such as: • measurement and documentation of observations • escalation of care • establishment of a rapid response system	SM	SM

	• communication about clinical deterioration		
9.2.1	Feedback is actively sought from the clinical workforce on the responsiveness of the recognition and response systems	SM	SM
9.2.2	Deaths or cardiac arrests for a patient without an agreed treatment-limiting order (such as not for resuscitation or do not resuscitate) are reviewed to identify the use of the recognition and response systems, and any failures in these systems	SM	SM
9.2.3	Data collected about recognition and response systems are provided to the clinical workforce as soon as practicable	SM	SM
9.2.4	Action is taken to improve the responsiveness and effectiveness of the recognition and response systems	SM	SM

Recognising clinical deterioration and escalating care

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

Responding to clinical deterioration

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

NSQHSS Survey

Organisation : Victorian Rehabilitation Centre, The
Orgcode : 211682

Communicating with patients and carers

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

Preventing Falls and Harm from Falls

Governance and systems for the prevention of falls

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

NSQHSS Survey

Organisation : Victorian Rehabilitation Centre, The
Orgcode : 211682

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	MM
10.5.3	Action is taken to increase the proportion of at-risk patients who are screened for falls upon presentation and during admission	SM	SM
10.6.1	A best practice assessment tool is used by the clinical workforce to assess patients at risk of falling	SM	SM
10.6.2	The use of the assessment tool is monitored to identify the proportion of at-risk patients with a completed falls assessment	SM	SM
10.6.3	Action is taken to increase the proportion of at-risk patients undergoing a comprehensive falls risk assessment	SM	SM

Preventing falls and harm from falling

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

Communicating with patients and carers

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

Organisation : Victorian Rehabilitation Centre, The
Orgcode : 211682

Recommendations from Current Survey

Not applicable.

Organisation : Victorian Rehabilitation Centre, The
Orgcode : 211682

Recommendations from Previous Survey

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

Recommendation: NSQHSS Survey 1114.2.6.2

Recommendation:

Implement the planned work to involve consumers and/or carers in the training of the clinical workforce.

Action:

A DVD has been developed and was produced in partnership with the TVRC consumer group. The DVD is made up of scenarios that the consumers had personally experienced whilst either a patient or the carer of a patient at TVRC. The Consumers were very keen to be strongly involved and participated in acting roles within the DVD, topics included medication administration, patient Identification and hand hygiene practices. The launch of the DVD was to the quality committee initially and then to staff at the Centre.

It is currently shown at Orientation for all new staff and in 2017 have shown in again to staff throughout the centre as a refresher for patient Centred care.

Staff attending orientation were asked to evaluate the DVD following viewing it, we had a response rate for the evaluations of 32%, the staff were asked to answer the following questions

- How informative/useful was this education sessions for you - 68% of the staff responded that they found it informative/useful
- They were asked to rate their knowledge before and then after watching the DVD, we found that 84% of the staff that responded stated that their knowledge had increase after watching the DVD

A Consumer brochure has been developed to outline the role of the consumer consultant at TVRC

Healthscope Clinical Handover DVD was developed with a consumer group at the corporate level with another of the Healthscope hospitals for all hospitals to utilise for staff education. For the production on the DVD a number of key stakeholders including consumers contributed in the planning stage, reviewing the proposed scenarios, who would be involved, terminology used and the ability to make them as realistic as possible. This DVD is being shown to staff at TVRC as an education tool around clinical handover. Staff were asked to complete an evaluation following watching the DVD and answer the following

- How informative/useful was this education sessions for you - 92% of the staff responded that they found it informative/useful
- They were asked to rate their knowledge before and then after watching the DVD, we found that 78% of the staff that responded stated that their knowledge had increase after watching the DVD

With changes to the consumer group at TVRC in 2016 our existing consumers had to move on and were no longer able to participate with us any longer due to changes in their circumstances. This has led to the recruitment of new consumer consultants and a new beginning of a consumer advisory group at TVRC

We have one consumer consultant who attends the Quality and Risk Management Meetings and provides feedback to the Quality and Risk Management Committee on Safety and Quality data including patient satisfaction results, feedback from the focus groups held and provides her input at the Quality and Risk Management Meeting

Our consumer consultant has attended at huddle session to educate the staff on her experience as a patient at TVRC and what was important to her as a patient.

Completion Due By: August 2017

Responsibility: Quality Manager

Organisation Completed: Yes

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

A DVD has been developed for the education of staff and is inclusive of consumers in the planning and participation in the video. The new group of consumers include extremely skilled people who are very committed to participating in all aspects of VRC service provision. One consumer has participated in education of staff directly, and staff discussed their greater understanding of the patient experience to surveyors. This recommendation is now closed.

Standard: Recognising and Responding to Clinical Deterioration in Acute Health Care
Criterion: Communicating with patients and carers
Action: 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

Recommendation: NSQHSS Survey 1114.9.7.1

Recommendation:

Ensure that information is provided to patients, family and carers - in a format that is understood and meaningful - on the importance of communicating indications of deterioration, and the use of local systems through which they can raise their concerns.

Organisation : Victorian Rehabilitation Centre, The
Orgcode : 211682

Action:

A rapid response brochure was developed to explain to patient, career, or visitor how to get additional assistance if they needed it if they were feeling unwell or worried about the person they were visiting. The brochure was developed with consumer input and review before being finalised

The brochure is contained in all admission packs for patients and given on admission to the ward it is also displayed around the Centre for visitors.

The Brochure was reviewed in 2017 when an update of the phone numbers was required, the review was conducted involving patients who were currently inpatients to see if they understood the information which 80% of the patients responded yes

Patient communication boards that were developed contained information on how to escalate care, a review of the communication boards showed that we had a difference between them and the brochure, the communication boards were undergoing an update so that the same time we updated the escalation of care section to match our brochure and discussed with patients in the ward what they thought of the proposed option and if it was easier to read and understand

Nurse in charge signs are at each nurse's station - with an extension number that can be used to contact the nurse in charge of the ward for that shift and this sign is updated at the beginning of each new shift

An audit conducted in October 2016 of patients understanding of the escalation of care process at TVRC -showed that 95% of patients that were asked were aware how to get help if needed.

The audit was repeated in April 2017 and of the patients that responded to the question 100% stated they were aware of how to get help if they required it

Information is also contained in the patient information directory and information has been developed to go onto the patient TV channel a project that is currently being worked in partnership with our consumers

Completion Due By: August 2017

Responsibility: NUM / QM

Organisation Completed: Yes

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

Processes are established to support patients/carers in escalating concerns regarding changes in clinical status and include inclusion of information regarding how to communicate concerns in a brochure, the patient information booklet which have been subject to review and bedside communication boards. The documents have been developed in consultation with consumers. Results of a surveys undertaken in 2016 and 2017 indicated that patients had good levels of knowledge regarding the escalation processes. The recommendation is closed.

Organisation : Victorian Rehabilitation Centre, The
Orgcode : 211682

Standard: Recognising and Responding to Clinical Deterioration in Acute Health Care
Criterion: Communicating with patients and carers
Action: 9.9.2 Information about the system for family escalation of care is provided to patients, families and carers

Recommendation: NSQHSS Survey 1114.9.9.2

Recommendation:

Ensure that information about the system for family escalation of care is provided to patients, families and carers.

Action:

Ensure that information about the system for family escalation of care is provided to patients, families and carers.

Action:

Information is provided in various ways to patient, family/carers at The Victorian Rehabilitation Centre

- Brochures - in all admission packs and available around the Centre
- Patient Communication boards
- Patient Guide
- Patient TV channel - current project
- Discussion with the patient on admission

When we survey TVRC patients about the receiving the information, in terms of the brochure and discussion around the communication board the response was poor, although 100% of patients were aware of the process to escalate their care. Discussion of these results lead to other suggested times of when to discuss with patients, at the time of admission, at bedside handover a time when there is a discussion with the patient and carer if present. It also identified the need to evaluate the communication boards and the information contained on them.

Completion Due By: August 2017

Responsibility: NUM / QM

Organisation Completed: Yes

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

In addition to the brochures and the patient information directory, information regarding the patient escalation of care system is to be included in the TVRC TV information channel which is to be installed in the near future. The recommendation is closed.

Organisation : Victorian Rehabilitation Centre, The
Orgcode : 211682

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

Recommendation: NSQHSS Survey 1114.9.9.3

Recommendation:

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

Action:

Patient/Family/Carer or visitor escalation is included in the HSP Policy 8.45 Clinical Deterioration and also in the TVRC Policy 8.9 MET call, new policy in 2016

RiskMan includes an extension for the Deteriorating patient and in this extension, is who activated the response and in the options to select is Patient, Family and Visitor. Reports are able to be run to see how many activations were by patient, family, visitors

In 2015 there were 0 activations by Patient, Family or visitors, with changes to practice and the education on the extension recording of who activated became more accurate

In 2016 there were 9 activations by Patient, Family or visitors therefore 8% of all escalation of care episodes was initiated by Patient, Family or visitors

In 2017 (Jan- Aug) year to date there were 26 activations by Patient, Family or visitors therefore 24% of all escalation of care episodes was initiated by Patient, Family or visitors

Patient/family activation has led to earlier intervention for the patient to prevent an adverse outcome.

Review of patient understanding of the escalation process by questionnaire in October 2016 showed - 95% of patients were aware how to get help if needed

In a repeat audit in April 2017 demonstrated that 100% of the patients who answered to the question on knowing how to get help if needed/escalate care responded yes

NSQHSS Survey

Organisation : Victorian Rehabilitation Centre, The
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Completion Due By: August 2017

Responsibility: NUM / QM

Organisation Completed: Yes

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

Results of a surveys undertaken in 2016 and 2017 indicated that patients had good levels of knowledge regarding the escalation processes. Results of a review of RiskMan incidents involving escalation of care for the period 2015-2016 show increasing activations by patients/carers. The recommendation is closed.

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

Recommendation: NSQHSS Survey 1114.9.9.4

Recommendation:

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

Action:

MET call process introduced in September 2016 to enhance the rapid response system available at TVRC, which includes Patient, family, visitor escalation
Education of staff that patients/family can escalate care and what that means, to ensure correct collection of information in RiskMan for deteriorating patient to be able to identify correctly who activated the escalation

Quality Improvement actions:

- Patient Communication boards - review underway in May 2017

- TVRC rapid response brochure - reviewed May 2017 for reprint

- TV Information Channel development with escalation of care to be included current project- consumers involved as key stakeholders

- Patient Information Directory - reviewed in June 2017 with consumer review and input

- Discussion with patients/family on admission and other relevant times - bedside handover during the discussion about their care and how they are feeling was seen as a prime discussion opportunity

NSQHSS Survey

Organisation : Victorian Rehabilitation Centre, The
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Review of patient understanding of the escalation process by questionnaire in October 2016 showed - 95% of patients were aware how to get help if needed

In a repeat audit in April 2017 demonstrated that 100% of the patients who answered to the question on knowing how to get help if needed/escalate care responded yes

Although during this survey we asked them about the brochure and communication board information and that response was very poor to knowing about it, even though the board is present in the room and the brochure is contained in the admission pack but their recollection of this was poor, this has lea to review of the information on the communication board for an update with consumer input to ensure it is clearer and easier to follow.

Completion Due By: August 2017

Responsibility: QM

Organisation Completed: Yes

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

Evidence is available showing that a range of strategies have been implemented to improve the system for family escalation of care and include: (i) introduction of the MET call process in 2016; (ii) inclusion of information regarding the steps to be taken for escalation of care in bedside communication boards, a brochure, patient information directory and TVRC TV channel; (iii) staff education and (iv) patient and carer education in admission processes and clinical handover. The recommendation is closed.

NSQHSS Survey

Organisation : Victorian Rehabilitation Centre, The
Orgcode : 211682

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**

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 : Victorian Rehabilitation Centre, The
Orgcode : 211682

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 : Victorian Rehabilitation Centre, The
Orgcode : 211682

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	41	3	44
Standard 2	4	0	4
Standard 3	34	5	39
Standard 4	31	0	31
Standard 5	9	0	9
Standard 6	9	0	9
Standard 7	0	0	0
Standard 8	19	1	20
Standard 9	15	0	15
Standard 10	17	1	18
Total	**179**	**10**	**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	8	1	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	**43**	**1**	**44**

NSQHSS Survey

Organisation : Victorian Rehabilitation Centre, The
Orgcode : 211682

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	49	4	53	Met
Standard 2	15	0	15	Met
Standard 3	36	5	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	23	1	24	Met
Standard 9	23	0	23	Met
Standard 10	19	1	20	Met
Total	**222**	**11**	**233**	**Met**