NSQHS Standards Second Edition Organisation-Wide Assessment

Final Report

Griffith Rehabilitation Hospital

Hove, SA

Organisation Code: 325073
Health Service Facility ID: 101196
Assessment Date: 23/02/2021 to 24/02/2021

Accreditation Cycle: 1

Contents

Preamble

How to Use this Assessment Report
The ACHS assessment report provides an overview of quality and performance and should be used to:

1. provide feedback to staff
2. identify where action is required to meet the requirements of the NSQHS Standards
3. compare the organisation's performance over time
4. evaluate existing quality management procedures
5. assist risk management monitoring
6. highlight strengths and opportunities for improvement
7. demonstrate evidence of achievement to stakeholders.

The Ratings:
Each **Action** within a Standard is rated by the Assessment Team.

A rating report is provided for each health service facility.

The report will identify actions that have **recommendations** and/or comments for each health service facility.

The rating scale is in accordance with the Australian Commission on Safety and Quality in Health Care's Fact Sheet 4: Rating Scale for Assessment:

Assessor Rating	Definition
Met	All requirements of an action are fully met.
Met with Recommendations	The requirements of an action are largely met across the health service organisation, with the exception of a minor part of the action in a specific service or location in the organisation, where additional implementation is required.
Not Met	Part or all of the requirements of the action have not been met.
Not Applicable	The action is not relevant in the health service context being assessed.

Suggestions for Improvement
The Assessment Team may provide suggestions for improvement for the health service to consider implementing. They are not required to be implemented for an action to achieve a met rating. Suggestions for improvement are documented under the criterion level.

Recommendations
Not Met/Met with Recommendation rating/s have a recommendation to address in order for the action to be rated fully met. An assessor's comment is also provided for each Not Met/Met with Recommendation rating.

Risk ratings are applied to actions where recommendations are given to show the level of risk associated with the particular action. A risk comment is included if the risk is rated greater than low. Risk ratings are:

1. E: **extreme (significant)** risk; immediate action required.
2. H: **high** risk; senior management attention needed.
3. M: **moderate** risk; management responsibility must be specified.
4. L: low risk; manage by routine procedures

Executive Summary

Introduction

Griffith Rehabilitation Hospital underwent a NSQHS Standards Second Edition Organisation-Wide Assessment (NS2 OWA) from 23/02/2021 to 24/02/2021. The NS2 OWA required 2 assessors for a period of 2 days. Griffith Rehabilitation Hospital is a Private health service. Griffith Rehabilitation Hospital was last assessed between 06 June 2017 and 07 June 2017. Below is a summary of the Health Service Facilities (HSFs) that were reviewed as part of this assessment:

Health Service Facility Name	HSF Identifier
Griffith Rehabilitation Hospital	101196

General Discussion

Griffith Rehabilitation Hospital (GRH) underwent a NSQHS Standards Second Edition Organisation-Wide Assessment (NS2 OWA) on the 23 and 24 February 2021. The NS2 OWA required two assessors for two days. The assessment was deferred from March 2020 due to the COVID-19 pandemic.

Griffith Rehabilitation Hospital (GRH) is managed by Healthscope, who are recognised as a leader in private health care nationally. The hospital has 64 beds, and these have currently been reduced to 58 beds in order to comply with COVID-19 requirements. A busy service for day rehabilitation and a hydrotherapy pool are also in place; these services were also temporarily reduced in 2020 to comply with COVID-19 restrictions.

Griffith Rehabilitation Hospital has a very enthusiastic and committed Executive that provides governance and leadership to continuously improve safety and quality. The hospital is also supported by Healthscope Corporate in regard to clinical and corporate governance, ensuring extensive information in relation to patient outcomes and performance and providing benchmarking and shared learnings.

Summary of Results

At Griffith Rehabilitation Hospital's Organisation Wide Assessment one Action was rated Met with Recommendation across 8 Standards. The following table identifies the Action that was rated Met with Recommendation.

Actions Rated Met With Recommendation	Action Required	Name of Health Service Facilities where action was deemed to be Met With Recommendation
5.22	Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency	All Facilities under membership

The recommendation associated with the above action ratings) are included below. This recommendation needs to be addressed by the health service before the next onsite assessment.

Action	Health Service Facility	Recommendation
5.22	All Facilities under membership	That the GRH research an alternative nursing care plan that includes all current aspects of nursing care and includes the need to check daily for pressure injury.

Further details and specific performance to all of the actions within the standards is provided over the following pages.

Griffith Rehabilitation Hospital

Sites for Assessment

Sites for Assessment - Griffith Rehabilitation Hospital

Griffith Rehabilitation Hospital HSF ID:101196	
Address: 13 Dunrobin Road HOVE SA 5048 Australia	Visited: Yes

Griffith Rehabilitation Hospital

Reports for Each Standard

Standard 1 - Clinical Governance

Governance, leadership and culture

Action 1.1	
The governing body: a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation b. Provides leadership to ensure partnering with patients, carers and consumers c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community d. Endorses the organisation's clinical governance framework e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce f. Monitors the action taken as a result of analyses of clinical incidents g. Reviews reports and monitors the organisation's progress on safety and quality performance	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.2	
The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.3	
The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.4	
The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.5	
The health service organisation considers the safety and quality of health care for patients in its business decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.6	
Clinical leaders support clinicians to: a. Understand and perform their delegated safety and quality roles and responsibilities b. Operate within the clinical governance framework to improve the safety and quality of health care for patients	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Healthscope Corporate and Griffith Rehabilitation Private Hospital Executive provide leadership to the hospital and guide management and clinical governance to provide high quality and safe healthcare the Management Committee, the clinical Committee and the Medical Advisory and Credentialing (MAC) Committee are the peak committees with a clear meeting structure providing reporting lines. The standing agenda items and minutes of meetings reflect that key issues for the hospital are discussed at these meetings.

There was a clear commitment at all levels of staff to safety and quality with projects recently completed or in progress to provide improved care for patients. One of the recent projects was the standard menu rollout this presented several options of meals with nutritional value resulting in an improvement in patient satisfaction with meals. Photographs of the meals were available to aid decision-making. This occurred via a change management process and following rollout a patient experience survey was undertaken. The assessors were informed by patients that following the rollout the meals were tastier.
There is a Healthscope overarching Aboriginal and Torres strait Islander Reconciliation Plan. GRH has very low numbers of Aboriginal and Torres Strait Islander people presenting to the facility; however, it was evident throughout Griffith that Aboriginal and Torres Strait Islander people were a priority. Artwork in the foyer and throughout the facility was very visible. Staff at Griffith have been meeting with a local Kaurna elder to further make the environment welcoming.

Patient safety and quality systems

Action 1.7	
The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.8	
The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.9	
The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: a. The governing body b. The workforce c. Consumers and the local community d. Other relevant health service organisations	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.10	
The health service organisation: a. Identifies and documents organisational risks b. Uses clinical and other data collections to support risk assessments c. Acts to reduce risks d. Regularly reviews and acts to improve the effectiveness of the risk management system e. Reports on risks to the workforce and consumers f. Plans for, and manages, internal and external emergencies and disasters	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.11	
The health service organisation has organisation-wide incident management and investigation systems, and: a. Supports the workforce to recognise and report incidents b. Supports patients, carers and families to communicate concerns or incidents c. Involves the workforce and consumers in the review of incidents d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.12	
The health service organisation: a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework6 b. Monitors and acts to improve the effectiveness of open disclosure processes	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.13	
The health service organisation: a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.14
The health service organisation has an organisation-wide complaints management system, and: a. Encourages and supports patients, carers and families, and the workforce to report complaints b. Involves the workforce and consumers in the review of complaints c. Resolves complaints in a timely way d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken e. Uses information from the analysis of complaints to inform improvements in safety and quality systems f. Records the risks identified from the analysis of complaints in the risk management system g. Regularly reviews and acts to improve the effectiveness of the complaints management system

Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.15	
The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher risk groups into the planning and delivery of care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.16	
The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.17	
The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that: a. Are designed to optimise the safety and quality of health care for patients b. Use national patient and provider identifiers c. Use standard national terminologies	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.18	
The health service organisation providing clinical information into the My Health Record system has processes that: a. Describe access to the system by the workforce, to comply with legislative requirements b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system	
Met	All facilities under membership
Met with Recommendations	

Not Met	
Not Applicable	

Assessment Team Summary:

Griffith Rehabilitation Hospital (GRH) is guided by policies are available from Healthscope on the (HINT) electronic system and by local policies developed specifically for Griffith. A policies and compliance tracking system is available to advise when policies are due for review . Currency of policies are monitored and reported to the governing body and to local committees.

There is a clear process to implement changes to legislation, regulations and standards. Where relevant, based on the risk, adherence to policies is monitored through audits.

Performance data is available through interactive dash boards. Data and information is accessible to the wards and there is evidence that staff use this information at their ward meetings. Staff are encouraged and supported to attend training and professional development opportunities. There are many examples of innovation and improvement across the organisation. Significant reductions UTIs have been achieved through implementing improvement processes.

Wards and Service streams also have access to performance data at the local level where staff discussed various actions they are undertaking to improve performance.

The governance of risk is defined by a number of Healthscope policies. GRH has an integrated risk register located in RiskMan, the risks are reviewed according to their level of severity, with Griffith achieving 100% of risks being reviewed within the timeframe. Discussion of shared learnings and review of KPIs lead to improvements to risks identified. Risks are discussed at Clinical and other committees relevant to the risk and at local meetings with staff.

All clinical and workplace health and safety incidents and near misses are reported through the RiskMan system.

A complaints management system is in place, with complaints being submitted to Healthscope Corporate and included in the quarterly reports. They are also discussed at relevant department meetings and communicated to staff to provide feedback and make improvements. Some of the improvements include: the review of shelving in showers, easier access to the patient's room cupboard.

Clinical performance and effectiveness

Action 1.19	
The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.20	
The health service organisation uses its training systems to: a. Assess the competency and training needs of its workforce b. Implement a mandatory training program to meet its requirements arising from these standards c. Provide access to training to meet its safety and quality training needs d. Monitor the workforce's participation in training	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.21	
The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.22	
The health service organisation has valid and reliable performance review processes that: a. Require members of the workforce to regularly take part in a review of their performance b. Identify needs for training and development in safety and quality c. Incorporate information on training requirements into the organisation's training system	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.23	
The health service organisation has processes to: a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan b. Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.24	
The health service organisation: a. Conducts processes to ensure that clinicians are credentialed, where relevant b. Monitors and improves the effectiveness of the credentialing process	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.25	
The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.26	
The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.27	
The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.28	
The health service organisation has systems to: a. Monitor variation in practice against expected health outcomes b. Provide feedback to clinicians on variation in practice and health outcomes c. Review performance against external measures d. Support clinicians to take part in clinical review of their practice e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems f. Record the risks identified from unwarranted clinical variation in the risk management system	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

GRH has a comprehensive orientation program for all new staff mandatory face-to-face induction, online via ELMO and in their workplace. The compliance with mandatory training was impressive, most being in the high 90%.

There is good access to professional development and staff are well supported to undertake further education and training.

Credentialling of staff occurs through the Medical Advisory Committee (MAC). A Healthscope policy and robust processes in place for the review of qualifications, responsibilities, accountabilities and scope of practice. Policies and procedures are in place for the introduction of new procedures, with applications through the MAC. Position descriptions clearly state the requirement of each position and include relevant safety and quality responsibilities. Selection processes for professional staff are well structured.

A well-established performance review process occurs for all staff working at Griffith. Staff are well supported to access and attend education relating to their field of work.

GRH provides information to clinicians regarding clinical practice and clinical care standards. Ample evidence was available to demonstrate that there were processes in place regarding the Clinical Care standards for antimicrobial stewardship and delirium.

Quality and safety performance, including clinical variation, is reported formally to the Clinical Committee and MAC. Some of the areas that GRH has compared clinical outcomes are for severe impairment, stroke rehabilitation and hip fracture rehabilitation.

Safe environment for the delivery of care

Action 1.29	
The health service organisation maximises safety and quality of care: a. Through the design of the environment b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.30	
The health service organisation: a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.31	
The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.32	
The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 1.33	
The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people	
Met	All facilities under membership

Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

There are well established policies and processes in place at Griffith to provide maintenance to buildings, plant and equipment to be serviced and maintained in compliance with legislative requirements through a planned maintenance schedule. The building is clean and well maintained and has logs and schedules to ensure that scheduled preventive maintenance occurs. The Maintenance Manager holds a Pool Operating Certificate. There is a pool maintenance program which includes areas to be checked, the procedure, frequency and by whom.

A number of workplace health and safety audits are conducted with an annual workplace and safety plan developed.

There is an impressive record of one lost time injury in the past 12 months with the General Manager being the Return-to-Work Coordinator and the hospital holding a 5-year licence that expires in 2022.

Accommodation for patients is based on clinical need and visiting hours are flexible if family or carers, although some modification has been required in the past 12 months due to COVID-19.

Standard 2 - Partnering with Consumers

Clinical governance and quality improvement systems to support partnering with consumers

Action 2.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for partnering with consumers b. Managing risks associated with partnering with consumers c. Identifying training requirements for partnering with consumers	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring processes for partnering with consumers b. Implementing strategies to improve processes for partnering with consumers c. Reporting on partnering with consumers	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

When developing and reviewing policies and procedures the risk and quality systems are used to ensure policies and procedures are based on contemporary best practice, legislation, professional guidelines and address newly emerging risks identified through the quality and risk systems.

Risks associated with Partnering with consumers were noted to be managed effectively.

Training requirements have been identified and include participating in the Healthscope SA Consumer forum two days a year.

The Elmo training management system is made available for the consumer consultant, and the Griffith Rehabilitation Hospital (GRH) designates mandatory training relevant to the role of Consumer Consultant. Staff have completed training in Partnering with Consumers, Patient Centred Care and Aboriginal and Torres Strait Islander training. The safety and quality systems are used when implementing policies and procedures, managing risks, and identifying the training needs to improve outcomes and reduce risk.

Outcomes of care and strategies for improvement in the Partnering with Consumers Standard are monitored through the risk and safety systems, and reports are received by the Griffith Clinical and Medical Advisory Committees. Reports are also received and analysed by Healthscope at a State and National level with results fed back regularly.

Partnering with patients in their own care

Action 2.3	
The health service organisation uses a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights16 b. Easily accessible for patients, carers, families and consumers	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.4	
The health service organisation ensures that its informed consent processes comply with legislation and best practice	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.5	
The health service organisation has processes to identify: a. The capacity of a patient to make decisions about their own care b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.6	
The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals, and make decisions about their current and future care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.7	
The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care	
Met	All facilities under membership
Met with Recommendations	

Not Met	
Not Applicable	

Assessment Team Summary:

The health service Charter of Human Rights is displayed in public and ward area and is consistent with The Australian Charter of Health Care Rights.

The informed consent processes are specific to the clinical procedures and treatments with risks and options clearly described.

Financial consent is consistent with Advisory AS18/10 “Informed Financial Consent”.

A Mini Mental test is used for all patients to assess a baseline for improvement, and if the Mini Mental is inconclusive, a Montreal Cognitive Assessment (MOCA) is used to assess executive function and identify more subtle changes.

The patient may designate a substitute decision maker, and one of the criteria for admission to this private rehabilitation hospital is some ability of the patient to be able to set their own goals in partnership with therapists and families.

The assessors were privileged to attend one of the weekly case conferences at which each patient's progress and weekly goals were assessed by the lead therapists, rehabilitation physician, nurse, and psychologist/occupational therapist. Although the case conferences had reluctantly been modified (COVID safety) to exclude the presence of the patient and family it was very apparent that that patients personal weekly goals had been discussed with the patient and relevant family prior to the conference taking place.

Future planning begins on admission, with patients’ end goals and discharge plans a topic of discussion for every patient.

Due to COVID safe restrictions, the multidisciplinary bedside handover has been ceased and the patient information board has been reviewed to ensure it contains multidisciplinary information to ensure the patient is fully informed of their progress. It was evident that the patient board was updated, and changes discussed as soon as information was available. Patients and families stated their great satisfaction and easy use of the boards in knowing what was happening daily and what the goal for the day was so they could participate in therapy as planned by the team.

Health literacy

Action 2.8	
The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.9	
Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.10	
The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided on discharge	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The demographic of the Griffith local community is one of an ageing population with very little diversity. GRH has identified the five most diverse populations and identified that very few are non-English speaking. Translated material for those five populations is available, and a translator service is readily available to everyone as needed. Pictograms and family members are used for communicating simple needs. Very few Aboriginal and Torres Strait Islander people live within the catchment area and rarely use the service, however all staff and the consumer consultant have completed cultural awareness training.

The consumer consultant has been largely unable to attend Griffith due to COVID restrictions and has been using the time to review, and in partnership with GRH improve over 40 items of patient information to ensure it meets the needs of patients, carers and families and is easy to understand and read via e-mail.

Partnering with consumers in organisational design and governance

Action 2.11	
The health service organisation: a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.12	
The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.13	
The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 2.14	
The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The consumer consultant is an active member of the Clinical Committee and participates in the design, evaluation and decision making at that level. She has had training on Aboriginal and Torres Strait Islander Culture and uses this knowledge to enhance her role. The consumer consultant interviews patients and/or families, and requests e-mail feedback post admission gathering a wealth of feedback from diverse patients which is then passed on to the executive team and used to improve the service. The Healthscope patient satisfaction survey has been consistently within the 85-100% 'good and above' range for the last several years, which is well above the KPI set by Healthscope.

The Healthscope Board has a diverse range of consumers that are involved in the governance, design and measurement and evaluation of healthcare and analyses, compares data, sets KPIs for all its organisations and provides feedback. Remedial action is taken using the quality and risk systems if KPIs are not met.

The GRH consumer consultant attends the Healthscope SA consumer forum two days per year and has been educated in the role of consumer consultant. Hand hygiene, manual handling, and safety and quality training are mandatory, and the ELMO training system is offered. The risk profile of Aboriginal and Torres Strait Islanders in Griffith has been determined as very low and GRH works with the Aboriginal and Torres Strait Islander arm of SONDER services to develop and review the action plan for Closing the Gap, and consult regarding other relevant issues. Artwork is seen throughout the organisation, and all patients are requested to identify their Aboriginal and/or Torres Strait Islander status. Griffith is currently conducting a quality project to decrease the number of patients who decline to answer that question. AS18/04 regarding Aboriginal and Torres Strait Islander actions are implemented appropriately at local and fully at the National level.

Consumer feedback is collected through the consumer consultant, patient complaints, the national patient survey and post admission patient surveys through e-mail to identify opportunities for improvement which are communicated to all staff via the education and training system, e-mail, notice boards and are managed through the quality and safety systems where relevant.

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

Clinical governance and quality improvement to prevent and control healthcare-associated infections, and support antimicrobial stewardship

Action 3.1	
The workforce uses the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for healthcare-associated infections and antimicrobial stewardship b. Managing risks associated with healthcare-associated infections and antimicrobial stewardship c. Identifying training requirements for preventing and controlling healthcare-associated infections, and antimicrobial stewardship	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of systems for prevention and control of healthcare-associated infections, and the effectiveness of the antimicrobial stewardship program b. Implementing strategies to improve outcomes and associated processes of systems for prevention and control of healthcare-associated infections, and antimicrobial stewardship c. Reporting on the outcomes of prevention and control of healthcare-associated infections, and the antimicrobial stewardship program	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when preventing and managing healthcare-associated infections, and implementing the antimicrobial stewardship program to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.4	
The health service organisation has a surveillance strategy for healthcare-associated infections and antimicrobial use that: a. Collects data on healthcare-associated infections and antimicrobial use relevant to the size and scope of the organisation b. Monitors, assesses and uses surveillance data to reduce the risks associated with healthcare-associated infections and support appropriate antimicrobial prescribing c. Reports surveillance data on healthcare-associated infections and antimicrobial use to the workforce, the governing body, consumers and other relevant groups	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The governance of infection prevention and control at Griffith Rehabilitation Hospital (GRH) is predominately from Healthscope with a part time infection prevention and control position onsite at Griffith 24 hours per week. The hospital is also part of the Healthscope Corporate subscription to HICMR which includes access to HICMR policy and procedure manuals electronically and can also be downloaded, audit tools, education material and ongoing contact and advice. This is further supported by a suite of Healthscope Corporate and Griffith specific policies.

Griffith has an infection control plan that is reviewed annually and integrates with the Healthscope Safety and Quality Plan. Griffith also has a Pandemic Plan and a Disaster Management and Recovery Plan. A second yearly audit is conducted by HICMR, the last one being in May 2019 with 75 recommendations. Following this an action plan was developed by Griffith and following considerable work all recommendations have now been implemented.

During the past year many changes have been made to ensure that Griffith complies with the requirements for the COVID-19 pandemic that include cleaning regimes and social distancing.

Consumers have been actively involved in infection prevention and control endorsing and reviewing brochures. Patients have been actively involved in the 'Its ok to Ask' program. Posters have been placed throughout the facility with photographs of staff from different disciplines encouraging patients to ask about hand hygiene or other questions they may wish to ask.

Infection prevention and control systems

Action 3.5	
The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare18, and jurisdictional requirements	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.6	
Clinicians assess infection risks and use transmission-based precautions based on the risk of transmission of infectious agents, and consider: a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated when clinically required during care b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance c. Accommodation needs to manage infection risks d. The need to control the environment e. Precautions required when the patient is moved within the facility or to external services f. The need for additional environmental cleaning or disinfection g. Equipment requirements	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.7	
The health service organisation has processes for communicating relevant details of a patient's infectious status whenever responsibility for care is transferred between clinicians or health service organisations	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.8	
The health service organisation has a hand hygiene program that: a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements b. Addresses noncompliance or inconsistency with the current National Hand Hygiene Initiative	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.9	
The health service organisation has processes for aseptic technique that: a. Identify the procedures where aseptic technique applies b. Assess the competence of the workforce in performing aseptic technique c. Provide training to address gaps in competency d. Monitor compliance with the organisation's policies on aseptic technique	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.10	
The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare[18]	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.11	
The health service organisation has processes to maintain a clean and hygienic environment – in line with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare18, and jurisdictional requirements – that: a. Respond to environmental risks b. Require cleaning and disinfection in line with recommended cleaning frequencies c. Include training in the appropriate use of specialised personal protective equipment for the workforce	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.12	
The health service organisation has processes to evaluate and respond to infection risks for: a. New and existing equipment, devices and products used in the organisation b. Maintaining, repairing and upgrading buildings, equipment, furnishings and fittings c. Handling, transporting and storing linen	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.13	
The health service organisation has a risk-based workforce immunisation program that: a. Is consistent with the current edition of the Australian Immunisation Handbook[19] b. Is consistent with jurisdictional requirements for vaccine-preventable diseases c. Addresses specific risks to the workforce and patients	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

It was observed that Personal Protective Equipment (PPE) was available at the point of care, with training rates for 2020 at 100%. Signage for standard and transmission-based precautions was in place that complied with the Australian Guidelines for Prevention and Control of Infectious Diseases in Healthcare.

A hand hygiene program is in place with compliance consistently higher than the national benchmark; the current compliance being 95%. An online education module is completed by staff with a high compliance of completion. It was noted that there was an abundance of hand hygiene product throughout, including hand hygiene stations at entrances and at point of care to encourage patients, visitors and staff to complete hand hygiene. It is impressive that the compliance rate of hand hygiene for medical staff was also meeting benchmarks.

Aseptic technique training modules occur via Aseptic Non-Touch Technique (ANT) eLearning module for clinical staff, the completion compliance of the module is currently 99%. Observational audits for non-touch aseptic technique are regularly conducted and compliance is monitored. All requirements for aseptic technique have been implemented. There was evidence of competencies for indwelling catheters being conducted with a 100% completion rate.

An impressive program for cleaning is in place for GRH, managed by the Hotel Services Manager, with regular auditing of all areas, with a current compliance rate of 96%. Procedures were in place for all routine and terminal cleaning. Where there is a bathroom shared by two patients a system has been put in place for nursing staff to notify cleaning and the bathroom is immediately cleaned to ensure that COVID requirements are met.

Griffith supplies cook fresh meals on site, is HACCP certified and audited annually by the Holdfast Bay council. Results are provided to the Management Committee.

All surfaces and equipment in the gym and hydrotherapy pool, including handrails are cleaned after each use, this was commented on by patients and observed by the assessors. The current reusable equipment eLearning training compliance is 95.5%.

The hydrotherapy pool water is microbiologically tested monthly by Clinical Labs for legionella, coliforms, EColi and pseudomonas. Since the change to the bromide-based disinfection, the results have been favourable.

Every six months samples of hot water from patient and staff areas via thermostatic mixing valves are randomly selected for Legionella by the contracted service Aqualutions Pty Ltd. Results are communicated to the Maintenance Manager and ICC and any positive results are acted upon according to the procedure for decontamination. Re-sampling and testing of the hot water are then undertaken to ensure effective flush.

Laundry of dirty linen is via an external Spotless service and the current audit for laundry practices was 100%. It was noted by the assessors that linen is stored in an enclosed in a dedicated room with self-closing door was recently installed.

A workplace immunisation program is in place governed by policy and risk based according to the HICMR risk matrix that includes an annual influenza vaccination campaign. The 2020 campaign had a 92% uptake.

Reprocessing of reusable medical devices

Action 3.14	
Where reusable equipment, instruments and devices are used, the health service organisation has: a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying • the patient • the procedure • the reusable equipment, instruments and devices that were used for the procedure	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

There is no reprocessing or sterilising that occurs at Griffith Rehabilitation Hospital.

A gap analysis has been completed for Griffith regarding AS/NZ 4187:2014 Reprocessing of Reusable medical devices in health service organisations with sterile stock stored in wire baskets and meeting requirements for storage. Advisory AS18/07: Reprocessing of reusable medical devices in health service organisations is met.

Antimicrobial stewardship

Action 3.15	
The health service organisation has an antimicrobial stewardship program that: a. Includes an antimicrobial stewardship policy b. Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing c. Has an antimicrobial formulary that includes restriction rules and approval processes d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard[20]	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 3.16	
The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy • antimicrobial use and resistance • appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

There is a robust Antimicrobial Stewardship Program in place with governance via the Clinical Committee and the Medical Advisory Committee. An Antimicrobial Stewardship Plan that is relevant to the facility, with a gap analysis conducted and meet the requirements of Fact Sheet 11, 'Applicability of Clinical Care Standards' and Advisory AS18/08: Antimicrobial Stewardship are met for the Antimicrobial Clinical Care Standard.

GRH has a system for the monitoring of antibiotics, has developed a traffic light restricted antimicrobial list to provide a visual aid for medical staff, monitoring of healthcare infections and the appropriateness of the antibiotic prescribed, pharmacist review of patients medication chart for AMS documentation, conducted an audit on AMS prescribing and utilised the 'Choosing Wisely - antibiotics for UTI in Older People' and has contributed to the submission of NAPS data.

Standard 4 - Medication Safety

Clinical governance and quality improvement to support medication management

Action 4.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for medication management b. Managing risks associated with medication management c. Identifying training requirements for medication management	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.3	
Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.4	
The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Griffith Rehabilitation Hospital (GRH) uses National Healthscope policies and procedures in managing medication safety. Policies and procedures are evidence based and reviewed regularly to ensure best practice is maintained.

Risks associated with managing medications are documented on the risk register and reduced through mitigation strategies. Errors, omissions, and mismanagement of medications are documented through the risk management system, reported to the Clinical Committee, and included in the National auditing and feedback system. Regular audit of the management system identifies gaps and errors, and opportunities for improvement that are implemented and monitored through the quality and safety systems. The results of medication management audits and outcomes are reported to the GRH Clinical Committee and nationally where they are compared to like organisations and any required remedial action is implemented. All staff complete medication safety training annually and have a high rate of compliance.

Consumers are involved with nurses in the initial consolidated medication list, and medication changes including alternate options are discussed with the prescriber. Any new medication is accompanied by a pharmacy printout, and patients are asked to tell nursing staff if they don't understand the information or are concerned. Medications are reconciled by the pharmacist on discharge.

A list of approved prescriber signatures is kept, and compliance is monitored within the medication audit. Only those staff who are authorised to administer medication including the Registered nurses and Endorsed Enrolled Nurses have a key to the medication room. The external pharmacist provides an imprest and disposal service.

The senior RN on duty is approved to hold the DDA keys and administer the medication.

Documentation of patient information

Action 4.5	
Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.6	
Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.7	
The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.8	
The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.9	
The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements	
Met	All facilities under membership
Met with Recommendations	

Not Met	
Not Applicable	

Assessment Team Summary:

A best possible medication history is compiled using the patient's current medication as identified by the current medication chart from the referring agency, the patient bringing their medications to GRH, information from the GP and pharmacist. The medications are reconciled by the registered nurse in partnership with the patient and documented in the Medication Management Plan (MMP) to be reconciled as medications are ceased or new ones started. The ALERT sheet at the front of the healthcare record documents allergies and adverse reactions and alert stickers are placed onto the front and back of each page of the medication charts and the MMP. Proper management of the processes including those required for adverse events during an episode of care is audited regularly, and any gaps reported to the Clinical Committee and addressed through the risk and quality systems.

Any adverse drug reactions are reported to the relevant medical officer and pharmacist, recorded in the healthcare record, and reported through the risk management system with alerts modified accordingly. The process is audited, and any gaps are subject to remediation.

The Therapeutic Goods Administration is contacted by the pharmacist in accordance with the guidelines.

Continuity of medication management

Action 4.10	
The health service organisation has processes: a. To perform medication reviews for patients, in line with evidence and best practice b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.11	
The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.12	
The health service organisation has processes to: a. Generate a current medicines list and the reasons for any changes b. Distribute the current medicines list to receiving clinicians at transitions of care c. Provide patients on discharge with a current medicines list and the reasons for any changes	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Policies and procedures for medication reviews are based on best practice and reviewed regularly. Medication reviews are conducted by the pharmacist for every patient prescribed more than four medications and/or as requested. Clinicians are able to use and print out MIMS patient information sheets, and the pharmacist provides information on each new medication and/or in response to patient request for information. The information sheets have been reviewed by consumers.

The MMP facilitates reconciliation of medications on admission, during the episode of care, and on discharge and the reason for those changes documented on the MMP. At transition of care or on discharge a current list of medications is printed out from the MMP. The processes are monitored during medication audits and demonstrate a high level of compliance.

Medication management processes

Action 4.13	
The health service organisation ensures that information and decision support tools for medicines are available to clinicians	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.14	
The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the: a. Safe and secure storage and distribution of medicines b. Storage of temperature-sensitive medicines and cold chain management c. Disposal of unused, unwanted or expired medicines	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 4.15	
The health service organisation: a. Identifies high-risk medicines used within the organisation b. Has a system to store, prescribe, dispense and administer high-risk medicines safely	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Clinicians have a wide variety of hard copy and electronic resources available to facilitate the safe use of medicines and includes Therapeutic guidelines for intravenous and antibiotic therapy, MIMS online, Don't Rush to Crush, PINCH and the nurses resource book.

The storage of medication is congruent with the manufacturer's instructions, legislation, evidence-based policies and pharmaceutical guidelines. All medications are locked securely in locked cupboards within the locked medication rooms. S4s are stored separately and counted out by two nurses one of whom is a registered nurse.

DDAs are stored in a safe with in a locked cupboard and counted out using the DDA register that is audited regularly by the pharmacist. to ensure the record is accurate. The registered nurse signs DDAs into the safe with the pharmacist and signs unused DDAs into the care of the pharmacist.

Temperature sensitive medications are stored in a purpose- built drug refrigerator that is monitored to alarm if the temperature exceeds the pre-set parameters. The alarm is sent to the nurse call system, and the maintenance officer is on 24-hour call. The GM is also alerted, and pharmacy consulted regarding the need to dispose of medications.

The identification of high-risk medications is facilitated with the use of a green bar code by the pharmacist. only registered nurses are approved to administer high risk medications, and the administration of high-risk medications is included in the annual medication education.

Standard 5 - Comprehensive Care

Clinical governance and quality improvement to support comprehensive care

Action 5.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for comprehensive care b. Managing risks associated with comprehensive care c. Identifying training requirements to deliver comprehensive care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.4	
The health service organisation has systems for comprehensive care that: a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment b. Provide care to patients in the setting that best meets their clinical needs c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify, at all times, the clinician with overall accountability for a patient's care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.5	
The health service organisation has processes to: a. Support multidisciplinary collaboration and teamwork b. Define the roles and responsibilities of each clinician working in a team	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.6	
Clinicians work collaboratively to plan and deliver comprehensive care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The provision of safe Comprehensive Care is directed through National Healthscope evidence-based policies and procedures that are reviewed regularly and as needed to ensure the best possible Comprehensive Care is maintained.

The risk register demonstrates documentation of risks associated with providing Comprehensive Care and mitigation strategies that reduce those risks. Monitoring of events such as incidents, adverse events, and patient feedback are managed through the quality and risk systems, reported to the Clinical Committee and included in the National Healthscope auditing and feedback system.

An appropriate range of mandatory training is required of all staff, and the compliance rate for all training attendance is remarkably high.

The quality improvement system was observed to be used when auditing and monitoring comprehensive care Identifying and implementing opportunities for improvement and reporting the results to the Clinical Committee, the workforce and all outcomes from the comprehensive care standard are reported to the National body for analysis and feedback.

All staff have completed person centred care training, and the assessors witnessed patient involvement in their care during handover, consistent use of the patient information board, case conference discussion and many other interactions between patients and all staff that verified the active participation of patients in their own care and shared decision-making was evident. Documented patient feedback is complimentary about the ability to share decision-making, and have their information needs met, and this was reinforced during assessors' interviews with patients.

National policies, plans and procedures support clinicians in developing comprehensive plans and treatment for their patients. The assessors observed the accommodation of patients within close proximity to the nursing station for extra observational needs, and the reduction of patients in multiple bed wards with extra cleaning of surfaces to ensure a COVID safe environment.

Patients who have historical aggressive tendencies, and those with major cognitive issues that are unable to set their own goals are excluded in the admission criteria, and very few patients require up transfer, however in the case of acute physical or mental deterioration Transfer to an appropriate facility is speedily arranged.

The clinician responsible for overall care is always noted on the patient board as is the attending nurse for the shift.

Throughout the visit assessors noted easy and effective communication between doctors, therapists and nurses that was supported by clinical notations. Attendance of the case conference, and bedside handovers demonstrated compliance with policies and processes related to multidisciplinary teamwork.

Developing the comprehensive care plan

Action 5.7	
The health service organisation has processes relevant to the patients using the service and the services provided: a. For integrated and timely screening and assessment b. That identify the risks of harm in the 'Minimising patient harm' criterion	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.8	
The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.9	
Patients are supported to document clear advance care plans	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.10	
Clinicians use relevant screening processes: a. On presentation, during clinical examination and history taking, and when required during care b. To identify cognitive, behavioural, mental and physical conditions, issues, and risks of harm c. To identify social and other circumstances that may compound these risks	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.11	
Clinicians comprehensively assess the conditions and risks identified through the screening process	
Met	All facilities under membership

Met with Recommendations	
Not Met	
Not Applicable	

Action 5.12	
Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.13	
Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that: a. Addresses the significance and complexity of the patient's health issues and risks of harm b. Identifies agreed goals and actions for the patient's treatment and care c. Identifies the support people a patient wants involved in communications and decision-making about their care d. Commences discharge planning at the beginning of the episode of care e. Includes a plan for referral to follow-up services, if appropriate and available f. Is consistent with best practice and evidence	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

A large proportion of GRH patients declined to reveal their Aboriginal Torres Strait Islander status. Some staff education about asking the question in a different way has resulted in great improvement, and GRH continues to monitor this closely through the administrative information system.

Patients are asked on admission if they have an advanced care plan, and if so to bring it on admission for inclusion in the healthcare record. If not, they are informed of the process, and if they wish are supported by clinicians in the process of documenting their plan.

Clinicians are provided with Healthscope endorsed tools that comply with Advisory AS18/14 "Screening and Assessment of Risk of Harm" and ensures comprehensive screening processes are implemented. Documentation audits identify gaps. Healthscope and GRH have completed the requirements of AS18/14 in good time and included further elements specific to rehabilitation facilities. The assessors perused a number of healthcare records and noted effective screening processes throughout the episode of care. Risks identified in the Minimising Harm criteria are all addressed. All patients have a Mini Mental test to provide a baseline against which to measure improved outcomes, and if the Mini Mental test is inconclusive a Montreal Cognitive Assessment tests executive function and more subtle changes.

A mental health history is taken, and is verified with family or carers, referring source such as GP, hospital, or residential care facility. Risk of self-harm is assessed, and social circumstances are prominent when considering rehabilitation and return to home or residential care facility. Any risks identified are assessed using evidence-based practice and management tools.

Healthscope has endorsed the comprehensive care plan that was rolled out in GRH in November 2019, and staff education occurred at that time.

The care plan is informed by the screening processes and developed by the multidisciplinary team in partnership with the patient and family towards meeting the patient's rehabilitation goals. The plan in partnership with the patient identifies and documents the support people who are to be involved in planning and implementing strategies to aid rehabilitation. Plans for discharge are addressed on the first day of admission taking into account patient rehabilitation and discharge goals.

GRH adds specific rehabilitation goals and plans of management to the comprehensive care plan to reflect specific individual needs. GRH completed the National audit tool 'compliance with comprehensive care plans' in 2020 achieving 67% compliance with comprehensive care planning and 81% for daily care plans, Further education of staff is planned to improve these outcomes.

GRH has completed the requirements of AS/18/15 having achieved all their planning stages and is currently liaising with Healthscope's other rehabilitation services to refine the comprehensive care plan to better fit rehabilitation services.

Documentation audits demonstrate a mostly high level of compliance with screening, assessment and care planning processes, and the results are supported by assessor findings when sighting the clinical records.

Delivering comprehensive care

Action 5.14	
The workforce, patients, carers and families work in partnership to: a. Use the comprehensive care plan to deliver care b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care c. Review and update the comprehensive care plan if it is not effective d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.15	
The health service organisation has processes to identify patients who are at the end of life that are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care[46]	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.16	
The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.17	
The health service organisation has processes to ensure that current advance care plans: a. Can be received from patients b. Are documented in the patient's healthcare record	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.18	
The health service organisation provides access to supervision and support for the workforce providing end-of-life care	
Met	All facilities under membership

Met with Recommendations	
Not Met	
Not Applicable	

Action 5.19	
The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.20	
Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care[46]	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

In partnership with the patient family or carer, an end goal and probable discharge date is identified on admission and documented on the comprehensive care plan. In partnership with the patient the multidisciplinary team review progress, set further goals every week at the weekly case conference one of which the assessors attended. The assessors noted discussion about behaviour, physical and mental health, and strategies to manage them effectively.

In the role of rehabilitation hospital those near end of life would not meet the criteria for admission, however GRH carries and end of life kit to assist clinicians in providing best possible care prior to transfer to a more suitable facility.

Patients are required to bring advanced care plans for inclusion in the healthcare record.

GRH does not provide end-of-life care, however support and supervision is available for all staff on request or automatically prior to transferring the patient to a more suitable service.

Minimising patient harm

Action 5.21	
The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.22	
Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency	
Met	
Met with Recommendations	All facilities under membership
Not Met	
Not Applicable	

Action 5.23	
The health service organisation providing services to patients at risk of pressure injuries ensures that: a. Patients, carers and families are provided with information about preventing pressure injuries b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.24	
The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for: a. Falls prevention b. Minimising harm from falls c. Post-fall management	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.25	
The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.26	
Clinicians providing care to patients at risk of falls provide patients, carers and families with information about reducing falls risks and falls prevention strategies	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.27	
The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.28	
The workforce uses the systems for preparation and distribution of food and fluids to: a. Meet patients' nutritional needs and requirements b. Monitor the nutritional care of patients at risk c. Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone d. Support patients who require assistance with eating and drinking	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.29	
The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard47, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.30	
Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to: a. Recognise, prevent, treat and manage cognitive impairment b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.31	
The health service organisation has systems to support collaboration with patients, carers and families to: a. Identify when a patient is at risk of self-harm b. Identify when a patient is at risk of suicide c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.32	
The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.33	
The health service organisation has processes to identify and mitigate situations that may precipitate aggression	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.34	
The health service organisation has processes to support collaboration with patients, carers and families to: a. Identify patients at risk of becoming aggressive or violent b. Implement de-escalation strategies c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.35	
Where restraint is clinically necessary to prevent harm, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of restraint b. Govern the use of restraint in accordance with legislation c. Report use of restraint to the governing body	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 5.36	
Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that: a. Minimise and, where possible, eliminate the use of seclusion b. Govern the use of seclusion in accordance with legislation c. Report use of seclusion to the governing body	
Met	
Met with Recommendations	
Not Met	
Not Applicable	All facilities under membership

Assessment Team Summary:

Best practice guidelines are used to screen all patients on admission and manage stage one and above pressure injuries and wounds. A wound management chart is best practice based and commenced to regularly assess and treat the wound or pressure area effectively. The incidence of pressure injuries for Griffith is 0.009% against the average Healthscope services of 0.07%, despite the aged patient profile.

Patients all receive a brochure and explanation of the ways to prevent pressure injuries, and all the beds are equipped with pressure relieving mattresses. Numerous pressure relieving devices are available, and their use assessed by Occupational Therapists.

The assessors noted that Pressure areas and wounds are screened, and appropriately managed when stage one or more is noted during the skin inspection on admission, However the need to screen patients for pressure injuries after admission is not clearly identified on the daily care plan. Griffith staff modify each care plan to include regular pressure area screening during the episode of care. The assessors have made a recommendation under Action 5.22 that the Daily Care Plan be reviewed to ensure regular checking of patient pressure areas after admission is included definitively on the Daily Care Plan.

Griffith Rehabilitation Hospital uses the extensively researched Healthscope Modified Falls Assessment Tool, and research conducted by Griffith Allied Health has demonstrated that falls are not reduced by the use of non-slip socks, in fact the opposite is true. They have not identified the cause but discourage their use. The Griffith Multi-Disciplinary Team (MDT) are encouraged to finalise the research and publish.

The well-equipped hydrotherapy pool and gymnasium are safely managed and overseen by the physiotherapy and occupational therapy disciplines, and every patient has an appropriate individual strengthening programme including assisted walking within the corridors, and in a well-constructed garden that provides various surfaces and steps for patients to negotiate.

All patients have a red sticker until they are able to walk safely unaided, and there is fierce competition between patients to reach green sticker status.

Griffith also rehabilitates patients who have had falls at home or while resident within other services and holds a falls prevention education session with those patients weekly. The assessors were privileged to attend one of these sessions and the interaction between patients and occupational therapist about their experiences and solutions was impressive.

Griffith Rehabilitation Hospital is very well- equipped with equipment devices and tools to safely manage falls risks. Clinicians involve carers and family in helping the patient to meet their daily and discharge goals. The assessors noted many occasions of therapists with family members and patients in wards and therapy areas or walking in the corridors, showing family members how to provide support and assistance. Written falls prevention information is clearly written and provided to patients and families.

Healthscope has centralised the menu for all its services following well researched dietary advice, however the food is prepared at Griffith with additional skilled dietary and speech therapy advice. In collaboration with the catering manager, cook and dietician the speech therapist has established the International Dysphagia Diet Standard Initiative (IDDSI) standards that ensure international consistency in providing the right textures for individual patients. Pureed diets are shaped to provide visually pleasing meals. A range of alternatives to the pre-set menu is provided, and for those with a very poor appetite all effort is made to provide them with their choice.

All patients are weighed weekly, and for those unintentionally losing weight supplements are provided. Patients are encouraged to be able to feed themselves with appropriately designed cutlery and equipment and if required, they are assisted and encouraged by occupational therapists or nurses each mealtime. Should a meal be untouched an alternative is offered. Jugs of water or cordial are changed daily or as required. Nutritional intake and output is recorded in cases of frailty, however frail aged patients would seldom meet the admission criteria.

All patients have a Mini Mental test prior to admission to assess their ability to set their own goals. If the Mini Mental is borderline the Montreal Cognitive Assessment is used to better assess executive function and other subtleties. People who are not able to set their own goals and participate in rehabilitation activities are not admitted.

Cognition is assessed in the Daily Care Plan and during nursing handover. Deterioration prompts the use of the Delirium Care Plan and discussion by the MDT. The family is contacted to participate with the MDT in identifying the cause and possible solutions. and if the deterioration continues the patient is transferred to a more suitable service.

Griffith recognises that if patients realise that they will be unable to meet their discharge goal they could consider self-harm or suicide. The mood chart is implemented, and the patient is monitored frequently. When there is a realisation that the goal is unlikely to be achieved the psychologist and family are present during discussion with the patient. Psychological support is offered by the psychologist on the MDT, and the patient and family consulted about referral to a mental health service if indicated.

If the patient threatens self-harm or suicide, they are transferred by the South Australian Ambulance Service (SAAS) to the nearest mental health service or public emergency department that is more equipped to safely manage the care of the patient.

All staff have had training in Workplace Aggression and Violence Education (WAVE) and use of family experience and/or intervention aid in calming the patient's frustrations. Griffith assesses the propensity for violence on admission through previous history provided by the patient, family, general practitioner and previous service providers, and excludes them for admission.

An emergency code black response procedure which is included in inductions and readily available throughout the hospital and therapy areas. Incidents are reported through the risk management system with twelve incidents of verbal and physical threats and two suicide attempts from two years data (January 2018 to December 2019).

Duress alarms scattered throughout the facility and a direct line to the managing security company provides a sense of security for staff who reported feeling very safe in the workplace.

Neither restraint nor seclusion are practised in Griffith Rehabilitation Hospital. Patients are monitored according to the Nurses- Specialling Policy until transfer to a more appropriate service.

Should the episode become aggressive or violent, the staff contact the security service and police as per the Code Black Emergency Policy.

Action 5.22
Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency
This recommendation applies to all Health Service Facilities within this Health Service Organisation
Assessor Rating: Met with Recommendation
Assessor Comment: The assessors could find no reference to daily skin checks on the Healthscope nursing care plan. Griffith Rehabilitation Hospital (GRH) staff are temporarily modifying the skin care section of the care plan to include daily nursing observation of pressure areas.
Recommendation:
That the GRH research an alternative nursing care plan that includes all current aspects of nursing care and includes the need to check daily for pressure injury.
Risk Rating:
Low
Risk Comment:
GRH staff are temporarily modifying the care plan to include daily nursing observation of pressure areas thus meeting 5.2.2. However, this is a temporary fix as GRH is not authorised to change the Healthscope document.

Standard 6 - Communicating for Safety

Clinical governance and quality improvement to support effective communication

Action 6.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.3	
Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.4	
The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes	
Met	All facilities under membership
Met with Recommendations	
Not Met	

Not Applicable	

Assessment Team Summary:

Griffith Rehabilitation Hospital (GRH) has a framework in place that identifies the key principles which guide clinical communication. These are guided by policy and procedure documents from Healthscope and local Griffith policies as well as various support tools that are utilised. Training is provided as part of the orientation process or when changes occur. A range of KPIs are used to measure the effectiveness of communication and these are reported to the Management Committee and Healthscope Corporate.

Patient information includes information on what to expect as part of the identification and handover process.

Correct identification and procedure matching

Action 6.5	
The health service organisation: a. Defines approved identifiers for patients according to best-practice guidelines b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.6	
The health service organisation specifies the: a. Processes to correctly match patients to their care b. Information that should be documented about the process of correctly matching patients to their intended care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Approved identifiers are provided in the Healthscope policy. The correct use of these is monitored by observational audits which are recorded in the suite of audit results and reported both locally to the Clinical Committee and staff and Healthscope. Any incidents regarding correct identification are recorded in the RiskMan incident reporting system.

Patient reported experience measures that relate to identification and handover are used extensively.

Communication at clinical handover

Action 6.7	
The health service organisation, in collaboration with clinicians, defines the: a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines b. Risks relevant to the service context and the particular needs of patients, carers and families c. Clinicians who are involved in the clinical handover	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.8	
Clinicians use structured clinical handover processes that include: a. Preparing and scheduling clinical handover b. Having the relevant information at clinical handover c. Organising relevant clinicians and others to participate in clinical handover d. Being aware of the patient's goals and preferences e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

The assessors attended clinical bedside handover at GRH, and it was very obvious that at all clinical handovers commences with the correct identification of the patient, that the incoming nurse identifies themselves to the patient and the patient is very involved with the handover. It was a very satisfying to witness interactive patient handovers. During handover, the communication board in the patient's room was being updated and the patient was asked if they wished to add information.

The gym and hydrotherapy pool also had sound processes for the handover of patients.

There are policies in place for the transfer of patients to other facilities and to attend appointments.

Communication of critical information

Action 6.9	
Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to: a. Clinicians who can make decisions about care b. Patients, carers and families, in accordance with the wishes of the patient	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 6.10	
The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

There are sound processes in place at GRH to communicate critical information.

The assessors were able to attend a case conference where each patient was discussed with the medical officer, nursing and allied health staff. During the COVID-19 pandemic, the hospital has implemented measures to obtain information from therapists and patients prior to the case conference and then information following the case conference therapists as the patient or their representative were not able to attend. However, the processes implemented ensure that the patient is informed pre and post the case conference. The goals are discussed with the patient pre case conference, each patient has been assigned a key worker on admission who is the 'go to' person for that person, with the medical officer remaining overall care. Following the case conference, the assessors observed the medical officer following up with key workers and the patient and the discharge planner conversing with the patients regarding their planned discharge.

Patients and their families are also provided with contact information to enable them to provide or receive information. There is also the PACE notification system in place for patients or families to notify urgent information.

Documentation of information

Action 6.11	
The health service organisation has processes to contemporaneously document information in the healthcare record, including: a. Critical information, alerts and risks b. Reassessment processes and outcomes c. Changes to the care plan	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Care plan changes in care or health status and transfer of patients were recorded in the health care record contemporaneously and assessors observed this process at various points of the patient journey. These included on admission, at case conference, on transfer and discharge of the patient.

Documentation audits are regularly conducted and are benchmarked with other Healthscope facilities, with GRH exceeding the compliance rate.

Standard 7 - Blood Management

Clinical governance and quality improvement to support blood management

Action 7.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 7.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of the blood management system b. Implementing strategies to improve blood management and associated processes c. Reporting on the outcomes of blood management	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 7.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Policies and procedures are all evidence based, and the Red Cross procedures are used as guidelines for the safe management of blood and blood products transfusion. Compliance with the management of blood and blood products is monitored regularly and outcomes improved through the quality and risk management systems.

All nursing staff are required to complete Blood Safe Training. Only 10-12 planned transfusions are conducted per year, and Griffith recognises the increased risks associated with few procedures a year.

The assessors suggest that training could be enhanced with the addition of practical role-playing.

Blood and blood product transfusions are all planned for medical reasons and conducted during the hours 9-5 on weekdays only. Patients are involved in making the decision about having the transfusion, the possible consequences, the alternative options, and the timing of the transfusion. A blood transfusion consent form is completed in every case.

The blood safe champion is a member of the State Webex team and brings contemporary learnings back to GRH. Audits ensure the effective use of blood and blood products, and include Hb prior to and following transfusion, the reason for transfusion, and the number of units used. Only one unit per transfusion is planned and supplied. by the Pathology. Further units can be supplied form the external (Clinical Labs) service. The results of monitoring activities are reported to the Clinical Committee, and Healthscope National for comparison with like services.

Suggestions for Improvement:

The assessors suggest that the addition of practical role-play could enhance the annual Blood Safe eLearning for nursing staff.

Prescribing and clinical use of blood and blood products

Action 7.4	
Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products by: a. Optimising patients' own red cell mass, haemoglobin and iron stores b. Identifying and managing patients with, or at risk of, bleeding c. Determining the clinical need for blood and blood products, and related risks	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 7.5	
Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 7.6	
The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 7.7	
The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 7.8	
The health service organisation participates in haemovigilance activities, in accordance with the national framework	
Met	All facilities under membership
Met with Recommendations	

Not Met	
Not Applicable	

Assessment Team Summary:

As a rehabilitation centre Griffith Rehabilitation Hospital (GRH) is using transfusion to increase the red cell mass, haemoglobin and iron stores in elderly patients, Blood and blood products are not supplied without a good rationale including diagnosis and Hb.

The assessors examined a number of healthcare records of patients who had blood transfusions and determined that all those records of transfusion contained documentation of decisions relating to blood management, transfusion histories, details of transfusion, Correct nursing documentation had been completed and included commencement time, skin assessment to provide a baseline for recognising a rash, baseline vital signs prior to transfusion and repeated 5 minutes following commencement, hourly during transfusion and observation for rash.

The National Red Cross Guidelines are readily available, and all policies and procedures are based on these. Healthscope has a contract with Clinical Labs, and GRH utilises the service to supply blood and blood products using appropriate rationale, and GRH complies with 'The Receipt of Blood Products Cold Chain and Delivery policy.

Blood Transfusion audits are reported to the Clinical Committee and included in the Healthscope reports. Adverse events are reported to the medical officer and managed through the risk management and quality systems and are discussed at the Clinical Committee and MAC. There have been only three adverse events have been recorded, none of which caused harm to the patient.

Managing the availability and safety of blood and blood products

Action 7.9	
The health service organisation has processes: a. That comply with manufacturers' directions, legislation, and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 7.10	
The health service organisation has processes to: a. Manage the availability of blood and blood products to meet clinical need b. Eliminate avoidable wastage c. Respond in times of shortage	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

GRH does not have a blood refrigerator and complies with the Receipt of Blood and Blood Cold Chain Delivery and Management policy. Healthscope policy only one instance of receipt of blood at 12 degrees has resulted wastage of one unit only.

Healthscope policy directs processes to trace blood and blood products from entry to discard or transfer. Documentation of the transfusion details in the patient's medical record, and the completion of the Blood register enable long term ability to trace every unit of blood to the patient.

The Labs risk register is reviewed six monthly to ensure control mechanisms remain effective, and blood has been available when needed. Urgent blood units can be accessed through Australian Clinical Labs.

GRH has processes that comply with manufacturers' directions, legislation, and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely and to trace blood and blood products from entry into the organisation to transfusion, discard or transfer blood and blood products.

GRH also has processes to manage the availability of blood and blood products to meet clinical need and eliminate avoidable wastage.

Standard 8 - Recognising and Responding to Acute Deterioration

Clinical governance and quality improvement to support recognition and response systems

Action 8.1	
Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.2	
The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems c. Reporting on effectiveness and outcomes of recognition and response systems	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.3	
Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

Governance for the recognising and responding to acute deterioration standard is included in the annual Griffith Rehabilitation Hospital (GRH) Safety and Quality Plan, a suite of Healthscope and Griffith Rehabilitation (GRH) policies, risk management and the reporting of incidents and consumer participation.

New emergency trolleys were implemented to more closely reflect the ANZCOR Guidelines and to have consistency with equipment for ease of use by staff. This was discussed at the MAC Committee prior to implementation and an extensive training program developed for staff.

All MET calls and incidents relating to Code Blue are entered into RiskMan and improvements made where required.

A suite of key performance indicators are collected including an observation and track and trigger forms audit and with continuing high compliance. Any actions required from these audits are reviewed by the Clinical Committee and results provided to staff and posted on the GRH Quality and Safety Board.

Consumers are included in the Healthscope Clinical Committee and patients are provided information on handover process and how to contact a staff member should their condition deteriorate.

Detecting and recognising acute deterioration, and escalating care

Action 8.4	
The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to: a. Document individualised vital sign monitoring plans b. Monitor patients as required by their individualised monitoring plan c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.5	
The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to: a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported d. Determine the required level of observation e. Document and communicate observed or reported changes in mental state	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.6	
The health service organisation has protocols that specify criteria for escalating care, including: a. Agreed vital sign parameters and other indicators of physiological deterioration b. Agreed indicators of deterioration in mental state c. Agreed parameters and other indicators for calling emergency assistance d. Patient pain or distress that is not able to be managed using available treatment e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.7	
The health service organisation has processes for patients, carers or families to directly escalate care	
Met	All facilities under membership
Met with Recommendations	

Not Met	
Not Applicable	

Action 8.8	
The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.9	
The workforce uses the recognition and response systems to escalate care	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

GRH and Healthscope have policies and processes in place regarding escalation of physical and mental health.

These include The Healthscope Delirium and Cognitive Care Impairment policy and the Delirium Clinical Care Standard. On admission all patients receive a CIRAT cognitive risk assessment and if two or more risk factors are identified a cognitive 4AT assessment. Alerts are also placed on the WebPAS system and kept at the point of care for those considered at risk of delirium. Early warning signs are identified, and family and carer consultations occur. If required specialling of the patient can occur or the patient is transferred to another facility.

The Griffith escalation of Care policy outlines the process should a patient deteriorate. Should a patient's condition rapidly deteriorate, 000 is called to transfer the patient to an acute facility. There are two emergency trolleys and AEDs available for use and these are checked regularly and processes reviewed. The emergency trolleys have recently been reviewed with new trolleys and a review of the contents.

GRH has the Patient and Carer Escalation (PACE) system in place for patients and their families and carers to escalate care. On admission patients and their carers are told about the system and how to escalate care. Information is provided is provided on cards that are in each patient's room. The assessors observed that all of the cards are behind the patient's bed, where they often are not able to view them.

Suggestions for Improvement:

1. It is suggested that consideration is given to relocating the PACE cards to a location in the room where the patient can see them.

2. A survey be undertaken of patients and their carers to ascertain if the position of the PACE card and the information provided regarding the system meets their needs.

Responding to acute deterioration

Action 8.10	
The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.11	
The health service organisation has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.12	
The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Action 8.13	
The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration	
Met	All facilities under membership
Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

GRH has processes in place to ensure that clinicians can provide support to deteriorating patients in a timely manner. Assessors were able to view employment documents where clinicians were employed with appropriate skills for the position. The annual basic life support training currently has a 97% compliance.

Safety procedures are in place for the hydrotherapy pool with therapists required to complete pool safety and retrieving a patient from the pool should a medical emergency occur.

GRH has procedures and policies in place, should a mental health or medical emergency occur, to rapidly transfer to another facility. Patients receive urgent care and an ambulance is called to transfer the patient to an acute facility. Staff will also notify family and telephone the facility to provide a verbal handover as well as providing documentation with the patient.

Recommendations from Current Assessment

Standard 5

Organisation: All facilities under membership
Action 5.22 : Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency

Recommendation:
That the GRH research an alternative nursing care plan that includes all current aspects of nursing care and includes the need to check daily for pressure injury.

Rating Summary

Griffith Rehabilitation Hospital

Health Service Facility ID: 101196

Standard 1 - Clinical Governance

Governance, leadership and culture

Action	Assessment Team Rating
1.1	Met
1.2	Met
1.3	Met
1.4	Met
1.5	Met
1.6	Met

Patient safety and quality systems

Action	Assessment Team Rating
1.7	Met
1.8	Met
1.9	Met
1.10	Met
1.11	Met
1.12	Met
1.13	Met
1.14	Met
1.15	Met
1.16	Met
1.17	Met
1.18	Met

Clinical performance and effectiveness

Action	Assessment Team Rating
1.19	Met
1.20	Met
1.21	Met
1.22	Met
1.23	Met
1.24	Met
1.25	Met
1.26	Met
1.27	Met

Action	Assessment Team Rating
1.28	Met

Safe environment for the delivery of care

Action	Assessment Team Rating
1.29	Met
1.30	Met
1.31	Met
1.32	Met
1.33	Met

Standard 2 - Partnering with Consumers

Clinical governance and quality improvement systems to support partnering with consumers

Action	Assessment Team Rating
2.1	Met
2.2	Met

Partnering with patients in their own care

Action	Assessment Team Rating
2.3	Met
2.4	Met
2.5	Met
2.6	Met
2.7	Met

Health literacy

Action	Assessment Team Rating
2.8	Met
2.9	Met
2.10	Met

Partnering with consumers in organisational design and governance

Action	Assessment Team Rating
2.11	Met
2.12	Met
2.13	Met
2.14	Met

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

Clinical governance and quality improvement to prevent and control healthcare-associated infections, and support antimicrobial stewardship

Action	Assessment Team Rating
3.1	Met
3.2	Met
3.3	Met
3.4	Met

Infection prevention and control systems

Action	Assessment Team Rating
3.5	Met
3.6	Met
3.7	Met
3.8	Met
3.9	Met
3.10	Met
3.11	Met
3.12	Met
3.13	Met

Reprocessing of reusable medical devices

Action	Assessment Team Rating
3.14	Met

Antimicrobial stewardship

Action	Assessment Team Rating
3.15	Met
3.16	Met

Standard 4 - Medication Safety

Clinical governance and quality improvement to support medication management

Action	Assessment Team Rating
4.1	Met
4.2	Met
4.3	Met
4.4	Met

Documentation of patient information

Action	Assessment Team Rating
4.5	Met
4.6	Met
4.7	Met
4.8	Met
4.9	Met

Continuity of medication management

Action	Assessment Team Rating
4.10	Met
4.11	Met
4.12	Met

Medication management processes

Action	Assessment Team Rating
4.13	Met
4.14	Met
4.15	Met

Standard 5 - Comprehensive Care

Clinical governance and quality improvement to support comprehensive care

Action	Assessment Team Rating
5.1	Met
5.2	Met
5.3	Met
5.4	Met
5.5	Met
5.6	Met

Developing the comprehensive care plan

Action	Assessment Team Rating
5.7	Met
5.8	Met
5.9	Met
5.10	Met
5.11	Met
5.12	Met
5.13	Met

Delivering comprehensive care

Action	Assessment Team Rating
5.14	Met
5.15	Met
5.16	Met
5.17	Met
5.18	Met
5.19	Met
5.20	Met

Minimising patient harm

Action	Assessment Team Rating
5.21	Met
5.22	Met with Recommendation
5.23	Met
5.24	Met
5.25	Met
5.26	Met
5.27	Met
5.28	Met
5.29	Met
5.30	Met
5.31	Met
5.32	Met
5.33	Met
5.34	Met
5.35	Met
5.36	Not Applicable

Standard 6 - Communicating for Safety

Clinical governance and quality improvement to support effective communication

Action	Assessment Team Rating
6.1	Met
6.2	Met
6.3	Met
6.4	Met

Correct identification and procedure matching

Action	Assessment Team Rating
6.5	Met
6.6	Met

Communication at clinical handover

Action	Assessment Team Rating
6.7	Met
6.8	Met

Communication of critical information

Action	Assessment Team Rating
6.9	Met
6.10	Met

Documentation of information

Action	Assessment Team Rating
6.11	Met

Standard 7 - Blood Management

Clinical governance and quality improvement to support blood management

Action	Assessment Team Rating
7.1	Met
7.2	Met
7.3	Met

Prescribing and clinical use of blood and blood products

Action	Assessment Team Rating
7.4	Met
7.5	Met
7.6	Met
7.7	Met
7.8	Met

Managing the availability and safety of blood and blood products

Action	Assessment Team Rating
7.9	Met
7.10	Met

Standard 8 - Recognising and Responding to Acute Deterioration

Clinical governance and quality improvement to support recognition and response systems

Action	Assessment Team Rating
8.1	Met
8.2	Met
8.3	Met

Detecting and recognising acute deterioration, and escalating care

Action	Assessment Team Rating
8.4	Met
8.5	Met
8.6	Met
8.7	Met
8.8	Met
8.9	Met

Responding to acute deterioration

Action	Assessment Team Rating
8.10	Met
8.11	Met
8.12	Met
8.13	Met

Recommendations from Previous Assessment

Nil