Accreditation Report

Quality Innovation Performance Accreditation Report

Assessment Details

Health Service Name	Dorset Rehabilitation Centre
Health Service ID	HP1325
Accreditation Contact	Mrs Suzanne Callaway
Standards	NSQHS Standard Ed 2

Assessors	Mr David Stevens – Assessment Team Leader Ms Julie Cartwright - Assessor
Date of Assessment	2 December 2021 – 3 December 2021
Assessment Type	Full Assessment
Assessment Location	146 Derby Street PASCOE VALE VIC 3044

Accreditation Status

Accreditation Decision	Accredited
Accreditation Decision Maker	Nicole McKenzie
Decision Maker Signature	
Date	7 January 2022
Accreditation Period	21 June 2022 – 21 June 2025

This assessment was conducted according to the requirements of the NSQHS Standard Ed 2 and Accreditation Program. The health service is required to maintain compliance with these standards throughout the accredited period.

Foreword

Accreditation is independent recognition that an organisation, practice, service, program or activity meets the requirements of defined criteria or standards. Accreditation provides quality and performance assurance for owners, managers, staff, funding bodies and consumers.

The achievement of accreditation is measured against the sector specific Standards which have been set as the minimum benchmark for quality. Compliance with the Standards is demonstrated through an independent assessment.

Accreditation can help an organisation to:
- Provide independent recognition that the organisation is committed to safety and quality
- Foster a culture of quality
- Provide consumers with confidence
- Build a more efficient organisation using a systematic approach to quality and performance
- Increase capability
- Reduce risk
- Provide a competitive advantage over organisations that are not accredited, and
- Comply with regulatory requirements, where relevant.

Continuous quality improvement (CQI) underpins all AGPAL/QIP accreditation programs and the organisation/practice/service through:
- Looking for ways to improve as an essential activity of everyday practice
- Consistently achieving and maintaining quality care that meets consumer/patient needs
- Monitoring outcomes in consumer/patient care and seeking opportunities to improve both the care and its results.
- Constantly striving for best practice by learning from others to increase the efficiency and effectiveness of processes

The following report is based on an independent assessment of the service's performance against National Safety and Quality Health Service (NSQHS) Standards 2nd Edition . The report includes compliance level ratings for each indicator, criteria and standard and includes explanatory notes for key findings. Where an indicator is not rated as 'met', corrective action is specified.

Assessment Ratings

Four levels of attainment are used consistently throughout this report to give an overall rating for each Standard. The levels of attainment are:
- Met
- Met with recommendations
- Not Met
- Not Applicable

In order to meet accreditation requirements all of the Standards must be rated as met or not applicable.

Executive Summary

Scope of Assessment

The scope of this report and the accreditation is described by the agreed Scope of Assessment and Accreditation Statement signed by the organisation and the Licensed Provider, the central elements of which are set out below.

Service

Dorset Rehabilitation Centre

Executive Summary

Dorset Rehabilitation Centre (DRC) is part of the Healthscope Group and is located in Pascoe Vale, Melbourne, Victoria. The hospital provides rehabilitation and medical services within the following case mix: cardiac, neurological, orthopaedic, respiratory and trauma rehabilitation. There is also a falls prevention and pain management program. The hospital is built on compact grounds which includes two fully equipped gymnasiums and a heated hydrotherapy pool. There are private and shared rooms and bathroom facilities. The 'Rehab at Home' program also runs out of the hospital.

This hybrid assessment included inspection of all internal and external areas; the ward, patient rooms, public areas, service areas, workshop, gymnasiums and hydrotherapy pool.

DRC has a multidisciplinary clinical team who provide care and services to in-patients 24/7 and out-patients Monday to Friday. The clinical team includes; nurses, physiotherapists, occupational therapists, exercise physiologists, psychologists, social worker, speech pathologist, dietician and visiting medical officers (VMOs). Services are funded by private health funds, DVA, Workcover & TAC and more recently throughout COVID-19 Public Relief with a huge backlog in subacute services.

DRC has a long history serving the community and improving rehabilitation outcomes for patients. The Senior Management Team provide strong leadership to clinicians and staff in implementing the objectives of the rehabilitation hospital and adhering to the broader values, mission and policies of the Healthscope Group.

The development of rehabilitation hospital services is based on individual and community needs, and a culture of continuous improvement and professional practice. DRC is responsive to changes in the needs of patients. The rehabilitation service empowers its patients and advocates on their behalf to ensure that their rehabilitation health needs are met. The patients interviewed spoke very highly of the clinical services provided, access to therapy including hydrotherapy, and the professional approach of staff. The environment is viewed as homely and comfortable.

The management and staff teams work together to build a strong culture of quality and safety. Clinical Governance processes are well supported by corporate policies and procedures, local induction and training. There are clear delegations of responsibility and understanding of roles across the hospital.

The professional skills of the specialists, doctors, nursing staff, allied health staff and their experience, as well as their ongoing training, professional development and clinical supervision assists in ensuring positive outcomes for rehabilitation patients, and communities more generally. DRC protects patient confidentiality, applies informed consent principles, and works to address any grievance, which is consistent with the service's high standard of ethical care.

DRC has a comprehensive infection control management plan in place. There is a Infection Prevention Co-ordinator who is supported by the HICMR. Infection control does not have its own committee but currently reports via an agenda item on the WHS Committee and then reports to the Quality and Safety Committee and Medical Advisory Committee (MAC). Safety and quality systems are used when implementing policies, managing risks and identifying training requirements for preventing and controlling healthcare-associated infections. There are two Gold Standard Hand Hygiene Auditors on site and this is reflected in the hand hygiene audit results for all classes of workers.

There is an effective antimicrobial stewardship program which involves pharmacist reporting and advice. The management of COVID-19 has been successful with no episodes of COVID19 reported for patients or staff. A gap analysis for compliance to Advisory AS18/07 - Reprocessing of reusable medical devices in health service organisations has been completed.

Governance of medication safety and quality at DRC is overseen by a Pharmacy Committee, with terms of reference and a set agenda that is aligned with the requirements of the Standard. The Committee is accountable to the Quality and Risk Management Committee and also reports to the MAC. Membership of the Committee is multidisciplinary and includes medical and nursing staff as well as an external pharmacist who provides expert opinion. Clinical pharmacists also play a critical role in monitoring medication prescribing and administration practices to ensure clinical safety. Corporate and local medication policy and procedures outline the requirements for the health service to promote accountable approaches to medication management. DRC has a medication audit schedule in place. Previous audit results that are less than satisfactory when compared to KPI targets have been acted upon. An example of this is medication safety and storage. Staff are required to complete mandatory training in medication safety that includes the principles of medication safety, information about common types of medication errors and the management of high-risk medicines. Mandatory training completion rates are high. At interview, clinical staff confirmed that they had received training in incident reporting and felt supported to identify medication errors and near miss events.

At DRC, patient centred care is aligned with patients' expressed goals of care and individual needs. Examples of this can be seen in patient involvement in pre-screening, goal setting, clinical handover and shared decision making involving all members of the treating team. A robust reporting framework is in place. Current guidelines and assessment tools are in line with current best practice. Audit schedules are in place as well as external benchmarking as per Healthscope policy. There have been many quality improvements around comprehensive care including post fall huddles;

simplification of the patient screening forms; updated patient care boards- all leading to improved outcomes. Interviews with staff from all areas found each team to be supportive of another resulting in a cohesive workplace. This was reflected by a high level of patient satisfaction with their care. The patients interviewed could not speak highly enough of the DRC team.

DRC has a robust clinical handover system in place for the transfer of responsibility and accountability for patient care between clinicians and other staff. Oversight of Standard 6 is provided by the Quality and Risk Management Committee. A number of policy and procedure documents support clinical handover across DRC. This includes a Clinical Handover Framework that outlines the minimum dataset for each type of clinical handover. Structured communication processes ensure that the agreed content is effectively communicated. Nursing Staff use ISOBAR for clinical handover with prompts on coloured reminders in each patient bedside file. A bedside handover approach is used and staff are sensitive to patient, family and carer participation. Observation of clinical handover between nursing staff at DRC finds that it was well done and patient-centred

Patient boards could be better matched in line with documented patient goals but this has already been noted as a quality improvement. Education on patient identification is provided to all staff on induction and forms part of the student nurse and graduate nurse training program. Participation in shared learnings provides a forum to discuss issues related to communication and clinical handover.

The Assessment Team interviewed a representative sample of governance and management, staff, clinicians, and patients. A wide range of documents were viewed and site inspections/observations made of practice. Overall, the Assessment Team found the DRC met all applicable standards under the NSQHS 2nd Edition. Some opportunities for improvement were identified for further consideration by the Senior Management Team.

Summary of Ratings

Overall Assessment of Standards

	Rating			
Standard	Met	Met with Recommendations	Not Met	Not Applicable
Clinical Governance Standard	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 1.8, 1.9, 1.10, 1.11, 1.12, 1.13, 1.14, 1.15, 1.16, 1.17, 1.18, 1.19, 1.20, 1.21, 1.22, 1.23, 1.24, 1.25, 1.26, 1.27, 1.28, 1.29, 1.30, 1.31, 1.32, 1.33			
Partnering with Consumers Standard	2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 2.9, 2.10, 2.11, 2.12, 2.13, 2.14			
Preventing and Controlling Healthcare-Associated Infection Standard	3.1, 3.2, 3.3, 3.4, 3.5, 3.6, 3.7, 3.8, 3.9, 3.10, 3.11, 3.12, 3.13, 3.14, 3.15, 3.16			
Medication Safety Standard	4.1, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 4.8, 4.9, 4.10, 4.11, 4.12, 4.13, 4.14, 4.15			
Comprehensive Care Standard	5.1, 5.2, 5.3, 5.4, 5.5, 5.6, 5.7, 5.8, 5.9, 5.10, 5.11, 5.12, 5.13, 5.14, 5.15, 5.16, 5.17, 5.18, 5.19, 5.20, 5.21, 5.22, 5.23, 5.24, 5.25, 5.26, 5.27, 5.28, 5.29, 5.30, 5.31, 5.32, 5.33, 5.34, 5.35			5.36
Communicating for Safety Standard	6.1, 6.2, 6.3, 6.4, 6.5, 6.6, 6.7, 6.8, 6.9, 6.10, 6.11			
Blood Management Standard				7.1, 7.2, 7.3, 7.4, 7.5, 7.6,

				7.7, 7.8, 7.9, 7.10
Recognising and Responding to Acute Deterioration Standard	8.1, 8.2, 8.3, 8.4, 8.5, 8.6, 8.7, 8.8, 8.9, 8.10, 8.11, 8.12, 8.13			

Summary of Improvement Opportunities

Improvement Opportunities

The following actions have been rated as Met, improvement opportunities which the health service may or may not choose to undertake have been provided for these actions:

Criterion	Improvement Opportunities
Patient safety and quality systems	Patient Safety and Quality Systems Documents/Records: 1.7 - Consider displaying patient healthcare rights posters and brochures in the main corridor of the hospital in addition to the patient waiting area and rooms. Patient Safety and Quality Systems Documents/Records: 1.15 - Consider development of a DRC Diversity Action Plan in addition to the Reconciliation Action Plan for Aboriginal people.
Clinical performance and effectiveness	Clinical Performance and Effectiveness Documents/Records: 1.20 - Review the training needs of staff to enable them to respond appropriately to increased areas of activity including vaccine management and cold chain management.
Partnering with consumers in organisational design and governance	Partnering with Consumers Documents/Records: 2.11 - Consider language and other cultural aspects of patients from the patient cohort which may impact on their experience of safety and quality. For example, those patients who call out for assistance in their room or in the pool or gym. There may also be specific significant and/or religious rites and celebrations which are important to the patient and their family or carers. Partnering with Consumers Documents/Records: 2.12 - Consider mapping the different ways outcome data from audits and surveys is presented to patients and if there are any further opportunities to engage them in formally reviewing and making suggestions on improvements for practice, safety and quality. Partnering with Consumers Documents/Records: 2.14 - Consider increasing contributions from rehabilitation patients in the development of staff education and training and orientation.
Clinical governance and quality improvement to prevent and control healthcare associated infections, and support antimicrobial stewardship	Infection Control Documents/Records: 3.1 - Consider either a separate Infection Control Committee or expand the agenda item on the WHS meeting to ensure all aspects of infection prevention care covered.
Infection prevention and control systems	Infection Control Documents/Records: 3.9- Review individual training records to ensure that all VMOs have been assessed as competent in aseptic technique either at DRC or at an external healthcare facility.

Criterion	Improvement Opportunities
	3.9- Consider compiling a list of all medical practitioners who have been deemed competent at aseptic technique and distribute this list at a ward level. Infection Control Documents/Records: 3.13 – Maintain details of staff vaccination or declination status and take all reasonable steps to encourage non-immune workers to receive the healthcare worker recommended vaccines as per the Australian Immunisation Handbook and Victorian Immunisation Department guidelines. All staff whether employees, casuals, contractors or VMO's status should be risk assessed by categorising healthcare workers into Groups A, B, C and D according to their job requirements and action taken appropriately as per policy.
Medication management processes	Medication Safety Documents/Records: 4.14 - Consider running an education session for nurses on Strive for 5 Guidelines including safe storage of vaccines and cold chian management.
Delivering comprehensive care	Delivering Comprehensive Care Documents/Records: 5.14 - Provide additional education regarding goal setting and evaluation for the multidisciplinary team, and support nursing staff to update the care plans and patient care boards accordingly.

Clinical Governance Standard

Leaders of a health service organisation have a responsibility to the community for continuous improvement of the safety and quality of their services, and ensuring that they are person centred, safe and effective.

Intention of this standard
To implement a clinical governance framework that ensures that patients and consumers receive safe and high-quality health care.

Criterion:	**Governance, leadership and culture** Leaders at all levels in the organisation set up and use clinical governance systems to improve the safety and quality of health care for patients.			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
1.1	Governance, leadership and culture 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	Met	Governance, Leadership and Culture Documents/Records: Review of governance documents, interviews and observations shows Dorset Rehabilitation Centre (DRC) has an effective clinical governance framework and system in place. The DRC Clinical Governance Framework is reflective of the wider Healthscope Clinical Governance organisational approach to clinical governance. The board and management promote a culture of safety and quality for rehabilitation patients. Clinician and staff roles are clearly defined, scope of practice is monitored and professional development supported. There is a structure of several subcommittees ranging from the Medication Advisory Committee (MAC) through to the Quality and Consumer Committee which are actively engaged in reviewing the effectiveness of the governance systems. Risks and incidents are recorded, responded to and resolved. There are effective reporting and escalation processes.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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.			
1.2	Governance, leadership and culture 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	Governance, Leadership and Culture Documents/Records: Review of governance documentation, interviews and observations shows the specific health needs of Aboriginal and Torres Strait Islander people are addressed in the organisation's safety and quality priorities. DRC participate in a Reconciliation Working Party as part of a Reconciliation Action Plan project. There is also annual participation in NAIDOC Week celebrations. There is acknowledgement of the Aboriginal land and several artefacts and pictures reflective of Aboriginal culture and heritage in the hospital foyer. People are asked to identify if they are from an Aboriginal background and demographic data is regularly reviewed. The organisation collects relevant statistics on the Aboriginal demographics in the region.	Met
1.3	Organisational leadership 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	Governance, Leadership and Culture Documents/Records: Review of clinical governance documents, interviews and observations shows a clinical governance framework is in place at DRC, auspiced through Healthscope Corporate office. This has associated quality goals and key performance indicators which are linked to a Clinical Governance Quality plan for 2020-2021 and OneHealthscope 2025.	Met
1.4	Organisational leadership The health service organisation implements and monitors strategies to meet the organisation's safety and	Met	Governance, Leadership and Culture Documents/Records: Review of governance documentation, interviews and observation shows strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people are implemented and monitored. This includes review by the Reconciliation Working Party.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	quality priorities for Aboriginal and Torres Strait Islander people			
1.5	Organisational leadership The health service organisation considers the safety and quality of health care for patients in its business decision-making	Met	Governance, Leadership and Culture Documents/Records: Review of governance documentation, interviews and observation shows business decision-making at DRC and more broadly in Healthscope takes into consideration the safety and quality of rehabilitation for patients. There is a Strategic Plan Rehabilitation Strategy for 2020 and a Clinical Governance Quality Plan for 2021 which help to guide the goals and subsequent activities and approach to ensuring safety and quality for rehabilitation patients.	Met
1.6	Clinical leadership 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	Governance, Leadership and Culture Documents/Records: Review of clinical governance documents, interviews and observation shows delegated safety and quality roles and responsibilities of clinical leaders are in place. Examples include the Medication Advisory Committee TOR and meeting minutes, Orientation Manual and position descriptions for the clinical staff. For example, there are policies and procedures for staff and managers to follow which include roles and responsibilities (Chain of Command Nursing Staff Policy), charters (Audit Risk and Compliance Charter) and position descriptions (Nurse Unit Manager).	Met

Criterion:	**Patient safety and quality systems** Safety and quality systems are integrated with governance processes to enable organisations to actively manage and improve the safety and quality of health care for patients.			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
1.7	Policies and Procedures The health service organisation uses a	Met	Patient Safety and Quality Systems Documents/Records: Review of clinical governance documents, interviews and observations shows DRC has processes for developing, authorising and monitoring the implementation of policy and	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		procedure documents. There are Policy and Procedure Guidelines, a Policy Review and Distribution Policy, Policy Guidelines and Document Control requirements. ***Improvement Opportunities*** Patient Safety and Quality Systems Documents/Records: 1.7 - Consider displaying patient healthcare rights posters and brochures in the main corridor of the hospital in addition to the patient waiting area and rooms.	
1.8	Measurement and quality improvement 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	Patient Safety and Quality Systems Documents/Records: Members of the governing body interviewed could describe how DRC uses organisation-wide quality improvement systems to improve safety and quality for rehabilitation patients. There is a strong incident reporting culture and a clear process to follow. The Quality Committee, WHS Committee, Quality and Consumer Committee and Partnering with Consumers Strategy 2020 - 2023 are all mechanisms to monitor and encourage continuous improvement for quality and safety.	Met
1.9	Measurement and quality improvement The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: a. The governing body	Met	Patient Safety and Quality Systems Documents/Records: Senior Management interviewed confirmed reports on safety and quality systems and performance are regularly provided. The Clinical Risk - Shared Learning Reports provide regular oversight on trends and patterns, and importantly the effectiveness of risk mitigation strategies. The Healthscope National Patient Experience reports provide further insight into safety and quality and clinical risk mitigation.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	b. The workforce c. Consumers and the local community d. Other relevant health service organisations			
1.10	Risk management 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	Patient Safety and Quality Systems Documents/Records: Document review, interviews and observations shows there is an effective risk management framework and systems in place. There are effective policy directions, escalation processes, training, registers, signage, and monitoring mechanisms to prevent and/or manage risks. DRC uses 'RiskMan' as the way of capturing, tracking and mitigating risk. There is a strong reporting culture and regular risk reports are provided to the Quality Committee and the MAC. Management and staff demonstrated a high level of risk awareness and preventative practices to reduce the likelihood of incidences.	Met
1.11	Incident management systems and open disclosure 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	Met	Patient Safety and Quality Systems Documents/Records: Review of clinical governance documents, interviews and observations shows there is an effective incident management system in place. There is specific training in RiskMan for rehabilitation services. Incident data is provided to patients and families/carers and staff. The use of Quality Boards in corridors and waiting areas around the facility helps to clearly communicate this information each month.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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			
1.12	Incident management systems and open disclosure The health service organisation: a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework b. Monitors and acts to improve the effectiveness of open disclosure processes	Met	Patient Safety and Quality Systems Documents/Records: Review of clinical governance documents shows an open disclosure program that is consistent with the Australian Open Disclosure Framework is in place. Staff interviewed confirmed they received training in open disclosure and understood its intent and the actions to follow. Open disclosure training is available on a e-learning platform and part of mandatory training.	Met
1.13	Feedback and complaints management 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	Met	Patient Safety and Quality Systems Documents/Records: Review of feedback and complaints management documentation, interviews and observations shows a process is in place to seek feedback from rehabilitation patients, carers, families and the workforce. This information is used to improve safety and quality systems. Recent improvements in response to feedback include the installation of the Quality Boards in public areas and displaying patient goals on a board in each patient room.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	c. Uses this information to improve safety and quality systems			
1.14	Feedback and complaints management 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	Patient Safety and Quality Systems Documents/Records: Review of feedback and complaints management documents, interviews and observations shows DRC has an effective complaints management system in place. Complaints are recorded, acknowledged, actioned and resolved in a timely manner. Information is provided to all stakeholders on complaint management including through the Quality and Consumer Committee. A Complaint Graph for 2021 provides an overview to inform organisational responses to trends and the effectiveness of actions taken. The DRC (Healthscope) feedback procedure outlines the process for reporting and managing suggestions, reporting and managing complaints, communication and actions with the staff member who is the subject of a complaint. Patients receive a comprehensive booklet on entry which describes the complaint management system and also have a laminated card hanging in their room on how to escalate any concerns they or their family/carers have.	Met
1.15	Diversity and high-risk groups The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its	Met	Patient Safety and Quality Systems Documents/Records: Review of governance documentation shows the patient population has been identified, including those who are at higher risk of harm. This information has been used for the planning and delivery of care. There are examples of patients rights available in a range of languages.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		Interpreter services are available as required. Management and staff demonstrated a competent understanding on the use of interpreters for patients who do not rely on family members and carers to relay important medical information, cover consent, and risks. Professional interpreters are often used. ***Improvement Opportunities*** Patient Safety and Quality Systems Documents/Records: 1.15 - Consider development of a DRC Diversity Action Plan in addition to the Reconciliation Action Plan for Aboriginal people.	
1.16	Healthcare records The health service organisation has healthcare records 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	Patient Safety and Quality Systems Documents/Records: Review of clinical governance documents, interviews and observations shows DRC has an effective rehabilitation records system. It is currently paper based though there are medical records for patients. The system enables the clinician to maintain accurate and complete healthcare records and comply with the security and privacy regulations. The system also supports a systematic audit of clinical information which occurs on a regular basis.	Met
1.17	Healthcare records 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	Met	Patient Safety and Quality Systems Documents/Records: DRC has processes in place to provide clinical information into the My Health Record System as this eventuates. Regular updates on the My Health Record are received and reviewed by Healthscope and sites are advised of any developments.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	b. Use national patient and provider identifiers c. Use standard national terminologies			
1.18	Healthcare records 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	Patient Safety and Quality Systems Documents/Records: Review of clinical governance documents shows audit results of completeness and integration of the current clinical record system.	Met

Criterion:	**Clinical performance and effectiveness** The workforce has the right qualifications, skills and supervision to provide safe, high-quality health care to patients			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
1.19	Safety and quality training 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,	Met	Clinical Performance and Effectiveness Documents/Records: Review of human resource documents shows orientation and induction documents that detail the process undertaken by staff and the safety and quality roles and responsibilities of the workforce and the governing body. There is a quality and risk analysis conducted on the orientation process. Management and staff undertake the Healthscope 'Foundation Course' for orientation.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	contracted, locum, agency, student or volunteer members of the organisation		Staff interviewed said the orientation process was comprehensive and effective.	
1.20	Safety and quality training 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	Clinical Performance and Effectiveness Documents/Records: Review of human resource documents, interviews and observations shows clinicians and staff have access to training and professional development. They are required to undertake mandatory training and undertake competency testing for hand hygiene. DRC has a schedule of clinical workforce education and training such as annual CPR and WHS training. Records of training attendance are available onsite. There is a manager responsible for education and training for this site and others which provides a planned and responsive approach to education. This ranges from individual refresher training on areas such as manual handling through to group face to face training on clinical procedures and practices. A training needs analysis is conducted on an annual basis. Staff interviewed felt they had sufficient access to education and professional development and found the onsite dedicated education role helped to support improvement in their skills and knowledge on a more regular basis. The site has relied more on e-learning in recent times which has proven to be effective in ensuring mandatory and elective training is maintained. This has also created greater flexibility and access to training for staff. ***Improvement Opportunities*** Clinical Performance and Effectiveness Documents/Records: 1.20 - Review the training needs of staff to enable them to respond appropriately to increased areas of activity including vaccine management and cold chain management.	Met
1.21	Safety and quality training	Met	Clinical Performance and Effectiveness Documents/Records: Review of human resource documents, interviews and observations shows DRC supports	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		staff in developing the cultural awareness of Aboriginal people and their rehabilitation needs. Staff interviewed said they participated in e-learning cultural awareness training module but also received follow up information on cultural awareness. The process of undertaking the reconciliation action plan has also helped to inform staff knowledge and inclusive practice.	
1.22	Performance management 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	Clinical Performance and Effectiveness Documents/Records: Review of human resource documents, interviews and observations shows a process is in place for performance reviews which are undertaken on a regular basis. This is supported by policy and procedure.	Met
1.23	Credentialing and scope of clinical practice 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' practice to ensure that they are operating within their designated scope of clinical practice	Met	Clinical Performance and Effectiveness Documents/Records: Review of human resource documents, interviews and observations shows management monitor the scope of practice of clinicians. This also occurs when there is a change of treatment and implementation of a new rehabilitation treatment. Credentialing compliance reports are completed on a monthly basis.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered			
1.24	Credentialing and scope of clinical practice 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	Clinical Performance and Effectiveness Documents/Records: Document review, interviews and observations shows a process is in place to ensure clinicians are credentialed. The site conducts an annual audit of credentialed clinicians. The Healthscope By-Laws govern the credentialing process in line with professional and legislative requirements.	Met
1.25	Safety and quality roles and responsibilities 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	Clinical Performance and Effectiveness Documents/Records: Review of human resource documents shows a process is in place to support staff with safety and quality responsibilities. This includes staff who are casual and/or temporary from an agency. There is a nursing agency and personal carer orientation guide and checklist. Position descriptions are thorough, up to date, and specific to the role. Staff interviewed stated they worked within their scope of practice.	Met
1.26	Safety and quality roles and responsibilities The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated	Met	Clinical Performance and Effectiveness Documents/Records: Review of human resource documents, interviews and observations shows a process is in place to provide supervision for clinicians to ensure that they can safely fulfil their designated roles. Supervision is also covered as part of the performance appraisal framework.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	roles, including access to after-hours advice, where appropriate			
1.27	Evidence-based care 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	Clinical Performance and Effectiveness Documents/Records: Observation of facilities and equipment shows best practice guidelines, clinical pathways, decision support tools and clinical care standards are available. Clinicians have access to clinical guidelines at point of service. Management and staff stated that the 'shared learning' reports were particularly helpful in informing practice improvement. For example, a recent incident where a resident suffered a cardiac arrest while on a shower chair has led to shared learning and further training on what to do in this event to maximise patient safety and prevent staff injury.	Met
1.28	Variation in clinical practice and health outcomes 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	Met	Clinical Performance and Effectiveness Documents/Records: Interview with management confirmed that DRC uses both external and internal systems for monitoring and improving clinical and rehabilitation patient outcomes. Root cause analysis is undertaken as well as shared learning reports generated on clinical risk. DRC may also receive shared learning reports from other Healthscope facilities which help to prevent risk and enhance practice.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	improvements in safety and quality systems f. Record the risks identified from unwarranted clinical variation in the risk management system			

Criterion:	**Safe environment for the delivery of care** The environment promotes safe and high-quality health care for patients			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
1.29	Safe environment 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	Safe Environment, Delivery of Care Documents/Records: Observation of facilities and equipment shows the physical environment includes consideration of safety and quality. A range of audits are undertaken from waste management through to pillow and mattress integrity, maintenance and fire. DRC has maintained compliance with COVID-19 requirements for entry/exit tracing, hand hygiene, use of personal protective equipment and social distancing.	Met
1.30	Safe environment 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	Met	Safe Environment, Delivery of Care Documents/Records: Observation confirms that the physical design of the environment includes consideration of safety and quality.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	environment when it is clinically required			
1.31	Safe environment The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose	Met	Safe Environment, Delivery of Care Documents/Records: Observation of facilities and equipment shows signage and directions within the organisation are clear and fit for purpose. This includes up-to-date fire signage, evacuation maps and warning signs. Disability access is enabled through parking spaces, use of ramps, rails, wide sliding doors and equipment.	Met
1.32	Safe environment 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	Safe Environment, Delivery of Care Documents/Records: Document review confirmed that consumer and carer information including the comprehensive handbook (Compendium) for patients is well received by patients as are the laminated cards on escalating concerns, the patient boards and Quality Boards.	Met
1.33	Safe environment 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	Safe Environment, Delivery of Care Documents/Records: Observation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people. There is acknowledgement of ownership of country in meetings and in the main reception area. Aboriginal artefacts help to encourage a welcoming and respectful environment.	Met

Partnering with Consumers Standard

Leaders of a health service organisation develop, implement and maintain systems to partner with consumers. These partnerships relate to the planning, design, delivery, measurement and evaluation of care. The workforce uses these systems to partner with consumers.

Intention of this standard
To create an organisation in which there are mutually valuable outcomes by having:
• Consumers as partners in planning, design, delivery, measurement and evaluation of systems and services
• Patients as partners in their own care, to the extent that they choose.

Criterion:	**Clinical governance and quality improvement systems to support partnering with consumers** Systems are designed and used to support patients, carers, families and consumers to be partners in healthcare planning, design, measurement and evaluation			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
2.1	Integrating clinical governance 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	Partnering with Consumers Documents/Records: Document review, interviews and observations shows the safety and quality system is used when implementing policies, managing risks and identifying training requirements for partnering with consumers. There is a consumer participation orientation checklist and quality key performance indicators for consumer participation. The Quality and Consumer Committee is one of several initiatives to partner with consumers in improving quality and safety outcomes for patients.	Met
2.2	Applying quality improvement systems 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	Met	Partnering with Consumers Documents/Records: Document review shows quality improvement systems are applied when monitoring, implementing and reporting on partnering with consumers. There is a consumer participation plan which helps to guide development of formal engagement with consumers, that includes review of key patient documents strategic directions, audit results, training for staff and recruitment processes. The consumer representatives spoke highly of the way the management and staff encouraged the	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	processes for partnering with consumers c. Reporting on partnering with consumers		consumer voice across the health service, provided training and support to them and were responsive to suggestions and concerns.	

Criterion:	**Partnering with patients in their own care** Systems that are based on partnering with patients in their own care are used to support the delivery of care. Patients are partners in their own care to the extent that they choose			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
2.3	Healthcare rights and informed consent The health service organisation uses a charter of rights that is: a. Consistent with the Australian Charter of Healthcare Rights b. Easily accessible for patients, carers, families and consumers	Met	Partnering with Consumers Documents/Records: Review of service facilities shows a charter of healthcare rights is easily accessible for patients, carers, families and consumers.	Met
2.4	Healthcare rights and informed consent The health service organisation ensures that its informed consent processes comply with legislation and best practice	Met	Partnering with Consumers Documents/Records: Interview with management confirmed the consent processes comply with legislation and best practice. This includes financial consent. Interpreter services are used as necessary to ensure consent is understood in whichever context it applies to.	Met
2.5	Healthcare rights and informed consent The health service organisation has processes to identify: a. The capacity of a patient to make decisions about their own care	Met	Partnering with Consumers Documents/Records: Document review, interviews and observation shows there are processes in place to identify a patient's capacity to make decisions and the process if a substitute decision-maker is required. There are processes for areas such as discussing advanced care directives and where a patient has dementia and/or mental incapacity, low literacy levels, and/or sensory loss such as hearing and sight.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves			
2.6	Sharing decisions and planning care 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	Partnering with Consumers Documents/Records: Document review, interviews and observations shows processes are in place for clinicians to partner with patients. The development of patient boards showing their goals and key clinical information provide evidence of this Patient experience reports show a high degree of satisfaction with the partnering approach and keeping them informed about the medical procedures and risks. There are patient experience reports and information on 'what matters to patients' to keep staff informed and focused on patient-centred care.	Met
2.7	Sharing decisions and planning care 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	Partnering with Consumers Documents/Records: Document review, interviews and observations shows the workforce is supported to form partnerships with patients and carers. This includes information in the foundation and orientation processes for management and staff as part of their mandatory training.	Met

Criterion:	**Health literacy** Health service organisations communicate with consumers in a way that supports effective partnerships			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
2.8	Communication that supports effective partnerships The health service organisation uses communication mechanisms that are tailored to the diversity of the	Met	Partnering with Consumers Documents/Records: Document review, interviews and observations shows communication mechanisms are tailored to patients and the local community in relation to their individual needs, language, cultural norms and health literacy level. For example, the handbook and Quality Boards are clear, concise and presented in a user-friendly manner.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	consumers who use its services and, where relevant, the diversity of the local community			
2.9	Communication that supports effective partnerships 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	Partnering with Consumers Documents/Records: Consumer documentation reviewed shows consumers are involved in the development and review of internally developed information. For example, information such as brochures on reducing pressure injuries and falls have been reviewed and added to by patients.	Met
2.10	Communication that supports effective partnerships 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	Partnering with Consumers Documents/Records: Review of patient documentation shows information is available, easy to understand, relevant to the clinical needs of patients and information needs for ongoing care is provided at end of treatment. For example, posters on cough etiquette and hand hygiene are informative, concise and use visual information. Discharge information has been reviewed to ensure the handover of care conveys critical information. This also relates to the information sheet provided to first responders in the event of an emergency.	Met

Criterion:	**Partnering with consumers in organisational design and governance** Consumers are partners in the design and governance of the organisation			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
2.11	Partnerships in healthcare governance, planning, design, measurement and evaluation 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 local community	Met	Partnering with Consumers Documents/Records: Patient documentation reviewed shows DRC is working on increasing the participation of consumers that reflect the diversity of local community in the governance, design, measurement and evaluation of rehabilitation care. ***Improvement Opportunities*** Partnering with Consumers Documents/Records: 2.11 - Consider language and other cultural aspects of patients from the patient cohort which may impact on their experience of safety and quality. For example, those patients who call out for assistance in their room or in the pool or gym. There may also be specific significant and/or religious rites and celebrations which are important to the patient and their family or carers.	Met
2.12	Partnerships in healthcare governance, planning, design, measurement and evaluation 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	Partnering with Consumers Documents/Records: Review of consumer documentation shows consumers who are partnering in the governance, design, measurement and evaluation of the organisation are provided with orientation, support and education. Role plays are conducted to support consumer engagement and there is a consumer participation presentation to inform consumers about the various ways they can become involved. ***Improvement Opportunities*** Partnering with Consumers Documents/Records: 2.12 - Consider mapping the different ways outcome data from audits and surveys is presented to patients and if there are any further opportunities to engage them in formally reviewing and making suggestions on improvements for practice, safety and quality.	Met
2.13	Partnerships in healthcare governance, planning, design, measurement and	Met	Partnering with Consumers Documents/Records: Document review shows DRC works in partnership with Aboriginal and Torres Strait	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	evaluation The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs		Islander communities to meet their healthcare needs. The development of the reconciliation action plan and cultural awareness initiatives are supporting the development of trust and understanding of how Aboriginal healthcare needs for rehabilitation can be met	
2.14	Partnerships in healthcare governance, planning, design, measurement and evaluation The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce	Met	Partnering with Consumers Documents/Records: Consumers interviewed confirmed they work in partnership with DRC to incorporate their views into workforce training and education. Training modules include the patient experience and journey through the healthcare service. ***Improvement Opportunities*** Partnering with Consumers Documents/Records: 2.14 - Consider increasing contributions from rehabilitation patients in the development of staff education and training and orientation.	Met

Preventing and Controlling Healthcare-Associated Infection Standard

Leaders of a health service organisation describe, implement and monitor systems to prevent, manage or control healthcare-associated infections and antimicrobial resistance, to reduce harm and achieve good health outcomes for patients. The workforce uses these systems.

Intention of this standard
To reduce the risk of patients acquiring preventable healthcare-associated infections, effectively manage infections if they occur, and limit the development of antimicrobial resistance through prudent use of antimicrobials as part of antimicrobial stewardship.

Criterion:	**Clinical governance and quality improvement to prevent and control healthcare associated infections, and support antimicrobial stewardship** Systems are in place to support and promote prevention and control of healthcare-associated infections, and improve antimicrobial stewardship			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
3.1	Integrating clinical governance 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	Infection Control Documents/Records: Review of infection control documents shows safety and quality systems from the Clinical Governance Standard are used when implementing policies and procedures, managing risks and identifying training requirements for preventing and controlling healthcare-associated infections and antimicrobial stewardship. 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 with a wide range of infection prevention policies in place. Staff are advised of changes and updates. Healthscope subscribes to HICMR for all sites which gives 24 hour access to policies, procedures, audits and advice. DRC has an Infection Control Coordinator onsite and there is a comprehensive infection control management plan in place. HICMR will be undertaking a gap analysis in line with the updated infection control standards. The Infection Prevention and Control Policy Manual will be updated in early 2022 in line with the new standards. b. Managing risks associated with healthcare-associated infections and antimicrobial stewardship. All incidents and risks are recorded in RiskMan and reported at the Quality and Safety Meeting. Although in the past, there was a separate meeting for Infection Prevention, at the moment at local level, it is just covered by a single agenda item on the	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			on the WHS Committee meeting. c. Identifying training requirements for preventing and controlling healthcare-associated infections and antimicrobial stewardship. Infection prevention is part of a mandatory training program that includes hand hygiene, donning and doffing of PPE and standard precautions. Clinical leads interviewed could describe how the safety and quality systems are used when implementing policies, managing risks and identifying training requirements for preventing and controlling healthcare-associated infections, and antimicrobial stewardship. Clinical leads interviewed could describe how the safety and quality systems are used when implementing policies, managing risks and identifying training requirements for preventing and controlling healthcare-associated infections and antimicrobial stewardship. Appropriate systems are in place for COVID-19 screening of staff and patients. The hospital is clean, clutter free and tidy despite being small and not purpose built. Good use is made of the space from an infection control perspective. Staff understand the systems in place for infection prevention. ***Improvement Opportunities*** Infection Control Documents/Records: 3.1 - Consider either a separate Infection Control Committee or expand the agenda item on the WHS meeting to ensure all aspects of infection prevention care covered.	
3.2	Applying quality improvement systems 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	Met	Infection Control Documents/Records: Review of infection control documents shows DRC 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. Performance monitoring is undertaken by way of risk audits carried out by HICMR. Any issues identified have action plans implemented at the appropriate level. There is an Infection Control Coordinator one day a week as well as 24-hour access to HICMR support.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		b. Implementing strategies to improve outcomes and associated processes of systems for prevention and control of healthcare-associated infections and antimicrobial stewardship. DRC has two Gold Standard Auditors to assess hand hygiene and submit data to HHA three times a year, even throughout COVID-19. c. Reporting on the outcomes of prevention and control of healthcare-associated infections and the antimicrobial stewardship program. DRC is involved in the ACHS clinical indicators program and submits data to Healthscope's KPI's, NAPS and VICNISS. There was only one infection recorded in RiskMan from May to August 2021. Clinical leads interviewed could describe how the quality improvement systems are used when monitoring, implementing strategies and reporting on the outcomes of prevention and control of healthcare-associated infections and the antimicrobial stewardship program. Verification confirms DRC applies the quality improvement system from the Clinical Governance Standard. Clinical leads interviewed could describe how the quality improvement systems are used when monitoring, implementing strategies and reporting on the outcomes of prevention and control of healthcare-associated infections and the antimicrobial stewardship program. This is a low-risk facility which uses single-use items only. Interview with the pharmacist demonstrated compliance with the requirements of AMS with reporting to the MAC. Evidence was available of various HICMR audits and action plans. Monthly pathology reports are reviewed for HAI's and are reported to the MAC and Quality and Safety Committee for review.	
3.3	Partnering with consumers Clinicians use organisational processes from the Partnering with Consumers Standard when preventing and managing healthcare-associated infections, and implementing the	Met	Infection Control Documents/Records: 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 by educating patients in infection prevention and providing patient information and posters throughout the health service. b. Meet the patient's information needs by partnership with a pharmacy service that	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	antimicrobial stewardship program to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making		provides patients with information on medications and antimicrobials if prescribed. c. Share decision-making by having a consumer on the Healthscope Infection Control Webex team. The patient experience survey reports that patients are highly satisfied with the cleanliness of the health service and the number of times all staff washed their hands. Observation of clinicians' practice demonstrated the use of the health service organisation's processes for partnering with consumers. Patients were involved in all aspects of care. General observation showed good relationships at all levels. Patients interviewed spoke very positively of nurses, allied health, clinicians and environmental staff.	
3.4	Surveillance 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	Infection Control Documents/Records: DRC has a surveillance strategy for healthcare-associated infections and antimicrobial use that: a. Collects data on healthcare-associated infections and antimicrobial from pharmacy reports on AMS prescribing and rates of infection via Riskman. b. Monitors, assesses and uses surveillance data to reduce the risks associated with healthcare associated infections and support appropriate antimicrobial prescribing. Data on AMS and infections is reported at the MAC and Quality and Safety Committees. c. Reports surveillance data on healthcare-associated infections and antimicrobial use to the workforce, the governing body, consumers and other relevant groups. Data is submitted to Healthscope KPI's, VICNISS, NAPS and ACHS Clinical Indicator Program. There was one infection reported in RiskMan from May to August 2021. Interview with clinical leads confirmed there is a surveillance strategy for healthcare-associated infections and antimicrobial use in place. Interview with the Chairman of the MAC confirmed there is a surveillance strategy for healthcare-associated infections and antimicrobial use in place.	Met

Criterion:	**Infection prevention and control systems** Evidence-based systems are used to prevent and control healthcare-associated infections. Patients presenting with, or with risk factors for, infection or colonisation with an organism of local, national or global significance are identified promptly, and receive the necessary management and treatment. The health service organisation is clean and hygienic.			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
3.5	Standard and transmission-based precautions The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare, and jurisdictional requirements	Met	Infection Control Documents/Records: Review of infection control documents shows processes are in place that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare for standard and transmission-based precautions. Review of infection control documents shows processes are in place that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare for standard and transmission-based precautions. Up to date policies and procedures are available via HICMR for staff to use. Staff are trained in transmission-based precautions and the use of PPE. COVID-19 screening is managed very well. Hand hygiene, donning and doffing of PPE and transmission-based precautions are an integral part of infection control training and updates. Clinical leads interviewed confirmed the processes for standard and transmission-based precautions are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare and jurisdictional requirements. Observation of standardised signage and other information resources were consistent with the Australian Guidelines for the Prevention and Control of Infection in Healthcare.	Met
3.6	Standard and transmission-based precautions 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	Met	Infection Control Documents/Records: Review of infection control documents shows processes are in place for clinicians to assess infection risks and use transmission-based precautions based on the risk of transmission of infectious agents that consider patients' risks, communicable diseases, accommodation needs to manage infection risks and to control the environment. Documentation shows processes are in place for precautions taken when the patient is moved within the facility or to external services and the need for additional	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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 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		environmental cleaning, disinfection and equipment requirements. Access to an Infection Control Coordinator once a week as well as a HICMR consultant assists with infection risks being minimised. There is a process in place for the screening of patients for infection at preadmission and on admission. Information on respiratory etiquette is given to patients and posters are displayed in patient areas. Patients at risk of infection can be isolated with the implementation of transmission-based precautions. Environmental staff are trained in additional cleaning requirements for rooms and equipment. Patient infectious status is noted on handover internally and to external services. Observation of facilities and equipment confirms that relevant equipment including personal protective equipment is available to the workforce. Hand sanitiser was at the end of each patient bed as well as at key areas throughout the health service. Staff reported that they have been trained in hand hygiene and donning and doffing of PPE. Cleaners interviewed stated they have additional staff at times when deep cleaning is required.	
3.7	Standard and transmission-based precautions 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	Infection Control Documents/Records: Review of infection control documents shows processes are in place to communicate relevant details of a patient's infectious status whenever responsibility for care is transferred. Alerts are placed on patient records so that any handover includes infectious status. Clinical leads interviewed could describe how they communicate the patient's infectious status when care is transferred.	Met
3.8	Hand hygiene The health service organisation has a hand hygiene program that: a. Is consistent with the current National Hand Hygiene Initiative, and	Met	Infection Control Documents/Records: Review of infection control documents shows processes are in place that are consistent with the current National Hand Hygiene Initiative. DRC has two Gold Standard Hand Hygiene Auditors and this is reflected in the Period 2 2021 hand hygiene results of 88 %. Results are published on the MyHealthscope website. Last available hand hygiene statistics were nurse 96.2%, medical practitioners 81.2%, allied health 81.8%, domestic	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	jurisdictional requirements b. Addresses noncompliance or inconsistency with the current National Hand Hygiene Initiative		staff 85.7% and student nurses 78.6%. Observation of facilities and equipment confirms that the health service organisation has a hand hygiene program.	
3.9	Aseptic technique 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	Infection Control Documents/Records: Review of infection control documents shows processes are in place for aseptic techniques. Aseptic technique training is mandatory for all nurses with competency assessed annually. There is a documented list of procedures requiring aseptic technique. Aseptic technique is audited and reported to the Quality and Safety Committee. Aseptic technique competency for nursing staff is 94%. Medical practitioners training requirements for aseptic technique have been risk assessed as having excellent control hierarchy in line with NSQHS key actions for credentialled practitioners information sheet 2019. Aseptic technique training has been planned for senior nurses in 2022 with a view for the trained nurse auditors to assess nurses and VMO's. Observation of facilities and equipment confirms that the DRC has processes for aseptic technique. Nurses interviewed were not able to confirm which medical practitioners are competent in aseptic technique but thought they would be able to access this information via CGov. ***Improvement Opportunities*** Infection Control Documents/Records: 3.9- Review individual training records to ensure that all VMOs have been assessed as competent in aseptic technique either at DRC or at an external healthcare facility. 3.9- Consider compiling a list of all medical practitioners who have been deemed competent at aseptic technique and distribute this list at a ward level.	Met
3.10	Invasive medical devices The health service organisation has processes for the appropriate use and	Met	Infection Control Documents/Records: Review of infection control documents and observation shows processes are in place that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare for the appropriate use and management of	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		invasive medical devices. There are sound policies and processes in place for the management of invasive devices. A list of IVC's in use is available including intravenous cannulae, in dwelling catheters, peg feeding tubes and PICC lines (inserted elsewhere) . Staff are trained in the management of invasive devices. Insertion of an IVC is risk assessed using a risk matrix (updated in 2021). Annual IVC audits are undertaken and evidence of one for a medical practitioner undertaken in May 2021 showed 90% compliance.	
3.11	Clean environment 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 Healthcare, 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	Infection Control Documents/Records: Review of infection control documents shows processes are in place to maintain a clean and hygienic environment. Policies cover all areas of DRC including wards, gymnasiums and the hydrotherapy pool. Environmental cleaning is of a very high standard at DRC. Cleaners have daily and weekly checklists and weekly walk arounds by the environmental services manager. In addition to usual cleaning, nurses have daily and weekly cleaning schedules. The environmental staff are employees and it is clear to see that they take pride in their work. Improvements made include the purchase of new Kleenmaid cleaning trolley with a new microfibre mop head system where mop heads are removed and cleaned offsite. HICMR undertake an annual audit of the whole cleaning process including work instructions and procedures, observation of practices, storage and use of chemical, education and training and general inspections. HICMR also undertake a food safety audit. The kitchen and food handling areas underwent a comprehensive third-party audit in November 2021 with no recommendations for improvement. The pool area and pool was very clean. Daily testing of pool water as well as weekly microbiological testing is undertaken. Consumer feedback on cleanliness is very positive.	Met
3.12	Clean environment The health service organisation has processes to evaluate and respond to infection risks for: a. New and existing equipment, devices	Met	Infection Control Documents/Records: Review of infection control documents and observation of facilities shows processes are in place to evaluate and respond to infection risks for all new and existing equipment. All new and existing equipment is assessed for infection risks. Storage of equipment is managed very effectively particularly given the small spaces available within the facility. Staff are trained to log equipment or repairs needed via the Kwiklook system. Weekly	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	and products used in the organisation b. Maintaining, repairing and upgrading buildings, equipment, furnishings and fittings c. Handling, transporting and storing linen		walk arounds of the building by environmental and maintenance staff ensures preventive maintenance is in place. Linen is provided by an external contractor and linen audits are undertaken by HICMR with 97% compliance with storage, delivery and discarding at point of generation. Observation of facilities and equipment confirms that DRC has processes to evaluate and respond to infection risks. Staff were observed to have good linen handling practices and nurses advised they have recently reviewed the size of the linen skips as a quality improvement. Fabric curtains in the pool area are to be replaced with disposable hospital grade curtains. Observation of waste management including clinical and cytotoxic waste was observed. Waste audits are undertaken annually by Veolia, the waste company. In 2020, a yellow clinical waste bag was found inside the general waste, this was acted upon with staff education. The same audit in 2021 showed full compliance with clinical and general waste disposal.	
3.13	Workforce immunisation The health service organisation has a risk-based workforce immunisation program that: a. Is consistent with the current edition of the Australian Immunisation Handbook b. Is consistent with jurisdictional requirements for vaccine-preventable diseases c. Addresses specific risks to the workforce and patients	Met	Infection Control Documents/Records: Review of human resource documents shows the workforce has the start of a risk-based workforce immunisation program in place. DRC should maintain details of staff vaccination status and take all reasonable steps to encourage non-immune workers to receive the healthcare worker recommended vaccines as per the Australian Immunisation Handbook. In addition, the Victorian Immunisation Department guidelines also determine risk by categorising health care workers into Groups A,B, C and D according to their job requirements. Review of immunisation records showed that DRC only offers an annual influenza vaccine to staff but is working towards providing other vaccines. There are large gaps in the vaccine status of staff and no records of any VMO's immunisation status. In November 2020, the vaccine status compliance was 11.7% and in a positive step, Healthscope offered serology testing to staff where measles, mumps, rubella, varicella and Hepatitis B status was unknown. Current compliance is 20.9% with a target of 90% compliance. Interview with nurses, allied health and cleaners confirmed they were offered the influenza vaccine as part of their role, and serology testing if required.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			Improvement Opportunities Infection Control Documents/Records: 3.13 – Maintain details of staff vaccination or declination status and take all reasonable steps to encourage non-immune workers to receive the healthcare worker recommended vaccines as per the Australian Immunisation Handbook and Victorian Immunisation Department guidelines. All staff whether employees, casuals, contractors or VMO's status should be risk assessed by categorising healthcare workers into Groups A, B, C and D according to their job requirements and action taken appropriately as per policy.	

Criterion:	**Reprocessing of reusable medical devices** Reprocessing of reusable equipment, instruments and devices is consistent with relevant current national standards, and meets current best practice			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
3.14	Reprocessing of reusable devices 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	Met	Infection Control Documents/Records: Review of infection control documents shows processes are in place for reprocessing reusable equipment, instruments and devices. At DRC all instruments and items are single use. A gap analysis against Advisory AS: 4187 has been undertaken to look at cleaning of equipment such as blood pressure cuffs and other clinical equipment. Observation of facilities and equipment confirms that the organisations processes for reprocessing of instruments are consistent with relevant national and international standards. Observation of equipment and devices showed that the health service cleans equipment after use including in the gymnasium and the hydrotherapy pool.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	and devices that were used for the procedure			

Criterion:	**Antimicrobial stewardship** The health service organisation implements systems for the safe and appropriate prescribing and use of antimicrobials as part of an antimicrobial stewardship program			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
3.15	Antimicrobial stewardship 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	Met	Infection Control Documents/Records: Review of infection control documents shows an Antimicrobial Stewardship Policy is in place that incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard. Clinicians have access to Therapeutic Guidelines and best practice resources on AMS prescribing. DRC has a representative on the Healthscope Infection Control Cluster Committee. As Infection Control is part of the WHS Committee, AMS is not a standing agenda item at DRC level however, this is about to be addressed with the reformulation of a separate Infection Control Committee for DRC and another hospital in its cluster. Clinical leads interviewed could describe the systems, processes and structures in place to support appropriate prescribing and use of antimicrobials. Observation of the facilities and equipment confirmed that current evidence-based Australian Therapeutic Guidelines and resources on antimicrobial prescribing are available to the workforce.	Met
3.16	Antimicrobial stewardship The antimicrobial stewardship program will: a. Review antimicrobial prescribing and	Met	Infection Control Documents/Records: Document review shows the antimicrobial stewardship program will review antimicrobial prescribing and use, use surveillance data on antimicrobial resistance and use to support appropriate prescribing, evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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 in relation to • 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		prescribing and use and report key performance metrics to clinicians and the governing body. Monthly surveillance reports including pathology and antibiotic prescribing reports for the pharmacy are reviewed by HICMR, the Quality and Safety Committee and the MAC. Inappropriate prescribing is followed up with the clinician. DRC is not a surgical hospital and does not undertake prophylactic prescribing.	

Medication Safety Standard

Leaders of a health service organisation describe, implement and monitor systems to reduce the occurrence of medication incidents, and improve the safety and quality of medication use. The workforce uses these systems.

Intention of this standard
To ensure clinicians are competent to safely prescribe, dispense and administer appropriate medicines and to monitor medicine use. To ensure consumers are informed about medicines and understand their individual medicine needs and risks.

Criterion:	**Clinical governance and quality improvement to support medication management** Organisation-wide systems are used to support and promote safety for procuring, supplying, storing, compounding, manufacturing, prescribing, dispensing, administering and monitoring the effects of medicines.			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
4.1	Integrating clinical governance 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	Medication Safety Documents/Records: Review of medication safety documentation shows the safety and quality system is applied when implementing policies, managing risks and identifying training requirements for medication management. Policies are comprehensive and detail responsibilities, training and reporting medication safety. There is a risk management system in place that identifies, records and follows up incidents. An external pharmacist sits in the Pharmacy Committee Meeting (last held in October 2021) and the HPS Pharmacy Practice Unit has developed a range of training material for staff. Observation of clinicians' practice demonstrated use of the health service organisation's processes for medication management. Nurses were observed administering medications. The changeover of medication charts from the NIMC to the PBS Hospital Chart was discussed	Met
4.2	Applying quality improvement systems The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness and performance of medication	Met	Medication Safety Documents/Records: Review of medication safety documentation shows the quality improvement system is applied when monitoring, improving and reporting on outcomes for medication management. Use of Tallman Lettering was observed. Nurses were able to describe how medication incidents are reported and reviewed via the Pharmacy Committee, Quality and Safety Committee and MAC. Audits of medication safety are undertaken including Patient ID and Medication Safety (2019), NSMC and MSSA 66.7% September quarter	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management		2021 (on alternate years), storage of high-risk drugs (May 2021), and cold chain (annually). Audit results of medication charts show an upward trend with areas identified including Patient ID on all pages (33%), and indications (18%) being the most problematic. These results are put into action plans and are discussed at the MAC. There was one incident logged in RiskMan regarding medication safety from May to August 2021 and these were managed in line with the Incident Management Policy. The Chairman of the MAC interviewed could describe how the quality improvement system is applied when monitoring, improving and reporting on outcomes for medication management.	
4.3	Partnering with consumers 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	Medication Safety Documents/Records: Review of medication safety documentation shows the partnering with consumer standards are applied to ensure patients are actively involved in their own care and that information needs are met. On admission, a best possible medication history (BPMH) is taken in conjunction with the patient or carer(s) with an opportunity to ask any questions about medications. The pharmacist is also involved in the collation of the BPMH, ADR history, medication reconciliation and medication management plan, and provides education and information to consumers as necessary including in other languages. Observation of clinicians' practice shows use of the health service organisation's processes for partnering with consumers.	Met
4.4	Medicines scope of clinical practice 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	Medication Safety Documents/Records: Review of medication safety documentation shows a process is in place for obtaining and documenting a BPMH. The process begins pre-admission with the Rehabilitation Liaison Coordinators obtaining the BPMH from the referral, GP and patient. This is then re-confirmed on admission by nursing staff and the VMO. Medications are recorded on the medication management plan. If the patient has a score of four or more on the Healthscope High-risk Assessment Tool, they are referred to the pharmacist to conduct the BPMH. Staff are trained in obtaining a BPMH.	Met

Criterion:	**Documentation of patient information** A patient's best possible medication history is recorded when commencing an episode of care. The best possible medication history, and information relating to medicine allergies and adverse drug reactions are available to clinicians.			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
4.5	Medication reconciliation 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	Medication Safety Documents/Records: Review of medication safety documentation shows a process is in place for obtaining and documenting a BPMH. The process begins pre-admission with the Rehabilitation Liaison Coordinators obtaining the BPMH from the referral, GP and patient. This is then re-confirmed on admission by nursing staff and VMO. Medications are recorded on the medication management plan. If the patient has a score of four or more on the Healthscope High-risk Assessment Tool, they are referred to the pharmacist to conduct the BPMH. Staff are trained in obtaining a BPMH. Verification shows processes are in place for clinicians to 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
4.6	Medication reconciliation 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	Medication Safety Documents/Records: Review of medication safety documentation shows a process is in place for medication reconciliation on admission, at transitions of care and on discharge. Any discrepancies between current medication orders and the BPMH are noted and reconciled with the assistance of a pharmacist review. Monitoring medication safety quality outcomes, policy, and KPI data inclusive of consumer consultant representation is within the Healthscope Medication WebEx team (with DRC representation) and the DRC Quality and Risk Management Framework. Verification confirms the 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
4.7	Adverse drug reactions The health service organisation has processes for documenting a patient's	Met	Medication Safety Documents/Records: Adverse Drug Reactions (ADR's) are recorded pre-admission and on admission. ADRs are recorded on every page of the medication drug chart. Quarterly audits of the NSMC are undertaken and in 2020, 90% of ADR's were documented on the patient medication	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	history of medicine allergies and adverse drug reactions in the healthcare record on presentation		chart. Verification confirms processes are in place for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation.	
4.8	Adverse drug reactions 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	Medication Safety Documents/Records: Review of medication safety documentation shows a process is in place for recording new medicine allergies and ADRs experienced during an episode of care. New medication allergies are reported in RiskMan for follow up at Pharmacy, Quality and Safety and MAC meetings. Alerts are documented on webPAS and medication history and patients with a known or suspected ADR or medication allergy are required to wear a red wrist band. Clinical leads interviewed described the process for ensuring all medicine allergies and ADRs experienced by a patient during an episode of care are recorded in the patient's healthcare record and reported in the incident management and investigation system.	Met
4.9	Adverse drug reactions 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	Medication Safety Documents/Records: Review of medication safety documentation shows a process in place for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration (TGA). This can be done by the VMO or the pharmacist. Interviews with clinical leads confirmed there is a process in place for reporting all new or suspected ADRs experienced by patients during their episode of care to the Therapeutic Goods Administration (TGA).	Met

Criterion:	**Continuity of medication management** A patient's medicines are reviewed, and information is provided to them about their medicines needs and risks. A medicines list is provided to the patient and the receiving clinician when handing over care.			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
4.10	Medication review	Met	Medication Safety Documents/Records: Review of medication safety documentation shows processes are in place for medication	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		reviews to be conducted and documented. Medications are reviewed at different stages in the patient's care and changes made as required. Clinical leads interviewed could describe the processes in place for medication reviews and how these are documented.	
4.11	Information for patients The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks	Met	Medication Safety Documents/Records: Review of medication safety documentation shows patient information about individual medicines needs and risks is available. Patients are given information about new and current medications by the VMO's, nurses and pharmacists. Information is available in different languages. Interview with clinical leads confirmed the process for providing patients with information about their individual medicines needs and risks. Interview with the pharmacist confirmed the process for providing patients with information about their individual medicines needs and risks. The pharmacist stated that the nurses at DRC are caring and cohesive and take particular care at discharge to ensure the patient and carers understand what each medication is for.	Met
4.12	Provision of a medicines list 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	Met	Medication Safety Documents/Records: Review of medication safety documentation shows a process is in place to generate a current medicines list.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	to receiving clinicians at transitions of care c. Provide patients on discharge with a current medicines list and the reasons for any changes			

Criterion:	**Medication management processes** Health service organisations procure medicines for safety. Clinicians are supported to supply, store, compound, manufacture, prescribe, dispense, administer, monitor and safely dispose of medicines			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
4.13	Information and decision support tools for medicines The health service organisation ensures that information and decision support tools for medicines are available to clinicians	Met	Medication Safety Documents/Records: Clinicians have onsite access to the Therapeutic Guidelines, MIMS (hardcopy) and the most up to date Yellow Injectables Book. In addition, there is access to an onsite clinical pharmacist every day. Observation of facilities and equipment shows that up-to-date decision support tools such as protocols, guidelines and medicine related information resources are available in clinical areas (in electronic or hard copy).	Met
4.14	Safe and secure storage and distribution of medicines 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	Met	Medication Safety Documents/Records: Review of medication safety documentation shows a process is in place for the safe and secure distribution and storage of medicines (including Schedule 8 medicines, temperature-sensitive medicines and cold chain management) and the correct disposal of unused, unwanted or expired medicines. The last safe medication and storage audit result was 33% compliance but a new medicine safety storage audit has been introduced this year and results are on an upward trend. There are plans in place to replace imprest cupboards with metal trays and improved storage methods. There is a vaccine fridge in the medication room that is data logged and managed according to Strive for 5 Guidelines.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	c. Disposal of unused, unwanted or expired medicines		Observation of facilities and equipment confirmed that the medication room is only accessible to appropriate persons by way of a swipe card. Although the area is compact, storage of medications is well organised. There is an air conditioner in the room to provide cooling. High-risk drugs were securely stored and documented appropriately. The vaccine fridge has its min/max and current temperature recorded twice daily and is logged on a graph. There are processes in place in case of a cold chain breach. Apart from the very knowledgeable Infection Control Coordinator, nurses interviewed were aware of what to do in the event of a breach but were not really aware of the Strive for 5 guidelines. Vaccines and other medications stored in the fridge were too close to the walls and not in containers maximising airflow. Nurses interviewed reported that sometimes legibility is an issue on patient medication charts but this is followed up with the clinicians concerned. Legibility is covered in the medication chart audit and is followed up by the MAC with letters being sent to identified clinicians requesting enrolment in an online medical record program. ***Improvement Opportunities*** Medication Safety Documents/Records: 4.14 - Consider running an education session for nurses on Strive for 5 Guidelines including safe storage of vaccines and cold chian management.	
4.15	High-risk medicines 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	Medication Safety Documents/Records: Review of medication safety documentation shows a process is in place for identifying, storing, prescribing, dispensing, administering and monitoring high-risk medicines. DRC uses APINCH for the management of high-risk medication and signage is evident in the medication room. An audit of high-risk medication management in 2019 and 2020 showed more than 95% compliance. Observation of facilities and equipment confirmed that high-risk medicines are administered and stored correctly.	Met

Comprehensive Care Standard

Leaders of a health service organisation set up and maintain systems and processes to support clinicians to deliver comprehensive care. They also set up and maintain systems to prevent and manage specific risks of harm to patients during the delivery of health care. The workforce uses the systems to deliver comprehensive care and manage risk.

Intention of this standard
To ensure that patients receive comprehensive care – that is, coordinated delivery of the total health care required or requested by a patient. This care is aligned with the patient's expressed goals of care and healthcare needs, considers the effect of the patient's health issues on their life and wellbeing, and is clinically appropriate.

To ensure that risks of harm for patients during health care are prevented and managed.
Clinicians identify patients at risk of specific harm during health care by applying the screening and assessment processes required in this standard.

Criterion:	**Clinical governance and quality improvement to support comprehensive care** Systems are in place to support clinicians to deliver comprehensive care			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
5.1	Integrating clinical governance 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	Clinical Gov and QI to Support Comprehensive Care Documents/Records: Document review shows processes are in place for implementing policies, managing risks and identifying training requirements to deliver comprehensive care. Comprehensive up-to-date policies and procedures are in place. Risks are assessed to minimise patient harm and are included in the comprehensive risk register. Comprehensive screening tools consistent with best practice are available for staff to use. Training is provided to staff on the individual aspects of comprehensive care as part of orientation and ongoing mandatory training.	Met
5.2	Applying quality improvement systems The health service organisation applies the quality improvement system from the Clinical Governance Standard when:	Met	Clinical Gov and QI to Support Comprehensive Care Documents/Records: Document review shows processes are in place for monitoring, implementing strategies and reporting on delivery of comprehensive care. Monitoring of comprehensive care is done by incident management, patient feedback and audits. Feedback at a local level is to the Quality and Safety and MAC committees. Data is submitted to Healthscope via the	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		KPI data and a HAC subset including falls and pressure areas is also closely monitored. Verification confirms DRC has systems in place for monitoring the delivery of comprehensive care and implementing strategies to improve the outcomes from comprehensive care and associated processes. Interview with staff evidenced many quality improvements in comprehensive care including the introduction of post fall huddles and Occupational Therapists improved referrals to sub-acute care.	
5.3	Partnering with consumers 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	Clinical Gov and QI to Support Comprehensive Care Documents/Records: Document review shows processes are in place to actively involve patients in their own care. It is evident from pre-admission to discharge that patients are a central part of their care at DRC. Laminated information is given to patients on admission regarding falls prevention and pressure area minimisation. Patient boards are placed near the patient with relevant information for patients to read. Patient feedback is very positive and monthly feedback is displayed on quality boards in areas of the hospital. The patient experience score reported on Qualtrix is 84% against a benchmark of 89% set by Healthscope. Interviews with patients and carers confirmed they are able to participate in decision-making about their care. Patients interviewed were exceptionally happy with all aspects of their care and their involvement in their care. According to the October Quality Board, 78% felt cared for and 75% thought they were involved in decision-making.	Met
5.4	Designing systems to deliver comprehensive care 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	Met	Clinical Gov and QI to Support Comprehensive Care Documents/Records: Document review shows systems are in place for comprehensive care that includes the development, documentation and communications of comprehensive plans, appropriate care settings, timely referral of patients with specialist healthcare needs and identification of the clinician with accountability for a patient's care. Clear and transparent patient flow processes are in place from admission to discharge. Clinicians are supported with tools and guided paperwork to develop comprehensive care plans best suited to the individual patient. Patients have a pre-admission assessment by the Rehabilitation Liaison Coordinator to ensure that DRC is appropriate to their needs. Evidence of timely referrals are in place, with patients flagged for urgent or special consideration. There is a clear structure of accountability in place in relation to patient	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		flow. Clinical leads interviewed could describe the processes in place to support clinicians to communicate, deliver and document comprehensive care in the setting that best meets patients' needs. Observation of clinicians' practice demonstrated use of the health service organisation's processes for comprehensive care.	
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	Clinical Gov and QI to Support Comprehensive Care Documents/Records: Review of human resource documents shows that the roles, responsibilities and accountabilities of the workforce are documented. At DRC there are clear lines of accountability between each multidisciplinary team. There is evidence of a supportive culture and a high level of collaboration when providing patient care. Verification confirms processes are in place to support multidisciplinary collaboration and teamwork and define the roles and responsibilities of each clinician working in a team.	Met
5.6	Clinicians work collaboratively to plan and deliver comprehensive care	Met	Clinical Gov and QI to Support Comprehensive Care Documents/Records: Document review shows processes are in place that enable clinicians to work collaboratively to plan and deliver comprehensive care. Each morning there is a team huddle between nursing and allied health staff to discuss patient goals and any changes. Processes are in place for structured clinical handover, communicating critical information and good documentation. Clinical leads interviewed could describe how they work collaboratively to plan and deliver comprehensive care. Observation of facilities and equipment shows a collaborative approach to plan and deliver care.	Met

Criterion:	**Developing the comprehensive care plan** Integrated screening and assessment processes are used in collaboration with patients, carers and families to develop a goal-directed comprehensive care plan			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
5.7	Planning for comprehensive care 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	Developing the Comprehensive Care Plan Documents/Records: Document review shows processes are in place for integrated and timely screening and assessment that identify the risks of harm. Screening begins at pre-admission to identify risks and minimise patient harm. In 2019, improvements to organisation-wide screening processes resulted in the screening form being reduced from 10 to 4 pages without affecting the screening outcomes. The minimising patient harm audit in April 2021 had overall compliance of 87%, the comprehensive risk screening component was at 90%. Clinical leads interviewed could describe how screening and assessment processes used to identify the risks of harm are integrated and timely.	Met
5.8	Planning for comprehensive care 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	Developing the Comprehensive Care Plan Documents/Records: Document review shows process are in place for identifying Aboriginal and Torres Strait Islander patients and recording this information in administrative and clinical information systems. Clinical leads interviewed could describe the processes in place for patients to identify as being of Aboriginal and/or Torres Strait Islander origin. Verification confirms DRC 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
5.9	Planning for comprehensive care Patients are supported to document clear advance care plans	Met	Developing the Comprehensive Care Plan Documents/Records: Document review shows process are in place for end-of-life care and advance care planning that are consistent with state or territory guidelines and directives. The social workers have attended training in advance care planning and are able to assist patients with preparing them. The social worker interviewed could describe how they support patients to document clear advance care plans. Policies and procedures are in pace for patients with advance care plans to have them documented in their records. Staff are	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			aware on how to find advance care plans in patient documentation. Clinical leads interviewed could describe how they support patients to document clear advance care plans.	
5.10	Screening of risk 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	Developing the Comprehensive Care Plan Documents/Records: Document review shows processes are in place for conducting routine screening to identify cognitive, behavioural, mental and physical conditions, issues and risks of harm and social and other circumstances that may compound these risks. Screening starts at pre-admission and staff are trained on screening processes and have best practice validated tools available to them to help with the screening process. Infection screening is part of the pre-admission process. In April 2021, screening compliance was 90%. Nurses interviewed could describe the processes used for screening of risk at presentation, during clinical examination, at history taking and at other appropriate times.	Met
5.11	Clinical assessment Clinicians comprehensively assess the conditions and risks identified through the screening process	Met	Developing the Comprehensive Care Plan Documents/Records: Document review shows processes are in place to comprehensively assess the conditions and risks identified through the screening process. Risks identified during the screening process are assessed in a timely manner and acted upon depending on documented pathways, including referrals to members of the multidisciplinary team and alerts in the patient record. Clinical leads interviewed could explain the process for assessing the conditions and risks identified through the screening process. Observation of facilities and equipment showed the use of standardised assessment processes, tools and resources.	Met
5.12	Developing the comprehensive care plan	Met	Developing the Comprehensive Care Plan Documents/Records: Documentation reviewed shows processes are in place for recording the findings of screening and clinical assessments. Policies and procedures are in place on documenting	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record		risks found at screening including alerts, referrals and follow ups. Observation of facilities and equipment shows that the workforce have computer access to healthcare records in clinical areas.	
5.13	Developing the comprehensive care plan 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	Developing the Comprehensive Care Plan Documents/Records: The consumer approved Healthscope Comprehensive Care Plan was redesigned in 2019 involving input from the multidisciplinary team. The Comprehensive Care Plan is consistent with best practice. The care planning and goal setting begins at pre-admission with the involvement of the patient and carer(s). One of the goals is looking at time of stay and discharge planning. The plan is updated during the stay with referrals to follow up services both internal and external to DRC. Observation of clinicians' practice confirms the use of the health service organisation's processes for shared decision-making in undertaken. Patients interviewed were satisfied that they were involved in decision-making and October 2021 feedback compliance was 75%. Compliance with the Comprehensive Care Plan in April 2019 was 80%, whilst compliance with the daily care plan was 86%.	Met

Criterion:	**Delivering comprehensive care** Safe care is delivered based on the comprehensive care plan, and in partnership with patients, carers and families. Comprehensive care is delivered to patients at the end of life
Rating:	**Met**

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
5.14	Using the comprehensive care plan 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	Delivering Comprehensive Care Documents/Records: The Comprehensive Care Plan includes goals of care and is updated during the patient stay if there are any changes in diagnosis, behaviour, cognition or physical condition. The Comprehensive Care Plan is evaluated against patient goals. In the April 2019 Minimising Patient Harm Audit, goals progression was 40% compliant and the matching of goals to the patient care board was 30% compliant. Observation of clinicians, carers and patients confirmed a collaborative approach to deliver a comprehensive care plan including monitoring and reviewing the plan as needed. ***Improvement Opportunities*** Delivering Comprehensive Care Documents/Records: 5.14 - Provide additional education regarding goal setting and evaluation for the multidisciplinary team, and support nursing staff to update the care plans and patient care boards accordingly.	Met
5.15	Comprehensive care at the end of life 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	Met	Delivering Comprehensive Care Documents/Records: Document review shows processes are in place for identifying patients who are at the end of life that are consistent with the Consensus Statement. Policies, procedures and a end of life toolkit are available for staff. Although DRC does not usually provide end of life care, staff are trained in its provision including following advanced care directives if they are in place. Nurses interviewed could describe the processes in place to identify patients who are at the end of their life and felt well supported and able to care for dying patients and their carer(s).	Met
5.16	Comprehensive care at the end of life The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice	Met	Delivering Comprehensive Care Documents/Records: Document review shows processes are in place to access specialist palliative care advice within DRC or externally. Clinical leads interviewed could describe how they gain access to specialist palliative care advice.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			Observation of facilities and equipment shows that information about how to access specialist palliative care advice is readily accessible for clinicians when providing care.	
5.17	Comprehensive care at the end of life 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	Delivering Comprehensive Care Documents/Records: Document review shows the requirements for documenting advance care plans in the patient's healthcare record. Clinical leads interviewed could describe the process in place to ensure that advance care plans are documented in the patient's healthcare record and that care is provided in accordance with these plans. Staff training in advanced care planning is scheduled for early 2022.	Met
5.18	Comprehensive care at the end of life The health service organisation provides access to supervision and support for the workforce providing end-of-life care	Met	Delivering Comprehensive Care Documents/Records: Document review shows processes are in place for accessing supervision and support in providing end-of life care. Staff are supported by policies and procedures and the End of Life Toolkit. Staff have access to an EAP and social workers onsite. Nurses interviewed felt very supported by their own team and other multidisciplinary teams within DRC.	Met
5.19	Comprehensive care at the end of life 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	Delivering Comprehensive Care Documents/Records: Document review shows processes are in place for routinely reviewing the safety and quality of end-of-life care. Morbidity and mortality cases are reviewed by the MAC where the safety and quality of end-of-life care provided to patients is compared with the planned goals of care and best practice. Observation of facilities and equipment confirmed that DRC is well equipped to provide end of life care.	Met
5.20	Comprehensive care at the end-of-life Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the National Consensus Statement: Essential	Met	Delivering Comprehensive Care Documents/Records: Document reviews shows processes are in place for clinicians to support patients, carers and families to make shared decisions about end-of-life care. Clinical leads interviewed could describe how clinicians are supported to deliver care that	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	elements for safe and high-quality end-of-life care		aligns with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care.	

Criterion:	**Minimising patient harm** Patients at risk of specific harm are identified, and clinicians deliver targeted strategies to prevent and manage harm			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
5.21	Preventing and managing pressure injuries 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	Minimising Patient Harm Documents/Records: Document review shows processes are in place for preventing and managing pressure injuries that are consistent with best-practice guidelines. Policies, procedures and screening tools are in line with best practice. Skin integrity and pressure injury risk is assessed at admission by nursing staff. Patients are given information on prevention of pressure injuries while staying at DRC and staff are educated in preventing pressure injuries. Aids and equipment are available and maintained in good order. Introduction of post fall huddles involving the patient have been a positive quality improvement initiative to help understand what happened and how to stop it happening again. There were four incidents of pressure injury from May to August 2021 (one was on admission). Observation of facilities and equipment shows that best-practice guidelines are used by the clinical workforce.	Met
5.22	Preventing and managing pressure injuries 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	Minimising Patient Harm Documents/Records: Document review shows protocols for time frames and frequency of skin inspections are in place. Assessment is within eight hours of admission and then skin is checked daily or following changes to condition or if the patient reports changes. Any changes are documented in the comprehensive care plan. Nurses are trained in wound management and care of pressure ulcers. Interview with clinical leads confirmed a process is in place to conduct comprehensive skin inspections to patients at risk of developing a pressure injury.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
5.23	Preventing and managing pressure injuries 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	Minimising Patient Harm Documents/Records: Document review shows processes are in place to manage patients at risk of pressure injuries including well maintained aids and equipment, patient education and information. Verification confirms that the health service organisation ensures that patients, carers and families are provided with information about preventing pressure injuries.	Met
5.24	Preventing falls and harm from falls 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	Minimising Patient Harm Documents/Records: Document review shows processes are in place for providing services to patients at risk of falls that are consistent with best-practice guidelines. All areas in the organisation are assessed for falls risk to minimise harm should a fall occur. There were 31 falls from May to August in 2021, 24 actual falls and 7 near misses. Implementation of post fall huddles and education has reduced the number of falls. The current measure is just above the Healthscope KPI benchmark of 0.41%. Observation of facilities and equipment shows the use of falls prevention plans. DRC is clutter free and staff are required to keep corridors as free as possible.	Met
5.25	Preventing falls and harm from falls 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	Minimising Patient Harm Documents/Records: Observation of facilities and equipment shows equipment, devices and tools are available to promote safe mobility and manage the risks of falls. DRC controls the environment as much as possible to prevent falls including wiping up spills immediately, adjusting chair and bed heights, ensuring call bells are within reach and the display of ‘call don't fall’ posters in bathrooms. Patients at high-risk of fall have a "Falling Star" attached to their Patient Care Board to remind staff. Falls are reported each month on the Quality Board and also publicly displayed on the DRC website. In October there were six falls.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
5.26	Preventing falls and harm from falls 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	Minimising Patient Harm Documents/Records: Review of consumer documentation shows information is available about falls risks. Verification confirms DRC provides care to patients at risk of falls and provide patients, carers and families with information about reducing falls risks and falls prevention strategies.	Met
5.27	Nutrition and hydration 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	Minimising Patient Harm Documents/Records: Document review shows processes are in place for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice. Patients are screened on admission with a malnutrition screening tool and depending on results, this will trigger a referral to the dietitian who works two days a week. DRC prepares freshly cooked meals for patients each day. Speech Therapists are able to screen for swallowing problems and if they are present, an alert is placed on the patient care board and on WebPAS. Occupational Therapists can assist with the positioning and use of correct implements to assist with eating. Observation of facilities and equipment shows that best-practice guidelines about nutrition and hydration are accessible for the workforce that prepares nutrition plans.	Met
5.28	Nutrition and hydration 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	Met	Minimising Patient Harm Documents/Records: Following screening and a comprehensive nutritional assessment by the dietitian, patient needs and requirements are documented in the care plan. Food supplements are available as well as food sourced from outside DRC if necessary. All support is given to patients to ensure they can eat and drink independently. Observation shows the preparation and distribution of food and fluids to support and meet a patients' nutritional needs and requirements. Observation of facilities and equipment shows that the kitchen staff prepare attractive fresh meals as per patient requirements.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	d. Support patients who require assistance with eating and drinking			
5.29	Preventing delirium and managing cognitive impairment The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to: a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard, where relevant b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation	Met	Minimising Patient Harm Documents/Records: Document review shows processes are in place for providing services to patients who have cognitive impairment or are at risk of developing delirium. DRC has a well-designed system to assess patients who are cognitively impaired or at risk of developing delirium. All patients are routinely screened using the CIRAT risk assessment tool. Any risks are flagged and incorporated in the patient care plan. Pathways include behaviour charts, spiralling charts, additional cognitive screening, discussion with carer(s), medication management and provision of a calm atmosphere and environment. Occupational staff play a big part in assessing patients with cognitive impairment. Observation of facilities and equipment confirmed that DRC has single rooms that provide a quiet environment but still enable close staff monitoring.	Met
5.30	Preventing delirium and managing cognitive impairment 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	Met	Minimising Patient Harm Documents/Records: Document review shows systems are in place for caring for patients with cognitive impairment. As DRC is a rehabilitation hospital, the VMO's are experienced in treating aged persons and are trained in recognising, preventing and treating cognitive impairment. Strategies such as de-escalation, calm voice and environment are used. Staff and families are trained to use CODE BLUE to escalate care if required. Clinical leads interviewed could describe how they are supported to recognise, prevent, treat and manage cognitive impairment.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care			
5.31	Predicting, preventing and managing self harm and suicide 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	Minimising Patient Harm Documents/Records: Document review shows systems to support collaboration with patients, carers and families when a patient is at risk of self-harm or suicide. Pre-admission screening includes questions on suicidal thoughts. Any risks are flagged early and are subject to a rapid escalation process. Depending on the risk assessment, patients can be "specialled", transferred out to a mental health facility or managed at DRC with additional monitoring and support, and removal of any objects that may allow the person to self-harm. There have been no incidents of self harm or suicide reported from May to August 2021. Clinical leads interviewed could describe the processes in place to ensure that staff work collaboratively to identify patients at risk of self-harm or suicide. Observation of facilities and equipment shows that information about referring patients to specialist mental health services is accessible to clinicians.	Met
5.32	Predicting, preventing and managing self-harm and suicide 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	Minimising Patient Harm Documents/Records: Document review shows people who have harmed themselves or reported suicidal thoughts have follow-up arrangements developed, implemented and communicated. Clinical leads interviewed could describe the processes in place for follow-up of people who have harmed themselves or reported suicidal ideation.	Met
5.33	Predicting, preventing and managing aggression and violence The health service organisation has processes to identify and mitigate	Met	Minimising Patient Harm Documents/Records: Document review shows processes are in place to identify and mitigate situations that may precipitate aggression. Patients are pre-screened for risks of aggression and mental health issues. Staff are trained to quickly identify episodes of aggression and escalate care. The design of the environment provides safe spaces and a garden to help reduce	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	situations that may precipitate aggression		episodes of aggression. Patients are allowed to move around and also have privacy within single rooms. Staff are trained on recognising and de-escalating aggression using Workplace Aggression and Violence Training (WAVE). Observation of facilities shows the design and use of the environment to minimise sources of potential conflict and additional stresses for patients. Staff report that they have received WAVE training and they also feel very supported by each other and management. Duress alarms and emergency buzzers are available.	
5.34	Predicting, preventing and managing aggression and violence 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	Minimising Patient Harm Documents/Records: Document review shows processes are in place to support collaboration with patients, carers and families for those identified at risk of becoming aggressive or violent. Observation of facilities and equipment shows that an on-call security service is available. Clinical leads interviewed could describe the processes in place for predicting, preventing and managing aggression and violence. Nurses interviewed felt confident in calling a CODE BLACK if necessary.	Met
5.35	Minimising restrictive practices: restraint 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	Minimising Patient Harm Documents/Records: Document review shows systems are in place to minimise the use of restraint. WAVE training for staff, pre-screening and assessment and identification of potential aggression are some processes in place. All episodes of aggression are recorded in RiskMan and reported to the appropriate level in the organisation for review. There were 11 behavioural incidents from May to August 2021. Verification confirms the health service organisation has systems in place to minimise the use of restraint where clinically necessary to prevent harm. Clinical leads interviewed could describe the processes in place to minimise restrictive	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			practices. WAVE training includes techniques for de-escalation to avoid physical restraint and environmental monitoring.	
5.36	Minimising restrictive practices: seclusion 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	Minimising Patient Harm Documents/Records: This action is not applicable to DRC as it is not a designated mental health service.	Not applicable

Communicating for Safety Standard

Leaders of a health service organisation set up and maintain systems and processes to support effective communication with patients, carers and families; between multidisciplinary teams and clinicians; and across health service organisations. The workforce uses these systems to effectively communicate to ensure safety.

Intention of this standard
To ensure timely, purpose-driven and effective communication and documentation that support continuous, coordinated and safe care for patients.

Criterion:	**Clinical governance and quality improvement to support effective communication** Systems are in place for effective and coordinated communication that supports the delivery of continuous and safe care for patients			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
6.1	Integrating clinical governance 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	Communicating for Safety Documents/Records: Document review shows safety and quality systems are used when implementing policies, managing risks and identifying training for effective and coordinated clinical communication. DRC has a local Clinical Handover Framework to support the transfer of clinical accountability and responsibility between healthcare professionals and enable continuity of care for the patient. There is no specific Communicating for Safety Committee but the responsibility is undertaken by the Quality and Risk Management Committee. Each morning there is a huddle for nursing and allied health staff to discuss patient goals for the day. Nursing handover is at the bedside using an iSoBAR framework. There is a weekly team meeting of nursing, occupational therapy, and physiotherapy managers to update patient progress towards goals and discharge. Clinical leads interviewed could describe how the safety and quality systems are used when implementing policies, managing risks and identifying training requirements for effective and coordinated clinical communication. Observation of clinicians' practice showed use of DRC's clinical communication processes. Observation of clinical handover at DRC found that the bedside handover was comprehensive and conducted in a structured manner.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
6.2	Applying quality improvement systems 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	Communicating for Safety Documents/Records: Document review shows quality improvement systems are applied when monitoring, implementing and reporting on the effectiveness and outcomes of clinical communication processes. Quality key performance indicators are reported quarterly. Results of audits, incidents and patient feedback related to clinical handover are reported at the Quality and Safety Meeting. The overall aim is to enhance patient safety by ensuring systems and processes are in place to provide a consistent approach to clinical handover. Interview with clinical leads confirmed the quality improvement system is applied when monitoring, implementing and reporting on the clinical communication processes. Verification confirms that DRC monitors the effectiveness of clinical communication and associated processes and implements strategies to improve clinical communication and associated processes.	Met
6.3	Partnering with consumers 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	Communicating for Safety Documents/Records: Document review shows consumer partnering processes are applied for involving patients, providing information and sharing decision-making. Clinical leads interviewed could describe how consumer partnership standards are applied when involving patients in their care, meeting their information needs and sharing decision-making. Observation of clinicians' practice showed use of the health service organisation's processes for partnering with consumers. Bedside clinical handovers were observed at DRC and demonstrated collaboration between the patient and nursing staff.	Met
6.4	Organisational processes to support effective communication The health service organisation has clinical communications processes to support effective communication when:	Met	Communicating for Safety Documents/Records: Document review shows clinical communication processes are in place for identification and procedure matching, transferring care and critical information about a patient's care. The clinical information system requires a minimum of three approved identifiers on registration and admission. An audit of handover to orderly transport in June and July 2021 showed 100% compliance in checking three patient identifiers.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		Clinical leads interviewed described the process for patient identification, procedure matching, clinical handover and communication of critical information or risks. Patient identification is confirmed before any examination, treatment, investigation, collection of pathology samples or drug administration. Verification confirms that DRC has clinical communications processes in place to support effective communication when identification and procedure matching and patient handover of care occurs.	

Criterion:	**Correct identification and procedure matching** Systems to maintain the identity of the patient are used to ensure that the patient receives the care intended for them			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
6.5	Correct identification and procedure matching 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	Communicating for Safety Documents/Records: Review of identification and procedure matching documentation shows the organisation has defined the approved identifiers according to best practice and at least three approved identifiers are required at any point of care. There were 12 incidents recorded in RiskMan from May to August 2021 concerning patient identification. Incidents are reviewed at the Quality and Safety Meeting. A new ID audit tool has now been designed and is ready for use. Verification confirms DRC 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

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			Review of identification and procedure matching documentation shows defined approved patient identifiers and processes to use at least three approved identifiers are in place. Clinical leads interviewed could describe the processes used to ensure consistent and correct identification of patients and when three approved patient identifiers are used.	
6.6	Correct identification and procedure matching 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	Communicating for Safety Documents/Records: Document review shows processes are in place for correctly matching patients to care and the information that should be documented. Interview with clinical leads confirmed processes are in place to correctly match patients to their intended care and the information that is documented and staff receive the required training. Annual mandatory training is undertaken regarding clinical handover to reduce the risk of patient mismatching.	Met

Criterion:	**Communication at clinical handover** Processes for structured clinical handover are used to effectively communicate about the health care of patients			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
6.7	Clinical handover 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	Met	Communicating for Safety Documents/Records: Review of clinical handover documentation shows it contains the required minimum information content, relevant risk and needs of the patient and the clinicians involved in the handover. The March 2021 audit results for clinical handover showed compliance rates above 93%, with checking of allergies against wrist band and alert sheet being the lowest score of 67%. This is being addressed by education and monitoring.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		Clinical leads interviewed could explain the minimum information content to be communicated at clinical handover and how this was decided and communicated to clinicians. Verification confirms DRC ensures that minimum information content is communicated at clinical handover, based on best-practice guidelines. Patients reported that the patient care boards are only updated 55% of the time each shift. This is on an upward trend towards the target which is 60%.	
6.8	Clinical handover 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	Communicating for Safety Documents/Records: Review of clinical handover documentation and interview with clinical heads demonstrated there is a structured clinical handover process in place. This includes preparing and scheduling clinical handover, discussing relevant information and patients goals and preferences. Clinical handover demonstrated a transfer of responsibility and accountability for care. Observation of clinicians' practice showed use of structured clinical handover processes and tools including iSoBAR.	Met

Criterion:	**Communication of critical information** Systems to effectively communicate critical information and risks when they emerge or change are used to ensure safe patient care
Rating:	**Met**

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
6.9	Communicating critical information 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	Communicating for Safety Documents/Records: Review of clinical communication documentation shows critical information, alerts and risks are communicated to clinicians, patients, carers and families. There were four incidents recorded in RiskMan relating to general care and communication from May to August 2021. Interview with clinical leads confirmed they use clinical communication processes to communicate critical information to other clinicians who make decisions about care and to patients, carers and families. Clinical staff use the iSoBAR clinical handover tool to ensure a standardised approach to clinical communication. DRC are looking at using a new system for notes called ABC - Ability, Behaviour and Communication. Verification confirms processes are in place to ensure that 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. The Heads of Department weekly huddle is a good example of this.	Met
6.10	Communicating critical information 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	Communicating for Safety Documents/Records: Document review shows communication processes are in place for patients, carers and families to directly communicate critical information and risks about care. Patients are given pamphlets on how to escalate care as well as education on ringing the call bell or asking for the nurse looking after them (who is named on the patient care board). There were 12 episodes of clinical deterioration from May to August 2021, some of which resulted in unplanned transfers to acute hospitals. All of these incidents were reviewed by the Quality and Safety Committee and the MAC. Clinical leads interviewed confirmed there are communication processes for patients, carers and families to communicate critical information and risks to clinicians.	Met

Criterion:	**Documentation of information** Essential information is documented in the healthcare record to ensure patient safety
Rating:	**Met**

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
6.11	Documentation of information 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	Communicating for Safety Documents/Records: Document review shows a process is in place that ensures complete, accurate and up to date information is recorded in the healthcare record. Paper records are still in use. Clinical leads interviewed described the process to ensure that completed, accurate and up to date information is recorded in the healthcare record. Observation of facilities and equipment shows that the workforce has computer access to healthcare records in clinical areas. Staff interviewed are looking forward to the implementation of electronic medical records in the future to improve legibility and access.	Met

Blood Management Standard

Leaders of a health service organisation describe, implement and monitor systems to ensure the safe, appropriate, efficient and effective care of patients' own blood, as well as other blood and blood products. The workforce uses the blood product safety systems.

Intention of this standard
To identify risks, and put in place strategies, to ensure that a patient's own blood is optimised and conserved, and that any blood and blood products the patient receives are appropriate and safe.

Criterion:	**Clinical governance and quality improvement to support** Organisation-wide governance and quality improvement systems are used to ensure safe and high-quality care of patients' own blood, and to ensure that blood product requirements are met			
Rating:	**Not applicable**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
7.1	Integrating clinical governance 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	Not applicable	Blood Management Documents/Records: This action is not applicable to Dorset Rehabilitation Centre as they do not use blood or blood products.	Not applicable
7.2	Applying quality improvement systems 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	Not applicable	Blood Management Documents/Records: This action is not applicable to Dorset Rehabilitation Centre as they do not use blood or blood products.	Not applicable

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	processes c. Reporting on the outcomes of blood management			
7.3	Partnering with consumers 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	Not applicable	Blood Management Documents/Records: This action is not applicable to Dorset Rehabilitation Centre as they do not use blood or blood products.	Not applicable

Criterion:	**Prescribing and clinical use of blood and blood products** The clinical use of blood and blood products is appropriate, and strategies are used to reduce the risks associated with transfusion			
Rating:	**Not applicable**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
7.4	Optimising and conserving patients' own blood 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	Not applicable	Blood Management Documents/Records: This action is not applicable to Dorset Rehabilitation Centre as they do not use blood or blood products.	Not applicable

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	c. Determining the clinical need for blood and blood products, and related risks			
7.5	Documenting Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record	Not applicable	Blood Management Documents/Records: This action is not applicable to Dorset Rehabilitation Centre as they do not use blood or blood products.	Not applicable
7.6	Prescribing and administering blood and blood products The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria	Not applicable	Blood Management Documents/Records: This action is not applicable to Dorset Rehabilitation Centre as they do not use blood or blood products.	Not applicable
7.7	Reporting adverse events The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria	Not applicable	Blood Management Documents/Records: This action is not applicable to Dorset Rehabilitation Centre as they do not use blood or blood products.	Not applicable
7.8	Reporting adverse events The health service organisation participates in haemovigilance activities, in accordance with the national framework	Not applicable	Blood Management Documents/Records: This action is not applicable to Dorset Rehabilitation Centre as they do not use blood or blood products.	Not applicable

Criterion:	**Managing the availability and safety of blood and blood products** Strategies are used to effectively manage the availability and safety of blood and blood products			
Rating:	**Not applicable**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
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	Not applicable	Blood Management Documents/Records: This action is not applicable to Dorset Rehabilitation Centre as they do not use blood or blood products.	Not applicable
7.10	Availability of blood 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	Not applicable	Blood Management Documents/Records: This action is not applicable to Dorset Rehabilitation Centre as they do not use blood or blood products.	Not applicable

Recognising and Responding to Acute Deterioration Standard

Leaders of a health service organisation set up and maintain systems for recognising and responding to acute deterioration. The workforce uses the recognition and response systems.

Intention of this standard
To ensure that a person's acute deterioration is recognised promptly and appropriate action is taken. Acute deterioration includes physiological changes, as well as acute changes in cognition and mental state

Criterion:	**Clinical governance and quality improvement to support recognition and response systems** Organisation-wide systems are used to support and promote detection and recognition of acute deterioration, and the response to patients whose condition acutely deteriorates. These systems are consistent with the National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration, the National Consensus Statement: Essential elements for safe and high-quality end of-life care, the National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state, and the Delirium Clinical Care Standard			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
8.1	Integrating clinical governance 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	Acute Deterioration Documents/Records: Document review shows there is a process in place that applies safety and quality systems when implementing policies, managing risks and identifying training requirements for recognising and responding to acute deterioration. Management and staff interviewed were clear on the policy directives and actions required to respond to acute deterioration in an individual's physical or mental health. Evidence was provided that staff learn from incidents and efforts are undertaken to reduce the impact on patients.	Met
8.2	Applying quality improvement systems The health service organisation applies the quality improvement system from	Met	Acute Deterioration Documents/Records: Document review shows there is a process in place that applies the quality improvement system when monitoring, improving and reporting on the recognition and response systems. RiskMan software helps management to record and track responses to acute	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		deterioration and identify opportunities for improvement as well as root cause analysis. At times, working parties are set up to work through a better practice solution to an event and improvement of organisational response.	
8.3	Partnering with consumers 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	Acute Deterioration Documents/Records: Document review shows there is a process in place that applies consumer partnership when recognising and responding to acute deterioration that includes involving patients, meeting their information needs and sharing decision-making.	Met

Criterion:	**Detecting and recognising acute deterioration, and escalation care** Acute deterioration is detected and recognised, and action is taken to escalate care			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
8.4	Recognising acute deterioration The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to:	Met	Acute Deterioration Documents/Records: Document review shows there are processes in place for clinicians to detect acute deterioration including vital sign monitoring plans and the tracking of changes. Monitoring processes include observation and behaviour charts. The organisation conducts audits of behaviour charts to ensure staff are following the correct procedure.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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			
8.5	Recognising acute deterioration 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	Acute Deterioration Documents/Records: Document review shows there are protocols in place for recognising acute deterioration in mental state that includes monitoring patients, including known early warning signs in their plan, assessment of possible causes of acute deterioration, required level of observation and the documentation and communication of observed or reported changes in mental state. This includes monitoring of suicide ideation and the potential for self-harm. Incident analysis is used to inform practice improvement.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
8.6	Escalating care 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	Acute Deterioration Documents/Records: Document review shows there are protocols in place for escalating care including agreed vital sign parameters, indicators of deterioration in mental state, parameters and other indicators for calling emergency assistance, management of pain and concerns about acute deterioration. Patients have an emergency call button in their rooms and staff are trained to call emergency services. Mock trials are conducted on responding to acute deterioration from both a patient and/or their visitor.	Met
8.7	Escalating care The health service organisation has processes for patients, carers or families to directly escalate care	Met	Acute Deterioration Documents/Records: Document review shows processes are in place for patients, carers or families to directly escalate care. The escalation of care procedure is laminated and placed in patient rooms. Staff interviewed could explain the escalation procedure and the different roles taken by staff in this event.	Met
8.8	Escalating care The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance	Met	Acute Deterioration Documents/Records: Document review shows the workforce has the ability to escalate care and call for emergency assistance. Staff explained how one person will take observations, another will call emergency services, a third records vital information to handover to the first responders and other staff perform CPR, apply first aid and keep the patient comfortable and as stable as possible.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
8.9	Escalating care The workforce uses the recognition and response systems to escalate care	Met	Acute Deterioration Documents/Records: Review of acute deterioration documents and records shows the workforce uses the recognition and response systems to escalate care.	Met

Criterion:	**Responding to acute deterioration** Appropriate and timely care is provided to patients whose condition is acutely deteriorating			
Rating:	**Met**			
Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
8.10	Responding to deterioration The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration	Met	Acute Deterioration Documents/Records: Review of human resource documents and interviews demonstrated clinicians have the skills required to manage acute deterioration. Staff participate in regular training to improve their awareness and skills. Staff report that recent training in mental health including early warning signs has been beneficial.	Met
8.11	Responding to deterioration 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	Acute Deterioration Documents/Records: Review of human resource documents shows there is rapid access to a clinician at DRC who can deliver advanced life support.	Met
8.12	Responding to deterioration 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	Acute Deterioration Documents/Records: Document review shows a process is in place for referral to mental health services for patients whose mental state has acutely deteriorated.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
8.13	Responding to deterioration The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration	Met	Acute Deterioration Documents/Records: Document review shows a process is in place for referral to services that can provide definitive management of acute physical deterioration. Comprehensive protocols provide up-to-date information to first responders. The Nurse Unit Manager undertakes patient follow up once they have been handed over to Emergency Medical Services to see if any further information can be provided. Review and reflection is undertaken by staff once a medical diagnosis has been received so that the patient's early warning signs are clearly understood.	Met

Quality
Innovation
Performance

Contact us

1300 888 329
info@qip.com.au
www.qip.com.au