Accreditation Report

Quality Innovation Performance Accreditation Report

Assessment Details

Health Service Name	The Victorian Rehabilitation Centre
Health Service ID	HP1327
Accreditation Contact	Mrs Suzanne Callaway
Standards	NSQHS Standard Ed 2

Assessors	Mr David Stevens – Assessment Team Leader Ms Julie Cartwright- Assessor
Date of Assessment	29 November 2021 – 30 November 2021
Assessment Type	Full Assessment
Assessment Location	499 Springvale Road GLEN WAVERLEY VIC 3150

Accreditation Status

Accreditation Decision	Accredited
Accreditation Decision Maker	Nicole McKenzie
Decision Maker Signature	
Date	7 January 2022
Accreditation Period	8 May 2022 – 8 May 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

The Victorian Rehabilitation Centre

Executive Summary

The Victorian Rehabilitation Centre (TVRC) is part of the Healthscope Group and is located in the Melbourne suburb of Glen Waverley. The hospital is set on an expansive site of 10 hectres and has three wards of 30, 33 and 30 beds respectfully. TVRC provides a wide range of rehabilitation services including those for orthopaedic, neurological, cardiac, respiratory and trauma patients.. There is an onsite hydrotherapy pool and gymnasium where patients can undertake exercise. The hospital also offers pain management and a state-of-the-art sleep studies unit. Recently, a rehabilitation in the home outreach service has been added which is auspiced from the hospital.

This assessment was conducted as a hybrid assessment with the Assessment Team Leader offsite and the Co-assessor onsite. The onsite observation included the three wards, two gymnasium, hydrotherapy pool, kitchen, laundry, cleaners' areas, corridors, storage areas, chemical storage, administration and office areas, foyers and public areas plus gardens and grounds.

TVRC's management and staff are committed to providing high quality, safe care and they draw on the intrinsic motivation of staff to deliver the best possible care for patients and their families. TVRC staff have the desire to always do better, to learn from what works well and address what is not. The hospital, as part of the Healthscope Rehabilitation Cluster and wider group, is engaged in research on evidenced based care including the 'My Therapy Project' and a Falls Working Party.

TVRC has a long history in 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 Sleep Studies Unit is an example of responding to community needs and provides a bespoke service to patients. While the unit has its own admission criteria, it is still part of the hospital and works within the clinical governance framework to promote safety and quality. The 'Rehab at Home' service operates independently as an outreach service, but comes within the governance and management systems of TVRC.

Patients spoke very highly of the clinical services, therapy programs (including hydrotherapy) and the professional approach of staff. The environment is viewed as homely and comfortable. The

buildings are well-maintained and improvements are made as required.

Management and staff 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 development of rehabilitation hospital services is based on individual and community needs, and a culture of continuous improvement and professional practice. TVRC caters to a wide diversity of patients and 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. Information Privacy Stewards help to inform and protect the privacy of patients through improvements made to the collection, storage and management of data.

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. TVRC makes efforts to protect patient confidentiality, apply informed consent principles and also to address any grievance, which is consistent with the service's high standard of ethics when working with patients.

TVRC is supported by Healthscope and Healthcare Infection Control Management Resource (HICMR) for managing the requirements of Infection Prevention and Control. Policies and procedures, staff training and an audit programme in place. Patients, carers and families are engaged in shared decision making to support safe practice. Governance of infection prevention at TVRC is overseen by an Infection Prevention Committee which reports to the Quality and Safety and MAC Committees. There is a robust reporting structure within Healthscope. 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. Infection control processes are in place for reprocessing of reusable equipment, instruments and devices. There is an effective antimicrobial stewardship program which involves pharmacist reporting and advice. Cleaning and maintenance were seen to be of a good standard. The management of COVID-19 has been successful with no episodes of COVID-19 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 TVRC is overseen by a Medication Safety Committee, with a 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 Medical Advisory Committee (MAC). Membership of the Committee is multidisciplinary and includes medical and nursing staff as well as a senior pharmacist who provides expert opinion. Clinical pharmacists also play a critical role in monitoring medication, prescribing and administration practices to ensure clinical safety. Patient engagement was evident through patient interview and observation.

Corporate and local medication policy and procedures outline the requirements for the health service to promote accountable approaches to medication management. TVRC has a medication audit schedule in place. Previous audit results have identified a practice gap in the legibility of some medication orders. This is being addressed by the MAC with notifications to the relevant practitioners on improving prescription legibility.

The pharmacist attends the site daily. Staff are required to complete mandatory medication safety training that includes the principles of medication safety, information about common types of medication errors and the management of high-risk medicines. The mandatory training completion rates were found to be 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.

Comprehensive care is an integral part of clinical governance from internal governance structures to risk assessment, quality improvement and workforce competency. Throughout the health service, patient care is aligned with patients' expressed goals of care and individual needs. Examples of this can be seen in shared decision making and risk screening. The reporting framework is functional and operating effectively in both directions. Current guidelines and assessment tools are in line with current best practice. Audit schedules are in place as well as external benchmarking. Throughout the organisation, staff were found to be very engaged and positive about the care they give and the support they receive from management. Patients are at the centre of comprehensive care. Patients who were interviewed expressed satisfaction with the service.

Policies, staff education and audits are available to support safe practice. Clinical handover is based on the iSoBAR format and TVRC as per policy uses four patient identifiers. Policy and procedure is available for patient transfers, discharge and escalation of care. The MDT handover, case conferences, hourly rounding and Executive rounding occurs to support patient safety.

Effective governance practices for medication safety are in place. Pharmacy services are provided by an external contractor. This service includes clinical pharmacy support for up to four days per week. Medications were seen to be appropriately and securely stored in the medication room or locked in the patient's bedside drawer. Processes are in place to support the management of high-risk medications, medication reviews and medication reconciliation. Patient engagement was evident through patient interview and observation.

Practices and processes supporting comprehensive care were in compliance with the NSQHS Standards. Patient alerts, patient screening/risk identification, the comprehensive care plan and the daily care plan were available for review and fully completed. A suite of audits are completed and these are benchmarked against other Healthscope services. The patient/carer/family are engaged and patient goals of care are identified and monitored. Multidisciplinary team work was observed.

A clinical handover system is in place for the transfer of responsibility and accountability for patient

care between clinicians and other staff at TVRC. In the absence of a Communicating for Safety Committee, oversight of Standard 6 is provided by the Quality and Risk Management Committee and the Nurse Unit Managers' Committee. A number of policy and procedure documents support clinical handover across TVRC. 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 and allied health use SOAP for clinical notes. A bedside handover approach is used and staff are sensitive to patient, family and carer participation. Observation of clinical handover between nursing staff of TVRC finds that it was generally well done. Patient boards are well utilised and updated during handover and these provide a snapshot of the patient journey.

The national Healthscope 'Back to Bedside' project has been well received and staff report that this has been associated with improvements in patient-centred and family-centred care. 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 is expected and 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 TVRC met all applicable standards under the National Safety and Quality Health Service Standards (second 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: 1.9 - Analysis of falls data showed an increase in falls in recent months. This issue was discussed with the Management Team and it was noted that there were some differences in the interpretation of the results. Review the analysis of patient fall data by the key variables included in the falls prevention program. Patient Safety and Quality Systems Documents/Records: 1.15 - Consider development of a Diversity Action Plan in addition to the Reconciliation Action Plan for Aboriginal people.
Clinical performance and effectiveness	Clinical Performance and Effectiveness Documents/Records: 1.26 - Consider development of a supervision procedure and audit tool to ensure the structure, frequency, and outcomes of supervision are monitored to identify further opportunities for improvement in practice.
Partnering with patients in their own care	Partnering with Consumers Documents/Records: 2.3 - Consider placing additional healthcare rights posters in the main reception area.
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 profile which may impact on their safety and quality of experience such as calling out for assistance in their room or the pool or gym. There may also be specific significant and/or religious rites, celebrations which are important to the patient and their family 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 orientation. This could be in the form of a series of patient

Criterion	Improvement Opportunities
	stories on different parts of the hospital, their experience of multi-disciplinary team work and mental wellbeing.
Infection prevention and control systems	Infection Control Documents/Records: 3.12 - Change room curtains in the pool area are made of cloth material and are checked weekly for wear and tear or staining. However, in line with best practice, TVRC should consider replacing these curtains with hospital grade disposable ones. Infection Control Documents/Records: 3.13 - Although good work is being undertaken to increase staff vaccination rates, TVRC should aim to document 100% of staff vaccination and serology status (as appropriate).
Reprocessing of reusable medical devices	Infection Control Documents/Records: 3.14 - TVRC should follow up the cleaning and disinfection requirements for temperatures and soaking of tubing with Knox Private Hospital. In addition to this, TVRC should evaluate the new CPAP Reprocessing Form once in use.
Medication management processes	Medication Safety Documents/Records: 4.14 - TVRC should ensure that an annual vaccine fridge audit is undertaken in line with the most up to date Strive for 5 Guidelines. A training update for staff responsible for maintaining the cold chain would be beneficial before 'flu season'. 4.14 - The MAC should continue to follow up poor legibility issues on medication charts.
Responding to acute deterioration	Acute Deterioration Documents/Records: 8.12 - Provide staff with training in crisis prevention and intervention and de-escalation techniques to protect the dignity and safety of the patient and the wellbeing of staff.

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 The Victorian Rehabilitation Centre (TVRC) has an effective clinical governance framework and system in place. The VRC 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. TVRC participate in a Reconciliation Working Party as part of a Reconciliation Action Plan project. There is also annual participation in NAIDOC week celebrations. In the foyer there is acknowledgement of the Aboriginal land and several artefacts and pictures reflective of Aboriginal culture and heritage. 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 documentation, interviews and observations shows a clinical governance framework is in place at TVRC 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 support the OneHealthscope 2025 Strategy.	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 TVRC 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 documentation, 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 documentation, interviews and observations shows TVRC has processes for developing, authorising and monitoring the implementation of policy	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		and procedure documents. There are Policy and Procedure Guidelines and a Policy Review and Distribution Policy, Policy Guidelines, and Document Control requirements.	
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 the organisation uses organisation-wide quality improvement systems to improve safety and quality for rehabilitation patients. There is a strong incident reporting culture and clear process to follow. The Quality Committee, WHS Committee, Quality and Consumer Committee, 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: The 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. 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		***Improvement Opportunities*** Patient Safety and Quality Systems Documents/Records: 1.9 - Analysis of falls data showed an increase in falls in recent months. This issue was discussed with the Management Team and it was noted that there were some differences in the interpretation of the results. Review the analysis of patient fall data by the key variables included in the falls prevention program.	
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 at TVRC. There are effective policy directions, escalation processes, training, registers, signage, and monitoring mechanisms to prevent and/or manage risks. The organisation uses 'RiskMan' as the way of capturing risks, tracking and resolving these. There is a strong reporting culture and regular risk reports are provided to the Quality Committee and 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	Met	Patient Safety and Quality Systems Documents/Records: Review of clinical governance documentation, interviews and observations shows there is an effective incident management system at TVRC. 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 help to communicate this information clearly each month.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	to communicate concerns or incidents c. Involves the workforce and consumers in the review of incidents d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers e. Uses the information from the analysis of incidents to improve safety and quality f. Incorporates risks identified in the analysis of incidents into the risk management system g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems			
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 documentation 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 is 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	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 posting up patient goals in boards in their rooms.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems c. Uses this information to improve safety and quality systems			
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 documentation, interviews and observations shows TVRC has an effective complaints management system. 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 Consumer Complaint KPI's for each quarter of 2021 to date provides an overview to inform organisational responses to trends and the effectiveness of actions taken. The TVRC (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	Met	Patient Safety and Quality Systems Documents/Records: Review of governance documentation shows the patient population has been identified,	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	The health service organisation: a. Identifies the diversity of the consumers using its services b. Identifies groups of patients using its services who are at higher risk of harm c. Incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care		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. Interpreter services are available as required. Family members and carers are involved as appropriate in discussions with clinicians and their patients for reviewing medical progress, consent and risks, only as appropriate with the permission of the patient. Interpreters are used as required. Patients are informed of their rights. ***Improvement Opportunities*** Patient Safety and Quality Systems Documents/Records: 1.15 - Consider development of a 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 documentation, interviews and observations shows TVRC 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 hospital has an electronic system for recording patient information.	Met
1.17	Healthcare records The health service organisation works towards implementing systems that can	Met	Patient Safety and Quality Systems Documents/Records: TVRC 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
	provide clinical information into the My Health Record system that: a. Are designed to optimise the safety and quality of health care for patients b. Use national patient and provider identifiers c. Use standard national terminologies			
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 documentation 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	Met	Clinical Performance and Effectiveness Documents/Records: Review of human resource documentation 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	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	describes roles and responsibilities for safety and quality for: a. Members of the governing body b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation		analysis conducted on the orientation process. Management and staff undertake the Healthscope 'Foundation Course' for orientation. 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 documentation, interviews and observations shows clinicians and staff have access to training and broader professional development. They are required to undertake mandatory training and undertake competency testing for hand hygiene. TVRC has a schedule of clinical workforce education and training such as annual CPR and WHS training. Record of attendance is available onsite. There is a manager responsible for education and training for this site and others which provides both a planned and responsive approach to education. This at times can be individual refresher training on areas such as manual handling through to group face to face training on clinical procedures, 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 role to education helped to support improvement in their skills and knowledge on a more regular basis. Recently, this has included training in mental health first aid. The site has relied more on e-learning in recent times which has proven effective in ensuring mandatory and elective training is maintained. This has also created greater flexibility and access to training for staff.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
1.21	Safety and quality training The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients	Met	Clinical Performance and Effectiveness Documents/Records: Review of human resource documentation, interviews and observations shows TVRC supports staff in developing the cultural awareness of Aboriginal people and their rehabilitation needs. Staff interviewed said they participated in a 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.	Met
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 documentation, interviews and observations shows a process is in place for performance reviews which are undertaken on a regular basis. This is supported directly 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	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
	that they are operating within their designated scope of clinical practice c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered			
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: Review of documents, 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 inline 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	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	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate		framework. ***Improvement Opportunities*** Clinical Performance and Effectiveness Documents/Records: 1.26 - Consider development of a supervision procedure and audit tool to ensure the structure, frequency, and outcomes of supervision are monitored to identify further opportunities for improvement in practice.	
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 TVRC facilities and equipment shows best-practice guidelines, pathways, decision support tools and clinical care standards are available. Clinicians have access to clinical guidelines at point of service. Management and staff stated the 'shared learning' reports were particularly helpful in informing practice improvement. For example, a recent incident where a resident was receiving Kinetic Pain Treatment who had an adverse event has led to shared learning and a review of this treatment modality before it is reintroduced at TVRC.	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	Met	Clinical Performance and Effectiveness Documents/Records: Interview with management confirmed TVRC 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. TVRC 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
	measures d. Support clinicians to take part in clinical review of their practice e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems f. Record the risks identified from unwarranted clinical variation in the risk management system			

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. TVRC 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	Met	Safe Environment, Delivery of Care Documents/Records: Observation that the physical design of the environment includes consideration of safety and quality.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce b. Provides access to a calm and quiet environment when it is clinically required			
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 fire signage, evacuation maps which have been kept up to date and warning signs. There is disability access 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: Review of documents/records 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 ranging from their involvement with reviewing key patient documents, strategic directions, audit results, training for staff and recruitment processes. The consumer representatives spoke highly of the way the management and	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	processes for partnering with consumers c. Reporting on partnering with consumers		staff encouraged the 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 TVRC service facilities shows a charter of rights is easily accessible for patients, carers, families and consumers. ***Improvement Opportunities*** Partnering with Consumers Documents/Records: 2.3 - Consider placing additional healthcare rights posters in the main reception area.	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: Review of documentation, interviews and observation shows there are processes in place to identify a patients capacity to make decisions and the process if a substitute decision-maker is required. There are processes for areas such as discussing advanced life 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: Review of documentation, interviews and observations shows processes are in place for clinicians to partner with patients. A very clear demonstration of this is in the development of patient boards showing their goals and key clinical information. 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 reports 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: Review of documentation, 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: Review of documentation, interviews and observations shows communication mechanisms are tailored to TVRC 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: Review of consumer documentation shows consumers contribute to internally developed information in its development and review. 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 consumer documentation shows information is available, easy to understand and relevant to the clinical needs of patients. Information needs for ongoing care is provided at end of treatment. For example, Posters on cough etiquette and hand hygiene are informative to consumers, use visual information and are concise. Discharge information has been revised 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: Review of consumer documentation shows TVRC is working to increase 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 profile which may impact on their safety and quality of experience such as calling out for assistance in their room or the pool or gym. There may also be specific significant and/or religious rites, celebrations which are important to the patient and their family 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: Review of documentation shows TVRC works in partnership with Aboriginal and Torres	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		Strait 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 health care 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 the organisation to incorporate their views into workforce training and education. Training modules include the patient experience and journey through the health care service. ***Improvement Opportunities*** Partnering with Consumers Documents/Records: 2.14 - Consider increasing contributions from rehabilitation patients in the development of staff education and training orientation. This could be in the form of a series of patient stories on different parts of the hospital, their experience of multi-disciplinary team work and mental wellbeing.	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: TVRC has a systematic approach to infection prevention and control. Review of infection control documents shows that there is access to a comprehensive suite of policies and procedures relating to infection prevention and control and Antimicrobial stewardship (AMS) management. The part time Infection Control Co-ordinator for the site is assisted by an external HICMR consultant. The Infection Prevention Committee meets quarterly and the results of HICMR risk assessments for each department are presented for discussion. Facility wide risk assessment results for the last four years are at a 97% completion rate on average. Electronic access to HICMR information, policies and procedures is accessible via password protected computers at each of the nurse's stations. TVRC contributes data to the Healthscope Quality KPIs quarterly and to the ACHS clinical indicators. This data is benchmarked against facilities of similar type and size. Risks and incidents are entered into RiskMan and followed up appropriately in a timely manner. The workforce has a good understanding of the incident management and reporting process. The audit schedule includes hand hygiene, PPE donning and doffing, aseptic technique and environmental cleaning.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			Infection control is part of staff learning and development beginning at orientation, followed by mandatory training, competency assessments, access to HICMR online learning, webinars and poster displays throughout the facility. Verification confirms the workforce uses the safety and quality systems from the Clinical Governance Standard. TVRC staff 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. There was a good understanding of risk management and reporting of incidents. Staff reported that they received training in infection prevention and control including hand washing, handling of sharps and infectious waste and standard based precautions and transmission. Observation of facilities and equipment confirmed that preventive maintenance was undertaken as the facility was of very good repair and exceptionally clean and tidy.	
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 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	Met	Infection Control Documents/Records: Review of infection control documents shows TVRC applies the quality improvement system from the Clinical Governance Standard when monitoring the performance of systems for prevention and control of healthcare-associated infections, the effectiveness of the antimicrobial stewardship program, implementing strategies to improve outcomes and reporting on the outcomes. This is evidenced by policies and procedures covering AMS, and a gap analysis undertaken in line with Advisory AS18/08 completed in June 2021, as well as results of audits. Hand hygiene audits undertaken as per the NHHI Audit 2 2021 result was 90.8% and the results are consistently at this level. Regular reviews of healthcare associated infections are undertaken and antimicrobial prescribing is tabled at the MAC, IPC and AMS committees for the Healthscope Eastern Cluster. Continuous improvements are made to the infection prevention and control system with results reported within the Healthscope Quarterly KPI data submitted and benchmarked quarterly. Consumers are involved in review of infection control pamphlets prior to distribution.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	prevention and control of healthcare-associated infections, and the antimicrobial stewardship program		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. Nursing and allied health staff 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. Staff were observed using infection control protocols including handwashing and screening of consumers. Staff interviewed were able to describe the comprehensive training received in infection prevention and control, including reporting incidents and managing identified risks.	
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 antimicrobial stewardship program to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision-making	Met	Infection Control Documents/Records: Review of infection control documents shows preventing and managing healthcare-associated infections and implementing the antimicrobial stewardship program involves patients in their own care, meets the patient's information needs and supports shared decision-making. Healthscope has a very active consumer on the Healthscope Infection Control Committee but not at TVRC level. However, consumers are involved in reviewing information including pamphlets prior to distribution. Consumers are actively involved in shared decision making. For example, if antimicrobials are required, explanations of why they are required, for how long and any potential side effects are discussed. Consumer feedback evidenced that they are very satisfied with the cleanliness of the facility and the level of hand washing by clinicians. Clinical leads interviewed could describe the processes for partnering with consumers to involve patients in planning and making decisions about infection prevention and control. The TVRC Patient Information Directory given to all consumers contains information on infection prevention and control for consumers and carers. There is great use of poster boards and information sheets throughout the facility, including use of antibiotics and respiratory etiquette	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
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: Review of infection control documents shows a surveillance strategy for healthcare-associated infections and antimicrobial use that collects data, monitors, assesses and uses surveillance data to reduce the risks. Surveillance data is reported to the workforce, the governing body, consumers and other relevant groups. TVRC has access to the HICMR website to access policies, procedures and surveillance toolkits as well as participating in the Healthscope Shared Learning Program to compare the number of infections with other sites in Australia. All infections are reported via RiskMan and tabled at the TVRC IPC Committee. Hospital-acquired SAB, Clostridium difficile and hand hygiene rates are reported as part of Healthscope KPI monitoring. NAPS and VICNISS data is tabled at the MAC. There is a strong reporting structure with clear lines of accountability in place. Infection rates are published on the MyHealthscope website. Verification confirms TVRC has a surveillance strategy for healthcare-associated infections and antimicrobial use.	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	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. Policies and	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		procedures are accessible and reviewed in line with requirements. Access to HICMR online is in place for staff for advice as well as an onsite Infection Control Co-ordinator. Observation of standardised signage and other information resources were consistent with the Australian Guidelines for the Prevention and Control of Infection in Healthcare.	
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 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	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. Consumers are pre-screened and are required to have a negative COVID-19 test prior to admission. Upon admission, screening includes an infection control and COVID-19 Screening Questionnaire. If a risk is identified on admission, staff would apply transmission-based precautions. 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 environmental cleaning, disinfection and equipment requirements. Environmental cleaning staff have undergone additional training in how to clean effectively once an infectious patient has been discharged. The discharge summary and transfer documents include information on the infectious state of the person being discharged or transferred to another health care facility. Clinical leads interviewed could describe how they decide on the need to apply transmission-based precautions and how they assess and mange infection risks when a patient presents for care. Observation of facilities and equipment confirms that relevant equipment, including personal protective equipment is available to the workforce. Further observation of	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			facilities and equipment confirmed that all rooms are single rooms providing an advantage for infection prevention and control.	
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. 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 jurisdictional requirements b. Addresses noncompliance or inconsistency with the current National Hand Hygiene Initiative	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. TVRC has high rates of compliance with the hand hygiene initiative- currently 90.8% across the facility. Assessment is undertaken by observation of individuals. Results are tabled at the IPC, MAC and Quality Committees and are published on the My Healthscope website. Consumers are empowered to ask staff if they have washed their hands or used hand rub prior to giving care. Interview with clinical leads confirmed the hand hygiene program is consistent with the current National Hand Hygiene Initiative. Observation of facilities and equipment confirms that TVRC has a hand hygiene program, with signage and good placement of hand rub and hand wash throughout the facility.	Met
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	Met	Infection Control Documents/Records: Review of infection control documents shows processes are in place for aseptic techniques. Policies and procedures are in place with the procedures identified that would require the application of aseptic technique including IV cannula insertion, wound dressings, PIC line dressings and urinary catheterization. An audit of four aseptic technique procedures in May 2021 showed 96% compliance. Clinical nursing staff undertake competency assessments twice a year and any gaps identified are addressed by training. VMO's can only undertake aseptic technique if it is part of their credentialling. There is no evidence of competency assessments for current VMO's but	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	technique c. Provide training to address gaps in competency d. Monitor compliance with the organisation's policies on aseptic technique		the health service has undertaken a risk assessment in line with the Australian Commission on Safety and Quality in Healthcare (the Commission) fact sheet Training Requirements for Credentialled Practitioners 2019. This credentialling is available for staff to access via Cgov Scope of practice and WEBPAS sites. As it is on the risk register, it is regularly reviewed. Nurses could describe the procedures where aseptic techniques are applied and confirmed that they have their competency assessed.	
3.10	Invasive medical devices The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare	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 the appropriate use and management of invasive medical devices. A list of invasive medical devices in use is available. The last annual invasive aseptic technique audit on five procedures (each having 21 steps) was 100% complaint. Audits are undertaken annually and reported at the IPC. Clinical leads interviewed could describe the processes TVRC uses to ensure that the workforce selects, inserts, maintains and removes invasive devices safely.	Met
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	Met	Infection Control Documents/Records: Review of infection control documents shows processes are in place to maintain a clean and hygienic environment. TVRC has processes in place to respond to environmental risks including workforce and contractor education. Cleaning is to a high standard within the facility. Consumer feedback on the cleanliness of their room and bathroom is very positive. The cleaners are employed by the hospital and comply with all environmental policies and procedures. Staff are trained in the use of PPE and decontamination of areas. Environmental cleaning audits are carried out three monthly with a very high level of compliance (97% average). Any areas for improvement are addressed and reassessed. External contractors such as, the linen provider comply with the relevant Australian standards as well as internal review. A waste audit was undertaken in June 2021 and it was found that the majority of waste is segregated appropriately. Results of audits or incidents are reported at the IPC.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	c. Include training in the appropriate use of specialised personal protective equipment for the workforce		Pool water undergoes microbiological testing monthly for E. Coli and Pseudomonas. There is a process in place to follow up issues with the HICMR consultant and close access to the pool as necessary. Observation of facilities and equipment confirms that TVRC has processes to maintain a clean and hygienic environment. Interviews with environmental staff confirmed the processes in use and showed they take pride in providing a clean and tidy environment.	
3.12	Clean environment The health service organisation has processes to evaluate and respond to infection risks for: a. New and existing equipment, devices and products used in the organisation b. Maintaining, repairing and upgrading buildings, equipment, furnishings and fittings c. Handling, transporting and storing linen	Met	Infection Control Documents/Records: Review of infection control documents shows processes are in place to evaluate and respond to infection risks for all new and existing equipment. The building is in good repair due to a preventative maintenance schedule. Staff are able to request and advise of equipment that is in need of repair or replacement. New equipment is assessed for ease of cleaning and disinfecting. Linen handling is kept to a minimum and is taken to a collection point by environmental staff where it is taken by the external linen service. Infection Control Interview/Observation: Observation of facilities and equipment confirms that TVRC has processes to evaluate and respond to infection risks. Clinical leads interviewed could describe the process for determining the infection risks for new and existing equipment, and the processes for handling, transporting and storing linen. Observation of facilities and equipment confirmed that nursing staff handled linen and waste appropriately. ***Improvement Opportunities*** Infection Control Documents/Records: 3.12 - Change room curtains in the pool area are made of cloth material and are checked weekly for wear and tear or staining. However, in line with best practice, TVRC should consider replacing these curtains with hospital grade disposable ones.	Met
3.13	Workforce immunisation The health service organisation has a risk-based workforce immunisation	Met	Infection Control Documents/Records: TVRC has an Immunisation Policy in place that is consistent with the Australian Immunisation Handbook. Staff are able to ask for an exemption (except for COVID-19) by completing an Immunisation Waiver Form. All new staff are asked to comply with	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		immunisations as per the occupational risk category or provide serology testing prior to employment. Staff immunisation history is maintained on a spreadsheet. Flu vaccines are offered to all staff annually and the up take is improving. The immunisation program is aligned with the Workhealth Safety Policy. Staff interviewed were able to describe what immunisations are offered, that is influenza annually. The current recorded immunisation rate amongst staff for all recommended vaccines for health workers (Influenza, Hepatitis B, MMR, Pertussis and Varicella) is 51%. ***Improvement Opportunities*** Infection Control Documents/Records: 3.13 - Although good work is being undertaken to increase staff vaccination rates, TVRC should aim to document 100% of staff vaccination and serology status (as appropriate).	

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	Met	Infection Control Documents/Records: The Sleep Studies Unit at TVRC pre-rinses used semi-critical RMDs, that is, CPAP masks and tubing, and then packs them in a container labelled dirty equipment for transfer to Knox Private Hospital Sterilising Services Department for cleaning and disinfection. The CPAP masks and tubing are not single use items but cannot be sterilised as the process damages them. The clean processed items are returned to TVRC in plastic packaging with accompanying disinfection labels in a container marked 'CLEAN to the TVRC address'. The cleaning/disinfection information and batch is transferred to the patient chart upon use for traceability. Tracking audits have commenced and are reported at the IPC. This	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	semi-critical equipment, instruments and devices that is capable of identifying • the patient • the procedure • the reusable equipment, instruments and devices that were used for the procedure		process has been reviewed by HICMR in February 2021 and improvements were made to transporting and PPE requirements when cleaning. The system has also undergone an external audit. On observation, assessors raised concerns about the pre-cleaning process after point of use, as the mask and tubing were rinsed with water only prior to packing into clearly labelled containers for transport to Knox Private Hospital for cleaning and disinfection. Review of the manufacturer's instructions for masks allows for rinsing in water, followed by thermal disinfection for 10 minutes at 80 degrees centigrade. The current cleaning printout states it is at 78 degrees centigrade for 10 minutes. According to manufacturer instructions the tubing needs to be completely soaked in cleaning fluid as part of the pre-cleaning process. This needs to be followed up with Knox Private by TVRC to provide extra assurance. There is no mention in the manufacturers' instructions on how long the masks last with continuous cleaning and disinfection i.e. if the shelf life is affected or reduced. Therefore, it is important to check the integrity of the items when reprocessing and sign this off. This quality improvement was put into place on the day. ***Improvement Opportunities*** Infection Control Documents/Records: 3.14 - TVRC should follow up the cleaning and disinfection requirements for temperatures and soaking of tubing with Knox Private Hospital. In addition to this, TVRC should evaluate the new CPAP Reprocessing Form once in use.	

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. Policies and procedures are in place with access to the Therapeutic Guidelines, a restricted antimicrobial list and staff training. AMS is a standing agenda item on the IPC. The action plan for Advisory 18/08 was completed in June 2021 including the pharmacist monitoring antimicrobial prescribing and reporting as part of HICMR infection surveillance monitoring. AMS is recognised in the risk register and the AMS Committee for the Eastern Cluster meets every two months. Observation of the facilities and equipment confirmed that current evidence-based Australian Therapeutic Guidelines and resources on antimicrobial prescribing are available to the workforce. TVRC held an Antibiotic Awareness Week with quizzes and poster boards throughout the hospital. Prizes were given to staff for the highest answers in the quiz.	Met
3.16	Antimicrobial stewardship The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing	Met	Infection Control Documents/Records: Review of documentation shows the antimicrobial stewardship program includes the review of antimicrobial prescribing and use, surveillance data on antimicrobial resistance, evaluates performance of the program and reports to clinicians and the governing body. Antibiotic use and compliance with guidelines is reported at the MAC and is audited at least bi annually. Surveillance reports from pathology are reviewed by the IPC coordinator and reviewed by HICMR for appropriate prescribing practices. Areas of improvement are identified through participation in the NPS program. All results are reported at the IPC and Eastern Cluster MAC and AMS Committees as well as being benchmarked within Healthscope. Verification confirms TVRC has an antimicrobial stewardship program in place. An AMS audit in June 2021 of 80 records showed no restricted antimicrobials were prescribed, 12	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		oral antibiotics, two oral and three topical anti fungals and two oral antivirals. This was reviewed at the MAC.	

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: Governance of medication safety and quality at TVRC is overseen by a Medication Safety Committee, with a terms of reference and a set agenda that is aligned with the requirements of the Standard. The Committee has a representative on the Healthscope National Medication Safety Team, and is accountable to the Quality Committee and also reports to the Medical Advisory Committee. Membership of the Medication Safety Committee is multidisciplinary and includes senior medical and nursing staff as well as a senior 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 to promote accountable approaches to medication management. TVRC has a medication audit schedule in place. Previous audit results for the May 2021 period include 100% compliance with management of high-risk medications and 100% compliance with labelling of injectables. An action plan is in development to address any practice gaps identified. Clinical leads interviewed could describe how the safety and quality systems are applied when implementing policies, managing risks and identifying training requirements for	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			medication management. Observation of nurses' practice demonstrated use of the health service organisation's processes for medication management. There is a robust system in place for safe medication management. Nursing staff interviewed were satisfied with the annual mandatory training, particularly the Med+Safe interactive modular training. There has been a 37% decrease in medication incidents since 2017.	
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 management b. Implementing strategies to improve medication management outcomes and associated processes c. Reporting on outcomes for medication management	Met	Medication Safety Documents/Records: Review of medication safety documentation shows the quality improvement system is robust and is applied when monitoring, improving and reporting on outcomes for medication management. It is noted that medication safety audit results have very high compliance rates (more than 90%) throughout the health service. Any gaps in medication safety are reported at the Medication Safety Committee so that action plans can be prepared. Data is submitted to Healthscope for benchmarking and ACHS clinical indicators twice yearly. Consumer involvement is at the Healthscope Medication Safety WebEx Committee where there is a consumer on board. Examples of quality improvements include the introduction of tamper proof bags for high risk medicines and monthly medication chart audits. Clinical leads interviewed could describe how the quality improvement system is applied when monitoring, improving and reporting on outcomes for medication management. The staff described a culture that supports incident reporting and quality improvement. Verification shows processes are in place for clinicians to implement strategies to improve medication management outcomes and associated processes.	Met
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	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. For example, input from consumers is surveyed with the intention of understanding their satisfaction with medication information. Information can be provided in different languages.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	b. Meet the patient's information needs c. Share decision-making		Interview with clinical leads confirmed the process from partnering with consumers is applied when involving patients in planning and making decisions about their medication management. Staff report that patient specific information is available in languages other than English and the interpreter service is requested as required. Nursing staff interviewed could explain the process for checking medications with consumers on admission and again at discharge. The pharmacist is able to obtain medication information in languages other than English if required. Observation of clinicians' practice shows use of the health service organisation's processes for partnering with consumers.	
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 including corporate credentialing and medication safety policy documents, shows processes are in place to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians. Visiting Medical Officers must be credentialed and have a prescribed scope of clinical practice before commencing clinical practice in any capacity. An annual nursing credentialing audit is completed using the Australian Health Practitioner Regulation Agency (APHRA). Interview with clinical leads confirmed processes are in place to ensure that only clinicians including a nurse practitioner, with the relevant authority prescribe, dispense or administer medicines. There are robust reporting, investigation and response processes in place to ensure immediate action if any clinicians are observed to be operating outside of their scope of practice. Verification confirmed that processes are in place to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians. The Assessment Team observed an effective communication system to promote medication safety including the use of shared learnings and input provided by the external pharmacist.	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 including corporate and local policies for medication management, shows a process is in place for obtaining and documenting a Best Possible Medication History (BPMH). This forms the basis for therapeutic decision making and supports the identification of adverse medicines events. All patients receive a comprehensive medication assessment by the nursing and medical staff on admission to the hospital Patients at higher risk of harm are referred to the pharmacy service for review. Clinical leads interviewed could describe the processes used to obtain and record a Best Possible Medication History (BPMH) in the patient's healthcare record. Staff interviewed could describe the process for obtaining a BPMH. Verification shows processes are in place for clinicians to take a BPMH, 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. A medication management plan is in place to ensure compliance with the medication reconciliation process. Medication reconciliation results are reported to the Australian Council on Healthcare Standards (ACHS) clinical indicator program twice a year and are at a satisfactory level. Verification confirms the clinicians review a patient's current medication order against their Best Possible Medical History and the documented treatment plan, and reconcile any discrepancies on presentation and at transition of care.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
4.7	Adverse drug reactions The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation	Met	Medication Safety Documents/Records: Review of medication safety documentation shows a process is in place for recording a patient's known medicine allergies and adverse reactions (ADRs) on presentation. Patient allergies are entered and documented on the patient alert sheet on admission. This information is updated as required and forms parts of the patients discharge summary. 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. Adverse medication events are discussed at the Medication Safety Committee and are reported to the relevant clinical review committees. Improvements have been made in recording ADR's on patient charts. Following a result of increased education and huddles, the results of complete and accurate recording is up to 100% in July 2021 from 69% in 2020.	Met
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 adverse drug reactions experienced during an episode of care. Alerts are included as part of the bedside clinical handover and red wrist bands are in use to indicate a medication risk. The reason for the red wrist band is established from the patient record. All ADR's are reported at the Medication Safety Committee. Clinical leads interviewed described the process for ensuring all medicine allergies and adverse drug reactions 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. All adverse drug reactions are reported through RiskMan and to the Senior Pharmacist who reports directly to the Therapeutic Goods Administration. Verification confirms processes are in place 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

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
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. All ADR's are discussed at the Quality and Consumer Committee that has consumer consultant representation (HSP). Medication Safety Interview/Observation: Interviews with clinical leads confirmed there is a process in place for reporting all new suspected ADRs experienced by patients during their episode of care to the Therapeutic Goods Administration. Verification confirms processes are in place for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements.	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 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	Met	Medication Safety Documents/Records: Review of medication safety documentation shows processes are in place for medication reviews to be conducted and documented. Pharmacy reports of prescription errors and near miss incidents are reported to the Medication Safety Committee and Quality and Risk Committee. Each clinical area has the most up to date version of the Australian Injectable Drug Handbook and hard copies of MIMS are also available for reference. The pharmacist is readily contactable and visits daily. Clinical leads interviewed could describe the processes in place for medication reviews	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	minimising the risk of medication-related problems c. That specify the requirements for documentation of medication reviews, including actions taken as a result		and how these are documented. Staff report that examination of incident trends across both hospitals has led to the development of local medication safety strategies.	
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 their individual medicine needs and risks is available in different languages. Interview with clinical leads confirmed the process for providing patients with information about their individual medicine needs and risks. Observation of facilities and equipment shows that information about medicine needs and risks is available for clinicians to use during discussions with patients and carers. Visiting Medical Officers and nursing staff have access to the Therapeutic Guidelines, up to date Injectables Book and hardcopy MIMS for prescribing information, consumer medicine information and pharmaceutical product images.	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 to receiving clinicians at transitions of care c. Provide patients on discharge with a current medicines list and the reasons for any changes	Met	Medication Safety Documents/Records: Review of medication safety documentation shows a process is in place to generate a current medicines list. This information is obtained on admission and updated throughout the patient's hospital stay. A medication management is in place for admission and this is updated and reconciled at various stages of the patient journey. Clinical leads interviewed described the process to generate a current medicines list and distribute at transition of care or patient discharge. Medication profiles are completed for high-risk patients and reviewed by a clinical pharmacist.	Met

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: Observation of facilities and equipment shows up-to-date decision support tools such as protocols, guidelines and medicine related information resources are available in clinical areas. The Medication Safety Committee is responsible for assessing the quantity and quality of available data and information related to medication safety and take appropriate actions to improve data/information sources. Clinical leads interviewed could describe how the health service organisation ensures that medicine-related information and decision support tools are up-to-date and available to clinicians at the point of decision-making. 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 c. Disposal of unused, unwanted or expired medicines	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 high-risk medicines, temperature-sensitive medicines and cold chain management) and the correct disposal of unused, unwanted or expired medicines. Clinical leads interviewed could describe how all medicines (including temperature-sensitive medicines) are stored, handled and disposed of according to manufacturers' directions legislation and jurisdictional requirements. Nursing staff stated that sometimes clinician handwriting is difficult to decipher and involves much time wasting contacting the particular clinician for verification. Monthly medication document audits are in place to review items such as this. Management and a clinician on the MAC explained that clinicians are notified by letter four times advising to	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			improve the legibility of their handwriting particularly around prescribing of medications. Verification confirms the health service organisation ensures the safe and secure storage and distribution of medicines. There is only one vaccine fridge at TVRC and this is maintained in line with Strive for 5 Guidelines. The temperature probe was found to be incorrectly placed but was repositioned into a vaccine box on the day to reflect accurate temperature recording. Staff interviewed were able to explain what to do in the event of a breach of the cold chain. The annual vaccine fridge audit on hand was in line with outdated Strive for 5 Guidelines. ***Improvement Opportunities*** Medication Safety Documents/Records: 4.14 - TVRC should ensure that an annual vaccine fridge audit is undertaken in line with the most up to date Strive for 5 Guidelines. A training update for staff responsible for maintaining the cold chain would be beneficial before 'flu season'. 4.14 - The MAC should continue to follow up poor legibility issues on medication charts.	
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. A High-risk Medication Policy is in place to mandate the minimum requirements for the safe management of high-risk medications across both hospitals. Introduction of a clear tamper proof bag for high-risk medicines brought with patients on admission has been a quality improvement. The medications are double checked and are then easier to count each day as per state drug requirements. Interview with clinical leads confirmed high-risk medicines are identified and a system is in place to store, prescribe, dispense and administer them. Information is displayed about medications universally considered to be high-risk. Verification confirms TVRC identifies high-risk medicines used within the organisation.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			Risk reduction strategies and best practice standards are in place for prescribing, dispensing or administering high-risk medications. Use of Tall Man Lettering is in place.	

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: Comprehensive care is an integral part of clinical governance from internal governance structures to risk assessment, quality improvement and workforce competency. Policies and procedures covering comprehensive care are up to date and readily available to staff. The oversight of comprehensive care at health service level is the responsibility of the Quality and Safety and Nurse Unit Manager Committees. A representative from TVRC is a member of the national Healthscope Comprehensive Group and evidence of minutes showed that comprehensive care has been discussed. A risk register is in place and is reviewed regularly. All incidents entered into RiskMan are reviewed, monitored, acted upon and reported at an appropriate level within the organisation. The available data on staff training showed training in risk management, quality improvement and all aspects of minimising patient harm including falls, nutrition and pressure area assessments.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			Verification confirms processes are in place for managing risks associated with comprehensive care. From pre-admission to discharge, risk management is a key component of the patient journey.	
5.2	Applying quality improvement systems The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the delivery of comprehensive care b. Implementing strategies to improve the outcomes from comprehensive care and associated processes c. Reporting on delivery of comprehensive care	Met	Clinical Gov and QI to Support Comprehensive Care Documents/Records: Review of documentation shows processes are in place for the monitoring, implementing strategies and reporting on delivery of comprehensive care. Review of documentation shows processes are in place for the monitoring, implementing strategies and reporting on delivery of comprehensive care. As well as committee review, delivery of comprehensive care is monitored by staff and patient feedback and incident analysis. There was evidence of good two-way communication by way of meetings, open door policies and performance reviews. Patients reported a very high level of involvement in their care at every level and felt that any issue would be dealt with promptly and appropriately. Quality improvements include learning bundles for specialing patients and patient care boards review. Clinical leads interviewed could describe how the quality improvement system is used to monitor, implement and report on the delivery of comprehensive care. Verification confirms TVRC has systems in place for monitoring the delivery of comprehensive care and implementing strategies to improve the outcomes from comprehensive care and associated processes.	Met
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	Met	Clinical Gov and QI to Support Comprehensive Care Documents/Records: TVRC ensures patients and carers are actively involved in their care at all levels. This was clearly evidenced at admission, at various therapies, morning meetings, clinical handover and discharge. Information is presented in different languages (as required) and tailored to the patient demographic. Shared decision making was evidenced during the pre-admission screening, on admission,	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	care b. Meet the patient's information needs c. Share decision-making		at various therapy attendances and at discharge. Patient feedback is collected and acted upon to make improvements.	
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 c. Ensure timely referral of patients with specialist healthcare needs to relevant services d. Identify, at all times, the clinician with overall accountability for a patient's care	Met	Clinical Gov and QI to Support Comprehensive Care Documents/Records: Document review showed a system is in place to deliver comprehensive care. Overall there is a standardised approach to care. There are clear and transparent patient flow processes including flagging of concerns identified during patient screening. Screening systems are in place to ensure that patients receive care that best meets their needs. Clinicians interviewed were able to describe how they can provide input into the design and delivery of care. Patients interviewed were very satisfied with their care. Patient Care Boards have recently been updated following review. Patient Care Boards are located in each room with patient information in large text.	Met
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: Document review showed excellent examples of structured communication tools that enhance collaboration and teamwork. Collaboration between therapy staff, nursing, psychologists, counsellors and visiting GP's ensures that the patient is at the centre of care planning. The governance framework clearly supports a multidisciplinary approach to patient care. iSoBAR is used effectively for clinical handover. Roles and responsibilities within the organisational structure are defined. Interviews with nurses, allied health and clinicians showed a collaborative approach is in place and staff demonstrated a clear understanding of their roles and accountabilities.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
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. In the delivery of comprehensive care, each clinician brings forward a different perspective in order that the patient can be involved in the shared decision-making process. Clinicians were observed working together in a collaborative manner and patients reported that clinicians always involve them in treatment and 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 to identify risk of harm. TVRC commences patient screening upon receipt of the referral in line with the "minimising patient harm" criterion of Standard 5. Prior to admission, patients are pre-screened and then upon admission to the service, a comprehensive risk assessment process is completed by the nurse. Any gaps in screening to minimise risk of harm or any red flags raised, can be seen immediately by the treating clinician. The Healthscope minimising harm audit measures comprehensive care planning and risk screening, in 2021 the result was 94%. 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	Met	Developing the Comprehensive Care Plan Documents/Records: Document review shows a process is in place for identifying Aboriginal and Torres Strait Islander patients, and recording this information in administrative and clinical information systems. Patients are asked to record and confirm cultural identity on	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems		admission. There are prompts and other reminders to encourage patients to self-identify if they wish. Staff are trained in cultural awareness.	
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. TVRC has a policy for end-of-life care and advance care planning. End-of-life care is not routinely provided but there are plans and processes in place to manage care if it is required. There are social workers onsite to assist patients with advance care planning needs. Clinical leads interviewed could describe how they support patients to document advance care plans.	Met
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 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. Document review showed relevant screening processes are used for patients at pre-admission, on admission, during clinical examinations and as required. Screening is undertaken on admission for allergies, cognitive impairment, presenting problem, falls risk, pressure areas and nutritional status. Any gaps or risks are documented by the nurse in the care plan and are escalated appropriately to the clinician and the appropriate clinical pathway is implemented in a timely manner. COVID-19 screening is part of the process of screening for all patients and visitors. Nurses were observed undertaking the screening process and involving patients and carers. Patients and clinicians interviewed were satisfied with the screening process.	Met
5.11	Clinical assessment Clinicians comprehensively assess the	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. Document review also showed that	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	conditions and risks identified through the screening process		any risks found during the screening process are assessed by the appropriate clinician and the patient may be placed on an appropriate clinical pathway for example, behaviour charts or a cognitive impairment screening pathway. Collaboration between all staff was observed during clinical assessments of patients. Patient feedback was positive in that they are involved in the clinical assessment and shared decision-making. The clinician satisfaction survey showed a high level of satisfaction with the screening process.	
5.12	Developing the comprehensive care plan Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record	Met	Developing the Comprehensive Care Plan Documents/Records: Documentation reviewed shows processes are in place for recording the findings of screening and clinical assessments. Appropriate recording of alerts was observed in medical records. The screening assessment is comprehensive and nurses document any risks in the plan in addition to usual screening risks. Clinicians can also add to this as necessary. Staff are trained in comprehensive care screening processes. The clinician interviewed could explain the process for documenting the findings of risk assessments including alerts in the medical record.	Met
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	Met	Developing the Comprehensive Care Plan Documents/Records: Document review shows shared decision-making processes are in place that are consistent with best practice. This includes the development of a comprehensive and individualised plan that addresses the significance and complexity of the patient's health issues and risk of harm and identifies agreed goals and actions for the patient's treatment and care. Document review shows support people are identified and discharge planning commences at the beginning of the episode of care including a plan for referral to follow-up services. The development of the comprehensive care plan is concise and tailored for the patient treatment. Patient goals are documented as part of the shared decision-making process. Clinicians were observed discussing patient treatment and goals with patients.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		Discharge planning is tailored to patient needs, such as discharge to home with or without support or to another service. Clinical leads interviewed could describe the processes in place for shared decision-making between clinicians and the patient, carer and support people. Observation of clinicians' practice confirms the use of the health service organisation's processes for shared decision-making is undertaken. There is a very collaborative approach to shared decision-making. Consumers reported that they felt very involved in goal setting and care.	

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	Met	Delivering Comprehensive Care Documents/Records: Document review shows processes are in place to ensure the workforce, patients, carers and families work in partnership to use the comprehensive care plan to deliver care, monitor the effectiveness, review and update and reassess the patient's needs if changes occur. Review of care plans showed that risks or concerns are documented as required. Comprehensive care planning forms part of the orientation program for nurses. Reviewing effectiveness of the care plan is undertaken at handover and NUM meetings. Any changes to the plan are documented in the medical record and shared with all decision-makers including patients.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur		Observation of clinicians, carers and patients confirmed a collaborative approach to deliver a comprehensive care plan including monitoring and reviewing the plan as needed. Evidence of patient and staff collaboration was observed during handover, transfer to allied health services and on admission.	
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. Patients are given the opportunity to participate in treatment decisions consistent with their level of decision-making capacity. Although TVRC does not necessarily provide end of life care, there are comprehensive policies in place to identify patients that may be dying. There is also access to onsite social workers for patients and carers to access. Clinical leads interviewed could describe the processes in place to identify patients who are at the end of their life.	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 the health service organisation or externally. TVRC has access to the Healthscope Policy on Voluntary Assisted Dying. Nursing staff onsite have access to an end of life toolkit. All staff and clinicians are able to access existing patient advanced care directives to aid in discussions with the patient and carers. Observation of facilities and equipment shows that information about how to access specialist palliative care advice is readily accessible for clinicians when providing care.	Met
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	Met	Delivering Comprehensive Care Documents/Records: Document review shows the requirements for documenting advance care plans in the patient's healthcare record. Training for nursing staff on advance care planning is planned for early 2022. Verification shows processes are in place to ensure that current advance care plans can	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	b. Are documented in the patient's healthcare record		be received from patients and are documented in the patient's healthcare record. Staff interviewed could explain the process for receiving and documenting advance care plans in patient medical records.	
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. TVRC has an EAP program in place for staff to access counselling and support services. Observation of facilities and equipment shows that information about support services is readily available for the workforce that provides end of life care.	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 for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care. All deaths are reported at the MAC meeting and deaths reported to the coroner are recorded as sentinel events. There is a robust review in process with 100% of all deaths reviewed.	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 elements for safe and high-quality end-of-life care	Met	Delivering Comprehensive Care Documents/Records: Document review shows processes are in place for clinicians to support patients, carers and families to make shared decisions about end of life care. TVRC has access to best practice resources about end of life care including the Clinical Excellence Commission and Healthscope's own Last Days of Life toolkit. Patient and carer goals are documented and discussed with clinicians and all members of the care team. Clinical leads interviewed could describe how clinicians are supported to deliver care that aligns with the National Consensus Statement: Essential elements for safe high-quality end-of-life care. Observation of facilities and equipment confirmed that the setup of single rooms in the facility is conducive to providing end of life care.	Met

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. Evidence based tools such as the Waterlow and MST scales are used at admission screening to assess skin and nutrition and best practice policies are in place. The workforce is trained in pressure injury prevention during orientation. 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. TVRC has a system wide approach to falls prevention. Evidence based tools and best practice policies are in place. Skin inspections are documented at screening, on discharge paperwork and at handover. Protocols are in place for timely review of skin integrity and wound assessments. Recent audits showed 100% of patients had a comprehensive skin assessment on admission. Verification confirms that 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. Patients confirmed that they receive regular skin checks.	Met
5.23	Preventing and managing pressure injuries The health service organisation providing services to patients at risk of	Met	Minimising Patient Harm Documents/Records: Document review shows processes are in place to manage patients at risk of pressure injuries. Patients are given pamphlets and ongoing advice about prevention of pressure areas. Staff have been trained in prevention of pressure injuries, wound care and how to use the equipment available.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		Verification confirms that the health service organisation ensures that patients, carers and families are provided with information about preventing pressure injuries. Observation of facilities and equipment confirmed that equipment available for pressure area management is maintained in good repair.	
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. Evidence based tools and best practice policies are in place. The workforce is trained in falls prevention during orientation. Falls risks are documented at screening, on discharge paperwork and at handover. All falls are reported to the Quality and Safety Committee for review. Falls are also available on My Healthscope for the general public as well as on the monthly statistics on Quality and Safety Boards in each ward. For example, there were two falls on Waratah Ward in October 2021. Clinical leads interviewed could describe the system in place for falls prevention, harm minimisation and post-fall management. Observation of facilities and equipment shows the use of falls prevention plans. 'Call Don't Fall' posters were observed in patient rooms, bathrooms and around the facility.	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. Equipment available to prevent falls including signage in hallways, lighting and call bells, is recorded on an equipment register and was observed to be well maintained. Nurses are trained in using the equipment at orientation and when any new equipment is purchased.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			Verification confirms equipment, devices and tools are available to promote safe mobility and manage the risks of falls.	
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. Information is in the Patient Services Directory at each bedside and poster displays throughout the facility. Annual Falls Day activities are undertaken in April each year. Verification confirms the health service organisation provides care to patients at risk of falls and provides patients, carers and families with information about reducing falls risks and falls prevention strategies. 100% of patients reported receiving information on falls prevention.	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. All patients are screened for malnutrition and have a comprehensive nutrition assessment undertaken on admission. Allergies are documented to ensure the nutrition plan is up to date and includes all relevant details. Monitoring of fluid and food intake is recorded if it is part of the care plan. 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	Met	Minimising Patient Harm Documents/Records: Document review shows systems for preparation and distribution of food and fluids are in place to meet, monitor, identify and support patients' nutritional needs and requirements. Patients at risk of malnutrition or who require dietary assistance are referred to a dietitian for a comprehensive nutritional assessment including ability to swallow, feed and open packages. Patients at risk are monitored at meal times by nursing staff. Signage is displayed in rooms if there are risks such as dysphagia. Nursing staff can assist patients with feeding at meal times. Nutritional supplements are available.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	c. Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone d. Support patients who require assistance with eating and drinking		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 food preparation areas are very clean, functional and meet annual audit requirements. Food presentation was of a high standard and was cooked from fresh ingredients each day. Patients reported satisfaction with the food.	
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. Patients are screened at admission with CIRAT, a best practice validated tool. Referrals can be made to the onsite cognitive impairment prevention and management program. Any risks are reported in RiskMan and referred to the clinician for treatment planning. The pharmacist is available to provide information on any drug related issues. Processes are in place to refer patients onto more suitable facilities if necessary. Staff are trained in Workplace Agression and Violence (WAVE). Clinical leads interviewed could describe the processes in place to manage safety and quality issues for patients with or who are at risk of developing cognitive impairment.	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	Met	Minimising Patient Harm Documents/Records: Document review shows systems are in place to care for patients with cognitive impairment. Clinical handover is used to ensure all staff are aware of the level of cognitive impairment. The pharmacist is involved if there are any medication issues or prescriptions. A calm environment is provided in a single room with staff adopting techniques learned in WAVE training.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	for caring for patients with cognitive impairment to: a. Recognise, prevent, treat and manage cognitive impairment b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care		Verification confirms processes are in place to recognise, prevent, treat and manage cognitive impairment.	
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. Patients are screened on admission and although, TVRC is not a mental health treatment facility, there is still a need to assess the mental health state of patents on admission. Staff are trained to identify patients at risk of self harm or suicide. There is a recovery-oriented approach to patient care along with a MET call policy in place if required. Staff interviewed felt confident in contacting the clinician or using a MET call if required.	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 for people who have harmed themselves or reported suicidal thoughts, have follow-up arrangements developed, communicated and implemented. All patients are followed up post discharge including those that reported suicidal thoughts. The discharge plan is collaborative and recovery oriented. Clinical leads interviewed could describe the processes in place to ensure follow-up for people who have harmed themselves or reported suicidal ideation.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			Clinical leads interviewed could describe the processes in place that ensures follow-up for people who have harmed themselves or reported suicidal ideation. There is a directory of health services to support people with suicidal thoughts. Patients also have access to social workers onsite who can provide assistance and support.	
5.33	Predicting, preventing and managing aggression and violence The health service organisation has processes to identify and mitigate situations that may precipitate aggression	Met	Minimising Patient Harm Documents/Records: Document review shows processes are in place to identify and mitigate situations that may precipitate aggression. Patients are given information about their stay including financial information. Communication and addressing concerns is seen as an important way of preventing aggression. A calm pleasant environment is provided onsite and staff are trained in Workplace Aggression and Violence Training (WAVE). Due to the increasing number of aggressive phone calls, the WHS Manager is looking at providing additional training in this area for administration staff early next year. Observation of facilities shows the design and use of the environment to minimise sources of potential conflict and additional stresses for patients. Each clinical area has a panic alarm that notifies security and/or local police. Methods are employed such as allowing freedom of movement, providing privacy and reducing stimulus to reduce the risk of aggression.	Met
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. Patients are asked to document triggers for the cause and any strategies to prevent aggression. Staff can than understand how to manage individuals appropriately. There is access to psychiatrist, psychologist, security or police depending upon the circumstances and risk assessment. Clinical leads interviewed could describe the processes in place for predicting, preventing and managing aggression and violence. The workforce feel well supported.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
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. There is a policy on restraint in case there is an instance where a patient needs to be restrained to prevent self-harm and staff are trained in minimising the use of restraint. Clinical leads interviewed could describe the processes in place to minimise restrictive practices.	Met
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 TVRC as it is not a gazetted health service organisation.	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 requirements for effective and coordinated clinical communication. TVRC has a local Clinical Handover Framework to support the transfer of clinical accountability and responsibility between healthcare professionals and to enable continuity of care for the patient. It is noted that the functions of a Communicating for Safety Committee are currently undertaken by the Quality and Risk Management Committee. Clinical leads interviewed could describe how 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 clinical communication processes. Observation of clinical handover at found that handover was comprehensive and conducted in a structured manner.	Met
6.2	Applying quality improvement systems The health service organisation applies the quality improvement system from the Clinical Governance Standard when:	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 and include audit results and incidents related to clinical handover. The overall aim is to	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		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 TVRC monitors the effectiveness of clinical communication and associated processes and implements strategies to improve clinical communication and associated processes.	
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. Observation of clinical handovers found that the patient was actively involved in the process.	Met
6.4	Organisational processes to support effective communication The health service organisation has clinical communications processes to support effective communication when: a. Identification and procedure matching should occur b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between	Met	Communicating for Safety Documents/Records: Document review shows clinical communication processes are in place for identification and procedure matching, transferring care and communicating critical information about a patient's care. The clinical information system requires a minimum of three approved identifiers on registration and admission. 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 clinical communications processes are in place to support	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	organisations; and on discharge c. Critical information about a patient's care, including information on risks, emerges or changes		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. Clinical leads interviewed could describe the processes used to ensure the correct identification of patients and when three approved patient identifiers are to be used. Verification confirms that TVRC 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
6.6	Correct identification and procedure matching The health service organisation specifies the: a. Processes to correctly match patients to their care	Met	Communicating for Safety Documents/Records: Document review shows processes are in place for correctly matching patients to their care and the information that should be documented. Interview with clinical leads confirmed processes are in place to correctly match patients to their care, the information that is documented and that staff receive the required training. For example, mandatory training in clinical handover is completed on an annual	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	b. Information that should be documented about the process of correctly matching patients to their intended care		basis to reduce the risk of patient mismatching. Verification confirms TVRC has processes to correctly match patients to their care.	

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 b. Risks relevant to the service context and the particular needs of patients, carers and families c. Clinicians who are involved in the clinical handover	Met	Communicating for Safety Documents/Records: Review of clinical handover documentation shows it contains the required minimum information content to be communicated at clinical handover. The latest audit results for clinical handover showed compliance rates above 92%. Clinical leads interviewed could explain the minimum information content to be communication at clinical handover and how this was decided and communicated to clinicians. Verification confirms TVRC ensures that minimum information content is communicated at clinical handover, based on best practice guidelines.	Met
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	Met	Communicating for Safety Documents/Records: Review of clinical handover documentation shows a structured clinical handover process (iSoBAR) is in place. Clinical handover processes are documented to ensure staff adequately prepare for clinical handover, schedule clinical handover at the appropriate times, the required information and clinicians are present, patient goals and preferences are included, patients are supported to participate and transfer of responsibility and accountability for care occurs.	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
	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		Interview with clinical leads confirmed there are structured clinical handover processes in place. Observation of clinicians' practice shows use of structured clinical handover processes and tools.	

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 and patients, carers and families. Interview with clinical leads confirmed they use clinical communication processes to communicate critical information to other clinicians who can make decisions about care and to patients, cares and families. Clinical staff use the iSoBAR clinical handover tool to ensure a standardised approach to clinical communication and a system-based process for documenting in patient notes. Allied health use SOAP or SOAPIE as a structure to document patient notes in a clear and consistent manner. Verification confirms processes are in place to ensure that clinicians and multidisciplinary	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			teams use clinical communication processes to effectively communicate critical information, alerts and risks in a timely way, when they emerge or change.	
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 how to call for assistance. Clinical leads interviewed confirmed there are communication processes in place for patients, carers and families to communicate critical information and risks to clinicians. Verification confirms there are communication processes in place for patients, carers and families to directly communicate critical information and risks to clinicians. The name of the nurse caring for the patient is written in large lettering on the patient care board.	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 complete 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.	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 The Victorian 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 The Victorian 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 The Victorian 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 The Victorian 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 The Victorian 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 The Victorian 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 The Victorian 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 The Victorian 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 The Victorian 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 The Victorian 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 systems 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 to identify opportunities for improvement as well as conduct a root cause analysis (as required). At times working parties are set up to work through a better practice solution to an event and how to improve 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 monitor vital signs and track changes to detect acute deterioration. Monitoring processes include observation and behaviour charts. The service conducts audits of patient behaviour chart to ensure staff follow 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 and other indicators for calling emergency assistance, management of pain and concerns about acute deterioration. Patients in their rooms have an emergency call button 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 and 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 record observations, another 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 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: Review of documentation shows a process is in place for referral to mental health services for patients whose mental state has acutely deteriorated. ***Improvement Opportunities*** Acute Deterioration Documents/Records:	Met

Actions	Description	Audit Attainment Level	Audit Comments	Final Attainment Level
			8.12 - Provide staff with training in crisis prevention and intervention and de-escalation techniques to protect the dignity and safety of the patient and the wellbeing of staff.	
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

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