NSQHS Standards Second Edition Organisation-Wide Assessment

Final Report

Cohuna District Hospital

Cohuna, VIC

Organisation Code: 210387
Health Service Facility ID: 100055
Assessment Date: 10/09/2019 to 11/09/2019

Accreditation Cycle: 1

Contents

Preamble

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

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

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

A rating report is provided for each health service facility.

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

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

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

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

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

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

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

Executive Summary

Introduction

Cohuna District Hospital underwent a NSQHS Standards Second Edition Organisation-Wide Assessment (NS2 OWA) from 10/09/2019 to 11/09/2019. The NS2 OWA required 2 assessors for a period of 2 day(s). Cohuna District Hospital is a Public organisation. Cohuna District Hospital was last assessed on 25/10/2016 and 26/10/2016. Below is a summary of the Health Service Facilities (HSFs) that were reviewed as part of this assessment:

Health Service Facility Name	HSF Identifier
Cohuna District Hospital	100055

General Discussion

Cohuna District Hospital (CDH) is a 16-bed acute rural Northern Victorian health service, comprising operating suite facilities, acute inpatient beds including maternity services, an urgent care unit, transitional care program beds, primary care services and residential aged care beds.

All CDH acute inpatient facilities were visited, and the assessment team met with Board members, a consumer representative, GP/VMOs, managers, staff, patients and carers. Elective surgical lists are only scheduled twice each month and no surgical procedures were being undertaken at CDH at the time of the assessment.

The assessment team was impressed with the level of collaboration and partnership that is evident across CDH and reflects the commitment by the Board, Executive and staff to engage consumers and the workforce in all aspects of the organisation.

The organisation has continued to improve its systems since the last assessment and there was evidence that staff are committed to improving care and services. Data is well used to drive ongoing improvement and the organisation benchmarks well against peers. Patients were very positive about the care they received and patient experience surveys support this view. The recommendations from the previous survey were reviewed and all have been closed.

The organisation clearly demonstrated to the assessment team an ongoing commitment to patient safety and quality improvement. All NSQHS Standards (2nd Edition) were assessed and were observed to have been met. No recommendations were generated. Appropriate action has been taken as a result of the recommendations from the previous NSQHS Standards (1st Edition) Survey, and all recommendations were able to be closed, with no further requirements.

The organisation is recommended for full accreditation.

Summary of Results

Cohuna District Hospital achieved a met rating for all **applicable** actions in all standards that were assessed and has achieved Accreditation (3 Years).

Cohuna District Hospital achieved a met rating for all facilities in all actions and therefore there is no requirement for a follow up assessment.

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

Cohuna District Hospital

Sites for Assessment

Sites for Assessment - Cohuna District Hospital

Cohuna District Hospital HSF ID:100055	
Address: 114-158 King George Street COHUNA VIC 3568	Visited: Yes

Cohuna District Hospital

Reports for Each Standard

Standard 1 - Clinical Governance

Governance, leadership and culture

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

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

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

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

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

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

Assessment Team Summary:

The Cohuna District Hospital & Cohuna Community Nursing Home Strategic Plan 2016-2020 sets priorities and provides the direction for Cohuna District Hospital (CDH) into the future. The strategic plan has undergone consultation with the community, consumers and with staff, and is referred to when business and quality planning is proposed and undertaken. There is a Clinical Governance Framework in place with clear delineation of safety and quality roles and responsibilities of the Board members, management, consumers and the staff delivering services. A comprehensive committee structure is clearly defined within the Clinical Governance Framework. Organisational safety and quality performance are monitored through a suite of reports including the quarterly Key Performance Indicator (KPI) Report.

The Board of Management (BOM) has endorsed the Aboriginal Health Plan 2017-2020 which is regularly reviewed to evaluate the progress of the strategies for the safety and quality priorities for Aboriginal and Torres Strait Islander people. The executive team participates in several external Aboriginal Health Partnership Groups, locally and regionally, including the Mallee District Aboriginal Service and the Gannawarra Local Agency meeting.

CDH in consultation with the local Aboriginal communities have developed an Acknowledgment of Country policy and have integrated this into daily practices, including acknowledgment of country at the commencement of meetings. A Reconciliation Action Plan has been developed and implemented in partnership with the Gannawarra Local Agency Meeting (GLAM). Aboriginal and Torres Strait Islander presentations to CDH acute services are reported to and monitored by the BOM.

Patient safety and quality systems

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

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

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

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

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

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

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

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

Met with Recommendations	
Not Met	
Not Applicable	

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

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

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

Action 1.18	
The health service organisation providing clinical information into the My Health Record system has processes that: a. Describe access to the system by the workforce, to comply with legislative requirements b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system	
Met	All facilities under membership
Met with Recommendations	
Not Met	

Not Applicable	

Assessment Team Summary:

There is a comprehensive range of policies readily available at the point of care through Protocol Management and Production Tool (PROMPT) to inform clinical processes and a suite of policies are in place to inform other corporate processes. Systems are in place to ensure policies and procedures are contemporary, evidence-based best practice, and are compliant with legislative and jurisdictional requirements.

There is a Risk Management Framework in place that was endorsed by the Board of Management in July 2018. Clinical and Corporate strategic risks are entered into the Victoria Health Incident Management System (VHIMS) Risk Register and are regularly reviewed by the BOM Audit and Risk Committee.

As per the requirements of ACSQHC Fact Sheet 14, a high-risk scenario was reviewed by the assessment team, using the assessment framework for safety and quality systems (PICMoRS). The risk selected was taken from the Patient Safety category of the Strategic Risk Report and is residual to a significant external review conducted previously. The assessment team was satisfied that the risks associated with the temporary diversion of birthing services at CDH are rigorously managed and that appropriate risk mitigation strategies are in place.

The incident management system used is the Victorian Health Incident Management System (VHIMS), which is easily accessible and understood by staff. Alerts to relevant staff are in place depending on the type of incident with relevant senior staff alerted to the incidents. Analysis of data is undertaken, and action plans initiated where areas for improvement have been identified. The complaints management process encourages accountability by initiating responses to complaints at manager and team level. Complaints management is reported through the quarterly Key Performance Indicator (KPI) Report and reviewed by the BOM Clinical Governance subcommittee.

Clinical performance and effectiveness

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

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

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

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

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

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

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

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

Action 1.27	
The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care	
Met	All facilities under membership

Met with Recommendations	
Not Met	
Not Applicable	

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

Assessment Team Summary:

Orientation is provided for all levels of staff and a formalised system of mandatory training is supported by a range of eLearning packages. Compliance is monitored and reported by department and reviewed by managers to ensure that they support their staff to complete all training requirements for their roles in safety, quality, and the provision of best practice in service delivery. RNs have been supported to undertake the Rural and Isolated Practice Endorsed Registered Nurses (RIPERN) training and Advanced Life Support (ALS) competence development.

CDH has a procedure in place for Recording and Responding to Aboriginality and Torres Strait Islander Status. The CDH Aboriginal Health Plan 2017-2020 focuses on four key areas including the cultural awareness and cultural competency of the workforce to meet the needs of the Aboriginal and Torres Strait Islander patients. Cultural awareness training is provided for all staff but is limited to online training.

The credentialing of medical practitioners at CDH is through the Loddon-Mallee Sub-regional Credentialing Committee. Scope of practice is clearly determined on an individual clinician basis with role descriptions in place for GPs, GP proceduralists, VMOs and Anaesthetists. All colonoscopies are performed by VMO surgeons who are credentialled in accordance with the Colonoscopy Clinical Care Standard. Internal arrangements are well established to ensure that medical clinicians' practice remains within agreed parameters. CDH is in the process of developing terms of reference for a locally based Credentialing Committee to be established later in 2019.

Nursing and allied health staff undergo their credentialing processes through internal systems. There are also annual review processes in place to ensure contracted allied health practitioners are appropriately credentialled.

Staff position descriptions identify quality and safety responsibilities and accountabilities. Staff interviewed by the assessment team, across the acute services of the hospital, demonstrated their commitment to their work and their understanding of quality and risk management. All employed staff participate in Performance Reviews annually or more frequently as required and agreed.

CDH Clinicians are supported to review their own practice and the clinical performance of the organisation through a range of strategies including national indicator data sets such as NAPS, HHAI and ACHS Clinical Indicators, and Morbidity/Mortality review meetings which are supported by the Director of Medical Services (DMS). There are multidisciplinary death/case reviews conducted by the DMS and reported to the Medical Consultative Committee (MCC), and to the BOM Clinical Governance Subcommittee.

Suggestions for Improvement:

Review opportunities for face-to-face education and events to support the development of cultural competence to support staff in meeting Aboriginal Health need.

Consider including a consumer representative on the CDH Credentialing Committee when established.

Safe environment for the delivery of care

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

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

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

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

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

Met with Recommendations	
Not Met	
Not Applicable	

Assessment Team Summary:

CDH has a well organised and monitored schedule of maintenance and servicing for buildings, utilities and equipment including medical devices. The CDH Fire Risk Management Strategy action plan sighted by the assessment team demonstrates the commitment of the organisation with funding allocated and progress of works. CDH has undertaken significant works to improve safety and security including implementing card access to the birthing suite and other acute areas. Automatic doors are also to be installed to secure the Operating Theatre and CSSD suite before the end of the year.

Criteria are in place to recognise and respond to unpredictable behaviours with code black strategies in place. De-escalation training has been provided for staff and security measures are in place. Safety glass has been installed at reception counters and lock down procedures are in place. The layout of CDH provides for access to calm and quiet environments.

Flexible visiting arrangements are in place for maternity, palliative and other acute patients to meet their needs. There is provision for family and carers to sleep and spend the night if required.

Key Area 1 of the CDH Aboriginal Health Plan 2017-2020 includes the intent to provide a culturally safe and welcoming environment for Aboriginal people. Strategies sighted included the Aboriginal flag flying at the hospital entrance, Aboriginal artwork in the main hospital corridor, and resource/guides to assist Aboriginal peoples.

Standard 2 - Partnering with Consumers

Clinical governance and quality improvement systems to support partnering with consumers

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

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

Assessment Team Summary:

CDH has implemented a number of improvements to meet the requirements of the second edition of the Partnering with Consumers Standard. Considerable evidence was provided in respect to consumer engagement. The organisation clearly demonstrated a strong commitment to the principles of partnering with consumers. From interviews conducted during the assessment, both formal and in clinical areas visited, it was evident to the assessing team there is a clear focus on consumer engagement and partnership. There is also a strong focus on models of care that place the consumer at the centre and there are numerous instances where consumers participate in service planning. The assessing team was impressed with the improvements made in engaging with consumers and the wider community.

The Consumer Advisory Committee meets quarterly and has recently been rebranded. It is now known as the Partnering with Consumers Committee. Oversight of this committee remains with the Board of Management. A sample of the previous Consumer Advisory Committee meeting minutes sighted indicated the committee is well supported by the community and its members. The Partnering with Consumers Policy also demonstrates the Board's commitment to consumers.

The CDH 2016-2020 Strategic Plan was revised in February of this year, and clearly articulates the Board's commitment to a partnership with consumers. This commitment was demonstrated by the appointment of a 0.2FTE Consumer Engagement Officer. The Quality Improvement Plan 2019-2020 also incorporates a raft of quality activities focused on the consumer. The assessing team also noted there is now a consumer representative on the Clinical Managers Committee.

CDH has established process to ensure consumers are involved in the development and implementation of policies and procedures related to partnering with consumers. It was evident CDH has utilised risk management systems to identify and monitor risks in developing and implementing these policies and procedures as referenced in these documents.

Partnering with patients in their own care

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

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

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

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

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

Not Met	
Not Applicable	

Assessment Team Summary:

CDH has adopted the second edition of the Australian Charter of Healthcare Rights. The assessing team noted the Charter has been strategically placed within the organisation and in clinical areas visited. A healthcare rights brochure is also given to patients or their carers on admission and/or is available in a patient compendium at the bedside.

Patients are actively involved in their care and consent for treatment or procedure well explained and documented. Consent processes include both clinical treatment consent and informed financial consent. CDH has a number of 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. Interpreter services are available if the need arises.

There is evidence CDH training programs support the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care. A number of education and training programs have been implemented to develop the skills of the clinical workforce to partner with patients in their care.

Suggestions for Improvement:

Although informative, examples sighted of the brochure "Information for private patients - helping us to help you…" indicate it was last reviewed in March 2016. It is suggested this brochure be reviewed to ensure currency in collaboration with the Partnering with Consumers Committee.

Health literacy

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

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

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

Assessment Team Summary:

There has been a raft of projects and health promotion activities which has been driven by feedback from patients, community service groups and, in particular, from the members of the Partnering with Consumers Committee. Meeting minutes sighted during the assessment indicated consumer representatives are engaged and represent the voice of the community to ensure issues relating to health literacy and community expectations are addressed. This is also supported by the Health Literacy Policy.

In-house brochures and information leaflets are reviewed by the Committee. On reading some of the current brochures the assessing team noted the layout and information is clear, concise and well presented. A number of commercially produced brochures are also strategically placed in clinical areas.

Online education programs are available to staff to assist communication activities with high risk groups.

Assessors noted a display board in the hospital corridor continues to be utilised by relevant clinical teams to inform staff and consumers. Photographs of previous displays were provided by CDH to support health literacy. Safety and quality data observed is in a format that is easily understood.

Partnering with consumers in organisational design and governance

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

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

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

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

Assessment Team Summary:

The organisation is extremely transparent and open to the community to publish and share experiences and improvements. As discussed previously, the Partnering with Consumers Committee is actively involved in the governance of the organisation. Meeting minutes sighted attest to this involvement.

Consumer representatives interviewed indicated they have been given opportunities to participate in the planning and implementing of safety and quality improvements.

The assessing team was advised an initial in-house orientation was provided to Partnering with Consumers Committee members. The Health Issues Centre provided further training for committee members. A consumer evaluation rated the training provided as either good or excellent. Access to further opportunities for training is available to committee members.

During interviews the assessing team was advised that committee engagement with planning and implementing had been slow but through continued support and encouragement the committee is now proposing clinical improvements such as opportunities to enhance patient discharge. Post-discharge phone calls are another measure in place to ensure all patients including Aboriginal and Torres Strait Islander people receive personal follow-up regarding their care. Audits sighted indicated a 100% compliance however this was for surgical patients only. The assessing team was advised that members of the Partnering with Consumers Committee have expressed interest in performing post-discharge follow-up contact for non-surgical patients. This initiative is being pursued by the Consumer Engagement Officer.

It is evident CDH is working in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs. CDH staff interviewed indicated the Aboriginal Health Plan 2017-2020 was reviewed in 2019 (V4) to align with the requirements of the National Standards as described in the ACSQHC User Guide for Aboriginal and Torres Strait Islander health requirements. The plan clearly articulates a number of strategies to promote engagement. CDH is encouraged to continue to pursue this initiative.

The Mallee District Aboriginal Health Service (MDAS) located in the neighbouring town of Kerang is able to provide assistance through referral. CDH maintains a strong partnership with MDAS through the Gannawarra Local Agency Meeting (GLAM).

The assessing team noted regular media releases appear in the local newspaper to inform consumers and the wider community. Sample CDH media releases were sighted.

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

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

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

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

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

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

Assessment Team Summary:

The Infection Prevention (IP) system at CDH is well embedded with the IP Committee having multidisciplinary membership. The IP Committee reports to the Board of Management Clinical Governance Subcommittee through the Clinical Managers Meeting and the Medical Consultative Committee. Policies and procedures were observed that meet legislative and jurisdictional requirements and are available to staff electronically via the PROMPT system. Audits are conducted to monitor compliance with policies and procedures including hand hygiene, aseptic technique competence, standard precautions, and environmental cleaning services. CDH participates in the Victorian Nosocomial Infection Surveillance System (VICNISS) to identify and benchmark hospital acquired infections.

Infection prevention and control systems

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

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

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

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

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

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

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

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

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

Assessment Team Summary:

Infectious screening is conducted through the pre-admission processes for day procedures, on presentation in the Urgent Care Centre (UCC) and during admission to the Acute Ward. The infectious status is documented on the Alert sheet at the front of the patient record and on the handover sheet. Procedures are also in place for screening all patients who have been transferred from other facilities.

Procedures are available for implementing standard and transmission-based precautions and all staff including cleaners are provided with education appropriate to their role. Disposable antimicrobial curtains are in use throughout all acute clinical areas. The Acute Ward has a single room with ensuite facilities to provide effective isolation for patients, however patients requiring negative pressure isolation are transferred to another facility with appropriate services.

Hand hygiene compliance is regularly audited and results are monitored by the IP Committee and reported through the Key Performance Indicator (KPI) report to the Board of Management. CDH has demonstrated its significant commitment to the Hand Hygiene Initiative (HHI) as evidenced by the hand hygiene audit result of 86% which exceeds the 2018/2019 national benchmark of 80%.

Competency-based training and assessment is in place for invasive devices with appropriate supervision and annual reassessment. Aseptic technique training is conducted with observational assessment for relevant clinical procedures. Regular compliance audits are conducted, and results monitored by the IP Committee.

Cleaning audits are undertaken and monitored by the IP Committee. The CDH kitchen complies with local Council requirements and a food safety plan is in place. Water systems are tested for legionella quarterly and flushing schedules are in place.

There is a workforce immunisation program in place that complies with the jurisdictional policy and national guidelines. An influenza vaccination program is in place with three nurse immunisers available, and an uptake rate by staff of 94% which exceeds the 80% required by DHHS.

Reprocessing of reusable medical devices

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

Assessment Team Summary:

Elective surgical lists are only scheduled twice each month and no surgical procedures were being undertaken at CDH at the time of the assessment.

The Central Sterilising Department (CSSD) was not in operation during the assessment visit however systems and processes were reviewed by the assessor. The system for the reprocessing of Scopes was observed to comply with the GENCA standards. The CSSD staff member is appropriately trained. There is an effective tracking system in place for scopes and instruments back to the individual patient. All instrument cleaning and sterilisation equipment is regularly serviced, and appropriate monitoring is in place.

CDH has demonstrated satisfactory progress towards full implementation of their plan for AS/NZS 4187:2014 and meets the requirements set out in Advisory AS18/07 (version 2 August 2019). Progress is regularly monitored by the IP Committee and the BOM Clinical Governance Subcommittee.

Antimicrobial stewardship

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

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

Assessment Team Summary:

There is an Antimicrobial Stewardship (AMS) program in place, which is monitored through both the IP Committee and the Medical Consultative Committee (MCC). Minutes and AMS matters arising are communicated to the Clinical Managers meeting, and the reports from CDH's participation in the National Antimicrobial Prescribing Assessment (NAPS) are presented to the BOM Clinical Governance Subcommittee. Pre-surgical prophylactic antibiotic prescribing is monitored by the MCC.

The CDH Infection Prevention – Antimicrobial Prescribing Policy and Procedure uses a traffic light system for restrictions with guidelines for restricted antimicrobials. There is a procedure to support switching from intravenous antibiotics to oral administration. Monthly reports are provided to CDH by Pathology Clinical Labs and there is pharmacy support from Bendigo. There is access to Infectious Disease (ID) specialist expertise from Bendigo and the Austin in Melbourne.

There are resources to assist prescribers in antimicrobial stewardship and an audit schedule is in place which is reviewed by the IP and MC committees. CDH has been successful in achieving a sustained reduction in the prescribing of 'orange' antimicrobials.

Standard 4 - Medication Safety

Clinical governance and quality improvement to support medication management

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

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

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

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

Assessment Team Summary:

The clinical governance system for medication management is well established in CDH. Representation on the Medication Safety Committee (MSC) includes the pharmacist from Echuca Regional Health (ERH). The MSC reports to the CDH Clinical Managers meetings which includes a consumer representative. Policies and procedures are in place which reflect best practice and meet legislative and jurisdictional requirements. The roles and responsibilities of clinicians, regarding prescribing and administering medications, are clearly described, and understood through formularies, standing orders for ALS competent staff, and Rural and Isolated Practice Endorsed Registered Nurses (RIPERN). Nursing staff have undertaken annual mandatory medication competency assessment. Medication incidents are reported through the Victorian Health Information Management System (VIHMS) and are reviewed by the MSC. Medication incidents are also reported in the Key Performance Indicator (KPI) report to the Board of Management.

Documentation of patient information

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

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

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

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

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

Not Met	
Not Applicable	

Assessment Team Summary:

The Medication Management Plan (MMP) was observed to be in use at CDH. With the exception of visitors to Cohuna, most of the patients are local residents and are managed by their GP who continues their care in the hospital setting. With patients who present who are not locals, CDH follows the same process to reconcile the medications and to obtain the best possible medication history.

The patient's medication history and current medications are documented on the MMP on admission. Allergies and adverse reactions are documented on the MMP and on the adult and/or paediatric National Inpatient Medication Charts (NIMC) which are in use. Allergies and adverse reactions noted are also flagged. New medications prescribed and, changed and ceased medications with explanation are also listed in the MMP.

Positive improvement strategies for medication safety at CDS include the introduction of the electronic NIMC which has overcome challenges associated with medication prescribing legibility, and the introduction of the National Insulin Administration Chart.

Continuity of medication management

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

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

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

Assessment Team Summary:

Medication reviews are conducted regularly by the admitting GP and the Echuca Pharmacist who attends CDH every week. Review outcomes are documented on the MMP and/or in the patient progress notes and changes are communicated to the patient.

Medications are managed effectively on discharge and transfer. A list of current medications together with an explanation of changes is provided to the patient or carer on discharge and to receiving services on transfer. Copies of the MMP and the NIMC are faxed to services when patients are transferred to other health care providers.

Medication management processes

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

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

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

Assessment Team Summary:

Information and support tools were observed to be available at the point of care including MIMS Online, and Therapeutic Guidelines. Standing orders and Nurse Initiated medication procedures are in place as is the MCC endorsed formulary.

Storage and distribution of drugs are safely managed, and there was strong evidence around ameliorating risks such as cold chain management and out-of-date stock. Procedures for the disposal of expired medications are in place. Medication management is audited quarterly, and results translated into improvement projects evidenced on the ward.

Standard 5 - Comprehensive Care

Clinical governance and quality improvement to support comprehensive care

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

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

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

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

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

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

Assessment Team Summary:

Reporting to the Board of Management the Clinical Governance and Quality Committee has oversight of Clinical Committees for safety and quality systems to support clinicians in the delivery of comprehensive care and minimising patient harm. Governance structures are appropriate for this small healthcare facility. CDH has taken a coordinated approach to the delivery of the total healthcare required by patients. It is evident care is aligned with the patient's goals and needs. Patients and carers are encouraged to participate in care plan decisions and set achievable goals. This is supported by the results of Bedside Audit Reports. These reports contain a range of comprehensive care-related data and are reported to the Clinical Governance and Quality Committee.

A suite of policies and procedures related to comprehensive care are available to clinicians on the PROMPT system. These are evidence-based, current and reviewed as required. This includes screening and assessment processes, shared decision-making, agreed goals of care and comprehensive care plans and processes for identifying patients at the end of life and managing their care appropriately. CDH Urgent Care Centre (UCC) continues to use the Queensland Primary Care manual should exceptional cases arise.

It was evident CDH has taken a risk assessment approach to workforce competency and training needs. For example, training needs identified in the recent Maternity Service review. Competency training also includes end-of-life care, the prevention and management of falls and pressure injuries, mental health, nutrition and hydration, and cognitive impairment. CDH staff interviewed had a good understanding and appreciation for comprehensive care principles.

CDH has an established quality improvement audit system and schedule. Planned audits of documentation on screening and assessment processes, patient preferences and goals, and shared decision making demonstrated high compliance rates.

Developing the comprehensive care plan

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

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

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

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

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

Met with Recommendations	
Not Met	
Not Applicable	

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

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

Assessment Team Summary:

Systems used at CDH enable and support the delivery of comprehensive care to patients. Care plans used reflect the needs of patients and are appropriate for the size and service level provided by this organisation. Nursing admission assessment templates and care plans have all been reviewed in 2019 and reflect comprehensive care concepts. A more comprehensive risk assessment is undertaken if screening indicates a high risk (e.g. a physical dependency risk assessment, aggression risk assessment, skin assessment and management and prevention plan, or malnutrition action flowchart).

From staff and patient interviews conducted by the assessment team it was evident that care systems are both multidisciplinary and collaborative. CDH acknowledged the medical and allied health care plans remain separate within the integrated medical record. CDH continues to work toward integrated care and assessment plans. Having said that, the listed actions in Advisory AS:18/14 and AS:18/15 required by December 2019 have been met.

There is integral support between the hospital, community health workers and general practitioners. However, it was noted that community nurse records sighted indicated that comprehensive care planning appears to be fragmented, with plans not documented. Documented care appears to be limited to maintaining records of medications given or wound dressings performed. A comprehensive care plan does not appear to be utilised. There is an opportunity here for a quality improvement activity to establish comprehensive care plans for community patients. See assessor suggestions below.

To enhance communication between patients and clinicians, whiteboards are strategically placed in all patient rooms to identify the clinician with overall responsibility for the patient, and to list daily patient goals and needs.

Processes are used to routinely ask patients if they identify as being of Aboriginal or Torres Strait Islander origin and record this information in administrative and clinical information systems. The assessing team was advised the Aboriginal and Torres Strait Islander population in the last census was only 43 (i.e. 1%). It was noted that very few patients admitted to CDH have identified as being Aboriginal or Torres Strait Islander.

Orientation packages for new clinical staff include screening assessments used at CDH. Policy and procedures used by clinicians outline processes for conducting screening and identify when routine screening should occur; the roles and responsibilities of members of the clinical team; processes for taking action when risks are identified and indications for repeating screening process; medical reviews or reassessments and changes to care plans. Clinical record audits indicate a high rate of compliance.

During the assessment, a number of patient records were reviewed confirming the delivery of comprehensive care is based on partnering with patients, carers and families to identify, assess and manage patients' clinical risks, and determine their preferences for care; and on communication and teamwork between members of the healthcare team. Discharge planning begins with the episode of care and includes plans for follow-up services after discharge. Community services are actively engaged in this process. Care plans are developed collaboratively with patients/carers and agreed treatments and strategies put in place. The consumer signs the care plan as evidence of their involvement.

Suggestions for Improvement:

Undertake a gap analysis on care planning for community nurse patients and develop a comprehensive care plan based on the National Standards. It is further suggested the Partnering with Consumers Committee be included in this quality activity.

Delivering comprehensive care

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

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

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

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

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

Met with Recommendations	
Not Met	
Not Applicable	

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

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

Assessment Team Summary:

The processes used at CDH provide clinical staff with guidance on aspects of comprehensive care and outline structured communication processes that are used to ensure members of the workforce understand their delegated roles and responsibilities when working as a multidisciplinary team. These include roles and responsibilities of the multidisciplinary team in delivering comprehensive care and processes for identifying patients at the end-of-life and managing their care appropriately. Clinical records reviewed during the assessment demonstrated care plans are regularly reviewed and updated in consultation with patients and carers.

A system is in place for preparing or receiving advance care plans in partnership with patients, families and carers. Policies and procedures that are appropriately sourced and referenced are available via PROMPT. A palliative care pathway, which was last reviewed in January 2017, is also available. Assessors noted references in the continuous improvement plan register for further developments/improvements in clinical pathways for palliative care.

Advance care directives are sought on admission and patients are supported in preparing one if they so request. Advanced care resources are available to patients and carers. It is suggested consideration be given to promoting awareness of advance care planning. Having said that, interviews with clinicians stated feedback from patient's families and carers indicated satisfaction with end-of-life care was high.

Staff advice and support regarding palliative care is given by Echuca Regional Health (Community Palliative Care Service). Staff interviewed indicated this service is well utilised.

Suggestions for Improvement:

Although comprehensive, examples of the 'Clinical Palliative Care Pathway' sighted indicate it was last reviewed in July 2016. The assessing team was advised CDH is in the process of moving towards a 'Death and dying pathway'. It is suggested the Partnering with Consumers Committee be included in the development of this pathway.

Minimising patient harm

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Assessment Team Summary:

There are policies and procedures in place, including exclusion guidelines, to ensure that admissions are appropriate and that safe care can be provided within CDH capability and clinician scope of practice.

Patients are routinely screened for pressure injuries and the potential for developing pressure injuries. Prevention plans for patients at risk of a pressure injury are consistent with best practice guidelines. There is a comprehensive screening tool based on the Braden Scale. This patient risk assessment tool is effectively used to develop a patient management plan. Audits sighted indicate a high compliance rate. The assessing team noted data sighted indicated the majority of pressure injuries reported at CDH occurred prior to admission.

It is evident that comprehensive skin inspections are carried out on admission and subsequently at regular intervals. The assessing team visited clinical areas and discussed the use of equipment and sighted pressure reducing devices which are available throughout the hospital. Clinical staff interviewed indicated additional equipment is available for preventing and managing pressure injuries when needed.

The assessing team reviewed several patient clinical records which consistently showed a comprehensive skin inspection was undertaken and documented appropriately. Discharge records were also reviewed to confirm that the patient record clearly identified the risk to patients from skin injuries.

Falls management and the prevention of falls are guided by policy and assessment processes, all supported through staff education. The assessing team was advised the number of serious falls was low. Falls are reported through the VHIMS system and investigated appropriately. Incidences of falls are reported to the Clinical Governance and Quality Committee. CDH uses a ‘Post Fall Pack’ containing a laminated card describing the steps staff are to follow, a Neurological Observation Chart, a fact sheet and a sticker to complete and insert in the patient's medical record. A well-documented ‘Post Fall Assessment and Management Plan’ is also in used.

There is a strong understanding of the importance of screening for risk of falls then acting in response to these identified factors. Extensive systems and supports are in place to prevent falls. These include a wide range of equipment, as well as increased identification at caregiver communication. There is a demonstrated good compliance record of falls screening processes at CDH.

It was apparent patients have opportunities to discuss falls prevention with clinicians on admission and during care. Patients or carers are involved in the development of the patient care plan. Patients are provided with equipment and devices to promote safe mobility and reduce harm from falls. Additional equipment is available for preventing and managing falls when needed through ‘Country Care’.

The assessing team noted both pressure injuries and falls have been included in the organisation's risk register. This register is maintained in VHIMS and is regularly reviewed and overseen by the Clinical Managers Committee. All risks are reported to the Board of Management quarterly. Quality indicators are derived from a range of data (e.g. falls and pressure injuries) and reported to the Clinical Governance Committee quarterly and the Clinical Managers Meeting and staff monthly, in comprehensive key performance indicator (KPI) reports.

Patients' nutrition and hydration needs are identified and documented in their comprehensive care plan. A mini nutritional assessment is undertaken on admission. General practitioners are consulted when changes in a patient's condition are identified. The assessing team observed assistance being provided to patients to ensure that their nutrition needs are met.

Systems for caring for patients with cognitive impairment are used at CDH to minimise the risk of harm or at risk of developing delirium. Reports sighted by the assessing team indicate the use of antipsychotics and other psychoactive medicines is minimal and in line with best practice and legislation.

CDH has implemented processes for recognising, preventing, treating and managing patients with cognitive impairment. A 'Mental Health Risk Assessment Medical' tool is used together with a 'Mental Health Assessment Nursing' tool. Instructions on these documents indicate patients with a low score are to be admitted to CDH and include instructions to prompt nursing staff when to seek further medical assessment. Mental health referrals are made via the Bendigo Mental Health Triage system and can be accessed via VITCU, or in person, with a Mental Health practitioner. In addition, a cognitive impairment screening tool using the 4AT is now used.

A Behavioural Policy and a Management of Mental Health Presentations Policy / Procedure are also used effectively. Both policies are current and referenced. The recently reviewed Restraint Policy / Procedure sighted is well documented and referenced. Policy and procedure includes mechanical restraint; physical restraint; and chemical/pharmacological restraint.

The assessing team noted a not applicable rating has been approved for Action 5.36. Seclusion is not practiced at CDH.

Suggestions for Improvement:

Whilst the RiskManQ Bedside Audit reports made available to the assessing team are comprehensive and compliance rates of a high standard, it was noted reference to documentation reviews related to restraint, delirium or cognitive impairment is not included. It was also noted these audits appear to reflect the first edition of the National Standards and not the second edition. It is suggested audits be reviewed to include restraint, delirium or cognitive impairment.

Standard 6 - Communicating for Safety

Clinical governance and quality improvement to support effective communication

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

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

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

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

Assessment Team Summary:

The Clinical Handover Policy has been reviewed since the last assessment event to provide a structured clinical handover processes to facilitate data collection to ensure relevant information is handed over, at what times this information should be handed over and how it should be given.

There are established processes to guide clinicians in clinical handover at the bedside and transfer or discharge of patients to another facility or service provider. The ISBAR handover tool has also been reviewed and aligned to the revised Clinical Handover Policy. Clinical handover is audited through the RiskMan Clinical Handover and Bedside Audits. Observational handover audits are conducted and reported at the Communicating for Safety Meeting and Clinical Managers Committee. Results are provided to staff through ward meetings and are minuted.

Clinical handovers are supported with a printed handover template which is updated daily. The assessing team noted a telephone handover pad based on ISBAR is also available for staff use.

Staff training on clinical handover is in place. All types of clinical handover, including transfer of patients to and from CDH, are reviewed and improvements made to the system. A number of strategies have been used to enhance consumer involvement in training. The assessing team was advised patient stories are shared with clinical staff and included in the Board of Management meetings. The assessing team also noted clinical staff have also been provided with learning opportunities through case reviews and patient feedback.

The iPM is used in the Urgent Care Centre and Acute Ward to assist after-hours admission and mitigate the risk of patient identification errors. Reference checklists are available to staff when admitting after hours. Staff can now generate patient labels through the iPM, further reducing the risk of patient identification errors. The regional health service has provided iPM training for administration staff. Clinical staff have also been given appropriate training. The iPM is also used to document that there is an existing advance care plan/directive in place.

A brochure on ‘Clinical handover Information for patients and carers’ has been produced by CDH. This includes information on what clinical handover at the bedside is, and what happens during the clinical handover. Suggestions are also included on how patients or carers can be involved in the handover process.

The assessing team was advised there have been three handover incidents recorded in the past 12 months, with two related to call bell availability issues. As a result, the organisation has secured capital funds to implement a campus wide integrated call bell and phone system by the end of 2019.

Correct identification and procedure matching

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

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

Assessment Team Summary:

This criterion is well understood and operationalised throughout the hospital. Patient identification bands consistent with the NSQHS Standards are in use at CDH. Staff education and training is provided and the system is monitored. There are a number of clinical policies and procedures available to guide staff in the requirements of this criterion and its application in the clinical setting. Compliance is regularly audited, and all incidents associated with patient identification and procedure matching are reported through the Victorian Health Incident Management System (VHIMS) system and appropriately investigated as required. The assessment team was advised there had been no reported serious adverse events reported in this area.

It should be noted although clinical handover was observed there was no clinical handover or procedure matching observed in the operating theatre as there was no list scheduled as was the case in the previous assessment.

Suggestions for Improvement:

Consider conducting the next assessment event during a time when the operating theatre is functioning to facilitate an observational handover.

Communication at clinical handover

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

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

Assessment Team Summary:

One of the assessors observed a bedside clinical handover from the morning to the afternoon nursing staff. These handovers are conducted three times a day. Prior to the commencement of the clinical handover a pre-shift staff 'huddle' was conducted. This enabled staff to coordinate the oncoming shift and kept staff informed of ward changes etcetera. Staff observed during the handover utilised the previously referenced ward generated handover sheet. Clinical bedside handover observational audits sighted indicated a high rate of compliance.

Staff were observed to be using ISBAR principles and involved patients and carers directly during the handover process. To enhance communication between patients and clinicians' whiteboards are located in all patient rooms to identify the clinician with overall responsibility for the patient and list daily patient goals and needs. There was evidence of considerable patient engagement in the process.

The assessing team noted CDH has included 'inadequate handover' and 'patient identification or procedure matching mismatch' in the organisation's risk register. As discussed previously, this register is maintained in VHIMS and is regularly reviewed and overseen by the Clinical Managers Committee.

Communication of critical information

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

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

Assessment Team Summary:

Critical information and risks to patient's care have been defined. Processes have been implemented to identify the clinicians who are responsible for a patient's care and make decisions about care at any given time. CDH has policy documents that outline the types of critical information that are likely to be received and actions to be taken in response and the methods for communicating critical information to the responsible clinician and the multidisciplinary team. This includes methods for communicating critical information to the patient, carer and family. There are also standardised templates to support communication of critical information such as the ISBAR communication telephone pad previously referenced.

Regular or triggered 'huddles' are a mechanism for everyone to discuss potential risks and identify safety issues.

Documentation of information

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

Assessment Team Summary:

Medical records reviewed during the assessment were noted to be contemporary and in accordance with Australian Standards. Clinical records are well-maintained and comprehensive. Policies, procedures and guidelines are in place and accessible to all staff. Records reviewed were legible and can be understood. This included the use of approved abbreviations and rules for clinician and patient identification.

Standard 7 - Blood Management

Clinical governance and quality improvement to support blood management

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

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

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

Assessment Team Summary:

CDH has organisation wide systems in place supported by evidence-based policy and procedures that ensure safe and high-quality care of patient's own blood, and that blood product requirements are met. The GPs plan all blood transfusions which are conducted in office hours on weekdays only. Written Informed consent is obtained prior to transfusion by the GP, and patients are provided with the written information outlining the risks involved. Written consent compliance and provision of written information is monitored regularly through the patient record audit system.

Blood management at CDH is governed and monitored through the Blood Management Committee (BMC) with performance being reported in the monthly Key Performance Indicator (KPI) report to the Board of Management.

Prescribing and clinical use of blood and blood products

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

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

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

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

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

Not Met	
Not Applicable	

Assessment Team Summary:

All medical staff attending CDH have completed online eLearning for blood management as have all the Registered Nurses (RN) who also participate in iSTAT training annually. There is an RN rostered on duty at all times, with advanced life support (ALS) training to respond to clinical deterioration in the event of an adverse reaction.

Pre-transfusion screening is conducted by the GP and previous transfusion history is reviewed, a formal prescription is used which includes the reasons for the transfusion and the product required is recorded. Adverse reactions are reported to the provider and through the Victorian Health Information Management System (VIHMS).

Since the previous onsite assessment, there has been an increase in the use of Ferric Carboxymaltose for the treatment of Iron Deficiency Anaemia, as a strategy to optimise and conserve the patient's own blood. The Drug Protocol for this was developed in collaboration with the pharmacist and the Medical Safety Committee.

Managing the availability and safety of blood and blood products

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

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

Assessment Team Summary:

O Negative blood is kept onsite at CDH, should urgent blood transfusion be required. This stored blood is monitored by the provider and is exchanged regularly.

The CDH checklist used for receiving blood ensures that products have been in sealed temperature-controlled containers and are the correct product for the correct patient. There has been no wastage.

Standard 8 - Recognising and Responding to Acute Deterioration

Clinical governance and quality improvement to support recognition and response systems

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

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

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

Assessment Team Summary:

CDH has established systems for recognising and responding to deteriorating patients. There are relevant policies for clinical deterioration and patient observation in place. These have been regularly reviewed with policies available to staff via PROMPT. These are current and referenced. An Escalation of Care Policy is in place to guide staff in the recognition and management of the deteriorating patient.

Overall, governance for this Standard sits with the Board of Management. Structures to support this Standard are appropriate for this small healthcare facility to promote safety and quality systems and support clinicians. Oversight of policy development is with the organisation's Clinical Governance Committee. This includes evaluation and feedback of compliance with relevant policies and clinical guidelines for escalation of care processes, including transfer of patients.

In line with Maternity Services Review recommendations Practical Obstetric Multi-Professional Training (PROMPT) provides emergency obstetric scenarios introduced across clinical disciplines to ensure staff preparation for escalation for deteriorating obstetric patients and neonates. Staff interviewed stated this training had been particularly helpful and useful and reinforced clinical skills. The assessing team was advised a Maternal and Neonatal Emergencies (MANE) program is planned for later in 2019.

Case reviews are presented at the Clinical Governance Committee. Mortality and morbidity reviews are undertaken by the DMS to monitor appropriateness of treatment and the cause of death for every Acute Care Ward death. Adverse events are recorded in VHIMS system and analysed. Case and mortality reviews by the DMS are reported to the Board of Management.

Detecting and recognising acute deterioration, and escalating care

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

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

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

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

Not Met	
Not Applicable	

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

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

Assessment Team Summary:

At the last assessment event CDH was a participant in the pilot for the rural rollout of paediatric specific 'ViCTOR' (Victorian Children's Tool for Observation and Response) charts. These age-specific paediatric, neonatal and special=care nursery charts have now been fully implemented. These charts utilise 'Between the Flags' principles and have clear escalation guidelines and physiological parameters. These are consistent with the requirements of the ACSQHC National Consensus Statement. Rapid response criteria are clearly defined on the observation chart with a threshold for each physiological parameter indicating abnormality, which is defined by a coloured zone.

The adult observation and response and maternity observation and response charts are well embedded into practice. All of these charts include clinical review and rapid response criteria which are based on observation parameters (track and trigger) built into the charts. Audits of the observation charts are undertaken as part of the audit program. The assessing team noted that results from the audits indicated some deficiencies in the documentation of an escalation of care according to observations recorded. Recognition and response to clinical deterioration has been listed in the organisation's risk register. See assessor suggestions below.

The assessment team noted patient observation charts were checked during observed clinical handovers utilising ISBAR processes and that audits of completeness of chart documentation have been conducted and demonstrate a good standard of documentation.

As previously referenced in this report, comprehensive care plans are used to guide the monitoring of people who are at risk of acute deterioration in mental state. Systems used alert staff to signs of deterioration in a person's mental state, including for people who have not been previously identified as being at high risk. Clinicians also use the Resuscitation Plan (65 years and above, chronic illness or terminal illness) which includes details for "Limitation of treatment" and clearly defined "Decision-making framework for resuscitation plan".

The assessing team noted CDH has secured capital funds to implement a campus wide integrated call bell and phone system by the end of 2019 to further assist consumer/family/carer escalation of care.

Suggestions for Improvement:

Review the audit frequency of observational charts and identify strategies to improve compliance rates for the documentation of escalation of care.

Responding to acute deterioration

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

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

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

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

Assessment Team Summary:

BLS and ALS are mandatory CDH training requirements. The assessing team acknowledges mandatory training is an ongoing process, however the August 2019 mandatory training report indicated compliance as being BLS practical 59.3%; BLS online 79.7%; PROMPT (maternity emergency) 51.9%. An 'Action Plan - Advanced Life Support and Basic Life Support education' to address noncompliance issues has been approved by the CEO and is being implemented.

Medical staff interviewed indicated ALS was a component of their recredentialing process. The assessment team was advised ALS requirements were current and "up-to-date". CDH has established processes to ensure rapid access at all times to at least one clinician who can deliver advanced life support. Protocols for escalating care when a person's mental state is deteriorating are available to clinicians, which includes designation of roles and responsibilities and timeframes for response.

The assessing team was advised there are two RIPERN nurses on staff with another two currently undertaking RIPERN qualifications. It is a documented CDH rostering policy requirement to have an ALS competent staff member on every shift. An on-call roster is in place for a VMO, GP Anaesthetist, GP Obstetrician and additional nursing staff.

There are established pathways to transfer to patients Bendigo, Echuca or Melbourne by road or air as required.

An emergency trolley is kept in the Urgent Care Centre (UCC) and the operating theatre. These trolleys are also for use in all other areas in the hospital. The assessing team noted the drawers contain both adult and paediatric equipment. It would be better practice for paediatric and adult equipment to be clearly separated to ensure that the wrong equipment is not used in an emergency.

Suggestions for Improvement:

1. As referenced above, the August 2019 mandatory training report highlighted non-compliance issues. CDH is in the process of implementing the 'Action Plan - Advanced Life Support and Basic Life Support education'. However, it is suggested the process for the monitoring of mandatory training and reporting be reviewed.

2. Review emergency trolleys in the UCC and the operating theatre so that paediatric and adult equipment is clearly separated to ensure that the wrong equipment is not used in an emergency.

Recommendation from Current Assessment

Nil

Rating Summary

Cohuna District Hospital

Health Service Facility ID: 100055

Standard 1 - Clinical Governance

Governance, leadership and culture

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

Patient safety and quality systems

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

Clinical performance and effectiveness

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

Safe environment for the delivery of care

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

Standard 2 - Partnering with Consumers

Clinical governance and quality improvement systems to support partnering with consumers

Action	Assessment Team Rating
2.1	Met
2.2	Met

Partnering with patients in their own care

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

Health literacy

Action	Assessment Team Rating
2.8	Met
2.9	Met
2.10	Met

Partnering with consumers in organisational design and governance

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

Standard 3 - Preventing and Controlling Healthcare-Associated Infection

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

Action	Assessment Team Rating
3.1	Met
3.2	Met

Action	Assessment Team Rating
3.3	Met
3.4	Met

Infection prevention and control systems

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

Reprocessing of reusable medical devices

Action	Assessment Team Rating
3.14	Met

Antimicrobial stewardship

Action	Assessment Team Rating
3.15	Met
3.16	Met

Standard 4 - Medication Safety

Clinical governance and quality improvement to support medication management

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

Documentation of patient information

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

Continuity of medication management

Action	Assessment Team Rating
4.10	Met
4.11	Met
4.12	Met

Medication management processes

Action	Assessment Team Rating
4.13	Met
4.14	Met
4.15	Met

Standard 5 - Comprehensive Care

Clinical governance and quality improvement to support comprehensive care

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

Developing the comprehensive care plan

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

Delivering comprehensive care

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

Minimising patient harm

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

Standard 6 - Communicating for Safety

Clinical governance and quality improvement to support effective communication

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

Correct identification and procedure matching

Action	Assessment Team Rating
6.5	Met
6.6	Met

Communication at clinical handover

Action	Assessment Team Rating
6.7	Met
6.8	Met

Communication of critical information

Action	Assessment Team Rating
6.9	Met
6.10	Met

Documentation of information

Action	Assessment Team Rating
6.11	Met

Standard 7 - Blood Management

Clinical governance and quality improvement to support blood management

Action	Assessment Team Rating
7.1	Met
7.2	Met
7.3	Met

Prescribing and clinical use of blood and blood products

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

Managing the availability and safety of blood and blood products

Action	Assessment Team Rating
7.9	Met
7.10	Met

Standard 8 - Recognising and Responding to Acute Deterioration

Clinical governance and quality improvement to support recognition and response systems

Action	Assessment Team Rating
8.1	Met
8.2	Met
8.3	Met

Detecting and recognising acute deterioration, and escalating care

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

Responding to acute deterioration

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

Recommendations from Previous Assessment

Standard 1

Organisation: Cohuna District Hospital
Action 1.3: The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality

Recommendation NSQHSS Survey 1016.1.2.1:
Review and update the governance framework for clinical audits to ensure that there are clear procedures in place for undertaking clinical audit that will ensure the data collected is relevant to CDH and aligned with relevant NSQHS Standards criterion.

Organisation Action:

The Clinical Governance Framework was reviewed in June 19 to align with the National Clinical Governance Framework (2017). RiskmanQ auditing was reviewed and audit frequency documented on the Audit Schedule. Whilst the frequency of auditing against some Standards reduced, high risk areas including Medication Safety and Deterioration Standards remain more frequently. It is acknowledged that some Riskman Q audit content is irrelevant to CDH, having been inherited when the module was enabled to regional health services through the Loddon Mallee Rural Health Alliance. RiskmanQ Audit modules are currently awaiting update to NSQHS V2 audit.

A comprehensive KPI report is presented to the BOM Clinical Governance committee quarterly with a monthly KPI report provided to the Clinical Managers meeting. Staff are provided with information to ensure consistency in interpretation of questions.

Completion Due By: February 2017

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

CDH Clinical Governance Framework - Delivering Quality & Safe Services was reviewed, updated and endorsed by the Board of Management (BOM) in July 2019. RiskManQ auditing was reviewed and audit frequency documented on the Audit Schedule. The clinical audit program in use at the time of assessment was observed to be relevant to CDH and aligned with the NSQHS Standards. Comprehensive KPI reports are presented to the BOM Clinical Governance committee quarterly and monthly to the Clinical Managers meeting.

Organisation: Cohuna District Hospital
Action 1.7: The health service organisation uses a risk management approach to: a. Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols b. Monitor and take action to improve adherence to policies, procedures and protocols c. Review compliance with legislation, regulation and jurisdictional requirements

Recommendation NSQHSS Survey 1016.1.1.1:
The accountability and endorsement of policy be reviewed according to the organisation's governance structure. The policy document template that supports the policy document to be updated to reflect this.

Organisation Action:

The Management of Policy Documents clearly states the process for development and stipulates the approval process through the organisational committee structure.

Through subscription to PROMPT document management system, the organisation is satisfied that policy documents are regularly reviewed and in a timely manner by allocated responsible staff.

Completion Due By: July 31, 2017

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

CDH subscribes to the Victorian PROMPT document management system. This supports the organisation to ensure policy documents are regularly reviewed and responsibility is allocated to appropriate staff members. The policy for the Management of Policy Documents states the process for development and stipulates the approval process through the organisational committee structure. All policies observed during the assessment were in date and approval processes were clearly documented in minutes of the BOM Clinical Governance Committee.

Organisation: Cohuna District Hospital
Action 1.8: The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems

Recommendation NSQHSS Survey 1016.1.6.1:
Develop cross links with the organisational quality improvement plan and all committees and working parties quality activities.

Organisation Action:

The CDH Continuous Improvement Plan 2019-2020 aligns with the National Model Clinical Governance Framework 2017.

The Plan was endorsed through organisational meetings up to the Board subcommittee, Clinical Governance and by the Partnering with Consumers committee.

CIs are recorded as Quality Activities in RiskmanQ.

A working Spreadsheet detailing all continuous improvements across the organisation was ceased as it was a duplication of activities documented in RiskMan.

Clinical teams were revised to include all clinical departments - acute, aged care, theatre and district nursing, in a whole of organisation approach to quality.

Completion Due By: June 2017

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

The CDH Continuous Improvement Plan 2019-2020 sighted during the assessment was endorsed through organisational meetings including the BOM Clinical Governance subcommittee and the Partnering with Consumers committee. All quality improvement activities and plans are recorded in RiskManQ.

Organisation: Cohuna District Hospital

Action 1.8: The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems

Recommendation NSQHSS Survey 1016.1.6.2:

Develop cross links with the organisational quality improvement plan and all committees and working parties quality activities and improvements made to maximise patient quality care.

Organisation Action:

In addition to the organisational CDH Continuous Improvement Plan 2019-2020, clinical teams performed a Gap Analysis against NSQHS V2 Standards. Each clinical team is currently working through the action plans resulting from the analysis. The Plans were developed by each team to ensure the work of clinical teams proceeds effectively. Progress is reported to by clinical team leads to Clinical Managers committee monthly. Action Plan progress relevant to NSQHS V2 Standards 1 Clinical Governance and 2 Partnering with Consumers are tabled monthly at Board of Management and Executive Department Operations meetings to enhance progress and governance oversight. Minutes Executive Department Operations committee are available on the Intranet and included in documents available to the Board of Management. Quality Activities are generated in RiskmanQ for each improvement and reports are available.

Completion Due By: April 2017

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

The CDH Continuous Improvement Plan 2019-2020 was sighted by the assessing team. NSQHS Standard specific clinical teams have performed gap analyses and are progressing action plans resulting from the analyses. The clinical team leads report on progress monthly to the Clinical Managers committee. The progress relevant to NSQHS Standard 1 Clinical Governance and 2 Partnering with Consumers is reported monthly at BOM and Executive Department Operations meetings. Quality Activities are generated in RiskManQ for each improvement and reports are available.

Organisation: Cohuna District Hospital

Action 1.8: The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems

Recommendation NSQHSS Survey 1016.2.8.1:
(1) Implement ongoing strategies to ensure consumers and/or carers participate in the analysis of organisational safety and quality performance.

Organisation Action:

Partnering with Consumers Committee members are provided with internal patient survey, external Victorian Health Experience Survey (VHES) results and Feedback data. The committee, which meets quarterly, has been presented with the Disability, Clinical Governance and Quality Improvement Plans and have reviewed the Aged Care Satisfaction Survey.

Training for the committee was provided onsite by Health Issues Centre in November 2016. Evaluation of the education was undertaken and results reported back to members.

80% reported the education as excellent or good, however one consumer was still unsure of her role as a consumer representative.

Management has worked with the group to provide guidance and advice to the group, reinforcing their importance in communicating and consulting with the wider community.

A further initiative to meet this recommendation has been consumer membership to the Clinical Managers Committee. This committee receives a comprehensive monthly clinical Key Performance Indicator (KPI) report facilitating consumer questions about results and input into improvements and decisions of the committee. Reports from clinical teams responsible for NSQHS and Aged Care Standards work are presented up to this committee including results from scheduled clinical auditing.

A consumer has recently participated in Root Cause Analysis (RCA) training.

Our Board of Management are service consumers with 5 of the 9 residing in Cohuna and the hospital catchment area.

Completion Due By: 31/12/2018

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

An initial in-house orientation was provided to Partnering with Consumers Committee members. The Health Issues Centre provided further training. A consumer has recently participated in Root Cause Analysis (RCA) training.

Partnering with Consumers Committee members interviewed indicated quality performance data such as internal patient surveys and Victorian Health Experience Survey (VHES) results have been made available to them. The committee also receives a clinical key performance indicator report to promote discussion and input into improvements and decisions. CDH has worked with the committee providing guidance. To support committee members, a Community Engagement Officer has been employed.

Organisation: Cohuna District Hospital

Action 1.8: The health service organisation uses organisation-wide quality improvement systems that: a. Identify safety and quality measures, and monitor and report performance and outcomes b. Identify areas for improvement in safety and quality c. Implement and monitor safety and quality improvement strategies d. Involve consumers and the workforce in the review of safety and quality performance and systems

Recommendation NSQHSS Survey 1016.2.8.2:
Implement ongoing strategies to ensure consumers and/or carers participate in the planning and implementing of organisational safety and quality improvements.

Organisation Action:

Consumer participation in planning/implementation of quality activities, arises from Continuous Improvements (CIs) identified through patient feedback, case study action plans where opportunities for improvement are identified.

The Partnering with Consumers committee are encouraged to assist CI planning/implementation from consideration of safety and quality data presented to them. Although progress has been slow, the committee is now proposing CIs. For example, from the patient surveys presented at the June 19 meeting, members have identified opportunities to enhance patient discharge. Members have now expressed an interest in participating in post-discharge telephone follow up.

Currently a range of survey and consumer feedback data is presented. The consumer sitting on the Clinical Managers committee receives meeting papers that include a monthly KPI report and clinical audit results. Documentation is forwarded by email, allowing time to read reviewed policies and revise the data to form questions and provide input into CIs.

Committee members were asked to complete a survey on Survey Monkey that included establishing their interest in participating on internal committees and data analysis.

Results were presented to members at the August 2018 meeting

Completion Due By: 31/12/2018

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

CDH has processes for involving consumers in the planning and implementation of quality improvement activities. It was evident to the assessing team CDH has given significant support to the Partnering with Consumers Committee to assist in the planning and implementation of quality and safety systems. To this end, a Community Engagement Officer has been employed. During interviews, the assessing team was advised committee engagement with planning and implementing has been slow but through continued support and encouragement the committee is now proposing clinical improvements such as opportunities to enhance patient discharge.

Organisation: Cohuna District Hospital
Action 1.9: The health service organisation ensures that timely reports on safety and quality systems and performance are provided to: a. The governing body b. The workforce c. Consumers and the local community d. Other relevant health service organisations

Recommendation NSQHSS Survey 1016.1.2.1:
Review and update the governance framework for clinical audits to ensure that there are clear procedures in place for undertaking clinical audit that will ensure the data collected is relevant to CDH and aligned with relevant NSQHS Standards criterion.

Organisation Action:

An Audit Schedule is in place. RiskmanQ auditing was reviewed and in some instances the audit frequency reduced to six-monthly. Medication, Blood and Deterioration remain more frequent as areas of higher risk. Audit results are presented to the Clinical Managers meeting monthly along with a comprehensive Key Performance Indicator report. Clinical leads assigned responsibility for work against each NSQHS / Aged Care Standard attend and report to the meeting. Audit results are fed back to the leads who are expected to develop initiatives to improve performance where results indicate. Staff are provided with information to ensure consistency in interpretation of questions.

Another comprehensive KPI report is presented to the BOM Clinical Governance committee quarterly.

Completion Due By: February 2017

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

CDH Clinical Governance Framework - Delivering Quality & Safe Services was reviewed, updated and endorsed by the Board of Management (BOM) in July 2019. RiskManQ auditing was reviewed and audit frequency documented on the Audit Schedule.

The clinical audit program in use at the time of assessment was observed to be relevant to CDH and aligned with the NSQHS Standards. Comprehensive KPI reports are presented to the BOM Clinical Governance committee quarterly and monthly to the Clinical Managers meeting.

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

Recommendation NSQHSS Survey 1016.2.9.1:
Implement ongoing strategies to ensure consumers participate in the evaluation of patient feedback data.

Organisation Action:

A Community Engagement Officer has been employed 0.2 EFT and has assumed responsibility for oversight of the Partnering with Consumers Committee, a sub-committee of the Board of Management. The name of the committee was changed from Community Advisory Committee to Partnering with Consumers committee to better reflect the intent of NSQHS Standard 2, and Terms of Reference attached. Patient survey and consumer feedback data is presented to the Committee for review, comment, CI input.

Information includes the CDH internal Inpatient and Maternity patient surveys and the Victorian Health Experience Survey (VHES) results.

Strategies are being developed with both the committee and the nursing staff to address any results which are below target.

Although committee members have historically shown reluctance to engage in suggesting and/or developing improvement opportunities, suggestions on how we might improve and expressions of interest in conducting or participating improvement initiatives are now emerging.

Completion Due By: 31/12/2018

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

CDH has implemented processes for involving consumers in the evaluation of patient feedback data. Patient survey and consumer feedback data is presented to the Partnering with Consumers Committee for review and comment. Data provided includes in-house inpatient and maternity patient surveys and data from the VHES when available. Committee meeting minutes supporting this were sighted.

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

Recommendation NSQHSS Survey 1016.2.9.2:
Implement ongoing strategies to ensure consumers participate in the implementation of quality activities relating to patient feedback data.

Organisation Action:

As with 1016.2.9.2 the engagement of a Community Engagement Officer has assisted members of the Partnering with Consumers Committee to consider presented data more thoroughly. Members are now considering possible Continuous improvements from the consumer feedback offered to them.

Consumer feedback data includes Inpatient survey, Maternity patient questionnaire and external VHES survey results.

Indeed, at the June 19 meeting members expressed interest in participating/conducting post discharge telephone calls to identify areas related to patient experience where improvements could be made.

Strategies for improvements are discussed with both the Committee and clinical staff to investigate any areas of improvement.

Members were asked in a Survey Monkey survey to indicate interest in sitting on internal organisational committees. As a result, a consumer is now an active member of the Clinical Managers Committee.

Completion Due By: 31/12/2018

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

As referenced previously, patient survey and consumer feedback data is presented to the Partnering with Consumers Committee for review and comment. Data provided includes in-house inpatient and maternity patient surveys and data from the VHES when available. Committee meeting minutes supporting this were sighted. The assessing team also noted areas for improvement have been identified in the minutes such as patient information on prescribed medications and advanced care planning. Recently, committee members expressed interest in participating in post-discharge telephone calls to identify areas related to patient experience where improvements could be made.

Organisation: Cohuna District Hospital

Action 1.16: The health service organisation has healthcare record systems that: a. Make the healthcare record available to clinicians at the point of care b. Support the workforce to maintain accurate and complete healthcare records c. Comply with security and privacy regulations d. Support systematic audit of clinical information e. Integrate multiple information systems, where they are used

Recommendation NSQHSS Survey 1016.1.9.2:
Review and strengthen policies and procedures related to the design of clinical records and forms to ensure documents and forms are contemporary and formally approved including version control.

Organisation Action:

Review occurs as part of scheduled process in PROMPT document management system to which CDH has contracted until June 2020. Reports from PROMPT enable policy/document history. This method is used to track review/alteration history.

As policies are reviewed, an *Author Box,* attached at the end of the document, is updated. The box displays policy history - date implemented, dates reviewed, next review date, document author (by designation) and relevant NSQHS 2, and/or Aged Care standards.

Filing in the medical record is uniform with the administration Compilation of Medical Record procedure revised to ensure systematic audit of medical record is facilitated.

Once updated policies/procedures and protocols are approved through the organisation's meeting structure, ensuring staff awareness of any amendments to the document. Documents are endorsed at clinical and operational meetings prior to uploading on PROMPT.

New and updated policies/procedures/protocols are listed in the staff newsletter which is emailed to all staff, to raise awareness.

Clinical Record forms have been revised to ensure version control and uniformity.

Completion Due By: October 2017

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

CDH subscribes to the PROMPT document management system which enables policy/document history tracking. This method is used to track the history of document and forms review. Documents are endorsed at clinical and operational meetings prior to being uploaded to the PROMPT system. All clinical records and forms sighted during assessment were contemporary and version control was in place.

Organisation: Cohuna District Hospital

Action 1.25: The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff

Recommendation NSQHSS Survey 1016.1.3.3:
Develop and implement policies and procedures for employing agency and locum staff so these are in place should locum or agency staff be required.

Organisation Action:

A Policy *Locum and Agency Staff* was developed and approved through the committee structure.

A checklist to ensure any locum or agency staff are aware of and able to fulfil their safety & quality responsibilities is an appendix to the policy.

The DCS engages recruitment companies in longer term locum placements under contract through the rural LAP program.

Completion Due By: July 2017

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

Policies and procedures are in place and are used for the employment of Locum and Agency Staff.

Organisation: Cohuna District Hospital
Action 1.25: The health service organisation has processes to: a. Support the workforce to understand and perform their roles and responsibilities for safety and quality b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff

Recommendation NSQHSS Survey 1016.1.4.3:
Develop and implement policies and procedures for employing agency and locum staff so these are in place should locum or agency staff be required.

Organisation Action:

A Policy *Locum and Agency Staff* has been developed and approved through the committee structure. A checklist to ensure any locum or agency staff are aware of and able to fulfil their safety & quality responsibilities is an appendix to the policy.

A short orientation package has been developed for use when agency or locum staff are engaged.

Completion Due By: July 2017

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

Policies and procedures are in place and are used for the employment of Locum and Agency Staff. A checklist for locum or agency staff regarding their responsibilities is appendixed to the policy. An orientation package has been developed for use when agency or locum staff are employed.

Organisation: Cohuna District Hospital
Action 1.27: The health service organisation has processes that: a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care

Recommendation NSQHSS Survey 1016.1.7.1:
(1) Review policies that support the development, adoption and implementation of clinical guidelines and pathways.
(2) Evaluate the extent to which documented clinical guidelines or pathways have been formally adopted by the clinical workforce and whether additional opportunities exist to adopt clinical guidelines or pathways as a quality improvement initiative.

Organisation Action:

Policy review occurs as part of scheduled process in PROMPT document management system over a three-year period.

Reports from PROMPT enable policy/document history.

This method is used to track review/alteration history.

As policies/procedures/guidelines and pathways are reviewed, responsible staff are required to reference according to relevant best practice.

The system in place is an ongoing review process.

Frameworks including Clinical Governance, Quality Improvement, Risk Management and Partnering with Consumer are Board of Management endorsed documents.

Evaluation of workforce compliance to policy/procedure is monitored through the VHIMS incident reporting system and non-compliance to policy data is recorded monthly.

The Board of Management quarterly Key Performance Indicator report details and trends VHIMS incidents.

Completion Due By: October 2017

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

Relevant policies have been reviewed as part of the scheduled process in the PROMPT document management system since the last organisation wide assessment. A range of evidence based contemporary clinical guidelines and pathways were sighted during this assessment. Clinical practice compliance to clinical guidelines and pathways is monitored in several ways including the VHIMS incident reporting system and multidisciplinary case reviews led by the DMS. Trended incident data is reported quarterly to the Board of Management through the Key Performance Indicator reports.

Standard 2

Organisation: Cohuna District Hospital
Action 2.10: The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that: a. Information is provided in a way that meets the needs of patients, carers, families and consumers b. Information provided is easy to understand and use c. The clinical needs of patients are addressed while they are in the health service organisation d. Information needs for ongoing care are provided on discharge

Recommendation NSQHSS Survey 1016.2.7.1:
Review safety and quality data displayed in the acute ward to ensure it is meaningful and relevant to consumers.

Organisation Action:

Partnering with Consumers Committee members are provided with results from various surveys. These are presented in formats they understand.

The display board in the Hospital corridor continues to be utilised by relevant clinical teams to inform staff, community and consumers safety & quality data and information in formats that are able to be understood. Every effort is made to ensure information in the annual Quality Account meets health literacy requirements for presentation of information that is understood by consumers.

Completion Due By: November 17

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

Consumers interviewed indicated data that is provided is relevant and meaningful. A display board in the hospital corridor continues to be utilised by relevant clinical teams to inform staff and consumers. Photographs of previous displays were provided by CDH to support this. Safety and quality data observed is in a format that is easily understood. The Partnering with Consumers Committee is provided with results from a number of quality activities that are presented in formats they understand.

Organisation: Cohuna District Hospital

Action 2.11: The health service organisation: a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community

Recommendation NSQHSS Survey 1016.2.2.2:
Undertake an evaluation of the Community Advisory Committee to ensure consumers are actively involved in decision making about safety and quality as stated within its Terms of Reference.

Organisation Action:

At the time of last survey, a newly formed Partnering with Consumers Committee had only met once.

Members opted for quarterly meetings and the committee has continued to meet four times annually with documented Agendas and Minutes. Minutes from the meeting are available on CDH Intranet for information of staff. A training opportunity for consumers on the committee was provided by the Health Issues Centre to inform members of their role.

The committee has now been meeting regularly for 3 years. A survey was conducted, and consumer response results presented back to members at the August 2018 meeting.

Completion Due By: 30/11/2018

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

The Community Advisory Committee was re-established in 2016 and is now known as the Partnering with Consumers Committee. This committee is well established and has been meeting quarterly for the last three years. The assessing team noted a survey of consumers was conducted and response results presented back to members. Consumers are actively involved in decision-making about safety and quality as evidenced in committee meeting minutes.

Organisation: Cohuna District Hospital
Action 2.11: The health service organisation: a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community

Recommendation NSQHSS Survey 1016.2.8.2:
Implement ongoing strategies to ensure consumers and/or carers participate in the planning and implementing of organisational safety and quality improvements.

Organisation Action:

The Partnering with Consumers (formerly Consumer Advisory) Committee was reformed in October 2016 and have met regularly for the past 3 years. Despite presentation of data from internal consumer surveys the external Victorian Health Experience Survey (VHES) members of the committee were reluctant to propose CI planning/implementation from the safety and quality data presented to them. This is now changing with members expressing interest in becoming involved in discharge follow up. A dedicated Consumer Engagement Officer position has also assisted progress. Further, the consumer sitting on the Clinical Managers committee is an active participant who asks questions and offers suggestions for improvements from presented data including audit results and KPIs. An example of an improvement: A workshop held in Bendigo in April 19 by Safer Care Victoria (SCV) invited health service members to participate in a scenario testing workshop to assist SCV to provide guidance to health services to achieve consumer representation on review teams following serious and sentinel events. Accompanied by 2 health service staff, our consumer attended, participated and enjoyed the opportunity to input into the workshop and network with consumers from other facilities.

Completion Due By: 31/12/2018

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

As referenced previously, the Partnering with Consumers Committee is now well established. The assessing team was advised members of the committee were initially reluctant to be involved in quality activities. However, committee members have more recently expressed interest in becoming involved in discharge follow up. A Consumer Engagement Officer position has been established which will promote consumer engagement. Consumer representatives interviewed indicated they have been given opportunities to participate in the planning and implementing of safety and quality improvements.

Organisation: Cohuna District Hospital
Action 2.12: The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation

Recommendation NSQHSS Survey 1016.2.3.1:
Evaluate the effectiveness of training provided to members of the Community Advisory Committee to ensure it meets the requirements of the organisation and committee members are prepared for their role.

Organisation Action:

The Partnering with Consumers committee are provided opportunities for training:

An initial orientation (internal) was provided to members in Oct 2016.

Health Issues Centre (HIC) attended in Nov 16 to provide training to consumers to assist knowledge of their roles as consumers of the health service (external).

Members completed a post training Survey Monkey in Dec 16 to evaluate the value of the HIC training.

Results indicated 2 of 10 (20%) respondents rated the education as poor, 80% rated as good or excellent.
Results of the survey were fed back to CAC.

We were able to identify that despite the education; some community members remain unsure of their role.
We have continued to address knowledge gaps through meetings of the committee. At the August 2018 meeting members were provided a PowerPoint presentation on the NSQHS V2 Standards with particular focus on Standard 2 Partnering with consumers and the role the committee, as consumers, have in the partnering process.

Other opportunities for education and information are advised to members as they are available.

Completion Due By: February 2017

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

The assessing team was advised an initial in-house orientation was provided to Partnering with Consumers Committee members. The Health Issues Centre provided further training for committee members. A consumer evaluation rated the training provided as either good or excellent. Access to further opportunities for training are available to committee members.

Organisation: Cohuna District Hospital
Action 2.12: The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation

Recommendation NSQHSS Survey 1016.2.8.1:
(2) Evaluate the effectiveness of training provided to Community Advisory Committee members to ensure they can participate in the analysis of organisational safety and quality performance.

Organisation Action:

Consumer committee members are provided with results from various surveys.

Training for the Group was provided onsite by Health Issues Centre. Evaluation of the education was undertaken and results reported back to members.

80% reported the education as excellent or good, however one consumer was still unsure of her role as a consumer representative. As in recommendation 2.3.1 the committee were provided education on NSQHS V2 in August 2018 to assist members in their role as consumers.

Management has worked with the group to provide guidance and advice to the group, reinforcing their importance in communicating and consulting with the wider community.

Completion Due By: 31/12/2018

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

As indicated previously, a consumer evaluation rated the training provided as either good or excellent. Access to further opportunities for training is available to committee members.

Organisation: Cohuna District Hospital
Action 2.14: The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce

Recommendation NSQHSS Survey 1016.2.6.2:
Develop and implement strategies to strengthen consumer involvement in training the clinical workforce.

Organisation Action:

Staff training results from various sources including patient feedback - compliments and complaints, survey and audit responses, and case reviews.

Learning for clinical staff has been enabled through a number of internal case reviews that have identified training opportunities.

For example, one case study identified that escalation of care timeliness was not optimal. Subsequently, Triage education was provided, and a PowerPoint presentation *Track and Trigger* developed and uploaded to the intranet.

Staff also has access to the Cleveland Empathy presentation which is available to staff via the CDH intranet.

Patient stories are included in the annual Quality Account. A patient story is included in the Board of Management meeting.

Completion Due By: August 2017

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

A number of strategies have been used to enhance consumer involvement in training. The assessing team was advised patient stories are shared with clinical staff and included in the Board of Management meetings. The assessing team also noted clinical staff have also been provided with learning opportunities through case reviews and patient feedback.

Standard 3

Organisation: Cohuna District Hospital
Action 3.2: The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of systems for prevention and control of healthcare-associated infections, and the effectiveness of the antimicrobial stewardship program b. Implementing strategies to improve outcomes and associated processes of systems for prevention and control of healthcare-associated infections, and antimicrobial stewardship c. Reporting on the outcomes of prevention and control of healthcare-associated infections, and the antimicrobial stewardship program

Recommendation NSQHSS Survey 1016.3.1.3:
Membership of the Infection Prevention and Control Committee be reviewed and updated to include input from local Visiting Medical Officer(s), Pathology and Regional Clinical Nurse Consultant / Specialist Infection Control and reporting by the Antimicrobial Stewardship Working Group be identified within the reporting lines of the Committee.

Organisation Action:

Infection Prevention Terms of Reference were reviewed in June 2017. The committee meets bi-monthly, minutes are on the Intranet for staff information and available up to the Clinical Managers meeting. Since retirement of the regional IP consultant who previously attended meetings, representation from the region has not continued, however they remain a source for advice as required.

The Director of Medical Services is now provided meeting papers including agendas and minutes thus providing opportunity for input/comment when unable to attend.

Reporting lines for AMS are stipulated in the revised Terms of Reference.

Completion Due By: 31/05/2017

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

The Terms of Reference for the Infection Prevention (IP) Committee were reviewed and the revised TOR have been endorsed. The membership now includes the DMS and the Regional IP Consultant. Antimicrobial Stewardship matters are discussed by the IP committee and the DMS refers information to the Medical Consultative Committee. The IP Committee minutes and relevant reports are provided to the Clinical Managers Committee and a monthly IP report is provided to the Executive Department Operations.

Organisation: Cohuna District Hospital
Action 3.2: The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of systems for prevention and control of healthcare-associated infections, and the effectiveness of the antimicrobial stewardship program b. Implementing strategies to improve outcomes and associated processes of systems for prevention and control of healthcare-associated infections, and antimicrobial stewardship c. Reporting on the outcomes of prevention and control of healthcare-associated infections, and the antimicrobial stewardship program

Recommendation NSQHSS Survey 1016.3.14.4:
Implement and strengthen processes to ensure action is taken to improve the effectiveness of AMS, this includes the submission of data to the NAPS study.

Organisation Action:

Submission to NAPS commenced November 2016.

Antibiotic usage is submitted to NAPS each month.

Reporting identifies our compliance compared to national benchmarking data.

Data is reported to Medical Consultative and Medication Safety committees, at acute and theatre clinical ward meetings.

Completion Due By: November 2016

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

CDH Antimicrobial Stewardship (AMS) program is monitored by the Infection Prevention Committee and the Medication Safety Committee. CDH participates in the National Antimicrobial Prescribing Assessment (NAPS) and the data is reported to the Medical Consultative Committee (MCC) and the Board of Management Clinical Governance Subcommittee. AMS is discussed at acute and theatre clinical ward meetings and pre-surgical prophylactic antibiotic prescribing is monitored by the MCC.

Organisation: Cohuna District Hospital

Action 3.16: The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy • antimicrobial use and resistance • appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing

Recommendation NSQHSS Survey 1016.3.14.3:
The Antimicrobial Prescribing Policy and Procedure to be updated to include the monitoring and evaluation of clinicians prescribing practices, antimicrobial usage and resistance.

Organisation Action:

AMS Policy amended.

Policy identifies: Effectiveness of AMS is evidenced through:
- NAPS data submission
- Antibiograms
- Switch to Oral

Regular NAPS data entry - reported to Medical Consultative and Medication Safety committees, at acute and theatre clinical ward meetings.

Work on Sepsis has been undertaken with adoption of a Sepsis policy and a flowchart for management of Sepsis implemented.

Completion Due By: 30/06/2017

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

The AMS Prescribing Policy has been updated to include expected prescribing practices including the switch to oral antibiotics, and the monitoring the effectiveness of the AMS program through processes including participation in NAPS data and the review of antibiograms. Pre-surgical prophylactic antibiotic prescribing is monitored by the Medical Consultative Committee (MCC).

Organisation: Cohuna District Hospital

Action 3.16: The antimicrobial stewardship program will: a. Review antimicrobial prescribing and use b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use d. Report to clinicians and the governing body regarding • compliance with the antimicrobial stewardship policy • antimicrobial use and resistance • appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing

Recommendation NSQHSS Survey 1016.3.14.4:
Implement and strengthen processes to ensure action is taken to improve the effectiveness of AMS, this includes the submission of data to the NAPS study.

Organisation Action:

Submission to NAPS commenced November 2016.

Antibiotic usage is submitted to NAPS each month.

Reporting identifies our compliance compared to national benchmarking data.

Data is reported to Medical Consultative and Medication Safety committees, at acute and theatre clinical ward meetings.

Completion Due By: November 2016

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

CDH Antimicrobial Stewardship (AMS) program is monitored by the Infection Prevention Committee and the Medication Safety Committee. CDH participates in the National Antimicrobial Prescribing Assessment (NAPS) and the data is reported to the Medical Consultative Committee (MCC) and the Board of Management Clinical Governance Sub Committee. AMS is discussed at acute and theatre clinical ward meetings and pre-surgical prophylactic antibiotic prescribing is monitored by the MCC.

Standard 6

Organisation: Cohuna District Hospital

Action 6.1: Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication

Recommendation NSQHSS Survey 10_16.5.1.1:
Progress implementation of the rollout of iPM through a structured project management strategy to ensure that implementation is achieved according to timetabled deliverables.

Organisation Action:

The Patient Identification and Procedure Matching Policy has been revised. The requirement for at least 3 approved identifiers is clearly stated within.

Incidents relating to identification/procedure mismatching are reported through Victorian Health Incident Management System (VHIMS).

Actions to resolve issues are allocated to managers. Incidents are presented/discussed through *Communicating for Safety* clinical team meetings and outcomes provided to the Clinical Managers committee. VHIMS are reported in a monthly KPI report to Clinical Managers and to the Board of Management via the quarterly KPI report.

iPM has been introduced to UCC and acute ward to facilitate after hours admission into iPM to minimise risk of Patient Identification errors. Additional reference checklists available for staff reference when admitting after hours.

Staff can now admit patients into iPM and generate patient labels thus reducing the risk of patient identificatin errors. Additional reference checklists available for staff reference when admitting after hours.

Administration staff attended a larger regional health service to receive training in the use of iPM and clinical staff then received training.

Completion Due By: 30/11/2017

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

The iPM has now been introduced to the Urgent Care Centre and Acute Ward to assist after hours admission and mitigate the risk of patient identification errors. Reference checklists are available to staff when admitting after hours. Staff can generate patient labels through the iPM further reducing the risk of patient identification errors. The regional health service has provided iPM training for administration staff. Clinical staff have also been given appropriate training.

Organisation: Cohuna District Hospital
Action 6.1: Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication

Recommendation NSQHSS Survey 1016.5.5.1:
The Correct Patient, Correct Side, Correct Site, Correct Procedure Policy be reviewed and updated according to guidelines to ensure correct patient, correct site, correct procedure in radiology.

Organisation Action:

The Correct Patient, Correct Side, Correct Site, Correct Procedure Policy was reviewed July 2017 to include all clinical departments- Acute, Theatre, Maternity, Haemodialysis, Radiology, Aged Care and UCC and approved through organisational meeting structure Aug & Sep 2017

Completion Due By: 30/09/2017

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

Since the last assessment event, the Correct Patient, Correct Side, Correct Site, Correct Policy has been reviewed. References include all clinical departments (i.e. Acute Ward, Operating Theatre, Maternity, Haemodialysis, Radiology, Aged Care and the Urgent Care Centre).

Organisation: Cohuna District Hospital
Action 6.1: Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication

Recommendation NSQHSS Survey 1016.6.1.1:
The Clinical Handover Policy to be reviewed and updated to include and be clear of the requirements for when handover is to occur, the minimum clinical information (data) required to be handed over and how it is to be delivered (the tools). This will then enable the organisation to be clear in regards to its auditing requirements.

Organisation Action:

The Clinical Handover Policy was revised to articulate a structured handover process, specify minimum data set and tools.

Endorsement through committee structure Sep 2017.

Completion Due By: 15/07/2017

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

The Clinical Handover Policy has been reviewed to provide a structured clinical handover process to facilitate data collection to ensure relevant information is handed over, at what times this information should be handed over and how it should be given.

Organisation: Cohuna District Hospital

Action 6.1: Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures to support effective clinical communication b. Managing risks associated with clinical communication c. Identifying training requirements for effective and coordinated clinical communication

Recommendation NSQHSS Survey 1016.6.1.3:
Review and update audit tool(s) to ensure revised policy handover policy requirements are met in practice.

Organisation Action:

In consultation with the Acute NUM the ISBAR handover tool was reviewed to ensure alignment with the revised Clinical Handover Policy. The Policy now includes specialist area including Radiology, aged care.

Clinical Handover is audited through the Riskman Clinical Handover and Bedside Audits.

A bi-annual observational handover audit has been conducted and reported at the Communicating for Safety meeting and Clinical Managers committee. Results are provided back to staff through minuted ward meetings.

Completion Due By: 31/07/2017

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

The ISBAR handover tool has been reviewed and aligned to the revised Clinical Handover Policy. Clinical handover is audited through the RiskMan Clinical Handover and Bedside Audits. Observational handover audits are conducted and reported at the Communicating for Safety Meeting and Clinical Managers Committee. Results are provided to staff through ward meetings and minuted.

Organisation: Cohuna District Hospital

Action 6.2: The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes

Recommendation NSQHSS Survey 10_16.5.1.1:
Progress implementation of the rollout of iPM through a structured project management strategy to ensure that implementation is achieved according to timetabled deliverables.

Organisation Action:

The Patient Identification and Procedure Matching Policy has been revised. The requirement for at least 3 approved identifiers is clearly stated within.

Incidents relating to identification/procedure mismatching are reported through Victorian Health Incident Management System (VHIMS). Actions to resolve issues are allocated to managers. Incidents are presented/ discussed through *Communicating for Safety* clinical team meetings and outcomes provided to the Clinical Managers committee. VHIMS are reported to the Board of Management via the quarterly KPI report.

iPM has been introduced to both Urgent Care Centre (UCC) and acute ward thus facilitating clinician ability to enter all UCC presentations and after-hours admissions into iPM to mitigate risk of patient identification errors.

Staff now have the ability to generate Patient Labels after hours for UCC and patient admissions.

Clinical staff received iPM education from administration staff who attended a larger regional health service for training in the use of iPM

Completion Due By: 30/11/2017

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

The iPM has now been introduced to the Urgent Care Centre and Acute Ward to assist after hours admission and mitigate the risk of patient identification errors. Reference checklists are available to staff when admitting after hours. Staff can now generate patient labels through the iPM further reducing the risk of patient identification errors. The regional health service has provided iPM training for administration staff. Clinical staff have also been given appropriate training.

Organisation: Cohuna District Hospital

Action 6.2: The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the effectiveness of clinical communication and associated processes b. Implementing strategies to improve clinical communication and associated processes c. Reporting on the effectiveness and outcomes of clinical communication processes

Recommendation NSQHSS Survey 1016.5.5.2:
As per 5.5.1 update the Correct Patient, Correct Side, Correct Site, Correct Procedure Policy to include Radiology and the required process for monitoring of compliance with procedure matching and patient identification.

Organisation Action:

Policy reviewed across all clinical departments- Acute, Theatre, Maternity, Haemodialysis, Radiology, Aged Care and UCC

Monitoring and auditing to monitor compliance is detailed in the revised policy. Audits include RiskMan Q Std 5 and Bedside audits

Endorsed through committee structure Sep 2017

Completion Due By: 30/09/2017

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

Since the last assessment event, the Correct Patient, Correct Side, Correct Site, Correct Policy has been reviewed. References include all clinical departments (i.e. Acute Ward, Operating Theatre, Maternity, Haemodialysis, Radiology, Aged Care and the Urgent Care Centre).

Standard 8

Organisation: Cohuna District Hospital
Action 8.1: Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for recognising and responding to acute deterioration b. Managing risks associated with recognising and responding to acute deterioration c. Identifying training requirements for recognising and responding to acute deterioration

Recommendation NSQHSS Survey 1016.9.1.2:
Review and update the Escalation of Care Policy to include processes for the monitoring and review of all Medical Emergency Responses and Clinical Reviews.

Organisation Action:

The Escalation of Care Policy has been extensively revised to include:

- measurement and documentation of observations
- escalation of care
- establishment of a rapid response system
- communication about clinical deterioration

Revision also includes use of National Observation Chart, ViCTOR Paediatric and Neonatal Charts.

The policy is support by the Case Review Policy which defines triggers that alert reviews and the Escalation of Care - Maternity Services Policy.

The Escalation of Care Policy was endorsed through the organisational committee structure.

Following endorsement this recommendation has been marked closed

Completion Due By: 30/09/2017

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

The Escalation of Care Policy has been extensively revised since the last assessment event. It includes references to the measurement and documentation of observations; escalation of care; rapid response systems; and communicating a patient's clinical deterioration. CDH now uses the National Observation Chart, ViCTOR Paediatric and Neonatal Charts. The Case Review Policy defines triggers that prompt reviews for escalation of care events.

Organisation: Cohuna District Hospital
Action 8.2: The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems c. Reporting on effectiveness and outcomes of recognition and response systems

Recommendation NSQHSS Survey 1016.9.4.3:
Review training program in place in use of the rapid response chart to ensure it meets the requirements to support implementation of the element 1: Measurement and documentation of observations as per the National Consensus Statement and the organisation reviews the data collection tool for escalation processes for ambiguity.

Organisation Action:

Clinical staff attended Triage education August 10th, 17. Further education was provided at Echuca Regional Health in 2019.

Track & Trigger PowerPoint education was developed August 2017 and made available to clinicians on the CDH intranet.

Education was monitored with completion of the training due by August 31st, 2017.

Evaluation of staff compliance for completion of the education occurred in early September with any staff failing to complete the education followed up.

Upon completion, this recommendation will be marked as complete.

The organisation introduced ViCTOR aged specific paediatric observation charts in Urgent Care Centre and acute ward. The Neonatal and Special Care Nursery charts were also implemented. Parameters on the charts assists identification of escalation of care.

Completion Due By: 15/092017

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

There is evidence triage training has been provided to clinical staff and is available on the CDH intranet. Staff compliance for the completion of required education is monitored and followed up. As noted previously, CDH now uses the National Observation Chart, ViCTOR Paediatric and Neonatal Charts. The Case Review Policy defines triggers that prompt reviews for escalation of care events. Audits on observation charts sighted indicate good compliance with escalation of care where abnormal vital signs have been recorded.

Organisation: Cohuna District Hospital
Action 8.2: The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems c. Reporting on effectiveness and outcomes of recognition and response systems

Recommendation NSQHSS Survey 1016.9.9.3:
Periodically review the effectiveness and performance of the system for family escalation of care.

Organisation Action:

Family escalation of care included in revised Escalation of Care Policy

Auditing conducted through RiskmanQ.

Results disseminated to clinical team for action.

Information for patients, families and carers included in Patient Information Book located at all bedsides and signage at bedsides 'if you are worried, we are worried' provides prompt for patient/family/carer escalation.

The Open Disclosure policy has been revised and enhanced in 2019 to enable better discussion and communication of escalation pathways.

Completion Due By: 31/05/2017

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

The Escalation of Care Policy has been reviewed and includes references to family escalation of care. Information is provided to patients and/or carers on escalating care when required. Escalation processes including room signage and face-to-face staff discussions to assist patients. The DMS reviews all episodes where there has been an escalation of care.

Organisation: Cohuna District Hospital
Action 8.2: The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring recognition and response systems b. Implementing strategies to improve recognition and response systems c. Reporting on effectiveness and outcomes of recognition and response systems

Recommendation NSQHSS Survey 1016.9.9.4:
Ensure that action is taken to improve the system for family escalation of care.

Organisation Action:

Patient brochure included in Patient Information Booklet all bedsides.

Staff reinforce with escalating care with patients/carers at admission - Reinforced at Ward Meeting Sept 2017

Explanation of escalation of care at admission on admission tick checklist.

If you are worried, we are worried posters displayed in inpatient wards.

Completion Due By: 30/09/2017

Responsibility:

Organisation Completed: Yes

Assessor's Response:

Recomm. Closed: Yes

As indicated previously, the Escalation of Care Policy has been reviewed and includes references to family escalation of care. Information is provided to patients and/or carers on escalating care when required. Escalation processes including room signage and face-to-face staff discussions to assist patients. The assessing team was advised CDH has secured Capital funds to implement a campus-wide integrated call bell and phone system by the end of 2019 to further assist family escalation of care.