

**Report of the Periodic Review for the
ACHS Evaluation and Quality Improvement Program**

Central Gippsland Health Service

Sale, VIC

Organisation Code: 21 17 86

Survey Date: 13-14 October 2009

ACHS Accreditation Status: **ACCREDITED**

Table of Contents

About The Australian Council on Healthcare Standards	2
Survey Report	5
PERIODIC REVIEW OVERVIEW	5
Criterion: 1.1.1	7
Criterion: 1.1.2	8
Criterion: 1.1.3	9
Criterion: 1.1.4	9
Criterion: 1.1.5	10
Criterion: 1.1.8	12
Criterion: 1.5.2	13
Criterion: 2.1.1	14
Criterion: 2.1.2	15
Criterion: 2.1.3	16
Criterion: 3.1.3	16
Criterion: 3.1.5	17
Criterion: 3.2.1	18
Criterion: 3.2.4	19
Rating Summary	21
Recommendations from Current Survey	22
Criterion: 1.1.2	22
Criterion: 1.1.5	22
Criterion: 1.5.2	22
Criterion: 3.2.1	23
Criterion: 3.2.4	23
Recommendations from Previous Survey	24



About The Australian Council on Healthcare Standards

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

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

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

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

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

What is Accreditation?

Accreditation is a formal process to assist in the delivery of safe, high quality health care based on standards and processes devised and developed by health care professionals for health care services. It is public recognition of achievement by a health care organisation, of requirements of national health care standards.

How to Use this Survey Report

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

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

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

- 1- Surveyor Team Summary Report
- 2 - Ratings Summary Report
- 3 - Summary of Recommendations from the Current Survey
- 4- Recommendations from the Previous Survey

1 Surveyor Team Summary Report

Consists of the following:

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

Criterion ratings

Each criterion is rated by the organisation and the surveyor team with one of the following ratings (except criterion 1.3.1 which is a developmental criterion)

- LA
- SA
- MA
- EA
- OA

The rating levels are:

LA – Little Achievement- Organisations that achieve an LA rating will have an awareness or knowledge of responsibilities and systems that need to be implemented but may have only basic systems in place. At this level there will be compliance with legislation and policy that relates to the criterion.

SA – Some Achievement- An organisation that achieves an SA rating will have achieved all the elements of LA and will have implemented systems for the organisation's activities. At this level there is very little or no monitoring of outcomes or efforts at continuous improvement.

MA –Moderate Achievement- An MA rating requires that all the elements of LA and SA have been achieved and that efficient systems in collecting relevant outcome data, monitoring, evaluation procedures and methods of improvement are in place.

EA – Extensive Achievement- In the EQUIP 4 program, all the elements in LA, SA and MA must be achieved. Also organisations will be able to demonstrate extensive achievement in a criterion if they satisfy one or more of the following requirements:

- internal or external benchmarking and subsequent system improvement, and / or
- the conduct of research that relates to that particular criterion, and / or
- the implementation of what would be considered to be advanced systems that relate to that criterion, and / or
- proven, excellent outcomes in that particular criterion.

Some organisations may be able to demonstrate achievement in more than one of these elements.

OA- Outstanding Achievement- The elements of LA, SA, MA and EA must be achieved as well as a demonstration of leadership in this criterion. Leadership in a criterion does not necessarily mean that that organisation is the best in Australia. It may mean that the organisation can demonstrate that it is one of the best or is outstanding amongst its peers.

Developmental Criterion (1.3.1) -

A developmental criterion is one that the ACHS has introduced to organisations for the purpose of creating awareness and for commencing collaborative national action in a specific area of health care. There is one developmental criterion that has been introduced in EQUIP 4 – criterion 1.3.1 - Health care and services are appropriate and delivered in the most appropriate setting.

When a developmental criterion is introduced:

- organisations will work towards achieving the elements of the criterion
- progress towards achievement of the criterion will be discussed during survey but will not be taken into account when determining the accreditation status of the organisation
- a progressive evaluation of the implementation of the standard / criterion will be undertaken by the ACHS

Criterion Comments -

Surveyor comments regarding individual criterion detailing issues and surveyor findings and opportunities for improvement. Comments are available for all mandatory criteria giving an indication of why the organisation is achieving at the given rating level.

Criterion Recommendations-

Recommendations are highlighted areas for improvement due to a need to improve performance under a particular criterion. Surveyors are required to make a recommendation where an LA or SA rating has been assigned in a criterion to provide guidance and to provide an organisation with the maximum opportunity to improve. Recommendations in the survey report need to be reviewed and prioritised for prompt action and will be reviewed by the surveyor team at the next on site survey.

Risk ratings and risk comments will be included where applicable- Risk ratings are applied to recommendations especially where the criterion rating is an SA or an LA to show the level of risk associated with the particular criterion.

Risk ratings could be:

E: extreme risk; immediate action required.

H: high risk; senior management attention needed.

M: moderate risk; management responsibility must be specified.

L: low risk; manage by routine procedures

High Priority Recommendations (HPR)-

These are applied to a particular criterion where

- consumer / patient care is compromised and / or
- the safety of consumers / patients and / or staff is jeopardised.

Surveyors complete a risk assessment to validate their decision to allocate a High Priority Recommendation. A HPR should be addressed by the organisation in the shortest time possible.

2 Ratings Summary Report-

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

3 Summary of Recommendations from the Current Survey-

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

Recommendations are structured as follows:

The criterion numbering relates to the month and year of survey and the criterion number. For example recommendation number OWS 0106.1.1.1 is a recommendation from an OWS conducted in January 2006 with a criterion number of 1.1.1

4 Recommendations from Previous Survey-

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

Survey Report

PERIODIC REVIEW OVERVIEW

During the course of the Periodic Review, three CGHS sites were visited, Sale Hospital and Sale and Loch Sport Community Health, with Loch Sport having their first visit by ACHS surveyors. This town services a community of approximately 800 residents and also experiences large population increases during peak holiday periods.

Performance across all mandatory criteria is at MA level except in continuous improvement for which an EA rating was confirmed. The surveyors were impressed with the leadership, teamwork and communication which are clearly supporting organisational performance and congratulate management and staff on their achievements.

The CGHS commitment to the Department of Human Services (DHS) traineeship program for fifteen trainees dispersed in allied health and non-clinical areas, such as the placement of apprentices in engineering and food services, is noted. This initiative should greatly support workforce shortages.

Clinical Function

The survey team was impressed with the commitment demonstrated throughout the CGHS to providing safe, high quality care to its communities. There was evidence of both internal and external review and evaluation of services. Although the evaluation processes have identified neither matters that needed to be improved, or scope for possible improvement, the survey team was pleased to note the commitment of staff to address these issues and to develop or enhance evidence-based, best practice in all areas.

Assessment and care planning processes have also been subjected to reviews and changes have recently been made in several areas, such as in the Emergency Department (ED) and for inpatient admissions. The evaluation of care delivery and outcomes involves a wide range of clinicians and forums and includes a formal reporting mechanism to the Board of Management. Comparative clinical care outcome data indicates that CGHS is achieving results that compare very favourably with its peers in many instances.

Consent processes are well documented and monitored and appropriate for the service role of the organisation.

Discharge processes are well coordinated and there is evidence of excellent communication between bed-based and community service providers.

Patient records are generally well documented and facilitate continuity of care. Compliance with clinical guidelines and procedures is audited as a component of the evaluation of care.

Evaluation of care by patients / consumers indicated a high level of satisfaction and patients approached by surveyors during the survey were very satisfied with all aspects of the care they were receiving.

CGHS has launched a very ambitious Care Coordination project to improve the integration of its services and thereby improve the journey of individual patients / consumers as well as to improve the overall health of the community. The organisation and the Executive team are congratulated for taking on this challenge with such enthusiasm and commitment.

The infection control management system is well documented and the effectiveness of the system is monitored through surveillance and a range of auditing processes, several of which are benchmarked with peer hospitals. The rate of occupational exposure incidents is of concern and a recommendation is made to enhance the education of clinical staff in relation to infection control risks.

Support Function

At CGHS the quality and risk frameworks are closely aligned. This has been achieved through recent initiatives such as the development of the Strategic Plan, 2009-2012, the increased emphasis on clinical governance and the attention paid to utilising and expanding the functionality of RiskMan for local use. Management and staff were able to provide ample evidence of both improvement activities relating to each standard. It was also pleasing to note that many of the future improvements documented in the self assessment had already commenced.

Systems to manage incidents and complaints are also accessible through the RiskMan reporting tool. Indications are that incidents and complaints are followed up in a timely fashion and it is also evident that improvements result from such events.

The surveyors were impressed with the CGHS integrated approach to managing these three mandatory criteria. Benchmarking is operational in some key areas and there are plans to formalise the range of activities and this is encouraged.

Corporate Function

The systems for credentialling and defining the scope of practice and managing policy are well established and it is evident that they support organisational performance in both these areas. The systems are further supported by the quality infrastructure and committee structures and processes which have well defined accountabilities to monitor compliance. In particular the policy and procedure system is a relatively simple system which is well regarded and used by staff and the CGHS staff could share their experience with other organisations if considered appropriate.

The surveyors were impressed with the level of staff awareness and participation in maintaining and improving the safety of the environment for patients, visitors and staff in the CGHS sites. Safety systems are well structured and supported with appropriate policies and procedures, a schedule of environmental audits, an OH&S Committee and OH&S representatives who are trained and represent a broad range of work areas. The OH&S Committee reports via the Safe Practice and Environment Committee to the Quality and Risk Committee. There was ample evidence of monitoring of key activities and action taken to respond to identified issues.

The laundry has been identified as an area for improved work practices including manual handling and a number of issues are being addressed through the current manual handling project.

Dangerous goods and hazardous substances are managed effectively, signage is appropriate and MSDS information sheets for relevant chemicals are maintained and accessible to staff.

Awareness of safe practice in radiology is evident.

Apart from a recommendation to improve staff security through provision of a duress alarm system at both Loch Sport and Rosedale, potentially isolated workplaces, performance in this standard is considered most satisfactory. The surveyors are aware that additional key performance indicators (KPIs) are under discussion and in the longer term may provide additional areas for benchmarking CGHS performance.

Function: Clinical

Standard: 1.1

Criterion: 1.1.1

The assessment system ensures current and ongoing needs of the consumer / patient are identified.

Organisation's self-rating: MA

Surveyor rating:MA

Surveyor's Comments:

CGHS has well documented assessment protocols and tools in use in all service areas. The SCOTT assessment format is used with clients accessing community based services.

There is evidence that improvements have been made to various assessment processes as a result of reviews, evaluations and trials of new or adjusted formats. The assessment format for acute inpatient services is currently being reviewed and the assessment format in the ED has also been subjected to recent review and improvement. There are some projects in progress (some with external funding) which involve evaluation of assessment systems. It has been identified that the current admission assessment for a patient's cognitive state is somewhat inadequate and the organisation is encouraged to explore evidenced based options to improve in this area. The Improving Care for Older People and the Care Coordination Project are both aimed at improving assessments and referral processes and providing accessible and appropriate care for the communities served by CGHS.

Antenatal assessment processes have been reviewed and this has resulted in the consideration of different models of care and the establishment of an antenatal clinic to provide women with the choice of having antenatal care provided mostly by midwives.

The assessment processes include the use of a wide range of risk assessment tools and there is evidence that effective risk management strategies are incorporated into care / service plans in response to identified risks. The format of the assessment tools also prompts referrals as required and the appropriateness of referrals is monitored. Allied Health staff are also developing discipline specific indicators for referral and guidelines to determine priority of same. The format of the assessment tools also facilitates risk assessment relating to discharge and prompts discharge planning from the time of admission.

Although CGHS does not have any designated mental health beds, if a patient with a known or suspected mental illness presents at the Emergency Department requiring general medical care, there are mental health staff on call to respond and undertake a mental health assessment and prepare a care plan to provide guidance in terms of appropriate support for the patient if inpatient care is required for the provision of general medical care.

Feedback from consumers via the Victorian Patient Satisfaction Monitor (VPSM) suggests that CGHS is perceived to be performing well in this area. In the most recent survey, the Health Service's Indicator for Access and Admission was 81 (up from 79 in the previous report) and higher than the average for similar sized hospitals (which was 77).

The organisation's self-rating of MA for this criterion is endorsed.

Surveyor's Recommendation:

HPR:No

Function: Clinical

Standard: 1.1

Criterion: 1.1.2

Care is planned and delivered in partnership with the consumer / patient and when relevant, the carer, to achieve the best possible outcomes.

Organisation's self-rating: MA

Surveyor rating:MA

Surveyor's Comments:

CGHS has adopted a systematic approach to the delivery of care, as evidenced by current clinical policies, procedures and guidelines, and by the use of evidence-based clinical pathways and guidelines in most areas. Various services have been subject to internal or external review to identify scope for improvement, including the Emergency Department, Allied Health Services and Maternity Services. In all these reviews, issues were identified that needed to be addressed and the survey team was pleased to note that in all cases, action plans had been developed, the implementation of which is being formally monitored and reported to the Board. One of the issues identified in the Maternity Services review related to the participation of staff in mandatory clinical education and competency assessments and it was noted that in some areas this was still quite low at the time of survey. A recommendation is made to address this matter. Further comment is made in criterion 3.2.4 regarding annual fire and evacuation training.

Variances and outcomes for specific clinical pathways have been subject to reviews and monitoring, such as the stroke management data (which indicated improving performance at CGHS, as well as high levels of compliance with various aspects of the best practice guidelines), the Blood Product Transfusion Guideline and the Resuscitation Plan, with changes being made to improve practice and care as required.

CGHS is congratulated on its commitment to providing timely dental treatment and on significantly reducing the waiting time for general care.

CGHS has used a Medical Emergency Team (MET) approach to respond to deteriorating patients, and ongoing evaluation of MET calls or incidents where it was perceived that a MET call should have occurred, has resulted in the establishment of several specialist METs (trauma, obstetric and paediatric), which facilitate appropriate response in a wide range of clinical situations where prompt action is required.

It was pleasing to note the strong executive support for undertaking the evaluation / reviews of services and the allocation of resources to support either the review or the implementation of recommendations from a review.

Results from the VPSM indicates quite a level of satisfaction with the treatment and related information which patients receive at CGHS. The indicator score in this category was 81, with the score for peer hospitals being 78. The VPSM indicator score for the physical environment was 78, up from the previous score of 74, and also greater than the score of peer hospitals which was 75.

Surveyor's Recommendation:

HPR:No

Information regarding participation of clinical staff, particularly those working in the Women's and Children's Unit, in mandatory education and competency assessments, be regularly monitored and strategies implemented to achieve target participation rates.

Function: Clinical

Standard: 1.1

Criterion: 1.1.3

Consumers / patients are informed of the consent process, understand and provide consent for their health care.

Organisation's self-rating: MA

Surveyor rating:MA

Surveyor's Comments:

CGHS has a policy regarding consent which is also currently undergoing a review. The policy defines those procedures and processes for which consent is required. However, the consent for the release of information (eg to other service providers) does not include information regarding the potential to withdraw consent (except in the case of community services which uses the SCTT consent format) and it is suggested that consideration be given to including this information for inpatients as well. Although a recent audit identified that there is scope for improvement in the level of compliance with obtaining consent to collect and transfer information with non-elective patient admissions, it was evident that this is already being effectively followed up.

Various forms are used to document consent and audits of medical records are undertaken to monitor compliance with the consent policy. Compliance with the consent policy is not formally monitored in the x-ray department and it is suggested that this be monitored formally to demonstrate compliance in terms of obtaining consent for all relevant procedures.

Surveyor's Recommendation:

HPR:No

Function: Clinical

Standard: 1.1

Criterion: 1.1.4

Care is evaluated by health care providers and when appropriate with the consumer / patient and carer.

Organisation's self-rating: MA

Surveyor rating:MA

Surveyor's Comments:

Care is evaluated at CGHS by both the health care providers and consumers / patients. Evaluation by the latter group occurs through the VPSM, through post discharge evaluations by means of phone calls or surveys (eg from the Day Procedure Unit or following discharge from Home Nursing care).

Care evaluation by CGHS clinicians occurs in a wide variety of ways and through various forums, of which the following are examples:

- Analysis of MET calls and Code calls which has resulted in changes in the criteria for making a MET call. Details of these calls are now being entered on the RiskMan database (which facilitates recording and analysis of incidents) which will enhance the overall analysis process;
- Review of results of ACHS clinical indicator data;
- Participation in the Limited Adverse Occurrence Screening (LAOS) program which provides feedback and peer review of a range of clinical incidents / events;
- Review of management of patients in the Critical Care Unit (CCU) via analysis of unplanned admissions to the Unit and submission of data to the ANZICS database resulted in changes in management strategies for some types of admissions;
- Review of results of Maternity Services Performance Indicator data, which demonstrates that CGHS maternity services perform well in comparison with peer hospitals in terms of a range of clinical indicators in this area;
- Review of deaths through the forum of the Morbidity and Mortality Committee;
- Multidisciplinary (including medical staff) case reviews of patients with complex care needs.

It was apparent to the survey team that there was a commitment to evaluate all aspects of care and to take action as required and ongoing re-evaluation, to achieve desired improvements. In some instances, these were still "works in progress", however, incremental improvements are being achieved and for this the organisation is congratulated.

A review of a random selection of patient records showed that the effect of administration of PRN analgesics was not being consistently evaluated. It is suggested that monitoring of this type of care be included in future audits of patient records.

Surveyor's Recommendation:

HPR:No

Function: Clinical

Standard: 1.1

Criterion: 1.1.5

Processes for discharge / transfer address the needs of the consumer / patient for ongoing care.

Organisation's self-rating: MA

Surveyor rating:MA

Surveyor's Comments:

As noted in the comments for criterion 1.1.1, there is evidence that discharge planning commences at the time of admission for most inpatients in the acute services. There is some duplication in the current forms for assessment and care planning / delivery for the documentation of discharge planning (eg clinical pathways include space for discharge planning, but a separate form for a discharge plan is also in use). However, as ongoing review of the documentation of assessment and care planning / delivery is occurring, this issue will most likely be addressed in the near future.

As noted in the comments for the recommendation from the previous survey for this criterion, significant improvement has been achieved in the rate of timely completion of discharge summaries. The organisation allocates resources for a designated discharge planner on the Sale site.

The systems for ensuring effective discharge and or transfer are evaluated in various ways, including the following:

- Specific post-discharge follow up phone calls as occurs for patients from the Day Procedure Unit;
- Quarterly monitoring of four Discharge Indicators - (as required by DHS) the results of which have been somewhat variable in the last three reports in that the most recent results (July 2009) are an improvement on the previous results (March 2009) but a reduction on the results of the previous report (November 2008). The Discharge Indicator results are analysed by service area which allows follow up action to be targeted to the relevant staff groups;
- Although re-admission rates are not formally monitored at present (due to software reporting difficulties) the re-admissions of patients with chronic diseases is monitored by the HARP (Hospital Admission Risk Program) Coordinator;
- Feedback is sought from patients via the VPSM and the Patient Safety Initiative Survey which involves patients discharged from all acute units at the Sale site. Results from these surveys have indicated high levels of satisfaction in most areas, particularly with information provided to patients;
- Average length of stay is monitored for some DRGs, eg for stroke patients and obstetric patients;
- Feedback is invited from community service providers regarding discharges from CGHS;
- Analysis of any incidents or complaints relating to discharges.

Transfers from CGHS are likely to occur when there is a need for orthopaedic or other complex surgery following major trauma or when a less acute level of care is required. The evaluation of transfers to other health facilities appears to be informal at present and a recommendation is made to formalise this process so that the level of satisfaction of receiving agencies, in relation to aspects of the process, such as the content of referral information provided, can be determined. There is also potential patient transfers to higher levels of care in the LAOS report.

Overall, although there are some deficits or duplications and scope for improvement, these issues appear to be well recognised and are in the process of being addressed.

Surveyor's Recommendation:

HPR:No

A process to formalise the evaluation of transfers from CGHS to other health services be developed in order to identify opportunities for improvement if required.

Function: Clinical

Standard: 1.1

Criterion: 1.1.8

The health record ensures comprehensive and accurate information is recorded and used in care delivery.

Organisation's self-rating: MA

Surveyor rating:MA

Surveyor's Comments:

CGHS appears to have a comprehensive health record management system in place, which includes a current procedural framework, a range of auditing and review processes and reporting mechanisms to monitor the effectiveness of the system. The Clinical Documentation Committee has the role of reviewing and authorising the development and/or modifications that are made to any forms used in the health records. All patients have a unique identifier and progress is occurring towards a Regional UR number system.

There is appropriate primary and secondary storage of records with disposal of records occurring as defined by CGHS policy and Australian Standards.

All clinical staff are informed of their responsibilities relating to the documentation of care as part of the orientation program.

CGHS is facing significant change in the foreseeable future as statewide software is introduced to enable a transition to electronic medical records or part electronic records to occur. It is anticipated that new legislation will be passed to provide a framework for the use of electronic records, eg, regarding security, storage and backup, sign off capacity and guidelines to define the interface between existing or ongoing hard copy records and electronic records.

There are some difficulties at current stage of implementation of the statewide patient management software which are creating additional work in terms of the generation of various reports (such as re-admission rates and transfers and Aboriginal patient) and it is to be hoped that these issues will be resolved in the near future.

Pathology and radiology results are provided electronically and radiology results are also provided in hard copy to the ED.

There is evidence of both regular evaluation of health records by means of documentation audits in all clinical departments / service areas, as well as evaluation of the content / quality of documentation in specific cases or for a specific project, eg, the documentation of the management of people presenting with stroke.

Departmental audits are based on the relevant documentation requirements for the area. Where audits have indicated that there is scope for improvement, recommendations are made to the department, which is required to take action or develop an action plan to address the problem/s. It is suggested that consideration be given to presenting the results of documentation audits as graphs and also trending the results over the year, to emphasise improvements or where they need to occur.

DRG coding is subjected to external auditing with acceptable results being maintained. Coders are able to attend annual workshops to maintain or enhance their skills.

Surveyor's Recommendation:

HPR:No

Function: Clinical

Standard: 1.5

Criterion: 1.5.2

The infection control system supports safe practice and ensures a safe environment for consumers / patients and health care workers.

Organisation's self-rating: MA

Surveyor rating:MA

Surveyor's Comments:

CGHS has a well documented infection control system in place. There is a qualified infection control nurse consultant with responsibility across the organisation. There is a suite of current infection control guidelines and procedures. Staff education relating to infection control occurs at orientation and is provided to individual units as needed. Appropriate signage and equipment is used to promote appropriate infection control practices, such as hand hygiene. Personal protective equipment is also provided for staff in all areas.

There is a reporting structure for infection control issues from the Infection Control Committee through to the Quality and Risk Committee.

The infection control nurse participates in a regional infection control network and is able to access peer support through this forum. The regional group has developed an audit tool and facilitates benchmarking of results.

A staff immunisation program is in place, although staff uptake of some vaccines is below the state average and the organisation is encouraged to continue to promote the advantages of staff participation in this program.

Since the last survey, an incident has occurred where it was found that a laproscope had been inadequately cleaned prior to being sterilised and used in another patient. A Root Cause Analysis was undertaken which resulted in several recommendations relating to processes and systems in CSSD, which are currently being implemented. It is suggested that the implementation and ongoing compliance with the recommendations be monitored by the Infection Control Committee and the Quality and Risk Committee.

In radiology there are plans to replace the current system for disinfecting ultrasound transducers with Trophon EPR.

There is evidence of internal and external monitoring of clinical and performance indicators relevant to the infection control strategy. External audits such as the Food Safety Audit and the DHS Cleaning Audit have indicated high levels of compliance.

Surveillance data is submitted to the Victorian Infection Control Nosocomial Infection Surveillance System for comparison with that of other hospitals, which has indicated that CGHS is performing well in some areas (such as use of prophylactic antibiotics) but the rate of occupational exposure events is significantly higher than its peer hospitals. Some of these events involve incorrect disposal of sharps by clinical staff, resulting in injury to cleaning staff. Although follow up action is occurring, it appeared to the survey team that there is scope to improve the participation of all clinical staff in relevant education and to ensure that the education includes some assessment of understanding and competency. A recommendation is made to address this issue.

CGHS participation in the statewide Hand Hygiene initiative and ongoing evaluation of this project involves monitoring of compliance by the Infection Control Nurse as well as monitoring of usage of hand cleansing products.

Surveyor's Recommendation:

HPR:No

A process be developed to ensure that information relating to infection control risks, relevant to individual roles and responsibilities, are understood by all staff.

Function: Support

Standard: 2.1

Criterion: 2.1.1

The organisation's continuous quality improvement system demonstrates its commitment to improving the outcomes of care and service delivery.

Organisation's self-rating: EA

Surveyor rating:EA

Surveyor's Comments:

The Draft 2009 Strategic Plan, *Promoting Wellness* provides the overarching focus for quality. The Quality Plan is developed and/or reviewed annually and it is evident that the increasing focus on clinical governance is also strengthening the CGHS approach to continuous improvement, eg a review of the CGHS committee structure is currently in progress. Improving workplace capability is one of the key areas of the strategic plan and implementation of this strategy (refer previous recommendation 2.2.3 is planned by mid 2010).

Implementation of the quality framework is lead by an enthusiastic quality team who are supported by both the Executive and the Board. The Quality and Risk Committee is a Board subcommittee, terms of reference are current and the membership includes Board members. Quality activities are extremely well planned, documented and implemented. Staff have access to the "Ubiquity" to register improvement activities which are risk rated and reported to the Quality and Risk Committee. Quality is a key component of each staff meeting. There is a consumer consultative committee and the community has recently been involved in the revised signage project with an excellent result for all visitors to the hospital.

Care is evaluated at CGHS by the health care providers and consumers / patients. The CGHS clinicians also evaluate care in a wide variety of ways and through various forums. It was evident that action is taken to achieve desired improvements.

As mentioned in the clinical function a number of reviews have recently been undertaken and progress is regularly reported to the Board, eg ED and Allied Health reviews. The co-location of Allied Health staff into excellent new facilities at Sale should continue to improve communication / networking and referral amongst these staff. An impressive suite of clinical indicators for Community Services were viewed during the Periodic Review. When implemented, these will provide a broad range of KPIs for benchmarking purposes.

Also impressive is the development of quality and clinical indicators which directly relate to the strategic plan. These will be reported to the Board on a regular basis.

Results of the 2009 staff survey demonstrated improvement since the 2006 survey. These results would be more meaningful if increased participation in the survey was achieved.

Management and staff are congratulated on the work undertaken which demonstrated a high level of commitment and achievement in continuous improvement.

Surveyor's Recommendation:

HPR:No

Function: Support

Standard: 2.1

Criterion: 2.1.2

The integrated organisation-wide risk management policy and system ensure that clinical and corporate risks are identified, minimised and managed.

Organisation's self-rating: MA

Surveyor rating:MA

Surveyor's Comments:

The risk management framework is accessible to all staff, managers and committees and is supported with related policies and procedures. The use of RiskMan and the recent and proposed enhancements to the tool demonstrated that CGHS wants to obtain the best available quantitative and qualitative data. Of particular mention is the comprehensive database developed for the management of contractors.

Corporate governance risks are documented in the risk register and are regularly reported to the Audit committee, a Board subcommittee. It was also evident that a range of committees are involved in risk identification and monitoring risk, eg morbidity and mortality. There are documented plans, amongst the many intended improvements, to have a centralised risk register for clinical and non-clinical areas and to review the risk management framework.

There is evidence of regular review of the risk register although the current system would be improved with a date to identify when the risk was added to the register. A consolidated risk register which includes clinical risks is planned and when available will be of great benefit to the whole organisation. Quality improvements follow the identification of risks and these are reported to the Leadership and Management Committee on a regular basis.

Surveyor's Recommendation:

HPR:No

Function: Support

Standard: 2.1

Criterion: 2.1.3

Health care incidents, complaints and feedback are managed to ensure improvements to the systems of care.

Organisation's self-rating: MA

Surveyor rating:MA

Surveyor's Comments:

Incidents and complaints (since mid 2009) are also managed using the RiskMan reporting tool which is used by Gippsland Health Alliance. Staff have contributed to upgrading the functionality of RiskMan and examples were discussed during the Periodic Review. There are documented policies and procedures to support the management of incidents and complaints. The enhanced reporting function was viewed during the Periodic Review and it is evident that access to improved data for decision making will be valued and used by CGHS. The incident reporting procedure has also been reviewed this year for alignment with the incident reporting functionality of RiskMan.

Proactive clinical incident monitoring has been undertaken using the CGHS LAOS and it is proposed that this also be integrated into the RiskMan system. As suggested in criterion 1.1.5, the transfer of patients to facilities which provide higher levels of care could also be incorporated into LAOS.

Comments have been made in the clinical function regarding the high level of patient satisfaction. Complaints are managed in a timely manner and the results of the VPSM confirmed this view. Improvements resulting from the management of incidents included the introduction of customer services training for staff and providing day procedure patients with information about making a complaint. The introduction of open disclosure is yet to be achieved and community consultation is intended as part of this process.

Surveyor's Recommendation:

HPR:No

Function: Corporate

Standard: 3.1

Criterion: 3.1.3

Processes for credentialing and defining the scope of clinical practice support safe, quality health care.

Organisation's self-rating: MA

Surveyor rating:MA

Surveyor's Comments:

The CGHS credentialling system is largely medical focussed at present. The framework is based on the DHS credentialling policy for Medical practitioners in Victorian Health Services, 2007. Although there is a plan to achieve a regional credentialling and scope of practice system, an effective system is operational and the credentialling procedure was reported to the August Leadership and Management Committee. There is evidence that the Credentials Committee, which has a minimum of two meetings per year, and the overall process for credentialling and defining the scope of practice works well. Until the appointment

of a Director of Medical Services, the Director of Nursing will continue to chair the Credentials Committee. Terms of reference have recently been reviewed, the Credentials committee membership has also been reviewed and now includes two dental officers. There is a policy for new interventions and the plan to improve the reporting of approved new technology to an appropriate committee is yet to be finalised. In discussion with the Board Chair and Executive staff it is evident that there have been occasions when appointments have been refused and further evidence that incidents and complaints relating to medical practitioners have been investigated and actioned.

Feedback to clinical areas is provided on the defined scope of clinical practice for clinical staff.

Random sampling of the Credentials Committee meeting minutes and the files of recent appointees confirmed a vigorous process in the appointment and re-appointment process for medical practitioners. Dental therapists have also recently been credentialed at CGHS in accordance with the DHS policy on clinical practitioners in Victorian Health Services.

There is also evidence of high levels of compliance with annual registration checks for all professional staff. Medical practitioners are required to submit CME points status on an annual basis.

The component of the system that relates to the management of medical staff is well supported by the Medical Executive Secretary. Clinical performance is monitored through LAOS, the Morbidity and Mortality Committee, the RiskMan incident reporting and the quality and risk framework. Performance development is undertaken on all honorary medical officers.

The plan to credential the St Vincent's Renal Nurse Practitioner is noted.

Surveyor's Recommendation:

HPR:No

Function: Corporate

Standard: 3.1

Criterion: 3.1.5

Documented corporate and clinical policies assist the organisation to provide quality care.

Organisation's self-rating: MA

Surveyor rating:MA

Surveyor's Comments:

Management of policies at CGHS is remarkable from two perspectives. Firstly, the simplicity of the system enables staff to have direct desktop access. Secondly, staff demonstrated a clear understanding of the difference between policy and procedure.

The policy framework is well established and maintained with good evidence of document control. An on line system has been operational for two years. Hard copy area specific manuals are available in ED and CCU. There is ample evidence of staff consultation in the policy development phase and clear lines of accountability for endorsement of procedures through the relevant committee. All new and reviewed policies are provided to a consumer for comment and are endorsed by the Board.

Policies and procedures contain appropriate and current references including Australian Standards and professional guidelines. The Leadership and Management Committee monitors compliance with procedures using audits, KPI reports, surveys and reviews. The librarian receives direct notification of legislative change which is then referred to the relevant manager. There are plans to improve the system for monitoring compliance with legislation and this will soon become a responsibility of the relevant management committee.

During the Periodic Review several staff confirmed a high level of satisfaction with access to current policies and procedures. The surveyors were very impressed with the standard of policy management and support the intended improvements included in the self assessment in further enhancing the CGHS policy system.

Surveyor's Recommendation:

HPR:No

Function: Corporate

Standard: 3.2

Criterion: 3.2.1

Safety management systems ensure safety and well being for consumers / patients, staff, visitors and contractors.

Organisation's self-rating: MA

Surveyor rating:MA

Surveyor's Comments:

The surveyors observed widespread staff awareness and action to maintain and improve the safety of the environment for patients, visitors and staff in the CGHS sites visited. Safety week is clearly well supported at Sale hospital, evidenced by the large number of safety posters on display. Communication between the Engineering Department and managers regarding the preventative maintenance program was apparent and staff expressed satisfaction with the level of service from the Engineering Department.

The OH&S framework includes defined accountabilities for the OH&S representatives and OH&S committee and is supported by policies and procedures including return to work for injured staff. The OH&S Committee reports to the Safe Practice and Environment Committee and subsequently to the Quality and Risk Committee. Monitoring of key activities and action taken to respond to identified issues and problems is evident, for example in response to workplace audits for which there is an established schedule for all CGHS sites. Incidents and injuries are reported quarterly and it was observed that while the number of work related injuries had decreased the insurance premium had increased, apparently caused by a long term injury claim.

Environmental and manual handling audits of the laundry have identified the need to redesign work practices and flow and these are currently under consideration. The manual handling project aimed at preventing back injury is a time limited project. An impressive status report was discussed during the Periodic Review and it will important to ensure that the improvement strategies can be maintained when the project funding concludes. As the patient assessment is currently under review it is suggested that the patients weight be recorded in patient assessment pre/on admission (refer to criterion 1.1.1).

Biomedical services are provided by the Latrobe Regional Hospital which provided weekly visits. Bulk electrical and related testing is undertaken on a six monthly basis.

Awareness of safe practice in radiology is evident. Alternative disinfection for ultrasound transducers is currently under consideration and it is expected that Trophon EPR will replace the current Milton process which is out dated. There is a Radiation Safety Officer and plan and the dental service have equipment maintained by an external provider.

Discussed during the Periodic Review were options for the provision of duress alarm capability for staff working at both Loch Sport and Rosedale in these relatively isolated areas.

Surveyor's Recommendation:

HPR:No

A duress security alarm be implemented for staff use in Loch Sport and Rosedale.

Function: Corporate

Standard: 3.2

Criterion: 3.2.4

Emergency and disaster management supports safe practice and a safe environment.

Organisation's self-rating: MA

Surveyor rating:MA

Surveyor's Comments:

It is evident that considerable time has been invested in improving emergency response within CGHS for both internal and external disasters. Suggestions made in the previous self assessment have been actioned. There is ample evidence that responses to some Codes have been recently revised. In response to a recognised need, specific MET team procedures have been developed and implemented for trauma, stroke, obstetric and paediatric emergencies (refer to criterion 1.1.2).

Processes to manage emergencies are operational, supported with policies and committee structure. There is evidence of CGHS participation in the broader community response. The recently developed checklist for bushfire readiness for Sale, Maffra and Heyfield hospital is an excellent initiative which is soon to be presented by the CGHS Safety Officer to the Statewide Safety Officers Forum. The adoption of a similar checklist for the remaining CGHS sites would enhance performance in this standard.

All required sites have had full fire inspections and the surveyors verified that all CGHS annual essential services checks on fire equipment had been completed. A number of recommendations from the full fire inspections remain ongoing, with some the subject of CGHS funding submissions to DHS. Action plans for each site are documented and regularly monitored. The Emergency Management Committee meets regularly and reports to the Safe Practice and Environment Committee.

The Rosedale and Loch Sport buildings are not subject to DHS requirements regarding regular full fire inspections as they are not bed based or do not provide sleeping accommodation. It is suggested that local council confirmation regarding the status of these premises, which are leased by CGHS, be obtained and recorded.

Compliance in fire and evacuation training, including the training for fire wardens is high with the exception of Womens and Childrens Health. This service needs to be monitored more closely to ensure that staff who do not undertake the mandatory training in the required timeframe are followed up promptly. However, it is expected that this will now improve following the recent appointment of a new Manager (refer to criterion 1.1.2). Hands on training for dedicated staff including engineering and environmental staff is currently being undertaken by an external specialist provider.

It is suggested that the fire and evacuation training resource be altered to reflect assembly points at sites other than currently included for Sale hospital. The surveyors also considered that the evacuation content of the desk top training could be more comprehensive. There have been evacuation practices in a number of CGHS sites, responses to false alarms and a recent Executive desktop exercise and debriefing following such events. The development and implementation of a schedule to ensure that all clinical and non clinical staff regularly practice and are aware of their responsibilities in the event of an evacuation would also enhance performance in this standard.

Surveyor's Recommendation:

HPR:No

A schedule for annual evacuation practice be developed and implemented for all areas within CGHS.

Rating Summary

Clinical

Criterion	Organisation's self-rating	Surveyor Rating	HPR
Crit. 1.1.1	MA	MA	
Crit. 1.1.2	MA	MA	
Crit. 1.1.3	MA	MA	
Crit. 1.1.4	MA	MA	
Crit. 1.1.5	MA	MA	
Crit. 1.1.8	MA	MA	
Crit. 1.5.2	MA	MA	

Support

Criterion	Organisation's self-rating	Surveyor Rating	HPR
Crit. 2.1.1	EA	EA	
Crit. 2.1.2	MA	MA	
Crit. 2.1.3	MA	MA	

Corporate

Criterion	Organisation's self-rating	Surveyor Rating	HPR
Crit. 3.1.3	MA	MA	
Crit. 3.1.5	MA	MA	
Crit. 3.2.1	MA	MA	
Crit. 3.2.4	MA	MA	

Recommendations from Current Survey

Function: Clinical

Standard:1.1

Criterion: 1.1.2

Care is planned and delivered in partnership with the consumer / patient and when relevant, the carer, to achieve the best possible outcomes.

High Priority: No

Recommendation:

Information regarding participation of clinical staff, particularly those working in the Women's and Children's Unit, in mandatory education and competency assessments, be regularly monitored and strategies implemented to achieve target participation rates.

Function: Clinical

Standard:1.1

Criterion: 1.1.5

Processes for discharge / transfer address the needs of the consumer / patient for ongoing care.

High Priority: No

Recommendation:

A process to formalise the evaluation of transfers from CGHS to other health services be developed in order to identify opportunities for improvement if required.

Function: Clinical

Standard:1.5

Criterion: 1.5.2

The infection control system supports safe practice and ensures a safe environment for consumers / patients and health care workers.

High Priority: No

Recommendation:

A process be developed to ensure that information relating to infection control risks, relevant to individual roles and responsibilities, are understood by all staff.

Function: Corporate

Standard:3.2

Criterion: 3.2.1

Safety management systems ensure safety and well being for consumers / patients, staff, visitors and contractors.

High Priority: No

Recommendation:

A duress security alarm be implemented for staff use in Loch Sport and Rosedale.

Function: Corporate

Standard:3.2

Criterion: 3.2.4

Emergency and disaster management supports safe practice and a safe environment.

High Priority: No

Recommendation:

A schedule for annual evacuation practice be developed and implemented for all areas within CGHS.

Recommendations from Previous Survey

Recommendation: OWS07081.1.5

Function: Clinical

Standard: 1.1

Criterion: 1.1.5 Processes for discharge / transfer address the needs of the consumer / patient for ongoing care.

High Priority: No

Recommendation:

A system be developed to ensure RMOs complete discharge summaries prior to their completion of a rotation.

Action:

Health Information Manager has a system in place to monitor the completion of summaries prior to the Hospital Medical Officer leaving the organisation.

In response to this recommendation, a Discharge Information Procedure has been developed outlining the requirements of Hospital Medical Officers to complete discharge summaries on the day of discharge as well as the required content of the discharge summary. This Procedure is provided to the Hospital Medical Officers in their orientation pack and on the day of orientation the Health Information Manager and Quality Manager meet with them to further explain the requirements of discharge summary completion. It is emphasised that the discharge summaries must be completed prior to leaving the organisation.

An extra computer has been relocated into the Health Information Services department so that Hospital Medical Officers have the availability of a computer to complete discharge summaries. As well the electronic discharge summary template is available on the PC's in the clinical units.

Previously in existence was a Stamp that was used to indicate that "The Discharge Summary has not been completed due to HMO Rotation". Since the system has been introduced to alert Hospital Medical Officers of the requirement to complete discharge summaries, this stamp has been removed.

Audit conducted 26th August 2009 - to establish that discharge summaries had been completed by the most recent Hospital Medical Officer prior to completing rotation. The audit revealed a 100% compliance to this requirement.

Completion Due By: 30/6/2008

Responsibility: Health Information Manager

Organisation Completed:

Surveyor's Comments:

Recomm. Closed: Yes

The actions described by the organisation were verified at survey. The recommendation has been well addressed and is closed.

Recommendation: OWS07082.1.3

Function: Support

Standard: 2.1

Criterion: 2.1.3 Health care incidents, complaints and feedback are managed to ensure improvements to the systems of care.

High Priority: No

Recommendation:

All clinicians be involved in clinical audit processes which inform the service-wide quality improvement / risk management process.

Action:

A procedure has been developed regarding management of surveys and audits which is to be presented to Leadership and Management Committee

· **The current list of clinical audits includes:**

ACHS Indicator for Laparoscopic Cholecystectomy

Leaks following Bowel Anastomosis

Stroke Management - including ACHS Indicator CT Scans - and Door to Needle Time Stroke Thrombolysis

ACHS Indicator for Triage Times

ACHS Indicator Door to Needle Time Cardiac Thrombolysis

Case audits through Morbidity and Mortality Committee

Case audits at Perinatal Audit Committee

Perinatal Indicators sent to Department of Human Services - audit of Birthing Outcome Summaries prior to sending

Physiotherapy has undertaken audit in the clinical setting, involving all Physiotherapy staff

Central Gippsland Health Service has just signed to be part of a survey conducted by Melbourne University, which will in part assess the "physical, mental and social wellbeing of COPD patients" - this applies to the Pulmonary Rehabilitation Group

All Participants within the cardiac, pulmonary, hip and knee, falls groups are surveyed pre and post to ascertain the effectiveness of the format of the groups.

Resuscitation Plan annual audit

Infection Control annual audit plan

Unplanned readmissions - Neonates - conducted by Paediatricians

Hospital Medical Officers audit all Medical Emergencies and Code Blue events

Specific Case Presentations at Grand Round by Multidisciplinary Groups

Dental Service / waiting list auditing

Physiotherapy auditing within the acute setting, involving all Physiotherapy staff

Central Gippsland Health Service has just signed on to be part of a survey conducted by Monash University which will in part assess the "physical, mental and social wellbeing of COPD patients" - this applies to the Pulmonary Rehabilitation Group

All participants within the cardiac, pulmonary, hip and knee and falls groups are surveyed pre and post treatment to ascertain the effectiveness of the format of the group

Speech Pathology (November 2008 and July 2009) have conducted audits in the acute wards to monitor if patients on texture modified diets are receiving the correct food / drinks.

Completion Due By: October 2009

Responsibility: Quality Department

Organisation Completed:

Surveyor's Comments:

Recomm. Closed: Yes

As outlined above, in late October 2009 the Leadership and Management Committee will receive the Clinical Services Division Draft Clinical Indicators for endorsement. This will be accompanied by a procedure to manage surveys and audits.
Action taken by Central Gippsland Health Service (CGHS) indicated that all clinicians are well represented in the clinical audit process and the results of clinical audits are reviewed in multidisciplinary forums and widely disseminated to all clinicians.

Recommendation: OWS07082.2.3

Function: Support

Standard: 2.2

Criterion: 2.2.3 The continuing employment and performance development system ensures the competence of staff and volunteers.

High Priority: No

Recommendation:

The implementation of the revised performance management system be continued.

Action:

Performance Development Procedure - implemented and current
Annual Performance Development is an expectation of Department Heads. This expectation has been delivered to the Department Heads Meeting - monitoring of the rate of interviews held to be undertaken by Directors
Performance Development Interview Tool has been reviewed
Data managed on the Payroll System (SAP) so that Department Heads may receive a report on staff who have not had annual Performance Development interviews

A major Plan for Improvement pertaining to this recommendation is:

In line with the Strategic Plan, Key Area Number 2 is: Workforce Capability = right person, right skills, right place, right time.

One strategy is identified as:

" Utilise the capability development framework to identify and develop talent and encourage the acquisition of additional capability through individual learning and development plans"

Completion Due By: June 2010

Responsibility: Chief Executive Officer

Organisation Completed:

Surveyor's Comments:

Recomm. Closed: Yes

It is evident that departmental heads are accountable for the annual review of staff performance. The tool used for staff interview has been revised and the payroll system provides a prompt for managers to ensure that staff who have not had annual reviews are followed up. Records viewed during the Periodic Review confirmed that this practice is continuous and there was also evidence that the majority of staff have had their recent annual review.

When implemented in 2010, a major new initiative for CGHS will provide a most comprehensive approach to ensure that the competence of staff and volunteers is incorporated into the continuing employment and performance development system. The new workforce capability framework, Strategic Plan Key Area 2, is based on the Hunter New England Health Service model and references national and international frameworks and systems. The framework is also premised on the understanding that capability is the link between strategy and performance as well as the importance of the relationship between the work to be performed and the personal abilities and attributes of the staff who carry out the work. The system shows great promise and will provide another mechanism for benchmarking performance.