HR 5.1.6

CLINICAL EDUCATION PACK

The following educational topics are **mandatory** training requirements under the National Standards for all of the Clinical Workforce in Australian Hospitals.

As part of the facilities annual compliance processes to the National Standards, the following self-directed learning educational information is provided:

- **Emergency Procedures**
  - Emergency codes
  - Emergency response assessment / RACE
  - Malignant Hyperthermia – Dantrium process
  - Evacuation
  - Power failure

- **Cardio Pulmonary Resuscitation**
  - Emergency trolley

- **Recognition And Management Of Patients Who Are Deteriorating**
  - Standard Clinical Tools
  - Mental Health
  - Alterations to calling Criteria

- **Infection Control**
  - Aseptic Technique
  - Hand Hygiene
  - Pandemic planning

- **Open Disclosure**
  - The process
  - Deciding not to go ahead
  - Points to remember

- **Complaints**
  - The complaints management process

- **Patient Centred Care**
  - Principles of patient centred care
  - Objectives of patient centred care
  - Model of care

- **Antimicrobial Utilisation**
  - Antimicrobial stewardship programme
  - Antimicrobial usage
  - Evaluation

- **Aboriginal and Torres Strait Islander Cultural Awareness**

EMERGENCY PROCEDURES

PRESMED AUSTRALIA facilities provide care for patients undergoing elective surgery. In the event of an emergency, the facility would cancel any remaining patients or operating lists while the situation was controlled, resolved and investigated.

EMERGENCY CODES

Flip Charts are prominently displayed in the facility at all telephones and staff are educated in their use. The following Emergency Codes are used to identify and announce a particular emergency situation and each code has a related policy:

CODE RED	Fire
CODE BLUE	Medical Emergency / Cardiac Arrest
CODE PURPLE	Bomb/Arson
CODE BLACK	Personal Threat
CODE ORANGE	Evacuation
CODE YELLOW	Internal Disaster
CODE BROWN	External Disaster

- The telephone system is the main communication link in an emergency situation. If the telephone system fails, call 112 from a mobile phone
- If the Fire alarm fails, and/or an alternate emergency service is required, telephone 000 and ask for the fire department or required emergency service.
- If a bomb or arson threat is received via the phone – Do Not Hang Up the Receiver – Leave the Line Open as this may allow the police to trace the call

MALIGNANT HYPERTHERMIA - DANTRIUM PROCESS

Stored in the Malignant Hyperthermia box in the Anaesthetic area.

- 24 Vials Dantrium
- Sterile Water for Injection

Additional Dantrium supplies are located at the closest public hospital, who are alerted as soon as Malignant Hyperthermia is detected in a patient. Advice can be given to the anaesthetist if required.

If an urgent delivery of Dantrium is required, the Police are asked to collect the Dantrium from the hospital and deliver to the facility

EMERGENCY RESPONSE ASSESSMENT / RACE

This should be undertaken simultaneously if possible, or in order that provides for the highest level of life safety.

- R – Remove persons from immediate danger if safe to do so
- A – Alert other people
- C – Confine the fire and smoke by closing all doors if safe to do so on exit
- E – Extinguish the fire if safe to do so.

EVACUATION

"IF IN DOUBT – EVACUATE" should be followed if it will be the safest action for patients and staff. Floor plans are displayed throughout the facility and detail the exits and emergency equipment locations. The emergency equipment available is fire blankets, fire extinguishers and a fire hose reel.

Stages of Evacuation

Depending on the nature of the emergency and instructions given by the Fire Officer or external emergency personnel, an evacuation could be staged as follows:

Stage 1
- An assembly area that is a safe distance from the fire and smoke.
- Once the area has been evacuated, doors should be closed to localise the fire/smoke/incident.

Stage 2
- When the fire is not being contained in its localised area, or smoke is percolating out to passages, corridors, etc., it will be necessary to evacuate the building.
- All available staff are required to assist in the movement of patient and others to a place of safety.

Evacuating Patients

Evacuate in group form and staged sections on direction of Fire Officer
- Ambulant patients, requiring a staff member to guide or direct them to a place of safety
- Semi-ambulant patients, requiring some physical assistance
- Non-ambulant patients who need to be physically moved or carried
- Non-compliant aggressive, violent or resistive persons

Methods of Assisting Patients in Evacuation

These are determined by clinical staff as to the most suitable method, depending on their condition and with due consideration to their ongoing medical needs.

- Fore and Aft carry
- Swing and hand seat carry
- Human crutch support
- Sheet
- Recliner chairs or Trolleys through EXIT doors

Evacuated Patients

- When the facility remains unsafe to be re-entered, the Fire Safety Officer / Delegate to arrange Ambulance support according to patient needs
- Contact the closest public hospital and advise the Emergency Department and Theatre of patients for transfer:
    - CCDH – Contact Gosford Hospital – 02 4320 2111
    - ESC – Contact Ryde Hospital – 02 9858 7888
    - CPH – Contact the Royal North Shore – 02 9926 7483
    - MDS – Contact Hornsby Ku-ring-gai Hospital - 02 9477 9123
- Patient Clinical Records accompany them out of the facility prior to transfer

ASSEMBLY AREAS

Assembly areas are shown on the evacuation diagrams and are documented on the flip charts within the facility.

- CENTRAL COAST DAY HOSPITAL: Car Park Entry on Ilya Avenue
- EPPING SURGERY CENTRE: Arden Anglican School, 50 Oxford Street Epping.
- CHATSWOOD PRIVATE HOSPITAL: Corner Archer & Albert Avenue Chatswood
- MADISON DAY SURGERY: Intersection of Burdett and Hunter Streets

POWER FAILURE

In the event of a power failure:

- The facility has a UPS (Uninterrupted Power Supply) Systems
- Emergency lighting will activate in each theatre, SSD and patient care areas.
- Torches are located in all areas of the facility for use in an emergency and to supplement the emergency lighting
- It is important to conserve power during the failure by switching off all unnecessary lights and electrical equipment
- The surgeon and anaesthetist will make a decision on how to proceed, by either terminating or completing the episode of care. All staff & AMP's must be aware that the UPS is able to supply power for the following time frames:

	CCDH	ESC	CPH	MDS
Estimated Run Time	60 minutes	30 minutes	Unlimited – Diesel Generator	65 minutes

CARDIO PULMONARY RESUSCITATION

CPR should commence with chest compressions and interruptions to compressions must be minimised. Priorities in CPR are defibrillation, oxygenation and ventilation together with external cardiac compression.

STEPS OF RESUSCITATION: DRABCD

1. Check for Danger (hazards, risks, safety)
2. Check for Response (if unresponsive)
3. Send for help
4. Open the airway
5. Check breathing (if not breathing / abnormal breathing)
6. Give 30 chest compressions (almost 2 compressions per second) followed by two breaths (should result in the delivery of five cycles in approximately 2 minutes)
7. Attach an AED (Automated External Defibrillator) if available and follow the prompts

COMPRESSION VENTILATION RATIO

30 compressions to 2 ventilations is recommended for all ages, regardless of the number of people present. Compressions must be paused to allow for ventilations but not to check for response or breathing.

DURATION OF CPR

Continue until:

- The patient responds or begins breathing normally
- It is impossible to continue (e.g. exhaustion)
- CPR is taken over by another health care professional
- CPR is directed to be ceased by a senior health care professional

EMERGENCY TROLLEY

The facility has an emergency trolley that contains equipment and medications that meet the Australian Resuscitation Council Guidelines 2010 and the NSW Ministry of Health requirements.

EQUIPMENT:

- Airways, laryngeal masks and ET tubes
- Bag – valve- mask
- IV cannulas, giving sets and fluids
- Oxygen and suction
- Defibrillator with AED function
- Dedicated Paediatric Broselow trolley for the facility's that admit Paediatric patients

MEDICATIONS:

- IV drug administration is preferable and most easily achieved via a peripheral cannula. An Intraosseous needle is available if required for safe, effective delivery of fluids and drugs.
- Medications available include:

Adrenaline	Magnesium
Amiodrane	Potassium
Calcium	Sodium bicarbonate
Lignocaine	

INFECTION CONTROL

Adherence to the principle of infection control is essential to reducing infections that are a direct or indirect result of healthcare. Patients and health care workers are the most likely source of the infectious agents and are the most common susceptible host. Health care workers and visitors may also be at risk of both infection and transmission. In health care settings the modes of transmission of infectious agents are contact (including blood borne), droplet and airborne).

In accordance with the principle, the facility has implemented work practices that reduce the risk of the transmission of infectious agents through a two tiered approach:

1. Standard precautions:

   Work practices are applied to everyone regardless of their perceived or confirmed infectious status that ensures a basic level of infection control.

   Strategies include:

   - Personal hand hygiene practice
   - Use of gloves, gowns, plastic aprons, masks/Shields, eye protection
   - Safe handling of and disposable of sharps- non touch technique
   - Environmental control- cleaning and spills management
   - Appropriate reprocessing of reusable equipment & instruments
   - Practising respiratory hygiene & etiquette
   - Aseptic technique
   - Appropriate handling of waste and linen

This practice is regularly monitored and reported back to MACC & Board of Directors

2. Transmission precautions:

   Effectively managing infectious agents where standard precaution may not be sufficient on their own. Additional transmission precautions are then implemented such as Contact, Droplet & Airborne.

   Strategies include:
   - Pre risk assessment
   - Isolating/ segregation of known patients,
   - Scheduling last on the list
   - Wearing specified personal protective equipment
   - Providing patient dedicated equipment

- Use of an appropriate Therapeutic Goods Administration- listed hospital grade disinfectant with special claims
- Using specific air handling techniques
- Restricting the movement of both patients & health care workers
- Restricting the number of visitors to the centre

RECOGNITION AND MANAGEMENT OF PATIENTS WHO ARE DETERIORATING

Prompt and effective review is an essential to managing patients who are clinically deteriorating.

Presmed facilities uses five clinical observation charts that supports clinicians to recognise when a patient is physiologically deteriorating and outlines the appropriate response.

Approved for use:

- Observation & Response Adult
- Observation & Response 0-12mths
- Observation & Response s 1-4
- Observation & Response 5-11
- Observation &Response 12-16yrs

This chart is automatically selected within the DOX medical record system. The Observation Chart incorporates a colour coded "Track and trigger" tool. Patients observations are documented in either the Yellow (Increased Surveillance, Orange (Clinical Review) or Purple zone (Emergency Call-Rapid Response) format to alert clinicians to patients who are deteriorating by graphically "tracking" their vital sign observations over time and "triggering" an appropriate escalation of care. The colour zone triggers actions for a clinical review request. The chart also includes a list of additional colour- coded escalation criteria that include other standard signs and symptoms of deterioration. Documentation includes treatment provided, changes to care plans and / or new criteria for escalation.

Escalation of care responses may be also be initiated by patients/carers. Research shows that facilitation escalation of care responses from patients/carers improves outcomes for patients. Presmed policy is that if patients/carers request a review of their care due to concerns about their health, then staff members must escalate their request to a AMP and ensure that the clinical review is documented in the *MR 10 Observations and response form.*

Alteration to Criteria

It is recommended that patients with clinical needs which differ from approved clinical management be documented in the medical record by the treating medical officer and alterations made to the calling criteria based on assessment of the patient. If abnormal observations are to be tolerated for the patient's clinical condition, write the acceptable ranges in the modification section where a Clinical Review or Emergency Call / Rapid Response will not be triggered.

Altered calling criteria are only to be used:

- To align calling criteria with the patients baseline vital sign observation baseline parameters when they are above or below the standard calling criteria
- If the course of the patients disease or condition, recovery from a particular intervention, is expected to be above or below the standard calling criteria
- If the proposed changes to the standard calling criteria will improve detection of patient deterioration

Mental Deterioration:

Presmed facilities have risk averse patient selection policies, that is, basically well patients are admitted. The patient selection policy specifically states that unstable mental health patients are not suitable for elective surgery. Pre-operative screening and assessment process with AMP's and nursing staff are effective. There have been no cases of patients being admitted across the PMA Group who have thoughts of self-harm, expressed suicidal ideation, violence and aggression. The use of restraint is not permitted and there has been no instances of restraint required across our Group.

Some people experience a period of confusion after anaesthesia and potential aggression, is relevant to our context and case mix, in these circumstances. In rare instances, they may behave aggressively while in this agitated state. Refer to Policy CM1.26 Delirium and Cognitive Impairment Risk Assessment and Interventions for further information.

Safe patient handling techniques may occur in the context of post-operative delirium, whereby Post Anaesthesia Recovery Unit (PACU) staff may be required to safely care for a patient waking up from their anaesthetic, in a disorientated and confused state. Post-operative delirium is monitored as a clinical indicator by the organization. Staff complete a QSIR report so that this indicator is reported to the MAAC and Board.

There is no chart available for tracking a person's mental state. If a response is initiated when it is recognised there is a deterioration in the mental state in a person for whom you are providing health care:

- Present an empathetic and calm response to a person's distress. This can immediately deescalate a situation. Be nonjudgmental, respectful
- Mobilise a person's existing supports will also contribute to an effective response
- Referral to a patient's GP, further Mental Health teams, ED staff will be made if required, on a case by case basis should there be ongoing issues with any of the above requiring further care. These discussions will be made with the patient and their family or carer
- Accessing the patients 'My Health Record' may contribute to improved communication with external care providers and improve continuity and coordination of care as people are transferred to an acute health service
- Clinicians should consider if symptoms indicate the person is experiencing delirium and manage the condition when it occurs.
- Consult the person experiencing deterioration about what is happening to them
- Incorporate information if known, a person's advance care plan and ensure this is incorporated into the response
- Use a structured clinical handover to effectively communicate about a person's health care

INFECTION CONTROL

ASEPTIC TECHNIQUE

Aseptic technique is a framework for aseptic practice. In aseptic technique, asepsis is ensured by identifying and then protecting key parts and key sites from contamination.

This is achieved by correct:

1. Hand hygiene,
2. Non touch technique,

3. Using new sterilised equipment and or
4. Cleaning existing key parts to a standard that renders them aseptic prior to use.

Core infection control components:

1. **Key parts and key sites identification and protection** - key parts must be identified and protected at all times. Aseptic key parts must only come into contact with other aseptic key parts and / or key sites.
2. **Hand hygiene** – Effective hand hygiene is an essential part of aseptic technique. It is known that hand hygiene is not always performed correctly thus identifying key parts and not touching them is vital in maintaining asepsis.

Aseptic fields

Aseptic fields provide a controlled aseptic working space to help maintain integrity of the asepsis during clinical procedures. Size of the aseptic field will be dependent upon the complexity of the procedure to be performed.

- Critical aseptic fields are used when key parts and or key sites (usually due to their size or number), cannot be easily protected at all times with covers and caps, or handled at all times by non-touch technique such as in the operating theatres.
- Critical micro aseptic fields involve covering or protecting key parts with syringe caps, sheaths, covers or packaging. The inside of caps and covers is sterile and provides optimum aseptic field for key parts.
- General aseptic fields are used for standard aseptic technique when key parts can be easily and optimally protected. The main general aseptic field does not have to be managed as a key part and is essentially promoting rather than ensuring asepsis

Standard Aseptic technique

- Typically short duration procedures (less than 20 minutes)
- Technically simple procedures
- Involve relatively few and small key sites and key parts
- Require main general aseptic field and non-sterile gloves
- Use of critical micro aseptic fields and non-touch technique is essential to protect key parts and key sites

Surgical Aseptic technique

- Technically complex procedures
- Involve extended period of time
- Large open key sites or large or numerous key parts
- Require main critical aseptic field and sterile gloves and full barrier precautions
- Use of critical aseptic fields and non-touch technique is used where practical to do so

HAND HYGIENE

The 5 moments of hand hygiene are:

1. Before touching a patient in any way

2. Before doing a procedure, once hand hygiene is done, nothing else in the environment should be touched prior to the procedure starting
3. After a procedure or exposure to body fluids to prevent health care working infection or environmental contamination
4. After touching a patient to prevent health care working infection or environmental contamination
5. After touching a patient surrounds or belongings, even though the patient has not been touched

- **HAND WASHING** should be done immediately if body substances contaminate them. Hand rub is not recommended if hands are grossly contaminated

- **HAND RUB** should be used for most hand hygiene activities as it is more effective, quicker to use and better tolerated by the hands. It is also easily accessed at the point of care.

- **A SURGICAL HAND WASH** or rub is required for surgical aseptic technique. The first wash of the day should be 5 minutes, with subsequent washes of 3 minutes or surgical hand rub completed. Alcohol based surgical hand rub is available at most facilities as a replacement to the traditional method. Antimicrobial surgical hand scrub agents and alcohol hand rub agents should not be used sequentially.

- **HAND HYGIENE AUDITS** are conducted throughout the year to ensure compliance of medical and nursing staff to the 5 moments of hand hygiene.

Glove use

If it is necessary to touch key parts or key sites directly, sterile gloves are used to minimize risk of contamination, body fluid exposure and / or exposure to any drugs that may be administered during the procedure. Disposable gloves are provided for non-sterile procedures; however this does not negate the need for hand hygiene to be performed. Hands must be washed and dried, or hand rub used, before donning gloves and after the removal of gloves. Latex free gloves are available on request

PANDEMIC PLANNING

PresMed facilities have a framework in place to aid a response to an influenza pandemic and to other outbreaks of other respiratory pathogens with pandemic potential. The plan is always “active’.

The plan provides a strategic outline of possible PresMed response activities that are tailored during an influenza pandemic response**.**

The development of this sub plan has been informed by the following pandemic plans:

- National whole-of-government influenza pandemic plan – National Action Plan for Human Influenza Pandemic (NAPHIP)

- National health influenza pandemic plan – Australian Health Management Plan for Pandemic Influenza (AHMPPI)

- NSW whole-of-government influenza pandemic plan – NSW Human Influenza Pandemic Plan (NSW HIPP).

The key objectives of the pandemic response for PresMed facilities are to:

- Minimise transmission, morbidity and mortality of the pandemic virus in patients and staff

- Inform, engage and empower health professionals to assist in the response to the pandemic

- Maintain effective functioning during the pandemic response so as to achieve optimum health outcomes during a sustained influenza pandemic

The strategies to date that have been implemented to COVID 19 are in accordance with Commonwealth Government, NSW Health, Local Public Health include:

- Pre-operative respiratory risk screening measures at the pre-op call.
- Temperature checking and respiratory risk screening on admission for all patients/carers/visitors.
- Reduction in the numbers of carer's waiting in the waiting room and their access to the clinical area.
- Temperature checking and respiratory risk screening daily for all staff, doctors and theatre visitors.
- Social distancing measures with added signage/Perspex barriers at reception.
- Extra daily cleaning measures for high-frequency touch surfaces.
- All staff and doctors have completed a competency of donning and doffing PPE.
- Education to all staff on PPE videos.
- Heightened awareness of staff and doctor health. Any staff member or doctor unwell required to not attend work and get tested.
- A risk-averse approach was adopted to all patients. All symptomatic patients have been cancelled following discussion with the surgeon/anaesthetist, sent for testing if relevant and rescheduled when they are negative and asymptomatic.

Health Care workers under Regulation 46 the "Work Health and Safety Regulations 2017 NSW" have a duty to when provided with PPE by their employer must:

- Use or wear PPE in accordance with any information, training or reasonable instruction provided by the facility, so far as they are reasonably able.
- Not intentionally misuse or damage the PPE
- Inform the facility of any damage, defect or need to clean or decontaminate (if reusable) any of the PPE if they become aware of it.

Health care workers should not use or add to prescribed PPE that is not provided by PresMed facilities.

OPEN DISCLOSURE

Open disclosure is the open discussion of adverse events that result in harm to a patient while receiving healthcare. The discussion takes place with the patient, their family and carers (support people). It is important to note that it is not a one-way provision of information – it is a discussion between two parties
And may take place in several meetings over a period of time and provides support for all parties involved.

Open disclosure is required when a patient has suffered some unintended harm (physical or psychological) as a result of treatment. This may be a recognised complication, unanticipated incident or a result of human or system error. It involves the requirement to say sorry without admission or blame and is an ethical practice that prioritises organisational and individual learning from error.

If no harm is immediately apparent but could appear in the future as a result of the adverse event, then disclosure should be initiated so that the patient knows what potential signs and symptoms to look out for. This is a matter of judgement made by the healthcare team.

The elements of open disclosure

- An apology or expression of regret, which should include the words 'I am sorry' or 'we are sorry'
- A factual explanation of what happened
- An opportunity for the patient, their family and carers to relate their experience
- A discussion of the potential consequences of the adverse event
- An explanation of the steps being taken to manage the adverse event and prevent recurrence.

THE PROCESS

1. Detecting and assessing incidents

- Provide prompt clinical care to the patient to prevent further harm.
- Assess the incident for severity of harm and level of response
- Provide support for any staff involved as required.
- Notify relevant personnel and authorities
- Ensure privacy and confidentiality of patients and clinicians.

2. Signal the need for Open Disclosure

- Acknowledge the adverse event to the patient, their family and cares, including an apology or expression of regret.
- This may be the only requirement for a low level incident.
- Negotiate with the patient, family &/or carer
    - The level of formality required
    - The time and place for disclosure to take place
    - Who should be present
- Provide written confirmation of the meeting
- Provide a contact for the patient , family /carer from the facility
- Avoid speculation or blame
- Maintain good verbal and written communication throughout the process

3. Prepare for Open Disclosure

- Hold a multidisciplinary team discussion to prepare
- Consider who will participate
- Appoint a leader for the discussion based on previous involvement with patient, family &/or carer
- Gather all necessary information
- Identify contact person if this hasn't been done

4. Engage in Open Disclosure

- Offer practical and emotional support to the patient, family and carer
- Support staff members throughout the process
- It may be necessary to hold several meetings or discussions to achieve all these aims

5. Providing Follow –up

- Ensure follow-up is done by senior clinicians or management where appropriate
- Agree on future care
- Share the findings of investigations and the resulting change in practice
- Off the patient, family &/or carers the opportunity to discuss the process with another clinician e.g., their GP.

6. Completing the Process

- Reach an agreement between the patient, family &/or carer and the clinician, or provided an alternative course of action
- Provide the patient, family &/or carer with final written and verbal communication that includes investigation findings
- Communicate the details of the adverse event, and outcomes of the process, to other relevant clinicians

7. Maintaining Documentation

- Keep the clinical record up to date
- Maintain a record of the Open Disclosure process
- File documents relating to the process in the clinical record
- Provide the patient with documentation throughout the process

DECIDING NOT TO GO AHEAD

- Decisions of non-disclosure, for any reason, need to be documented in the clinical record.
- The timing may be dependent on the condition of the patient and the availability of their support person.
- It may be deemed that the incident doesn't warrant Open Disclosure
- The decision must be defensible in public.

POINTS TO REMEMBER

- An apology is not an admission of guilt and neither is an expression of regret.
- Acknowledging an adverse event, apologising or expressing regret, is not an admission of liability.
- Open disclosure does not, of itself, create legal liability. Liability is established by a court based on evidence which may include statements made either before or after the event.
- Don't pre-empt results of investigations, apportion blame, state or agree that anyone is liable for the harm caused.

COMPLAINTS

Patients are made aware that the facility has a patient complaints process in the Patient Information Booklet which patients receive at the time of booking. Complaints can be directed to the Chief Operating Officer or Clinical Manager/DON. Alternatively, patient or carers may lodge a complaint directly with:

Complaints – Health Care Complaints Commission (HCCC)
Or
NSW Private Health Branch

THE COMPLAINTS MANAGEMENT PROCESS

The aim is to ensure that identified risks arising from complaints are managed appropriately, that complainants' issues are addressed satisfactorily, that effective action is taken to improve care for all patients, and that facility staff are supported.

STAGE 1: RECEIVE THE COMPLAINT

The key actions for staff when receiving a complaint are to:

- Actively listen to the complainant;
- Empathise, understand and acknowledge their viewpoint;
- Express regret that they have had a poor experience, and
- Assure them steps will be taken to investigate and resolve their concerns.
- Look for solutions

- Acknowledge receipt of the complaint
- Record the complaint - create a comprehensive record of conversations, concerns, names, addresses, hospital numbers, providers, etc. Other key aspects are the service provided, dates and times. The written record of the complaint is the basis of any action taken about the complaint.

STAGE 2: ASSESS THE COMPLAINT

There are several steps:

- Identify the issues raised
- Identify the parties involved
- If necessary obtain patient authorities
- Rate the severity of the complaint using *L&M 3.5.1 'Severity Assessment Code Matrix'*

STAGE 3: INVESTIGATE THE COMPLAINT

- Obtain a sufficient amount of clinical and other information in order to decide what has occurred and identify appropriate action.
- Analyse the information collected and prepare Investigation Report

STAGE 4: RESOLVE THE COMPLAINT

The parties to a complaint are advised about the outcome. This may be achieved by providing a copy of the investigation report or it may be more appropriate to communicate the report's information in a letter format.

Conciliation

A complaint may not have been serious enough to warrant a full investigation, although a straightforward resolution may not be possible. Conciliation is a process whereby a conciliator facilitates the resolution of disputes. A complaint may be suitable for conciliation if there has been a breakdown in communication between the parties, if insufficient information was provided, if an inadequate explanation was given for an adverse outcome, or if there was an inadequate service. The Chief Operating Officer (COO), in conjunction with the Managing Director (MD) and Board of Directors, will make the determination for engaging external conciliation.

Recording and using complaints data

Complaints information is used to record data, to monitor trends and to assist in service quality improvement as part of the facilities key performance indicators.

PATIENT CENTRED CARE

Patient Centred Care is used to create a health service that is responsive to patient, carer and consumer input and needs. The application of patient centred care provides a standard of nursing care and clinical performance that reflects best practice. Ensuring that there are effective partnerships between consumers and the organisation at all levels of healthcare provision, planning, and evaluation have been associated with decreased readmission rates, decreased healthcare acquired infection rates, reduced length of stay, and improved adherence to treatment regimens.

THE PRINCIPLES OF PATIENT CENTRED CARE

- The patient is empowered to make decisions about their care.
- It is respectful of and responsive to the preferences, needs and values of the patient.
- The nurse is responsible for the care they provide and has the role of educator
- A professional service is provided in a professional and contemporary model of care

OBJECTIVES OF PATIENT CENTRED CARE

- Care delivered in a timely, safe and appropriate manner according to professional standards, medico-legal and statutory requirements.
- Nursing delivery of inpatient care will be reflective of patient acuity and staff skill level.
- Care is co-coordinated to ensure the best possible outcomes for the patient.
- Care delivered in a timely, safe and appropriate manner according to professional standards, medico-legal and statutory requirements.
- Nursing delivery of inpatient care will be reflective of patient acuity and staff skill level.
- Care is co-coordinated to ensure the best possible outcomes for the patient.

MODEL OF CARE

- The patient is the centre of care.
- A relationship is established with the patient by
  - Staff introducing themselves,
  - Staff discussing the plan of care,
  - Staff asking the patient if they need anything before leaving them,
  - Staff asking the patient if there was anything that they expected to happen, or didn't expect to happen, that occurred today

ANTIMICROBIAL UTILISATION

Adherence to the principles of prudent antibiotic use is essential to avoid the danger of emerging drug resistance and provide best practice and quality care for the facility's patients.

The Facility recommends that antibiotics used should be appropriate for Clinical Specialty and the surgical prophylaxis intended to achieve. The Medical Advisory & Audit Committee has been proactive in the Facilities Antimicrobial Stewardship Policy development as the lead clinical advisory and oversight body. This policy has also been endorsed by the Facility Board. All Accredited Medical Practitioners (AMP's) have been informed of the Facilities approach to surgical prophylaxis and antimicrobial usage.

Antimicrobial usage is documented on MR9 Surgeons Record (operation report) for all patients. The Facility stocks minimal and limited supplies of alternative antibiotics.

Antimicrobial Stewardship Programme

Management in conjunction with the MAAC and Board review clinical indicators (L&M 3.2.2. Clinical Indicators and Audits) as part of our ongoing surveillance program. Indicators include:

- ACHS: Re-admission Cataract within 28 days – Endophalmitis
- ACHS: Re-admission Glaucoma within 28 days – Endophalmitis
- ACHS: Re-admission Retina within 28 days – Endophalmitis
- QPS: Post-operative infections

Antimicrobial Usage

Ophthalmology

- Evidenced-based literature supports the utilization of intra-cameral Cephalosporin's injected at the end of cataract surgery cases - (cataract surgery amounts to 80% of the total surgical workload across the PMA Facilities) 0.048% (.48 infections per 1000 cases) with Cephalosporin vs 0.35% (3.5 infections per 1000 cases) without Cephalosporin [ESCRS 2013]

- The MAAC endorsed surgeons having the choice of two Cephalosporin's – Cephazolin and Cefuroxime. This is because Sydney Eye Hospital utilisers Cephazolin whilst many of the European studies utilize Cefuroxime. Both have the same efficacy for surgical prophylaxis.

- The prescribing of Cephazolin and Cefuroxime for cataract surgery prophylaxis is consistent with the Therapeutic Guidelines (Australian): Antibiotic (2019). These Guidelines and eMIMS are available in every PMA Facility.

- A compounding pharmacy provides prepackaged Cephazolin and Cefuroxime. Surgeons may elect to utilize either of these two antibiotics.

- Alternative pre-packaged antibiotics will not be provided by the Facilities in order to discourage other antibiotic utilization inconsistent with the evidence in the literature.

- The use of intracameral antibiotics continues to be entirely up to the discretion of the treating Surgeon.

- Minimal supplies of alternative antibiotics are available at the Centre for peri-operative utilization. These antibiotics must be prepared by the scrub or surgeon at the time of use. A clinical competency is undertaken every year by scrub staff to ensure their compliance.

- **The MAAC and Clinical Microbiologist have identified Vancomycin as a restricted antibiotic for ophthalmic perioperative utilization. Vancomycin's use is restricted across the PMA Facilities.**

- Ophthalmic Surgeons and peri-operative nursing staff document on MR9 - Surgeons Record the antimicrobial used and administered.

- Povidone-Iodine (5-10%) (PVI) is used for all pre-operative antisepsis, unless allergy/contraindication, then aqueous chlorhexidine 0.05% is utilized.

- PVI is applied for three minutes to the cornea, conjunctival sac and periocular skin.

- Pre and post-operative antibiotic eye drops/ung are utilized at the Facilities as per Doctors standing orders. The eye drops/ung utilised is consistent with the Therapeutic Guidelines – Antibiotic.

- RANZCO'S "*Guidelines on Toxic Anterior Segment Syndrome*" 2015 provides advice on the potential causes of TASS, including the avoidance of post-operative PVI and ointment.

The MACC has determined that it is up to the individual surgeon's clinical preferences regarding this RANZCO Guideline.

Evaluation:

An audit of Antimicrobial Usage within each PMA Facility is conducted annually.

ABORIGINAL AND TORRES STRAIT ISLANDER CULTURAL

ABORIGINAL AND TORRES STRAIT ISLANDERS

The National Aboriginal Community Controlled Health Organisation (NACCHO) is the national peak Aboriginal health body representing Aboriginal community controlled health services throughout Australia. According to NACCHO, the model of primary health care is in keeping with the philosophy of Aboriginal community control and the holistic view of health that this entails:

> "Aboriginal health is not just the physical well-being of an individual but is the social, emotional and cultural well-being of the whole community in which each individual is able to achieve their full potential thereby bringing about the total well-being of their community." (Griew, 2008)

The following factors are important:

- Genuine local Aboriginal and Torres Strait Islander (ATSI) community engagement to maximise participation, up to and including full community control.
- A multidisciplinary team approach employing local community members.
- Service delivery that harmonises with local Aboriginal and Torres Strait Islander ways of life.

Current reform proposals in relation ATSI primary health care emphasise the importance of a family-centred approach. Family in this context has a broad community focus and recognises, for example, that Aboriginal and Torres Strait Islander children often have other significant carers in addition to their biological mother and father. Family-centred primary health care takes a life course approach, which, without neglecting adult health, focuses on establishing early life resilience and advantages in child development.

Australian Commission on Safety and Quality in Healthcare National Safety and Quality Health Service Standards Version 2

CLINICAL GOVERNANCE: STANDARD 1

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

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 & Torres Strait Islander (ATSI) Patients

- Ensure that actions to improve cultural competency are implemented and monitored for effectiveness
- Management reviewed the organisation's education and training policies and programs to ensure that they adequately cover the cultural competency and monitor workforce participation in training

- Day procedure services may have a small ATSI patient population. For many ATSI people receiving care in a day surgery, their risk of harm will be similar to that of the general patient population using the service

- Assessment of actions required to meet this standard is based on patient case-mix statistics

ASSESSMENT OF CASE-MIX

Presmed Facilities	ATSI Admissions (1July 2020 to 30 June 2021)	% ATSI Admissions vs Last Year
Chatswood Private Hospital	47 admissions	0.52% (LY 0.52%)
Epping Surgery Centre	10 admissions	0.45% (LY 0.52%)
Central Coast Day Hospital	67 admissions	1.26% (LY 0.93%)
Madison Day Surgery	1 admission	0.03% (LY 0%)

- The ATSI population % by Northern Sydney Local Health District is 0.4% (total: 3,360) and the Central Coast Local Health District is 3.8% (total: 12,485).
  Source: NSLHD & CCLHD Aboriginal Health Unit webpages July 2019

Based on our small number of admissions and small community size it is appropriate for our facilities to provide cultural awareness training to meet this standard as below:

This information is included in the Staff and AMP Mandatory Annual Clinical Education Pack.

STRATEGIES FOR IMPROVEMENT - CULTURE

- Having an effective culture in place means that an organisation has a defined set of values and principles and demonstrates behaviours, attitudes, policies and structures that enable it to work effectively. These values are embedded within our organisation's policy and procedures.
- Our existing Cultural & Linguistic Diversity (CALD) Policy recognises that health service organisations should acknowledge and be respectful of the cultural factors and complex kinship relationships that exist in the local ATSI community.
- Ensuring that health services and providers are culturally competent will lead to more effective health service delivery and better health outcomes.

STRATEGIES FOR IMPROVEMENT - EDUCATION & TRAINING

ATSI may not see mainstream health services offering them a safe and secure place to get well. Culture can influence ATSI people's decisions about when and why they should seek health services, their acceptance of treatment, the likelihood of adherence to treatment and follow up, and the likely success of prevention and health promotion strategies.

In many cases they experience:

- Isolation from community and kin
- Language barriers in understanding health messages and difficulty in informing clinicians of their needs
- Financial difficulties in gaining access to treatments (travel costs) and funding the costs of treatments
- Perceived inferior treatment

STRATEGIES FOR IMPROVEMENT – CULTURAL AWARENESS

History & Culture

- Timelines, white settlement, removal of cultural practices & denial of traditional lands, men's and women's business, apology & reconciliation
-

Identity

- The dreaming, land connectedness & spirituality, totems, language & significant events

Aboriginal Health

- Health statistics, 'closing the gap', aboriginal community controlled health sector & services, historical relationships

Communication

- Protocols, elders, consultation, community-based organisations, first language

Existing Barriers for Access to Health Services

- Racism, prejudice & discrimination, language,
- Education, employment, isolation, past experiences, community connectedness

There are clear significant disparities between ATSI people's standards of health to non-ATSI Australians. ATSI people's life expectancy is ten years less than non-ATSI people.

- ATSI experience a higher prevalence of chronic diseases, and chronic disease risk factors compared to non-ATSI. Circulatory disease, cancer, diabetes and respiratory disease accounts for approximately 70% of indigenous deaths.

LOCAL PRIORITIES

- NSLHD Aboriginal health priorities include HTN, diabetes, COPD, Coronary Artery Disease and Congestive Heart Failure.
- CCLHS Aboriginal health priorities include chronic care and pregnancy, child and family health.

FURTHER RESOURCES

- Further resources are available on both the NSLHD & CCLHD Aboriginal Health Unit websites.
- In our facilities reception areas and on our website we have the following ATSI specific eye-health promotion education booklet *All About Eyes – I See For Culture* an International Centre For Eye Care Education Publication (2009)

Staff should offer this book to any of our ATSI patients

Please sign the *Clinical Annual Compliance Form* once you have completed The above *Clinical Education Pack*, and return to your Clinical Manager / Director of Nursing.