Report of the Organisation Wide Survey for the ACHS Evaluation and Quality Improvement Program

Mt Alexander Hospital

Castlemaine, VIC

Organisation Code: 21 07 83

Survey Date: 9-10 September 2008
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ACHS Accreditation Status: ACCREDITED

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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

FUNCTION SUMMARY: CLINICAL

The Mt Alexander Hospital (MAH) staff and leadership group demonstrate a strong commitment to ongoing performance improvement and the delivery of high quality care and services to the community.

There are good assessment tools in place to support the multi disciplinary team in the identification and documentation of clinical issues and risks. A wide range of specialty and discipline related assessment tools are used, particularly in the rehabilitation setting. The survey team encourage the introduction of Functional Independence Measure (FIM) to support evaluation of care and benchmarking in the rehabilitation area. The documentation of the patients history and assessment by the doctor was done well in the selection of charts reviewed by the survey team. Discharge planning is a significant area of focus for the clinical teams in the acute ward and rehabilitation unit. Multidisciplinary team meetings are held in each area. The meeting in the acute ward targets patients who have exceeded their expected date of discharge. The ACAS officer has a welfare role; from this perspective she looks at broader support needs for patients who are isolated in their home or who have limited community support, including arranging transport home for the patient. There are measures in place to evaluate discharge planning, however the overall level of evaluation needs to be strengthened. The surveyors have recommended regular reviews of patients who are readmitted within 28 days and those inpatients that have been transferred for higher acuity care.

There are good tools in place to support care planning and delivery, and the identification and follow up of variances. A recommendation has been made regarding the systematic use of aggregated variance data. There are very good processes for multidisciplinary engagement in care planning within the rehabilitation team, with each allied health team and ACAS contributing to the patient review and updating of the plan. The acute ward have introduced the Longer Stay Older Patient initiative. Although births in the hospital are increasing, the surveyors note that the overall numbers are still relatively low. The survey team has made a recommendation regarding the need to have a formally structured clinical skills maintenance program, which should be mandatory for all nursing staff rostered as midwives. Recommendations have also been made regarding security issues associated with the location of the emergency room, and the need to upgrade the day stay patient facilities. There is a good system for care evaluation which includes all staff. Care evaluation forms part of the overall quality and risk management programme, details of which are comprehensively displayed on the hospital intranet. There is a schedule of audits and reviews for all staff and treatment groups and results are reported appropriately so that the Board is well informed of performance levels. At present, activities are not well outcome focussed and it is suggested that the emphasis needs to move to that of evaluation of the outcomes of care. The hospital requires a completed consent form before an elective patient will be accepted onto the theatre bookings list. A good level of consent compliance has been achieved. The correct patient/procedure/site policy compliance is monitored, and in the early stages of benchmarking comparison within the network. Audits show good levels of compliance, however this is largely due to the scrub nurse initiation of the team time out check procedure. A recommendation has been made to improve the level of surgeon initiation of this important check procedure, the rating for this criterion has been re-assigned to MA.

There are a range of ongoing care programs for patients with chronic illness. Program evaluation is based on feedback from the patients and assessment of their ongoing education needs. The survey team has recommended strengthening ongoing care evaluation through the introduction of indicators which reflect patient outcomes. The health service has appointed a nurse practitioner (candidate) to coordinate the Palliative Care service. There are some policies in place, however the survey team has identified areas where further policies should be developed. Carer surveys have been carried out, and staff education sessions evaluated, however overall the level of structured evaluation needs to be improved in order to achieve an MA rating.
Clinical care is enhanced by the use of an excellent clinical record that is appropriate for the facility. The service is well managed and according to feedback surveys well appreciated. Some of the IT systems need replacing and once this is achieved, the capacity of the service to provide good clinical information for review and evaluation will improve.

The strong networks with local doctors, and health service websites are used to inform the community of services offered by MAH. Service streams such as rehabilitation and the emergency department have good measures in place to prioritise access to services. There is a good level of awareness of the health service capabilities and its role designation, this could be strengthened through integrating the unit based admission criteria into a policy outlining admission and exclusion criteria for the service. There were good examples of the use of evidence based guidelines, however there is scope to introduce a more systematic approach to the use of evidence based information in care delivery.

Medication management is competently supervised by the pharmacists who provide a comprehensive and professional supply and clinical service. There is good reporting and follow up of medication incidents and errors and appropriate education of staff. Management and supply of blood and blood products is primarily by the pathology provider, whilst the administration of same is the hospital's responsibility. Two areas require attention; the consent process and form, and the training and credentialling of staff. However it is acknowledged that the size and limited role of the hospital means that use of blood products is low. There are clear policy frameworks for the management of falls and pressure area risk. Patient risk assessment tools are well utilised, these link to a range of care and safety interventions. Data on falls and pressure area incidents are used well to support evaluation.

Infection control policies are based on the regional policies. The infection control committee receive regular reports with trended data on infection rates, MROs and compliance with environmental audits. The survey team has noted the need for the VMO representative on the committee to attend more meetings. Hand hygiene audits show a good level of compliance overall, however there is scope for continued improvement and a greater focus on departments and disciplines where compliance is lower. Infection control programs in food services, theatre and related services and environmental services are well documented, with audits and documentation in place. Evaluation is sound, with good examples of benchmarking which have been used to identify performance improvement opportunities. The survey team has supported the EA rating in the infection control criterion.

There are good links between the health service, consumers and the community. There is scope to improve the structures which support consumer engagement, and to strengthen the level of evaluation. The survey team has re-assigned the rating for criterion 1.6.1 to MA. Patient rights and responsibilities are outlined in the patient information booklet. The health service has a clear understanding of the cultural and linguistic groups within the community. Policies and procedures are in place to support staff in service provision. The Cultural Care Plan received very good feedback from the DHS.
**Function: Clinical**  
**Standard: 1.1**

**Criterion: 1.1.1**

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

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**Surveyor's Comments:**

Clinical policies provide a framework for patient assessment. The general assessment and health history, undertaken on admission, has a good focus on the identification of risks such as pressure area and falls risk, and issues which may delay discharge. Additional assessment is undertaken in the specialty areas, the tools and methodologies used reflect professional guidelines and current practice. Assessment data is reviewed to ensure that patients are referred to the appropriate allied health teams and community based services.

A selection of clinical records was reviewed by the survey team; these showed well documented medical assessment and clinical history notes, and good evidence of the engagement of the multi disciplinary team in the ongoing assessment of patients.

The rehabilitation team use a range of assessment tools; Modified Barthels Index, Mini Mental, and tools to assess mobility and independence. This data is used systematically to update progress on care goals and discharge planning. The survey team note that FIM scores are not used. Many rehabilitation units use these scores to identify the level of improved function achieved during the admission. The survey team suggest that consideration be given to introducing FIM scores to support evaluation of care and to enable benchmarking with similar units and nationally through AROC. Wound care assessments are well documented. The ACAS team are actively involved in the rehabilitation ward, where patients require additional support or placement after discharge a comprehensive assessment is documented.

The acute ward includes acute medical and surgical patients, midwifery and the emergency room. Triage guidelines and assessment protocols are in place. The team has introduced a thrombosis risk screening tool. A number of records included the patients clinical summary from the GP practice electronic record. This provides a very good health history, recent assessment and medication profile. The survey team encourage this initiative.

Evaluation of assessment includes review of progress notes to assess the degree of completion of assessment documentation, reviews to confirm that the correct referrals were made based on the assessment data.

**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:**
Care plans and clinical pathways are used to plan and coordinate care. Variances are recorded in the acute ward and rehabilitation ward. These are followed up on a case by case basis, however the systematic use of aggregated variance data would strengthen the evaluation of care delivery and identify further improvement opportunities – a recommendation has been made.

The rehabilitation team actively uses patient variances to prompt updating of the rehab plan and discharge plans. The multi disciplinary team systematically evaluates care delivery and updates the care plan as the client progresses and goals are achieved. The ACAS team participates in the rehab case review meetings, this supports continuity of care into hostel or nursing home placement or care delivered by community based services.

The Longer Stay Older Patients initiative has been introduced in the acute ward, with a focus on assessment and person centred care. The overall goal of the program is to minimise functional decline during the hospital stay.

Regular clinical observations are in place to identify changes in the patients clinical status. Where a staff member is concerned about a deteriorating patient the senior nurse on duty reviews the patient and contacts the treating doctor or the doctor on call for advice. Where higher acuity care is required the patient is generally transferred to the Bendigo Health Care Group.

Clinical policies are effectively managed. There are clear procedures for the development of new policies, and a tracking system to identify policies which are approaching their review date. The health service has access to regional policies to support staff in specialty areas. The survey team note that new procedures have recently been introduced to improve compliance with regulations related to the checking out of Schedule 8 drugs from the DD cupboard in theatres. Compliance with the new procedures should be monitored over the next three to six months to ensure good practices are fully embedded.

The number of births at the hospital is rising (62 in 2006, and 70 in 2007), however the overall numbers are still relatively low. The service has a good number of midwives (18) and a midwifery post graduate student placement. Given the number of births it is conceivable that some midwives would have only one or two deliveries in a year, and some may have no deliveries during the period. There are a number of measures in place to support midwives in maintaining skills and updating knowledge. Staff have participated in the La Trobe University rural midwifery update, and the NETS team provide educational updates. There is early discussion about accessing a rotation placement at Bendigo Health Care Group – the survey team encourage this initiative. There is a need to develop and implement an annual mandatory structured program - clinical skills and knowledge updates, and clinical placements in a busy birthing unit - for all midwives who are rostered in that role, to ensure maintenance of specialty skills and recency of practice. The survey team has made a recommendation.

The day stay patient accommodation has fallen well behind similar units. There is a need to redevelop the unit to improve both patient amenity and privacy. The survey team has made a recommendation.
The emergency room is located within the acute ward adjacent to the staff station. There are a number of issues related to this location which should be addressed. The area is distant from the ambulance bay. Once the ED client and those who attend with him/her are in the ward area, there is no means to separate them from the inpatients should an aggression management situation arise. A recommendation has been made (refer to criterion 3.2.5) to consider relocating the emergency room closer to the ambulance bay and in an area which would enable separation from the inpatient area.

Care delivery is effectively evaluated on a case by case basis, with good systems to identify and respond to variances. Other evaluation includes follow up of clinical incidents and review of average length-of-stay trends.

**Surveyor's Recommendation:**

1. The aggregated variance data for higher volume case categories be regularly analysed in order to evaluate care outcomes and to identify improvement opportunities.

2. A structured program of annual mandatory clinical skills and knowledge updates, along with clinical placements in a busy birthing unit be developed, to ensure that all midwives rostered in that role maintain their specialty skills and recency of practice.

3. The day stay patient accommodation area be redeveloped to upgrade the facility, with particular attention to patient amenity and privacy.
**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:**

Consent policies are appropriate for the size and nature of the health service. Consent for elective procedures must be documented before the patient can be booked for surgery. The completed form is forwarded from the doctors' rooms with the request for admission documentation. The operating theatre team include a plain language check of the patient's consent in their patient identification checks when the patient arrives in the pre-operative holding area.

An incident form would be completed in any situation where the procedure went beyond the scope of the documented consent. A situation was discussed which demonstrated good principles of review, in that case it was clinically necessary due to complicating factors in the consented procedure.

Compliance audits are carried out, with good levels of compliance. There is some comparison of data with other units through the Operating Theatre Managers group. This is encouraged.

Many organisations have developed a guideline outlining all situations where consent is required, the level of consent and how it is to be documented. The survey team suggest that such a guideline be developed.

**Surveyor's Recommendation:**  
**HPR:** No
Organisation: Mt Alexander Hospital
Orgcode: 210783

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:

There is a detailed and comprehensive plan for the evaluation and review of services provided. Activities are reported through the appropriate Director's committee with a subsequent report to the Board. There is a program and reporting schedule for each clinical department and activity and this is detailed on the intranet together with all other quality reporting schedules. There is scope for improvement by now focussing on evaluating outcomes of care. Most current activities are system and audit based, for example, some programs aimed at management of chronic conditions are probably reducing hospital admissions for some conditions. Whilst process and access KPIs are known, the numbers of admissions prevented is not.

Medical specialists are not well engaged in peer review and care evaluation as all are primarily based elsewhere. It is thought that they should be encouraged to include their Mt Alexander Hospital cases in review activities at their parent hospital, with subsequent reporting to the Director of Medical Services. General practitioners participate in a mortality review process and need to extend this to include morbidity and outcome evaluations.

Surveyor's Recommendation: HPR: No

1. The hospital move the emphasis of care evaluation audits and reviews to focus more on the outcomes of care. This should include the medical staff becoming more involved in morbidity reviews as well as mortality reviews.

2. Specialist medical staff be encouraged to involve Mt Alexander Hospital patients in their peer review activities at their primary hospitals and report accordingly to Mt Alexander Hospital.
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:

There is effective multi disciplinary engagement in discharge planning across the service. Along with the case review meetings in the rehab unit, the clinical team on the acute ward meets twice weekly to develop and update discharge plans for patients with complex discharge needs; referrals can also be made to the ACAS team and social worker. The estimated date of discharge is used to identify outliers for inclusion in the review.

There are a range of patient discharge advice sheets provided for maternity and some surgical patients. The Domiciliary Midwife visits patients in the home after discharge. Patients are provided with updated medication advice by the pharmacist, and a list of appointments.

There are well understood transfer processes in place. The NETS team are contacted for the retrieval of neonates. The small number of patients each year requiring higher acuity care are generally transferred by ambulance to Bendigo Health Care Group. There is no formal involvement of the VMOs in the review of patients transferred out for higher acuity care; a recommendation has been made. Most hospitals review tertiary transfers to identify if they were appropriate for admission to the facility, and to evaluate the transfer process and timeliness of the decision to transfer the patient.

The rehabilitation team has evaluated the discharge planning processes. A phone survey was carried out by the ACAS team to get feedback from discharged patients. This has highlighted the need to streamline procedures for communicating with the patients GP and for making other appointments. The ACAS team meets each month with community service providers. This is an opportunity for issues with discharge planning to be raised. Where a patient has complex home care needs the ACAS/welfare officer phones the patient within the first five days of discharge to confirm that all services are in place. Patient ratings for discharge planning in the Victorian Patient Satisfaction Monitor are on par with other health services of a similar size.

The survey team has supported the self-assessment rating of MA, however there is a need to strengthen evaluation in this area. This could be achieved through the formal follow up and review of patients who are re-admitted within 28 days of discharge to identify whether additional services could have been put in place, and the review of admitted patients who are transferred for higher acuity care.

Surveyor's Recommendation:                                   HPR: No

1. A formal process be implemented involving the visiting medical officers (VMOs) to review admitted patients who are transferred for higher acuity care.

2. The evaluation of discharge planning be strengthened through the regular review of patients who are readmitted within 28 days of discharge, and those inpatients who are transferred out for higher acuity care.
Function: Clinical  Standard: 1.1

**Criterion: 1.1.6**

Systems for ongoing care of the consumer / patient are coordinated and effective.

**Organisation's self-rating:** MA  **Surveyor rating:** MA

**Surveyor's Comments:**

There are good processes in place to provide continuity of care with community based providers, including multidisciplinary team meetings to plan service requirements, and discharge documentation provided by the treating doctor, nursing and allied health referrals.

The health service provides a range of programs including cardiac rehabilitation, respiratory and renal programs and diabetes support. Patient education is provided along with printed material about their condition and the management of their illness.

Strategies to reduce acute hospital presentations for clients with chronic illness are focused on patient support and education. Evaluation in this area needs to be formalised, a recommendation has been made. Many organisations monitor average bed days for key patient categories. Programs are evaluated through client feedback and follow up to identify additional educational needs.

**Surveyor's Recommendation:**  **HPR: No**

The evaluation of patient outcomes for the ongoing care programs be improved.
Organisation Wide Survey - Survey Team Summary Report
Organisation: Mt Alexander Hospital
Orgcode: 210783

Function: Clinical  Standard: 1.1

**Criterion: 1.1.7**

Systems exist to ensure that the care of dying and deceased consumers / patients is managed with dignity and comfort.

Organisation's self-rating: MA  Surveyor rating: SA

**Surveyor's Comments:**

The appointment of a nurse practitioner (candidate) to coordinate the Palliative Care service has provided a specialist resource person for staff training and to support care planning a delivery. A range of activities have taken place to raise awareness in amongst the medical and nursing staff about palliative care.

The policy framework related to the care of dying and deceased patients includes enduring power of attorney, and advanced care directives. The clinical team are reviewing the Respecting Patient Choices program as a foundation for further developing policy in this area. There is a need for policies or procedures to more clearly outline staff responsibilities in the event of a coroner’s case, and to document the process for authorising the removal of deceased persons from the mortuary.

Palliative care planning is generally initiated by the patient’s doctor, with referral to the community nursing team. Palliative care patients are primarily managed in the home setting, with admission to hospital where specific needs arise. The nursing team indicate that there has been some increase in the percentage of referred patients who have a non-cancer diagnosis, however the significant majority of palliative care patients have a cancer diagnosis. The community based team uses a palliative care pathway, and an end of life pathway is being developed. The community team participates in case reviews where the patient or family has complex needs.

There are support mechanisms for patients, families and staff members, including follow up by the community nursing team and the pastoral care team.

There are plans to carry out carer surveys; these were last undertaken two years ago. There is some data used to evaluate the service and for DHS reporting, this includes the number of patients who die at home. The level of structured evaluation of the palliative care program needs to be increased – a recommendation has been made. The survey team has re-assigned the rating for this criterion to SA.

**Surveyor's Recommendation:**

1. Policies and procedures covering advanced Palliative Care planning and End-of-Life pathways be developed and implemented.

2. Procedures on management of the deceased person be reviewed and updated to include the classification of staff who are authorised to release the person to the funeral directors, and the format of the health service death register be updated to clearly record the name of the authorised person who released the deceased.

3. Regular evaluation of the Palliative Care Program be carried out to assess program effectiveness and to identify opportunities for improvement.
Risk Rating: Low

Risk Comments:
Risk rated as low.

Function: Clinical
Criterion: 1.1.8
The health record ensures comprehensive and accurate information is recorded and used in care delivery.

Organisation’s self-rating: EA
Surveyor rating: EA

Surveyor’s Comments:
The hospital and its associated services maintain a health record that is consistent with national standards and which suits its purposes. Where services have amalgamated records have been merged with one identifier. Nursing home records have a separate volume but have the single identifier. Clinical entries in the notes are of a high standard and detailed enough to ensure continuity of care.

Appropriate content and coding audits are conducted regularly including a medical officer peer review of their case notes. The patient administration system is old and is soon to be replaced. At present it impedes the capacity of the service to provide clinical information in an efficient way. A new system as planned will significantly improve the quality and usefulness of reports used by clinicians.

Surveyor’s Recommendation: HPR: No
Function: Clinical

Criterion: 1.2.1
The community has information on, and access to, health services and care appropriate to its needs.

Organisation's self-rating: MA

Surveyor rating: MA

Surveyor's Comments:

The health service has strong networks with the local GPs, including participation on advisory committees where new services and program initiatives are considered. Hospital services information and program brochures are circulated to the GP rooms and community setting.

The local community receives information on Mt Alexander Hospital through health feature articles in the local newspaper. Electronic access to service information is available on the MAH website and the Connecting Care website.

Evaluation includes feedback on documents at the Community Services Committee, and questionnaires at program level to identify how the participants heard about the program. The strategic planning reviews consider data on referral patterns for the local area.

Surveyor's Recommendation:

HPR: No
**Function: Clinical**

**Criterion: 1.2.2**  
Access and admission to the system of care is prioritised according to clinical need.

| Organisation's self-rating: MA | Surveyor rating: MA |

**Surveyor's Comments:**

There are systems to ensure prioritisation of access to the health service. The triage process in the ED is used to prioritise review by the medical officer on call, and to support the admission decision. The hospital runs an elective surgery program, with lists coordinated through the doctors rooms. Rehabilitation patients are assessed for appropriateness of admission through the review of transfer documentation. In addition where the patient is to be transferred from Bendigo the Unit Manager visits and assesses the patients suitability for rehabilitation.

**Surveyor's Recommendation:**  
HPR: No

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**Function: Clinical**

**Criterion: 1.3.1**  
Health care and services are appropriate and delivered in the most appropriate setting.

| Organisation's self-rating: MA | Surveyor rating: |

**Surveyor's Comments:**

Appropriateness is managed within the framework of health service capabilities. The level of clinical services offered is constrained by the levels of medical cover and facilities to provide high dependency care. There are systems in place to monitor clinical incidents to identify inappropriate admissions and procedures.

There are references at program level and in the medical officers application paperwork which refer to admission criteria. The survey team suggested that the hospital bring together the admission policies for the clinical units into an integrated admission and exclusion policy for the health service.

This criterion is an ACHS developmental criterion. Therefore, a surveyor rating is not applied to this criterion.

**Surveyor's Recommendation:**  
HPR: No
Function: Clinical  
Standard: 1.4

**Criterion: 1.4.1**

Care and services are planned, developed and delivered based on the best available evidence and in the most effective way.

**Organisation's self-rating:** MA

**Surveyor rating:** SA

**Surveyor's Comments:**

There is evidence of the use of evidence based guidelines in the provision of clinical care within the clinical areas. Examples include assessment tools, triage guidelines, criteria for admission to the low risk birthing service, and wound care protocols. Many policies and procedures are referenced to protocols used in major tertiary centres and other state based guidelines. There is however scope for a more structured and systematic approach to the used of evidence and the way evidence use is evaluated in its application to clinical care delivery. The survey team has rated this criterion at the SA level and a recommendation has been made.

**Surveyor's Recommendation:**

HPR: No

The hospital implement processes to ensure the systematic evaluation of the use of evidence sources to ensure the effectiveness of care, and map care processes to identify points where evidence utilisation could be strengthened.

**Risk Rating:** Low

**Risk Comments:**

Risk rated as low.
Function: Clinical

Standard: 1.5

**Criterion: 1.5.1**
Medications are managed to ensure safe and effective practice.

| Organisation's self-rating: MA | Surveyor rating: MA |

**Surveyor's Comments:**
The pharmacy service includes a supply service and clinical service that suits the needs of the hospital. All medication charts are reviewed by the clinical pharmacist and prescription errors and interactions followed up directly with the prescriber. Medication errors and incidents are logged onto the risk management database (SHE) and reported to the Clinical Risk Management Committee. Review and quality matters including reports on medication incidents are also reported through the Clinical Risk Management Committee.

**Surveyor's Recommendation:**
HPR: No
Organisation: Mt Alexander Hospital
Orgcode: 210783

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: EA
Surveyor rating: EA

Surveyor's Comments:

The health service has adopted the regional infection control manual, with additional local policies approved by the infection control committee. An experienced registered nurse is allocated two days per week to cover the infection control officer role, with senior advice provided by the infection control team at the nearby Bendigo Health Care Group.

The Infection Control committee meet second monthly, priorities include infection surveillance and the continued roll out of the hand hygiene program. The committee has carried out a self evaluation. The survey team note that the committee has a VMO member, however that person attends infrequently. A recommendation has been made.

The health service uses the VICNISS model of infection surveillance, including IV line monitoring and follow up of multi-resistant organisms. Staff notify the infection control officer of infections, in addition the pathology provider forwards copies of microbiology test reports. The team discussed a recent situation in which a small number of hostel residents had gastroenteritis symptoms; an effective range of measures were immediately put in place to minimise the risk of spread. Infection control data is trended and reported at senior clinical committees and the Infection Control committee, including occupational exposures, wound and IV related infections, multi-resistant organisms and outbreak reports. The RICPRAC environmental audit tools are used in the clinical and support areas to identify compliance with infection control principles.

Hand Hygiene is a priority area for the health service. Education and audits are in place, using the state Five Moments model. Availability of alcohol based hand rub has been improved, and usage rates are monitored. Audit results have improved from 40% compliance in 2006 to 70% this year. There is scope to continue to improve hand washing compliance by targeting specific departments and disciplines where performance needs to improve – a recommendation has been made.

The infection control officer covers the immunisation program and follow up of occupational exposures. There are clear processes for testing and follow up after occupational exposure, including counselling; the staff member is referred to the nearby Bendigo Health Care Group if the source is known to be positive.

Theatre, Endoscopy and CSSD have documented procedures to support staff compliance with standards and regulatory requirements. Patient and instrument flows in theatre are appropriately managed. The CSSD team have good records of equipment validations, including performance qualification testing on the steriliser. The Meditrap system is used for steriliser batch tracking. The Endoscopy team use the GENCA guidelines for scope re-processing, including regular microbiological testing of scopes. Many endoscopy units have introduced a detailed form for documenting proof of process, with the person cleaning the scope initialing for completion of each critical step in the reprocessing of the scope. The survey team suggest that more detailed proof of process documentation should be introduced.
Food services and environmental services have well structured programs. These are supported by staff education and audits to ensure that standards are maintained.

Evaluation broadly across the infection control criterion is well structured, and includes feedback to the clinical and support teams. The service benchmarks in a range of areas with other regional services. Environmental audits and hand hygiene compliance rates are compared, VICNISS data is benchmarked with state data. There are good examples of the use of benchmarking to identify improvement opportunities, for example, the need to have annual performance qualification testing on the sterilisers was identified in following up the AS 4187 audit results with other centres. The survey team has supported the self-assessment rating of EA for this criterion.

**Surveyor's Recommendation:**

**HPR:** No

1. Measures be implemented to ensure that the visiting medical officers (VMOs) are regularly represented at the Infection Control committee.

2. Measures be implemented to ensure the continued improvement of hand hygiene compliance, including measures targeted at improving performance for departments and categories of health care worker where compliance is lower.
Function: Clinical  Standard: 1.5

**Criterion: 1.5.3**  
The incidence and impact of pressure ulcers are minimised through a pressure ulcer prevention and management strategy.

| Organisation's self-rating: MA | Surveyor rating: MA |

**Surveyor's Comments:**

The health service has a Preventing Pressure Areas project. A power point presentation has been developed for staff education, including material on the grading of pressure ulcers. The program has improved the reporting of stage one pressure areas.

The assessment tools include a pressure area risk assessment. Compliance with the completion of this tool is monitored. The tool is scored, with links to interventions to reduce the risk level, this is done well. Patients are provided with printed material to assist their understanding of pressure area management.

The surveyors pre-survey documentation indicated that some dressings are cut for use and the unused portion is saved for later use, this was followed up at survey. The unused portion is put back into its original package and sealed with tape, and the dressing is used only for the individual patient. The survey team suggest that senior infection control advice be gained to ensure that this complies fully with single use only policies.

Evaluation includes reviews of the completion of the risk assessment tool, evaluation of care interventions and monitoring of trends with pressure area reporting.

**Surveyor's Recommendation:**  

HPR: No
Function: Clinical

Standard: 1.5

Criterion: 1.5.4

The incidence of falls and fall injuries are minimised through a falls management program.

Organisation's self-rating: MA
Surveyor rating: MA

Surveyor's Comments:

Local policies and procedures provide a good framework for staff to identify and manage falls risk. Risk assessment tools are in place; these link to a range of interventions. Higher risk patients have a specific plan developed to manage their care needs. A client information sheet has been developed to inform the patient and family about practical measures they can take to reduce the risk of a fall. Falls incident data, and the follow up of injuries, has been evaluated. The health service is in the early stages of data sharing on falls incidents within the Loddon Mallee Network.

Surveyor's Recommendation: HPR: No
Function: Clinical  Standard: 1.5

Criterion: 1.5.5
The system for prescription, sample collection, storage and transportation and administration of blood and blood components ensures safe and appropriate practice.

Organisation's self-rating: MA  Surveyor rating: SA

Surveyor's Comments:
The role and size of the hospital plus the proximity to a larger centre mean that the demand for blood and blood products is minimal. Blood products are supplied by the private pathology provider that supplies other pathology services to the hospital so that the interaction of Mt Alexander Hospital staff is only to collect packs when needed and to administer to the recipient. There is an issue with the consent form. National standards require that specific consent is obtained as for any other invasive procedure or treatment. The hospital apparently encountered resistance from the medical staff when a consent form was introduced and a compromise "Confirmation of Consent“ form was introduced instead. This requires the patient to sign a form stating that they had discussed the procedure with the doctor who had warned of the risks rather than having the form signed by both patient and doctor at the time of the consultation that led to the administration of blood products. It is also a requirement that all health professionals administering blood or blood products be suitably educated and trained and that they be formally credentialled. The hospital has not completely instituted a suitable education and credentialling system to date but it is acknowledged to be a work in progress. A training session held in April 2008, and whilst good in content, it was attended by only eight people, some of whom worked in areas where administration of blood products was less likely than in the acute ward. There has not been any follow up or formalisation of the training and numerous staff have not attended training. This needs to be attended to. Use of blood products is monitored and is deemed appropriate for the role of the hospital.

Surveyor's Recommendation:

1. A specific consent form for the administration of blood or blood products be introduced and the process of obtaining consent be made similar to that of other invasive procedures with sign off by doctor and patient.

2. The hospital introduce compulsory training and accreditation of staff required to administer of blood and blood products. The recently conducted program be extended to all relevant staff and their competence recorded.

Risk Rating: Moderate

Risk Comments:
The risk is moderate.
Function: Clinical  
Standard: 1.5

Criterion: 1.5.6
The organisation ensures that the correct patient receives the correct procedure on the correct site.

Organisation's self-rating: EA  
Surveyor rating: MA

Surveyor's Comments:
There is a policy covering correct patient/procedure/site, and the responsibilities of VMOs and staff in checking, marking the site and documentation. Education sessions have been run to raise staff awareness. The Team Time Out is recorded on the count sheet. Audit results show good levels of compliance. Senior staff indicate that some surgeons are taking the lead with the patient/procedure/site checks, however in most instances the scrub nurse initiates the check procedure. The theatre team have recently commenced benchmarking compliance rates with other hospitals within the theatre network. There is however a need to improve the level of doctor initiating of the team time out checks – a recommendation has been made. The survey team has re-assigned the rating for this criterion to MA.

Surveyor's Recommendation:  
HPR: No
Measures be introduced to improve the level of doctor initiating of the team time out checks.
**Function:** Clinical  
**Standard:** 1.6

**Criterion: 1.6.1**

Input is sought from consumers, carers and the community in planning, delivery and evaluation of the health service

| Organisation's self-rating: SA | Surveyor rating: MA |

**Surveyor's Comments:**

There is a framework in place to support consumer and community input into health service strategic directions and programs. There are consumer representatives and community members on key committees, including the Board, community consultative committee, and the carers meeting.

The Board receives analysis of the patient satisfaction surveys and Quality of Care reports. The Maternity Advisory committee receives a statistical report which reflects activity and service delivery.

Evaluation includes evaluation of committee effectiveness, and evaluation of consumer feedback trends. The structure of consumer and community engagement could be strengthened through an audit of committees to identify those for which a consumer member would add new insights and perspectives. A well structured survey of consumer representatives on committees could be used to evaluate their perspectives on the impact they are having at committee level, and the improvements or changes which they have influenced. The survey team has re-assigned the rating for this criterion to MA.

**Surveyor's Recommendation:**  

| HPR: No |
**Function:** Clinical

**Standard:** 1.6

**Criterion:** 1.6.2

Consumers / patients are informed of their rights and responsibilities.

**Organisation's self-rating:** MA

**Surveyor rating:** MA

**Surveyor's Comments:**

Patient rights and responsibilities are included in the patient information booklet; a notation is made by staff when this document is given to the patient. An audit across acute, sub-acute and community areas showed good compliance in providing patients and clients with the information. The rights and responsibilities policy is referenced to legislation and regulations, and is accessible to staff on the intranet.

Evaluation includes patient survey feedback - recall of receiving the information, understanding of the material and whether they had a chance to ask questions to clarify.

**Surveyor's Recommendation:**

HPR: No
Function: Clinical  Standard: 1.6

**Criterion: 1.6.3**
The organisation makes provision for consumers / patients from culturally and linguistically diverse backgrounds and consumers / patients with special needs.

**Organisation's self-rating: MA**  
**Surveyor rating: MA**

**Surveyor's Comments:**

There are good frameworks for supporting patients and clients with culturally and linguistically diverse (CALD) needs. Cultural care policies/procedures are available on the intranet, these include information on how to access interpreter services and menu choices.

The health service has a good understanding of language groups and cultural groups within the region. The town’s major employer, processed meats, employs many new migrants from Sudan and Burundi. Castlemaine has an active community based refugee re-settlement group. The community health team has a development worker who manages the liaison with other community service groups. This is an important linkage in identifying health services required. Telephone interpreter services are available.

There is a small indigenous community in the region. An indigenous elder is on the community consultative committee. The health service have access to support from the Aboriginal liaison officer from the nearby Bendigo Health Care Group. A range of art works have been purchased.

Evaluation includes analysis of feedback from the Victorian Patient Satisfaction Monitor. The service received very good feedback on the Cultural Care Plan submitted to the DHS.

**Surveyor's Recommendation:**  
**HPR: No**
FUNCTION SUMMARY: SUPPORT

The surveyors were impressed by the commitment and management of the quality improvement system operating in the hospital and its associated services. There is obvious commitment from the executive and this commitment permeates the hospital at all levels. All staff and services are involved with the program and observance of reporting schedules. Risk management is well managed with an appropriate system for incident and complaints reporting including clinical risk incident reporting. Staff understand their responsibilities and respond appropriately. There is an overarching risk management policy and system in place supported by a data base that is soon to be replaced with a more advanced program.

Mount Alexander Hospital (MAH) has in place a very effective Human Resources, the program's success can be measured by several parameters including very high staff morale, as indicated by an annual independent climate survey, and high staff retention rates across all job categories. Special mention is made about the recent highly successful campaign to reduce sick leave across the hospital and to benchmark this KPI with comparable organisations. The foundation of the HR system is the Strategic HR Management Plan 2008-2010, the implementation of which is overseen by a Human Resource Improvement Committee and monthly progress reports to the Board. Innovative staff recruitment and retention strategies are in place and these are subject to regular evaluation and refinement. They include creative advertisements in the city press. MAH is to be congratulated on the assertive approach it has undertaken to improve the take-up at departmental level of the staff performance management review/appraisal system. The organisation offers a comprehensive staff development program which includes 15 compulsory staff education days each year, to optimise the attainment of the organisational goal of 100% staff attendance at mandatory training, annual clinical competency audits for all nursing staff and a locally-developed aggression management training program for select staff groups. MAH has an active Staff Consultative Committee functioning as a forum for management and industrial associations to discuss issues of concern and to consult about new initiatives. Overall MAH provides excellent facilities and opportunities for its staff and this is rewarded by the high esteem with which the hospital is held not only by staff but by the local community.

The information management system is adequate for the needs of the hospital and associated services but as some of the systems are old and due for replacement there are some impediments to streamlined reporting. However, the information technology plan allows for replacement of key software in the near future. Information and data management systems provide for the essential needs of the hospital and are well utilised by staff and management. Financial and key clinical reporting is adequate for needs and essential reporting is timely. New improved systems will enhance the capacity to support the hospital's strategic and operational roles. There is an integrated approach to I&CT planning that ensures a considered approach to the introduction of new programs.

The surveyors were impressed with the hospital's role in health promotion. There is good coordination with the needs of the community and good cooperation with outside agencies. The approach to community better health is commended.
Organisation: Mt Alexander Hospital  
Orgcode: 210783

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<thead>
<tr>
<th>Function: Support</th>
<th>Standard: 2.1</th>
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<tbody>
<tr>
<td><strong>Criterion: 2.1.1</strong></td>
<td>The organisation's continuous quality improvement system demonstrates its commitment to improving the outcomes of care and service delivery.</td>
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**Organisation's self-rating: EA**  
**Surveyor rating: EA**

**Surveyor's Comments:**  
The hospital's quality improvement system is well managed and coordinated and is closely aligned to its role and function. There is an overall plan, with responsibilities clearly allocated. The plan, reporting framework and responsibilities of all staff and departments is posted on the intranet and can be accessed by any staff with network access. Reporting is through directors to their relevant improvement committee with regular reporting to the Board. The surveyors were shown numerous examples throughout the hospital of the quality plan at work with subsequent improvement to services. The commitment to the quality program by all staff and departments was impressive. The surveyors noted that the clinical audit and review activities need to progress to an emphasis on clinical outcomes rather than process and audit. (See 1.1.4)

**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.

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<th>Organisation's self-rating: MA</th>
<th>Surveyor rating: MA</th>
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**Surveyor's Comments:**
There is an overall risk management policy and programme that is appropriate to the needs of the hospital and associated services. The program is supported by a database (SHE) which is old and less functional than would be desired. The surveyors noted that it is due to be replaced by the RiskMan software which will improve functionality and reporting. 

It was noted that the hospital had recently moved to a four level risk rating matrix from a three to bring them in line with common practice (same as the SAC rating score matrix). Sentinel events are currently set aside from other incidents and reports because of their mandatory reporting status to the DHS and now should be included in the incident reporting system as they will automatically be a level one risk. The Clinical Risk Management Committee meets regularly and there is regular reporting to the Board. Selected ACHS indicators are regularly collected and reported. Non-clinical risk matters are reported through the appropriate improvement committee ultimately to the Board.

**Surveyor's Recommendation:**

| HPR: No |

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### 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.

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<th>Organisation's self-rating: MA</th>
<th>Surveyor rating: MA</th>
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**Surveyor's Comments:**

The hospital has a system in place to manage incidents and complaints as well as customer feedback. A common report form is used and this allows for categorisation and risk rating. There are regular customer feedback surveys (Victorian Patient Satisfaction Monitor) that are reported to the Board after comparison with like hospitals and services. OH&S incidents and near misses are managed appropriately by risk rating and entering into the SHE database as are all other clinical incidents. The system in place ensures that hospital staff manage incidents and complaints appropriately and well.

**Surveyor's Recommendation:**

| HPR: No |
Function: Support  

Standard: 2.2

**Criterion: 2.2.1**

Human resources planning supports the organisation’s current and future ability to address needs.

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<th>Organisation's self-rating: MA</th>
<th>Surveyor rating: MA</th>
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**Surveyor's Comments:**

The surveyors were impressed with the organisation’s Strategic Human Resources Management Plan 2008-2010. Implementation of which was reported by the Human Resources Director at the monthly Board Meeting. This plan was the culmination of an extensive consultation process that involved key stakeholders.

There are updated human resource policies and procedures, including those on recruitment and retention, management response to industrial action and staff replacement which, when implemented, ensure the safety and quality of care to consumers of the organisation. These are readily accessible to staff on the hospital’s intranet.

The organisation has in place a Human Resource Improvement Committee which facilitates staff involvement in the evaluation of items in the Human Resources Plan. An impressive initiative is the People Matters (staff) survey, the results of which are reviewed and forwarded to the Executive for action as required.

The organisation is congratulated on the early success of its project to reduce sick leave through an educational strategy and incentive program and its participation in the Victorian Agencies Benchmarking Project involving comparing performance on this important KPI with 17 comparable agencies.

**Surveyor's Recommendation:**

HPR: No
Function: Support  
Standard: 2.2

**Criterion: 2.2.2**
The recruitment, selection and appointment system ensures that the skill mix and competence of staff, and mix of volunteers, meet the needs of the organisation.

**Organisation's self-rating:** MA  
**Surveyor rating:** MA

**Surveyor's Comments:**
The organisation currently has well over 100 volunteers working for it, all of whom have been appropriately trained in line with the locally developed Volunteer Standards and Guidelines Manual, which is subject to scheduled review.

The surveyors were impressed with the organisation's participation in an ambitious recruitment campaign involving a colourful advertisement in the Melbourne press. There was also evidence of a range of successful staff retention strategies, including an onsite hospital staff gym, an enhanced staff cafeteria facility and a staff recognition/award program.

A range of performance indicators (eg absenteeism rate, % attendance at hospital orientation day program, staff turnover) are used to evaluate and refine current recruitment strategies. Evaluation is a core component of the orientation program for new staff and the results are used to continually refine the program. The organisation also conducts an annual climate survey, the results of which indicate that staff satisfaction with working at Mt Alexander Hospital is incrementally increasing from a high baseline involving seven key parameters.

**Surveyor's Recommendation:**

HPR: No
Function: Support                                                                 Standard: 2.2

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

Organisation's self-rating: SA   Surveyor rating: MA

Surveyor's Comments:
The organisation is congratulated on its decision to introduce the Cambron human resource computer software package in the coming months as a user-friendly strategy to encourage staff compliance across the board with completion of performance management reviews. In preparation for this initiative, departmental managers are being primed and the surveyors were impressed with the efforts being made in some departments to achieve a high degree of compliance using a paper-based form tailored to the needs of the departmental staff. The percentage of staff having completed an annual performance appraisal is one of a number of KPIs that all department heads are required to report on to their respective directors on a monthly basis. The surveyors noted that performance on this KPI was progressively improving from a low base and that departmental heads generally had a positive attitude to and good understanding of the value of performance management reviews and this in turn was having a positive impact on their staff.

The surveyors noted that the organisation had an appropriate policy in place for managing a complaint about a clinician and that comprehensive personnel records include participation in training and educational programs are maintained with restricted access provisions. Staff position descriptions are updated as part of the annual appraisal process.

The surveyors noted that nursing and allied health departments maintained an electronic record of the registration status or similar of all staff employed in their department.

Surveyor's Recommendation: HPR: No
The organisation continue to promote performance development as a positive non-punitive strategy that enhances the performance of both the individual and the organisation until a near 100% rating on this important KPI is achieved.
Function: Support

Criterion: 2.2.4

The learning and development system ensures the skill and competence of staff and volunteers.

Organisation's self-rating: MA
Surveyor rating: MA

Surveyor's Comments:
The surveyors noted that there is a comprehensive Staff Development Program in place which is progressively evaluated and monitored. This program is coordinated conjointly by the Human Resource Officer and the Clinical Nurse Educator. The latter conducts an annual nursing needs analysis and one result of the most recent analysis was the purchase of a CD on Communicating with Dementia Patients from the Aged Care Channel to address an identified skills deficit. Audits on clinical competencies for nursing staff are also conducted on an annual basis.

Other staff development initiatives developed by the organisation include:
- A Prevention of Aggression and Violence Workshop conducted over one day, at which 120 staff attended in early 2008.
- A Compulsory Staff Education Day, conducted 15 times each year, which is a proactive approach to promoting 100% staff attendance at mandatory training. The organisation is congratulated for the assertive approach taken to ensure that this training is accessible to all staff including those who work exclusively at night.
- A special orientation program for volunteers held annually.
- The purchase of 11 laptops to facilitate an optimally flexible approach to staff development.
- The utilisation of select skilled staff to conduct in-house training to other staff, for example, infection control, clinical documentation, manual handling, wounds care.

The surveyors noted that the Human Resource Officer coordinated, monitored and evaluated all student placements, including those of medical students, and that the Clinical Nurse Educator conducted all refresher and return-to-practice training for nursing staff.

Surveyor's Recommendation:
HPR: No
**Criterion: 2.2.5**  
Employee support systems and workplace relations assist the organisation to achieve its goals.

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<th>Standard: 2.2</th>
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**Surveyor's Comments:**  
The surveyors noted that there is a functional Staff Consultative Committee in place that meets monthly and provides a regular forum for management and representatives of industrial associations to consult about issues of concern or proposed initiatives. This committee is evaluated by participating stakeholders and has been assessed as an appropriate vehicle for staff to address their concerns to management and vice versa.

The organisation recently reviewed the contract of the Employee Assistance Program (EAP) provider and based on an evaluation of the service provided has decided to seek other tenders for this important staff resource. The EAP is actively promoted via poster throughout the organisation.

The organisation is congratulated for providing a "nurturing and caring" environment for its staff, which is reflected in the extraordinarily high job satisfaction rates obtained by independent survey each year.

**Surveyor's Recommendation:**

HPR: No
Function: Support  
Standard: 2.3

**Criterion: 2.3.1**
Records management systems support the collection of information and meet the organisation's needs.

**Organisation's self-rating:** MA  
**Surveyor rating:** MA

**Surveyor's Comments:**
The hospital supports relevant information systems to ensure that all necessary records are kept and managed to ensure compliance with all external and internal requirements. The clinical record is of a high standard and financial and corporate records are well maintained. Staff are able to access information necessary for their management and reporting requirements. However, it is noted that the patient administration system in use, whilst it does provide required information, limits the capacity of staff to work efficiently in some cases. The proposed replacement system timed for about 12 months hence will be a significant improvement.

The hospital complies with all requirements for an MA rating.

**Surveyor's Recommendation:**  
HPR: No

Function: Support  
Standard: 2.3

**Criterion: 2.3.2**
Information and data management and collection systems are used to help meet the strategic and operational needs of the organisation.

**Organisation's self-rating:** MA  
**Surveyor rating:** MA

**Surveyor's Comments:**
The hospital has a good range of information programs that are aligned to the needs of staff in management and reporting roles. Whilst there are some relatively up to date programs in place, there are some that are older and consequently do not have the functionality to optimise strategic and operational needs of the hospital and staff. See criterion 2.3.4 for further comment. However, the hospital is able to adequately meet all reporting requirements and cater for the essential information needs of staff.

**Surveyor's Recommendation:**  
HPR: No
Function: Support

Criterion: 2.3.3
Data and information are used effectively to support and improve care and services.

Organisation's self-rating: SA

Surveyor rating: SA

Surveyor's Comments:
Hospital staff use information available in the conduct of audit and evaluation projects. Because some of the data and information systems are outdated and do not readily provide information in an easily obtainable format, the capacity of staff to use information is sometimes limited, for example, the patient management system does not have a good search function which means that staff may have to spend excessive amounts of time extracting simple access and utilisation data for clinical reviews or audits. This limits external comparisons and benchmarking in the evaluation of care process. Similarly, the risk management database is outdated and is scheduled for replacement with RiskMan software in line with much of the rest of the state.
By contrast, the budgeting and finance software, Powerbudget, allows detailed reporting and information for managers that significantly enhances their management responsibilities. The proposed introduction of Oracle systems will improve capability in such things as purchasing and supply including online ordering.
The surveyors agreed with the self-assessment rating of SA, there being several key initiatives still a work in progress.

Surveyor's Recommendation:
The hospital continue to resource the replacement of older software systems with modern programs to assist and enhance both clinical reporting including evaluation of outcomes of care and corporate and support service reporting.

Risk Rating: Moderate

Risk Comments:
The inability to obtain data for KPI in a timely manner restricts the organisation in the evaluation of services and program. The purchase and installation of the RiskMan program will support the organisation in their quest for improving their already quality program to enable them to compare and contrast with other health organisation of similar source and measured KPIs.
Function: Support

Criterion: 2.3.4
The organisation has an integrated approach to the planning, use and management of information and communication technology (I&CT).

Organisation's self-rating: MA
Surveyor rating: MA

Surveyor's Comments:
Information and communication technology is effectively planned and managed. There is a plan for the replacement of outdated systems based on the requirements of the hospital. Programs to be introduced in the near future include Microsoft Office 2007, Oracle systems, RiskMan, and Isof soft patient administration.
There is a framework for PC and work station replacement and an inventory of all hardware and software. There are policies and procedures governing the use all I&CT matters.
There are plans and precautions in place for continuation of business in the event of disaster and this was updated in April 2008.

Surveyor's Recommendation:
HPR: No
Organisation: Mt Alexander Hospital
Orgcode: 210783

Function: Support

**Criterion: 2.4.1**
Better health and wellbeing for consumers / patients, staff and the broader community are promoted by the organisation.

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<th>Surveyor rating: MA</th>
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**Surveyor's Comments:**
It was noted that Community Health Services that are independent of the hospital services are funded for most health promotion initiatives in the district, so Mt Alexander Hospital operates in conjunction with them and other community bodies. However, there have been significant initiatives sponsored by the hospital that were targeted to community and staff. The range of activities includes a fruit and vegetable project, smoking cessation, school canteen project, healthy workplace award and a healthy options program in the staff cafeteria and kiosk. All allied health departments are involved in health promotion activities.
Primary Care Partnerships designed to get the community members to work together have featured community cooperation in notably mental health and oral health leading to fluoridated water in the town.

**Surveyor's Recommendation:**
HPR: No
Function: Support

Criterion: 2.5.1
The organisation's research program promotes the development of knowledge and its application in the health care setting, protects consumers / patients and manages organisational risks associated with research

Organisation's self-rating: MA

Surveyor rating: SA

Surveyor's Comments:
The size of the hospital and its related services means that research projects are not commonly undertaken. No clinical trials are current and most research is social research based on students' masters programs or similar. There is however, a process for consideration and approval of projects that is entirely appropriate for the hospital and which requires Board approval. However, research does not play a large enough role in the functions of the hospital for it to invest in the requirements for satisfying the elements to attain an MA rating. Consequently the rating is adjusted to SA.

Surveyor's Recommendation:
HPR: No
The hospital consider further investment in research support and infrastructure if the number of proposals become significant, or if the nature of proposals involve interventional procedures or treatments.

Risk Rating: Low

Risk Comments:
Risk rated as low.
FUNCTION SUMMARY: CORPORATE

A new CEO was appointed to Mount Alexander Hospital (MAH) in early 2008 and since that time a number of new managerial initiatives have been implemented. These include the engagement of an external contractor to develop a five year strategic plan to commence in 2009 and the development of departmental Operational Plans, the implementation of which is reported to the Board on a monthly basis. These reports incorporate 17 KPIs reflecting a wide range of service activity and performance. MAH has an established practice of conducting annual planning days involving all major stakeholders. It was apparent to the surveyors that MAH is highly valued by the local community and community outreach is a high priority for management.

The organisation has a number of significant challenges to address, the most notable being its ageing infrastructure on a hilly uneven site. The Executive and Board are congratulated on the assertive approach they are taking to attract enhancement funds to manage this issue.

The surveyors were impressed by the organisation’s effective utilisation of a number of software programs which enable evaluation and monitoring of compliance with 1200 items of legislative and other requirements pertaining to health facilities (Health Legal), and genuine cost centre management at departmental level (Power Budget, which generates monthly finance reports via KPIs which are benchmarked internally and externally). The proposed introduction of RiskMan before the end of 2008 will further empower the middle managers to be accountable for their respective departmental performance.

In the past 12 months the following core components of governance were reviewed and refined:
- Delegations Manual (this is routinely updated on an annual basis)
- Committee structure and reporting arrangements
- Contracts with the hospital’s major external providers, namely those for pathology and radiology services; an ongoing evaluation of each contract has now been out in place involving KPIs
- Policy framework which has resulted in the identification of nine higher-order policies requiring Board endorsement and development of a standardised template for revised procedures, which are being progressively reviewed and updated.

A high priority recommendation (HPR) and AC60 has been advised for criterion 3.1.3 and the rating has been adjusted to SA. Although there is a set of procedures and policies relating to appointment and credentialling of medical practitioners they have not been followed in 2008. It is unclear whether the policies and procedures are consistent with the Department of Human Services Policy and the National Standard for Defining Scope of Practice.

MAH has established a very effective multi-faceted safety management system which includes a proactive OHS Committee (with membership including 14 trained staff representatives), an efficient incident reporting and review system and a mandatory safety improvement training program for all staff. The system is managed conjointly by the OHS Officer and Clinical Nurse Educator. To further improve this system, a recommendation is made to review the Terms of Reference of the OHS and SP&E Committees with the objective of streamlining their functioning by possibly merging them into one committee as there is considerable overlap in both their membership and purpose.

The organisation maintains a range of evaluative mechanisms and processes to ensure the Executive is well informed of the current status of the physical environment and infrastructure and all equipment, supplies and consumerables. The surveyors noted numerous instances of management making informed decisions about the purchase of new equipment, etc to ensure that the environment is optimally safe for patients, staff and visitors. To enhance this system and provide it with an all encompassing coordinating function, a recommendation is made that a comprehensive Disability Access Plan, based on risk management principles, be developed for the site.
MAH has very effective and progressive waste management, emergency/disaster and security systems in place which are subject to continuous evaluation. Auditing is a feature of each of these systems and a recommendation has been made that action plans be routinely developed in response to all audits to ensure that all identified risks are appropriately managed, and that the cycle of continuous quality improvement is maintained and sustained. A specific recommendation is made with respect to realigning the configuration/layout of the hospital’s accident and emergency department as it is considered that the current after-hours arrangement puts at risk staff and patients in the adjacent acute section of the hospital.

**AC60 FUNCTION SUMMARY**

The senior management team has undertaken a very large amount of work in updating the credentialling and scope of practice processes for medical staff accredited to the health service. The actions taken meet the requirements of the AC 60 recommendations.

Please also refer to criterion 3.1.3 for further comments.
Function: Corporate  
Standard: 3.1

Criterion: 3.1.1
The organisation provides quality, safe care through strategic and operational planning and development.

Organisation's self-rating: MA  
Surveyor rating: MA

Surveyor's Comments:
As indicated earlier in this report, MAH does not have a current Strategic Plan the last one having lapsed in 2007. Since the appointment of the new CEO eight months ago, however, each hospital department has been required to develop an annual Operational Plan and associated Risk Management Plan, using standardised formats. These plans cover the financial year. A contractor has been engaged to develop a Strategic Plan that would involve extensive consultation key stakeholders to take effect from 2009 and negotiations are underway to alter the model of the facility to an integrated rural flexi-service model.

An impressive system is now well established whereby each department reports monthly to their respective director on the progress of implementing their Departmental Operational Plan. These reports incorporate 17 KPIs that reflect a wide range of service activity and performance. The Executive actively follow up on issues of concern as they are reported and there is a transparent document trail outlining this process.

MHA conducts an annual planning day to which all stakeholders are invited. These include all community partners such as Police, Ambulance, GPs and a range of non-government agencies.

The Executive and Board are concerned about the capacity of the current allocated budget to appropriately address the future challenges the hospital faces associated with its ageing infrastructure and building configuration on a site with extreme topographical features. The surveyors congratulate the Board and the new CEO for their assertive approach in seeking enhanced government funding to enable MAH to continue to appropriately deliver quality services to the local community in a safe environment.

The Community Consultative Committee, whose membership includes six independent community representatives and members of the MAH Executive, meets bimonthly to review MAH’s annual Quality Plan and Annual Report and is consulted about proposed initiatives and issues impacting on the organisation.

The surveyors were impressed with the entrepreneurial approach undertaken by the Executive to forge new partnerships and liaison arrangements with prominent non-health organisations in the town. An excellent example of this activity is the plan for the hospital to enhance its conference facility so that it can be hired out to commercial firms and other organisations.

Surveyor's Recommendation:  
HPR: No
Governance is assisted by formal structures and delegation practices within the organisation.

Organisation's self-rating:  MA
Surveyor rating: MA

Surveyor's Comments:
MAH has a comprehensive Delegations Manual which is updated annually and benchmarked with facilities of similar size and functionality.

In the past six months, the MAH Board has undergone significant review of the way it conducts its meetings, of the type of reports and data it reviews and of the training it provides to its new members. The Board has a unique “open door” policy whereby anyone is able to attend their meetings and it is clearly committed to transparent, accountable governance.

Health legal computer database records compliance and review of legislative requirements and contains 1200 items. The software contains an automatic flagging function that nominates a Director to review compliance with a particular requirement within a set timeframe.

MAH is congratulated for its recent introduction of Power Budget software which has enabled cost centre management to become a genuine feature of the organisation. Each department now uses the Power budget facility to provide monthly financial reports to the Executive and Board. These reports are user-friendly and contain a range of finance related KPIs which are congregated into an organisational report which is benchmarked with comparable hospitals. These trended and comparative reports are reviewed by the Board.

The CEO has recently re-introduced a monthly Departmental Heads meeting where he has explained and promoted a progressive delegation policy which empowers Departmental Heads to have greater decision making powers coupled with a more transparent and less threatening accountability function. This process of devolution has resulted in an increase of 22% in staff satisfaction across the organisation.

The services of an external auditor have been commissioned by the new CEO to enable the organisation’s financial risks to be managed independently of the Executive.

Since March 2008, the hospital’s committee structure has been the subject of review and progressive refinement. Currently the following committees and groups report to the Board:
- Clinical and Risk Management Committee
- Medical Staff Group
- OHS Committee
- Staff Consultative Committee
- Audit Committee
- Medical Credentialling Committee
- Project Control Group.

The Committee review process has so far resulted in the deletion of the Finance, Patient Care and Improving Performance Committees with their respective responsibilities delegated to other committees. A recommendation will be made that this process be expedited.

The surveyors strongly suggest that the organisation will be in a good position to achieve an EA rating on this criterion at next review once the changes instigated over the past eight months are consolidated and
Board members complete their BOM education.

**Surveyor's Recommendation:**

HPR: No

The review of the MAH committee structure should be expedited to minimise overlap in function and optimise efficiency. This particularly pertains to the Safe Practice and Environment Committee and the OHS Committee.

**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 hospital has a process for the credentialling and appointment of medical staff set out in the hospital's document entitled "Rules, Regulations and Conditions of Appointment Governing Visiting Medical and Dental Staff" but it has not been followed recently. The process involves a Credentials and Medical Appointments Advisory Committee comprising Board members, executive staff and appropriate medical officers relevant to each appointment. However, the Committee has not met in 2008.

Currently there are some new appointees on temporary appointments awaiting confirmation of their appointments and some medical officers whose three year appointments have ended but have been reappointed without formal consideration of their application and without Board agreement of their appointment.

It is unclear why the agreed process has not been followed but it has exposed the hospital to some risks. There appeared to be a notion that a less rigorous approach to credentialling, appointment and determining scope of practice is acceptable. The risk is that, as has occurred in other states, because medical practitioners at appointment or renewal of appointment have not been subjected to a rigorous process could be practising outside their competence or scope of practice or even without registration or insurance. The risk for this is rated high so a high priority recommendation is necessary and the rating for compliance with the criterion is SA. The hospital could readily fix the problem within sixty days by reinstituting the agreed process including reconstituting the Credentials and Medical Appointments Advisory Committee to deal with those new specialists and those renewing their three year appointments and ultimately secure Board approval as is legally required.

There is a Department of Human Services Document which is a policy guideline for the appointment, credentialling and defining the scope of practice in rural health services which in turn is based on the National Standard for Credentialling and defining the Scope of practice which health services are expected to follow. They provide a framework for a rigorous approach to appointing, credentialling and defining scope of practice for medical practitioners and all health services are expected to comply with provisions of both documents. It is unclear just how the current system matches up to these two documents and whether there any deficiencies or inconsistencies. The hospital needs to compare its processes to these documents and alter and amend their document so as to be compliant. This can be readily achieved within sixty days. A timetable for rectification of any problems revision of the hospital's policy and process would need to be documented with timelines for those responsible.
There are no guidelines for expected qualifications and training for each specialty, nor for general practitioners relevant to the role of the hospital. It is suggested that there needs to be a document for each specialty that sets out the requirements by which credentials are assessed and scope of practice agreed. The medical colleges set the standards for education, training and qualification for their relevant specialties. They are also able to provide advice on qualifications obtained overseas and requirements for ongoing education and certification if required, for example, all surgeons should be in possession of College certification for ongoing practice. In some instances, colleges have combined to agree on criteria for special procedures and treatments such as endoscopy and general practice anaesthetics and such criteria should be adopted by the hospital.

Given that there only a few specialties providing services to Mt Alexander Hospital, the hospital could readily prepare suitable documents outlining the necessary criteria for appointment, credentialling and defining scope of practice that could be used in considering the current outstanding appointments. A similar process could happen at a later stage to define the limits of general practice including criteria for GP obstetrics and anaesthetics.

The Human Resources Department has in operation a sound policy and system for appointment and credentialling of non medical professional staff. The system works well and is accepted by all. Nursing, allied health and other professional staff undergo a rigorous process of assessment of their applications that ensures that all practice within their competence.

Recommendations 1, 2 and 3 are rated HPR and should be able to be addressed in sixty days so advanced completion should be offered. Completion would enable the rating to be adjusted to MA.

Recommendations 4 and 5 are not considered high priority and can be completed before the next ACHS event.

**An Advanced Completion within 60 Days (AC-60) Review was conducted on 16 December 2008**

**High Priority Recommendations made at the OWS (9-10 September 2008)**

1. The hospital formalise the appointments of those new medical officers on temporary appointments and those whose triennial appointments have ended by following the set process including reconstituting the Credentials and Medical Appointments Advisory Committee to consider the applications and ensuring subsequent Board approval.

2. A gap analysis be conducted between the hospital's processes as documented and both the Victorian Department of Human Services document relating to the appointment, credentialling and defining the scope of practice in rural health services and the National Standard for Credentialling and Defining Scope of Practice so as to identify any deficiencies and incompatibilities. Where deficiencies or inconsistencies are detected, the hospitals policies and procedures be changed in conjunction with a timetable for implementing change.

3. For each specialty group that provides services to Mt Alexander, prepare a document in consultation with the relevant College setting out the expected criteria by which to assess an applicant's credentials and define the scope of practice. Such a document would include as a minimum such things as registration, essential qualifications, training, licensing where required, recertification and participation in CME and which procedures required evidence of higher education and training or certification.

**AC60 Action Taken by Organisation to address Recommendations**

**Objective:**
Ensure current procedures reflect best practice and national standards

1. **Actions:** Benchmark with other organizations
Who: G Kelly
When: 18/09/08
Progress/Comments: Information received from other organisations and sent to A Ip and C Mitchell. Comparisons of systems conducted.
18/09/2008-Complete

2. Actions: Complete gap analysis with the "National Standard" (the National Standard on credentialing and defining the scope of clinical practice 2004 developed by Australian Council for Safety and Quality in Healthcare) and update Standing Orders/Credentialing and Medical Appointments Committee procedures (Intranet) to comply.
Who: G Kelly/A Ip
When: 25/09/08
Progress/Comments: 30/09/2008-Gap analysis completed.
25/09/2008-Board of Management discussion and recommendation re terms of reference credentialing committee.
8/12/2008-Draft update to standing orders developed and agenda for approval at BOM 18/12/2008.

3. Actions: Development of templates to ensure credentialing aspects covered and scope of practice clearly detailed. Implement sample templates in DHS booklet "Credentialing and privileging (defining the scope of clinical practice for medical practitioners in Victorian Rural Health services. March 2006. with the additions of CBMS item numbers.
Who: G Kelly/A Ip/T White
When: 25/09/08
Progress/Comments: 13/11/2008- Complete

4. Actions: Establish check list of requirements for new and review practitioners-by extending the Health Services checklist on the "standard" pro-forma pack and add CMBS item numbers where required (e.g. education requirements, annual registration requirements).
Who: A Ip/T White
When: 02/10/08
Progress/Comments: 30/10/2008 - Completed Refer health service checklist in pro-forma ("standard") packs. Undertake referee report and CMBS details.

5. Actions: Audit all practitioner’s files to establish those that are not compliant and follow up outstanding items to ensure complete records. Update credentialing spreadsheet to ensure checklist requirements for each practitioner. Maintain list of completed practitioner records to enable a credentialing meeting to be held.
Who: T White/L Pollard
When: 09/10/08
Progress/Comments: 13/11/2008 -additional administrative hours allocated to follow up on incomplete documentation received.
26/11/2008 Documentation almost complete -scanned and faxed to specialists prior to credentialing meetings.

6. Actions: Discussion of credentialing requirements at VMO meeting.
Who: A Ip
When: 31/10/08

7. Actions: Establish a prioritised list of practitioners requiring credentialing-high risk (surgeons) first. Establish number of deliveries and anaesthetics that GP’s are completing annually.
Who: A Ip/G Kelly
When: 10/10/08
Progress/Comments: 13/10/2008-completed Obstetricians, anesthetists, surgeons then GP’s
1/12/2008 Data collated on number of deliveries and anaesthetics provided by GP’s
8. **Actions:** Notify practitioners of what is required of them by formal letter with dates required. Follow up if no response within 1 or 2 weeks.

New specialist requires an application form including all items listed on the front page check list, and CMBS item number and referee check.

Review specialist –to complete reapplication form (over the next year however all will be asked to complete the initial application form)

**Who:** T White/G Kelly check  
**When:** 11/10/08  
**Progress/Comments:** 13/11/2008-Letters and reminder letters have been sent to all practitioners. Majority of documentation has been received.

9. **Actions:** Schedule meeting of Medical Credentialing Advisory Panel to coincide with receipt of documentation.

**Who:** A Ip/G Kelly  
**When:** 30/10/08  
**Progress/Comments:** 14/11/08-meetings scheduled for 27/11/2008 (Anesthetists/general practitioners and surgeons) and the 4/12/08 (obstetricians).

10. **Actions:** For each speciality group-establish in consultation with relevant college or craftsman the number of required specialty procedures required to entitle ongoing practice-number of births, number of anaesthetics, number of procedures.

**Who:** A Ip/Craftsmen/CEO  
**When:** 31/12/08  
**Progress/Comments:** 4/12/2008-Meeting held and following decisions made:

For GP Obstetricians the minimum requirement recommended is 5 deliveries a year and participation in CME equivalent to recommendations by RACGP or ACCRM for requirement of practising as GP Obstetricians (currently being at least one full days equivalent workshop of updating skills for GP Obstetrics)

For GP Anaesthetists, a minimum of 150 MOPS points or equivalent in Anaesthetics continuing education activities per triennium and three yearly review by Credentialing Committee

For GP, proof of participation in triennium RACGP CME program requirements or ACRRM program requirements.

For other specialties, participation in mandatory CME programs or if not mandatory, the specialty college equivalent of required CME activities.

11. **Actions:** Hold credentialing meeting and ensure appropriate credentialing through formal committee and documented.

**Who:** BOM/G Kelly/A Ip  
**When:** Early November  
**Progress/Comments:** 27/11/2008 –meeting held(Anaesthetists/general practitioners and surgeons reviewed) 4/12/08 meeting held obstetrics.

12. **Actions:** Follow up actions post credentialing meeting-letters containing provisional requirements or clarification to be sent to 2 anaesthetist, 1 GP anaesthetist, one GP obstetrician, one Orthopaedic Surgeon and one GP registrar requesting further requirements to made evident, including in many cases proof of additional education attended. Copy of letter to be filed.

**Who:** A Ip/T White  
**When:** 12/12/08  
**Progress/Comments:**

13. **Actions:** Develop approval letter including re registration details and for what period of approval. This letter to be forwarded post approval through credentialing committee and the BOM.

Develop certificate to send with letter.

**Who:** G Kelly/A Ip/T White
When: Post meetings.
Progress/Comments: Letter template already developed prior to this process. 8/12/2008-certificate still to be developed.

14. Actions: Resurvey by ACHS surveyors-16th December. All documentation to be available. Meeting to be scheduled when time determined by ACHS.
Who: A Ip/G Kelly
When: 16/12/2008
Progress/Comments: 09/12/2008. Meeting scheduled. 1pm 16/12/2008-CEO office

15. Actions: To be considered-radiology and pathology-ensure contract stipulates appropriate credentialing of practitioners.
Who: G Hill
When: 31/01/09
Progress/Comments:

16. Actions: Specialities of dental, cardiology consults and psych-meeting to be held in January
Who: A Ip
When: 31/01/009
Progress/Comments:

17. Actions: QA to be completed
Who: C Mitchell
When: 30/11/08
Progress/Comments: QA 7487-commenced

18. Actions: Implement system for monthly checking (Use outlook initially-eventually CAMBRON calendar as a reminder prompt) of those practitioners due for re-credentialing within the next 3 months and establish set correspondence and requests to be forwarded prior to re-credentialing required.
Who: T White
When: 31/12/08
Progress/Comments:

19. Actions: Implement CAMBRON system as the system for maintaining documentation and reminders regarding medical credentialing.
Training to be provided to T White, transfer of data, establishment of reminder system.
Who: T White
When: 31/01/09
Progress/Comments: 8/12/2008-data entry into CAMBRON commenced.

20. Actions: Schedule 6 monthly meetings of credentialing committee to ensure evaluation and ongoing monitoring.
Who: A Ip/G Kelly/T White
When: Ongoing.
Progress/Comments:

Surveyor's Comments at Advanced Completion within 60 Days Survey
The senior management team has undertaken a very large amount of work in updating the credentialling and scope of practice for the health service. A review has been undertaken of the Standing Orders for credentialling of medical and dental officers. The review found that the protocols were in harmony with the state and national guidelines, however there were some aspects in the process which were found to be cumbersome.
The Credentialling and Medical Advisory Committee (C-MAC) membership has been updated. The membership includes the DMS, CEO, an independent craft group member, and one to three Board members. The committee has met three times since the Organisation-Wide Survey. The backlog of interim appointments and medical officers who are beyond the triennial re-appointment period have been addressed. The independent craft group representatives advised on scope of practice decisions.

The C-MAC has reviewed and defined the scope of practice for medical officers in the following groups – General Practice, GP Obstetrics, GP Anaesthetics, Anaesthetics, Obstetrics & Gynaecology, Plastics and Ophthalmology. There are a number of physician specialties with a single member, psychiatry and dentistry, which are yet to be finalised. The C-MAC and Quality Improvement Coordinator have a well structured action plan in place to ensure completion of the required work.

In some instances the re-appointment was made with proviso’s, for example providing evidence of ongoing CME activity. The health service needs to ensure that there is a robust system to ensure that doctors comply with those proviso’s – a new recommendation has been made. The C-MAC scope of practice statement gives the specialty area of practice and a list of approved procedures based on the doctors requested list of CMBS item numbers. The independent craft group representatives reviewed each doctors qualifications and experience and advised the committee on the procedures which should be approved. The C-MAC recommendations are scheduled to go to the Board for ratification in mid December.

Following Board approval the scope of practice details for each doctor will be circulated to the theatre manager and after hours managers. A spreadsheet system has been developed to track registration, CME activity etc. The Cambron system will be used to track follow up on the proviso’s.

**Surveyor’s Recommendation:**

1. A system be implemented to flag when medical officers are due to provide evidence related to proviso’s required to maintain their appointment, including recording of the evidence provided and timely follow up at the executive level where such evidence is not provided.

2. The hospital develop a similar document for general practice that defines the approved levels of practice for GPs that is consistent with the role and functional of the hospital, with specific mention of GP obstetrics and anaesthesia and any special procedures. This be done in time to be used for renewals of three year appointments and for any new applicants.

3. Once revised policies and procedures are established, the hospital evaluate the system to ensure its effectiveness in reducing risk, and compare its performance with similar sized institutions.
Function: Corporate

**Standard: 3.1

Criterion: 3.1.4
External service providers are managed to maximise quality care and service delivery.

Organisation's self-rating: MA
Surveyor rating: MA

**Surveyor's Comments:**
MAH has major contracts with external providers of pathology and radiology services. A new provider of pathology services was contracted in 2008 and a Pathology Liaison committee was set up to progressively evaluate this contract and the service it provided utilising a set of KPIs. The radiology contractor now is also providing monthly KPI reports in addition to providing input into the evaluation of the implementation of the organisation's Radiation Management Plan. These enhanced reporting arrangements are assessed as being beneficial by all parties.

An electronic Contracts Register is maintained and monitored by the Director of General Services, the Chief Engineer and the Purchasing Manager. This register contains information of the status of contracts with all external service providers.

The surveyors encourage the organisation to progress its proposed plans for improvement with respect to this criterion (e.g. benchmarking of the Radiology satisfaction audit) as achievement of same will facilitate an upgrading to an EA rating at next survey.

**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.

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**Surveyor's Comments:**

As noted previously, MAH has in place an electronic compliance register (Health Legal) containing over 1200 requirements impacting on the organisation. These include all by-laws, Australian Standards, legislation and policies. A flagging system is embedded in the system which ensures that compliance with each of these requirements is reviewed on a regular basis.

The organisation’s policy framework has recently been reviewed and upgraded. There are now only 9 high-order policies that require Board endorsement and all other issues are addressed by more explanatory procedures which are being progressively reviewed and reformatted in alignment with a generic template. The Executive’s objective is that all policies and procedures are formally reviewed and updated every two years or at most every three years. The surveyors noted that there were still some procedures that had not been reviewed for at least five years and it is strongly suggested that all procedures yet to be reviewed be risk rated so that they can be prioritised for early or urgent review to ensure that any outstanding medium to high clinical risks are managed via an appropriately updated procedure. It is further suggested that MAH develop an annual schedule to formally evaluate the implementation of a small cohort of important procedures to facilitate optimal compliance with their requirements.

**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 were impressed with the organisation's multi-faceted safety management system which included the following components:
- A proactive OHS Committee with membership including 14 trained safety wardens (employee representatives) and eight management representatives. This committee is responsible for ensuring that monthly safety inspections are conducted in all departments of the hospital using a standardised checklist. This committee meets monthly and has initiated a plethora of interventions and new purchases to address identified hazards or high-risk procedures.
- The employment of an onsite OHS Officer who not only coordinates a schedule of safety audits and staff training sessions but also is available as a safety and risk consultant to staff and managers across the organisation.
- The Safe Practice and Environment (SP&E) Committee is a peak organisational committee with membership including several Directors, the OHS Officer, the Quality Manager, the Infection Control Officer, the Chief Engineer, the Supply Manager, the Hotel Services Manager and staff representatives. This committee meets monthly and has standing agenda items that include Safety, Waste, Emergency and Security. This committee has overseen a range of impressive safety projects including the installation of 13 security cameras, the replacement of the kitchen dishwasher, the establishment of the laundry chemical shed, the installation of a nurse call and TV handset and the replacement of the cardboard compactus in the Supply Department.
- A database of dangerous goods and hazardous substances material data sheets, which is updated regularly and has an embedded flagging system to ensure all MSDS are current. This database is accessible to all; staff on the intranet.
- A Radiation Management Plan
- An extensive mandatory training program for all staff which has an underlying safety improvement agenda.
  - A Clinical Manual Handling Program/ Folder available in all departments
  - Safe Operating Procedures in all departments; these are regularly reviewed and updated.
  - A proactive staff injury management program
  - A site master plan which contains an audit of the condition of the physical environment and identifies planned service requirements based on risk management principles.
  - An incident reporting system (see details in earlier part of report).

The surveyors congratulate the management and staff of Mount Alexander Hospital for their enthusiastic support of the above described safety management system. Particularly commendable is the collection and measurement of data on a range of safety KPIs which are compared monthly with 13 like organisations. Consolidation and expansion of this benchmarking exercise will position the organisation well to achieve an EA rating at next review. The imminent introduction of RiskMan as a central electronic repository of all clinical and non-clinical risks will further enhance the current infrastructure.

At the departmental level, a concern was identified regarding the management of deceased patients and a recommendation will be made to address this specific issue.
Surveyor’s Recommendation:

1. The terms of reference and functioning of the SP&E and OHS Committees be reviewed via a process of consultation with key staff with the objective of considering a merger of these committees given the significant overlap in their functioning and objectives and shared membership. The surveyors propose that a merged committee would facilitate a more streamlined and efficient safety system.

2. The manual handling practice for the transfer of deceased patients from the acute unit to the mortuary holding bay be reviewed.

Function: Corporate

Criterion: 3.2.2

Buildings, signage, plant, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.

Organisation’s self-rating: MA

Surveyor rating: MA

Surveyor’s Comments:

MAH has in place a comprehensive range of mechanisms that ensure the Executive and Board is well informed about the current status of the physical environment and infrastructure and all equipment, utilities, supplies and consumables. These include:

- A Hospital Fabric survey which identified and costed refurbishment requirements for the campus; the ageing hospital buildings on a steep hilly location is a major challenge for the Executive and this survey provides the basis for submissions for enhancement capital funding.
- The electronic BEIMS Program / Preventative Maintenance Schedule, which is managed by the Engineering Department and identifies and prioritises maintenance work required to be addressed according to risk potential.
- A quarterly Essential Services Maintenance Audit.
- A comprehensive Equipment Asset Register which lists over 600 items of medical, lifting, trolley and medical gas equipment currently in use across the hospital. The register is subject to an annual audit which ensures all recently acquired equipment is included and identifies equipment for disposal.
- An annual independent Food Safety Audit that monitors the hospital’s compliance with relevant legislation.
- An annual Engineering Performance Review using a set of KPIs that are trended over time.
- An annual electrical equipment audit that ensures that all electrical equipment has been tested and tagged for safety.
- An annual Capital Works Program, which provides a list of costed infrastructure requirements based on risk assessment.
- A biannual Signage Review Plan and associated audits, the latest of which (May 2008) resulted in new signs to car parking, exits, no entry, disabled parking and wheelchair parking.
- An Asbestos Audit, the last conducted in April 2007.
- Participation in the annual Victorian Patient Satisfaction Monitor, which provides management with consumer feedback about the impact of their initiatives to improve the physical environment, the quality of meals and cleanliness of facilities.

The surveyors were impressed with the above described mechanisms and how they generated detailed contemporary information to hospital management to enable informed decisions to be made about budget allocation and submissions for enhancement funding. During the survey there was a clear demonstration of proactive management response to address infrastructure issues that posed a risk to patient and staff safety. A good example of this was the recent purchase of a Razorback vehicle that enables the safe transport of trolleys and other equipment across the campus thereby minimising the real potential for
manual handling injuries.

The surveyors consider that the organisation has the capacity to improve on its already good performance on this criterion and accordingly a recommendation will be made to facilitate this process.

Surveyor's Recommendation: HPR: No

MAH develop a comprehensive Disability Access Plan, based on risk management principles, to provide a coordinating umbrella function for the vast array of initiatives that are undertaken and being planned to improve the physical infrastructure of the hospital.

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<tr>
<td><strong>Criterion: 3.2.3</strong></td>
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<tr>
<td>Waste and environmental management supports safe practice and a safe environment.</td>
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<th>Organisation's self-rating: MA</th>
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Surveyor's Comments:
There is in place a facility Waste Management Policy and Plan.

The surveyors were impressed with the genuine commitment shown by staff and management to both waste minimisation/recycling and energy conservation. The organisation has separate waste streams for paper, cardboard, sharps, printer cartridges, mercury and scrap metal. There is an arrangement for external auditing of waste, the last being in 2007 when a significant degree of cross contamination of streams was identified. This process can be enhanced by developing a formal action plan to address non-compliance issues.

MAH is congratulated for its innovative water recycling project in the laundry and for its project approach to reducing carbon emissions by, for example, replacing the energy inefficient dishwasher in the kitchen.

Data is collected on a number of energy utilisation and expenditure KPIs and this trended information is reviewed monthly at peak committee level.

The organisation was able to demonstrate progressive improvement in both its conservation of energy and minimisation of waste.

Surveyor's Recommendation: HPR: No
Detailed Action Plans, specifying a timeframe and responsible persons, be developed in response to all waste audits conducted.
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:
The facility has developed an impressive multi-faceted Emergency and Disaster Management System comprised of the following components:
- A Hospital Emergency Plan
- An Emergency Procedures Manual
- Critical Hospital Operating Contingencies (CHOC), which covers the organisation’s response to a range of water, gas and building emergencies including bush fires.
- Membership of the Shire Municipal Emergency Response Committee; the hospital has participated in one tabletop exercise organised by this committee in the past two years.
- The appointment of 30 trained Fire Wardens in every department of the hospital; the Fire Wardens are interested staff who undertake external refresher training every two years and are responsible for coordinating an emergency response at departmental level when a hospital emergency is called.
- An annual desktop and full evacuation drill schedule
- Audits of false fire alarms
- Audits of staff attendance at mandatory fire drill/desktop and assertive follow up of non-attending staff to ensure optimal attendance.

The surveyors were advised by management that they were successful in seeking and being provided with $1.2 M in one-off enhancement funding in 2005 to address high risk issues identified in the last Fire Audit. They also noted that the format of the Fire Action Plan did not contain risk ratings or a time frame and a recommendation will be made to address this deficit.

Surveyor’s Recommendation:
HPR: No
The Fire Action Plan be reformatted so that all recommendations are risk rated and provided with an associated timeframe for implementation.
Function: Corporate  
Standard: 3.2

**Criterion: 3.2.5**

Security management supports safe practice and a safe environment.

**Organisation's self-rating:** MA  
**Surveyor rating:** MA

**Surveyor's Comments:**  
The organisation has an updated security policy and conducts regular comprehensive security audits, the last being in February 2008. This audit made only a few minor-league recommendations that suggest that MAH has an effective security system in place. Again, a recommendation will be made regarding the development of an action plan to incorporate risk rated recommendations from these audits, which are conducted every two years.

The security system includes the following components:
- 24/7 security officer attendance on site; these officers are trained and accessible to all staff.
- The strategic installation of 13 security cameras with appropriate signage to reassure staff and visitors
- Audits of the personal duress alarm system, the latest conducted in May 2008.
- The inclusion of security issues in the Checklist that is used as a template for monthly Workplace Inspections conducted in each hospital department.
- Monthly review of security-related incidents by the SP&E Committee.
- A Violence and Aggression Prevention Program, is mandatory for all relevant staff and subject to ongoing evaluation and improvement.

On visiting the Accident and Emergency Department, the surveyors were concerned about its configuration which impacted on the adjacent acute inpatient area, particularly outside business hours. A recommendation will be made to address this security and safety issue.

**Surveyor's Recommendation:**  

1. In response to Security Audits, Action Plans be developed that risk rate each recommendation and include a timeframe for implementation.

2. MAH put in place a strategy and allocate funds to realign the Accident and Emergency Department so that after-hours access and the waiting area are separated from the adjacent acute inpatient area.

**Risk Rating:**

**Risk Comments:**
## Rating Summary

### Clinical

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# 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:**

1. The aggregated variance data for higher volume case categories be regularly analysed in order to evaluate care outcomes and to identify improvement opportunities.

2. A structured program of annual mandatory clinical skills and knowledge updates, along with clinical placements in a busy birthing unit be developed, to ensure that all midwives rostered in that role maintain their specialty skills and recency of practice.

3. The day stay patient accommodation area be redeveloped to upgrade the facility, with particular attention to patient amenity and privacy.

## 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.

**High Priority:** No

**Recommendation:**

1. The hospital move the emphasis of care evaluation audits and reviews to focus more on the outcomes of care. This should include the medical staff becoming more involved in morbidity reviews as well as mortality reviews.

2. Specialist medical staff be encouraged to involve Mt Alexander Hospital patients in their peer review activities at their primary hospitals and report accordingly to Mt Alexander Hospital.
Function: Clinical  

**Criterion: 1.1.5**

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

High Priority: No

**Recommendation:**

1. A formal process be implemented involving the visiting medical officers (VMOs) to review admitted patients who are transferred for higher acuity care.

2. The evaluation of discharge planning be strengthened through the regular review of patients who are readmitted within 28 days of discharge, and those inpatients who are transferred out for higher acuity care.

---

Function: Clinical  

**Criterion: 1.1.6**

Systems for ongoing care of the consumer / patient are coordinated and effective.

High Priority: No

**Recommendation:**

The evaluation of patient outcomes for the ongoing care programs be improved.

---

Function: Clinical  

**Criterion: 1.1.7**

Systems exist to ensure that the care of dying and deceased consumers / patients is managed with dignity and comfort.

High Priority: No

**Recommendation:**

1. Policies and procedures covering advanced Palliative Care planning and End-of-Life pathways be developed and implemented.
2. Procedures on management of the deceased person be reviewed and updated to include the classification of staff who are authorised to release the person to the funeral directors, and the format of the health service death register be updated to clearly record the name of the authorised person who released the deceased.

3. Regular evaluation of the Palliative Care Program be carried out to assess program effectiveness and to identify opportunities for improvement.

---

**Function: Clinical**  
**Standard:** 1.4

**Criterion: 1.4.1**

Care and services are planned, developed and delivered based on the best available evidence and in the most effective way.

**High Priority: No**

**Recommendation:**

The hospital implement processes to ensure the systematic evaluation of the use of evidence sources to ensure the effectiveness of care, and map care processes to identify points where evidence utilisation could be strengthened.

---

**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:**

1. Measures be implemented to ensure that the visiting medical officers (VMOs) are regularly represented at the Infection Control committee.

2. Measures be implemented to ensure the continued improvement of hand hygiene compliance, including measures targeted at improving performance for departments and categories of health care worker where compliance is lower.
Function: Clinical  

**Criterion: 1.5.5**

The system for prescription, sample collection, storage and transportation and administration of blood and blood components ensures safe and appropriate practice.

High Priority: No

**Recommendation:**

1. A specific consent form for the administration of blood or blood products be introduced and the process of obtaining consent be made similar to that of other invasive procedures with sign off by doctor and patient.

2. The hospital introduce compulsory training and accreditation of staff required to administer of blood and blood products. The recently conducted program be extended to all relevant staff and their competence recorded.

Function: Clinical  

**Criterion: 1.5.6**

The organisation ensures that the correct patient receives the correct procedure on the correct site.

High Priority: No

**Recommendation:**

Measures be introduced to improve the level of doctor initiating of the team time out checks.
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**Criterion: 2.2.3**
The continuing employment and performance development system ensures the competence of staff and volunteers.

**High Priority:** No

**Recommendation:**
The organisation continue to promote performance development as a positive non-punitive strategy that enhances the performance of both the individual and the organisation until a near 100% rating on this important KPI is achieved.

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**Criterion: 2.3.3**
Data and information are used effectively to support and improve care and services.

**High Priority:** No

**Recommendation:**
The hospital continue to resource the replacement of older software systems with modern programs to assist and enhance both clinical reporting including evaluation of outcomes of care and corporate and support service reporting.

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**Criterion: 2.5.1**
The organisation's research program promotes the development of knowledge and its application in the health care setting, protects consumers / patients and manages organisational risks associated with research

**High Priority:** No

**Recommendation:**
The hospital consider further investment in research support and infrastructure if the number of proposals become significant, or if the nature of proposals involve interventional procedures or treatments.
Function: Corporate          Standard:3.1

**Criterion: 3.1.2**
Governance is assisted by formal structures and delegation practices within the organisation.

High Priority: No

**Recommendation:**
The review of the MAH committee structure should be expedited to minimise overlap in function and optimise efficiency. This particularly pertains to the Safe Practice and Environment Committee and the OHS Committee.

---

Function: Corporate          Standard:3.1

**Criterion: 3.1.3**
Processes for credentialing and defining the scope of clinical practice support safe, quality health care.

High Priority: No

**Recommendation:**

1. A system be implemented to flag when medical officers are due to provide evidence related to proviso’s required to maintain their appointment, including recording of the evidence provided and timely follow up at the executive level where such evidence is not provided.

2. The hospital develop a similar document for general practice that defines the approved levels of practice for GPs that is consistent with the role and functional of the hospital, with specific mention of GP obstetrics and anaesthesia and any special procedures. This be done in time to be used for renewals of three year appointments and for any new applicants.

3. Once revised policies and procedures are established, the hospital evaluate the system to ensure its effectiveness in reducing risk, and compare its performance with similar sized institutions.
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<tr>
<td>Safety management systems ensure safety and well being for consumers / patients, staff, visitors and contractors.</td>
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**Recommendation:**
1. The terms of reference and functioning of the SP&E and OHS Committees be reviewed via a process of consultation with key staff with the objective of considering a merger of these committees given the significant overlap in their functioning and objectives and shared membership. The surveyors propose that a merged committee would facilitate a more streamlined and efficient safety system.

2. The manual handling practice for the transfer of deceased patients from the acute unit to the mortuary holding bay be reviewed.

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**Recommendation:**
MAH develop a comprehensive Disability Access Plan, based on risk management principles, to provide a coordinating umbrella function for the vast array of initiatives that are undertaken and being planned to improve the physical infrastructure of the hospital.
### Waste and environmental management supports safe practice and a safe environment.

**High Priority:** No

**Recommendation:**
Detailed Action Plans, specifying a timeframe and responsible persons, be developed in response to all waste audits conducted.

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

**High Priority:** No

**Recommendation:**
The Fire Action Plan be reformatted so that all recommendations are risk rated and provided with an associated timeframe for implementation.

### Security management supports safe practice and a safe environment.

**High Priority:** No

**Recommendation:**
1. In response to Security Audits, Action Plans be developed that risk rate each recommendation and include a timeframe for implementation.

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