NATHALIA DISTRICT HOSPITAL

Quality & Safety Framework 2015-16

DEFINITIONS

Quality: the extent to which our health care or service produces a desired outcome.

Quality Improvement: an ongoing response to quality assessment data about a service in ways that improve the processes by which services are provided to consumers / patients.

Quality and Safety Framework: a document that outlines at a minimum what area requires improvement, how an organisation intends to carry out that improvement, timeframes and responsibilities.

Risk: the effect of uncertainty on objectives. Nathalia District Hospital's objectives have different aspects, such as clinical, financial, health and safety or environmental, and they apply at the strategic, organisation-wide and ward levels. In the context of risk, uncertainty is defined as "the state, even partial, of deficiency of information related to understanding or knowledge of an event, its consequence, or likelihood". Any deviation from the expected can result in a positive and/or negative effect. Therefore, any type of risk, whatever its nature, may have either (or both) positive or negative consequences.

Risk Management: the coordinated activities to direct and control an organisation with regard to risk.

Risk Register: a centralised record that identifies for each known risk.

NATIONAL COMMITMENT TO QUALITY, RISK & SAFETY

The Australian Commission on Safety and Quality in Healthcare developed the National Safety and Quality Health Service (NSQHS) Standards to drive the implementation of safety and quality systems and improve the quality of health care in Australia. The 10 NSQHS Standards provide a nationally consistent statement about the level of care consumers can expect from health services. Australian Health Ministers endorsed the Australian Safety and Quality Framework for Health Care in 2010.

The NSQHS Standards provide a mechanism that tests whether relevant systems are in place to ensure standards of safety and quality are met and that quality improvement mechanisms are in place. The primary aim of the NSQHS Standards is to protect the public from harm and to improve the quality of health service provision.

The Victorian Quality Improvement Framework for Healthcare 2013-2022 specifies three core principles for safe and high-quality care

- Care is consumer centred
- Care is driven by information
- Care is organized for safety and quality

Consumer centred care means

- Care is safe, equitable, efficient, effective and appropriate
- Care is flexible and accessible to patients when and where they need it
- Healthcare staff respect patient choices, needs and values
- Partnerships between patients, their family, carers and healthcare providers work towards responding to patient needs

Consumer driven care means

- Using evidence date knowledge to guide care given
- Safety and quality data is collected, collated, evaluated and fed back to consumers to drive improvement
- Action is taken to improve patient experiences

Care being safe means

- Safety is at the centre of care delivered, both for the staff and the patient
- There is a culture of continuous quality improvement in consumer centred care

NATHALIA DISTRICT HOSPITAL COMMITMENT TO QUALITY, RISK & SAFETY

Nathalia District Hospital (NDH) aims to provide quality health care which recognizes the dignity of all persons, creates a healing environment for all in our community, encourages staff to work together to provide personalized care and to operate in an ethical and fiscally responsible manner without compromising the patient's care needs. NDH's Quality Framework takes the three defining principles of the Victorian Quality Improvement Framework for Healthcare 2013-2022 and incorporates these quality management principles in all of its operational, clinical and non-clinical activities, ensuring optimal safety for all staff, patients / clients / consumers / residents / volunteers and visitors at all times. The Quality Framework assists in operationalizing the NDH Strategic Plan.

Our Quality Improvement Program will evaluate and improve processes of patient care that focuses not on individuals, but on systems of patient care. The system should be safe, effective, patient-centered, timely, efficient and equitable. Quality improvement efforts will aim to improve the structure and processes involved in health care and then monitor related outcomes. The structure is the way the health care system is designed and the conditions under which care is provided. The processes are all the activities that constitute health care, such as prevention, diagnosis, treatment and education. It is important to monitor the outcomes associated with any quality improvement endeavour to ensure that the implemented change actually results in improvement in clinical, functional, cost and/or satisfaction related outcomes.

The Quality Framework must be driven by the organisation's mission, vision and values. This will ensure that the organisation's purpose is clear, there are distinct goals set and established actions to improve. The Mission, Vision and Values are described, agreed upon and communicated throughout NDH.

VISION

Leading our community towards better health

MISSION

Working collaboratively to provide quality health and well-being services to our community

OUR VALUES

- **Integrity:** We engage others in a respectful, fair and ethical manner, fulfilling our commitments as professionals. We ensure the highest degree of dignity, equity, honesty and kindness.
- **Accountability:** We ensure quality patient care and use of resources appropriately in an open and transparent manner.
- **Collaboration:** We work as a team and in partnership with our staff, our community and other health care providers..
- **Knowledge:** We create opportunities for education and health promotion.
- **Excellence:** We are committed to achieving our goals and improving quality of care by delivering efficient, safe, person centred, innovative, knowledge based healthcare.

NATHALIA DISTRICT HOSPITAL QUALITY IMPROVEMENT PROGRAM ROLES AND RESPONSIBILITIES

The Board of Management is responsible for assuring that high quality care is provided to all our patients. The Board of Management delegates the implementation of this Quality Plan to the Hospital's leadership team through Patient Care Review Committee (PCRC) and the Continuous Quality Improvement Committee. Clinical review will occur through the Clinical Standards Committee chaired by the Director of Medical Services, Results and recommendations from this committee will be evaluated at PCRC.

Patient Care Review Committee will review:

- Medication Management
- Infection Rates and Incidents
- Pressure Injuries and their Management
- Falls and their Management
- Antimicrobial Stewardship Program
- Comments, Suggestions and Complaints
- Incident Management
- Approve recommendations from Quality Activities

Continuous Quality Improvement Committee will:

- Approve Policies and Procedures
- Develop and Implement Operational Plans Based on the Hospital's Strategic Plan
- Make Recommendations from Quality Activities
- Identify the Need and Effectiveness of Staff Training Programs
- Develop Action Plans from External Surveys and Audits to Address Gaps
- Review Data from KPI Monitoring and Make Recommendations for Improvement
- Monitor Risk Through Risk Reports
- Manage Legislative Compliance

Quality improvement is defined as ongoing response to quality assessment data about a service in ways that improve the process by which services are provided to consumers / patients.

Quality Improvement Activities must reflect the principles of the Quality Cycle which is as follows:

Monitoring
It is not possible to know whether the best possible care or service is being provided if there is no information about that care or service. It is therefore an essential component of the quality cycle to collect data on different aspects of care and service being provided. Monitoring allows identification of the aspects of any problem, gathers data for analysis or establishes a baseline. Monitoring can be undertaken through surveys, audits, observations, record reviews, extracting data from databases etc.

Assessment
An assessment of the current situation needs to be made by analysing the data from the monitoring phase of the cycle.

Action
Suitable, practical solutions for system improvement take into consideration the needs of the consumer / patient and staff and the needs of the service and organisation. Actions should be prioritised and then taken according to the assessment decisions

Evaluation
To ensure the required result is achieved, the following need to be addressed

- Did the action achieve the required result / outcome?
- Is there any more that can be done for this activity / initiative / project? Is it complete?
- Is the best possible care and service being provided?

Monitoring which was undertaken in the first phase can be repeated and the results compared.

Feedback
Feedback needs to occur at all phases as it keeps all relevant parties informed of progress, allows them to have input and makes them aware of the outcome and changes in the organisation. The NDH Quality Team has a documented Operational Plan that lists activities being undertaken according to the nominated time frame.
Activities may include

- Accreditation Programs
- Clinical Review
- Consumer Feedback
- Audit Programs
- Risk Management
- Legislative Compliance

ACCREDITATION PROGRAMS

Nathalia District Hospital undergoes a variety of Accreditation programs or external surveys.

Accreditation is a public recognition by a healthcare accreditation body of the achievement of accreditation standards by a healthcare organisation, demonstrated through an independent external peer assessment of that organisation's level of performance in relation to those standards.

External reviews undertaken include:

- Australian Council on Healthcare Standards (ACHS)
- Aged Care Standards
- Commonwealth Common Care Standards
- National Safety & Quality Standards
- Food Safety Standards
- Work Cover Performance Standards
- Department of Veteran Affairs
- Auditor General financial audit

Several contracted service are required to undertake their own level of accreditation:

- Medical Imaging
- Sterilizing
- Pathology Collection

Survey recommendations from ACHS surveys, Aged Care Reviews and Commonwealth Common Care Standards are overseen by the Continuous Quality Improvement (CQI) Committee.

Recommendations are included in the Quality Plan and where necessary – the Quality Improvement Register.

CLINICAL REVIEW

Clinical Review refers to reporting and analysis of

- Clinical indicators
- Clinical incidents and other client / patient / resident incidents
- Clinical audits

Clinical indicators are a measure of the clinical management and / or outcome of care that should screen, flag or draw attention to a specific clinical issue. Clinical indicators identify the rate of occurrence of an event and are used to assess, compare and determine the potential to improve care. They assist in assessing whether or not a standard in consumer / patient care is being met by indicating potential problems that might need addressing.
Clinical indicators are on the annual audit schedule
Acute care: Falls, pressure injuries, infectious rates
Aged care: 5 Public Sector Residential Care Indicators

Clinical audits are systematic independent examinations and reviews to determine whether actual activities and results comply with planned arrangements in such areas as medication reconciliation, client files audits and urgent care reviews.

Clinical incidents - Patient / client / resident incidents that are unrelated to the natural course of the illness and / or differing from the expected outcome of consumer management are reported by staff on VHIMS.
Managers are alerted by email of an incident that has occurred and undertake appropriate investigation. Patient incidents are summarized and reported monthly through CQI, reviewed at the Clinical Standards Committee and then evaluated through Patient Care Review Committee.
The report outlines statistical information on

- The number of incidents by month
- Risk scores and relevant details
- Incidents by impact on the healthcare user
- Recommendations for new procedures

CONSUMER FEEDBACK

Consumer Advisory Committee

The role of CAC at Nathalia District Hospital is to

- Facilitate discussion about health issues, priorities and needs
- Advise and advocate on behalf of the community
- Assist in the evaluation of processes and programs
- Report results to Patient Care Review Committee

Consumer feedback is sought through a variety of means: feedback forms, Internet responses and discharge follow up (written and/or verbal).
Complaints are managed by line managers with support of senior managers.

Consumer feedback is reported through CQI and then Patient Care Review Committee.
The report outlines statistical information on

- The number of complaints by month
- Method of feedback
- Type of complaint
- Family meetings
- KPIs – complaints acknowledged within two days and closed within 28 days

Consumer surveys are conducted as per audit schedule and all services are included.
Surveys undertaken include

- Inpatient / resident /client satisfaction
- Staff surveys
- Family feedback
- Specific services eg catering

Results reported to CQI Committee

AUDIT AND QUALITY IMPROVEMENT ACTIVITIES PROGRAMS

An audit is a systematic independent examination and review to determine whether actual activities and results comply with planned arrangements. The Quality Team oversees and monitors an audit schedule that includes all departments and provides quantitative and qualitative data to identify opportunities for improvement.

Audit schedule: The Quality Team has developed an audit schedule which is reviewed annually. The audit schedule applies to Acute, Aged Care and Community Health.
Where relevant the audit schedule has approved audit forms for each audit. Audit schedule will include areas such as but not limited to risk management, quality and infection control activities, incident / accident / hazard and corrective action evaluations.

Quality improvement activities: are conducted under direction of the Quality Coordinator as part of the quality improvement program. Quality improvement activities are scheduled events to gain feedback or monitor compliance and ensure quality outcomes result.
Quality improvement activities are implemented using the following:

1. **Feedback via needs and satisfaction analysis with all customers:** patients, clients, residents, families, carers, volunteers, visitors, internal and external contractors, staff and management.
2. **Ad Hoc Processes:** verbal and written communication from customers, to address problems / issues as they arise.

Benchmarking: Where relevant, audit results are benchmarked externally with different agencies through the Quality Management Network. Benchmarking is defined as "the continuous measurement of a process, product or service compared to those of the toughest competitor, to those considered industry leaders, or to similar activities in the organisation, in order to find and implement ways to improve it. One of the foundations of both total quality management and continuous quality improvement.

Individual site results are reported monthly to the relevant committee and any actions resulting noted. Collated data are reported to CQI, including actions planned. Results outside acceptable parameters may transfer to the quality improvement register for further action and re-audit.

Reporting: Feedback on the results and recommendations from Quality Improvement Activities occurs through:

- ⇒ MONTHLY: reports to CQI on outcomes achieved. CQI minutes are recorded and disseminated to all staff.
- ⇒ BIMONTHLY: The Clinical Review Committee and summaries of CQI reports are presented to Patient Care Review Committee.
- ⇒ ANNUALLY: CQI Team Leaders review all performance indicators and identify any changes needed in the quality program.
- ⇒ ANNUAL REPORT: The Quality Coordinator submits a Quality of Care Report to the Board of Management for the organisational Annual Report requirements.

RISK MANAGEMENT

The NDH Risk Management Policy provides for the application of a consistent approach to risk management across the organisation using the Australian Standard. For each identified risk, clinical and non clinical, there will be identified strategies to monitor and review each risk together with measurable key performance indicators to ensure the risks are being managed effectively. Risk management is seen as a systematic way of identifying and assessing adverse consequences and designing strategies to assist in the prevention and minimisation of the adverse effects upon consumers of our services.

The Risk Register is available via the Intranet and is classified under three different headings:

- Corporate: financial, occupational health and safety and emergency management
- Support: Quality and risk management, human resource management and information technology
- Clinical

Risk management is overseen by the CQI Committee. The management of risks is reported monthly to relevant committees: Board of Management, Patient Care Review Committee, CQI or OH&S.
Risk management is an integral part of corporate objectives, plans and management systems
Risk is managed in accordance with AS/ISO 3000.

Part of the risk management strategy will include clear role delineation of all staff, together with an orientation and annual education program designed to make staff aware of changing goals and priorities needed to deliver quality care and ensure an ongoing culture of best practice in clinical care.

LEGISLATIVE COMPLIANCE

Changes in legislation are identified through Department of Health alerts, weekly checks on the "What's new" on www.legislation.vic.gov.au and information from various committees.
Changes and their impact is monitored by the senior executive weekly and by monthly review of high risk legislation. These results are reported to the Board of Management monthly.
A register of changes is managed by the Director of Nursing and is accessible to all managers.
Access to legislation is available through the Internet.

POLICIES & PROCEDURES

Policies, procedures and work instructions are the overarching documents that NDH adheres to.
Policies clearly define actions that must be complied with. They are risk linked to the risk register.
Work instructions guide tasks to be completed.
Administration staff manage the review of all policies, procedures and guidelines.

EVALUATION OF THE QUALITY PLAN

Results of the Quality Improvement Program are to be shared with consumers and the community through the annual Quality of Care Report. This is to include data on quality outcomes and consumer stories where lessons learned are shared.

The Quality Plan will be reviewed and evaluated annually to ensure it remains effective to meet the changing needs of our consumers and their families. A summary of activities, improvements made, care delivery processes modified, projects in progress and recommendations made will be kept and tabled annually through Patient Care Review Committee.

OBJECTIVES FOR 2015-2016

1. Review the Antimicrobial Stewardship program.

Who	Team 3: Infection Control	Team Leader: Margie Hodge
How	From the results of the Hume Region Infection Control Audit identified possible improvements needed to the program. Clearly document the team responsible for Antimicrobial Stewardship at Nathalia District Hospital. Develop a protocol for limiting use of restricted antibiotics with assistance from a pharmacist. Once approved, educate GPs and clinical staff on the approved restrictions.	

2. Develop a resident centred care model which involves residents in their care plan development by June 2015.

Who	Aged Care Team	Team Leader: Margie Hodge
How	Develop a “Resident Centred Care” policy, which identifies how residents are to be involved and drive their care. Provide education to staff on the policy and changes to the model of care. Assess staff knowledge of the current program and their compliance level. Once implemented, evaluate resident satisfaction in the level of involvement in their care.	

3. Promote the person centred care model across all services within the health service.

Who	Team 2: Partnering with Consumers	Team Leader: Bev Hutchins
How	Review the “Person Centred Care” policy with cconsumers to identify options for improvement in the model of care Provide mandatory education to staff, volunteers and contractors on this policy. Assess staff knowledge of the current program and their compliance level. Gain ongoing feedback from consumers to evaluate client satisfaction in the level of involvement in their care.	

4. Improve medication safety by the evaluation and improvement in the medication reconciliation plan by August 2015.

Who	Team 4: Medication Safety	Team Leader: Julie Pridmore
How	Define the reconciliation system to be driven at Nathalia District Hospital. Ensure staff understand their role in medication reconciliation using the approved reconciliation process. Audit compliance to the completion and effectiveness of medication reconciliation. Evaluate the effectiveness of outcomes for our patients.	

5. Upgrade the safety and security systems at Nathalia District Hospital by September 2015.

Who	Team 15: Corporate Services	Team Leader: Roy Peachey
How	Review the current security and safety systems at Nathalia District Hospital with support of Victoria Police. Develop an effective Code Grey protocol Upgrade the duress alarm and call systems to support increased safety and security. Educate all staff to the changes and upgrades of the safety and security systems.	

6. Review the deteriorating patient "Between the Flags" program by May 2015.

Who	Team 9: Recognising and Responding to the Clinical Deterioration in Acute Health Care	Team Leader: Kylie Murray
How	Identify gaps in compliance to the "Recognising and Responding to the Clinical Deteriorating Patient" policy. Ensure all charts and records clearly identify reportable levels in all vital signs, both in acute and residential aged care. Assess staff knowledge of the actions required if the vital signs are recorded outside acceptable limits. Ensure all senior staff have completed Advanced Life Support training.	

7. Evaluate the effectiveness of Clinical Handover practices by July 2015.

Who	Team 6: Clinical Handover	Team Leader: Judy Nave
How	Review the risks associated with clinical handover processes at Nathalia District Hospital Ensure there is an appropriate audit schedule in place of clinical handover that is consistent with identified clinical handover risks Evaluate the effectiveness of clinical handover system and tools used. Develop an action plan to address any issues of concern including timelines and responsibilities.	

8. Achieve compliance in all 44 Aged Care Standards in June 2015.

Who	Aged Care Team	Team Leader: Margie Hodge
How	Complete the aged care workbook with input from all staff. Develop a plan which identifies how any gaps will be addressed. Liaise with team members and monitor progress towards completing preparations. Report progress monthly to keep team members informed.	

9. Achieve Australian Commission on Safety and Quality in Healthcare full National Standards accreditation in September 2015.

Who	Team 1: Governance for Safety and Quality in Health Service Organisations	Team Leader: Leigh Giffard
How	Work towards addressing the gaps identified in the 2014 gap analysis. Ensure sufficient time is allocated to effectively address identified gaps. Liaise with team leaders for each National Standard and monitor progress. Complete a monthly report to assist the monitoring process and keeping other team members informed.	

10. Achieve AGPAL accreditation for Nathalia Medical Clinic by November 2015.

Who	Nathalia Medical Clinic Staff	Team Leader: Lyn Peterson
How	Complete a gap analysis. Develop a plan which identifies how gaps will be addressed. Liaise with all staff, allocate tasks and monitor progress against the gap analysis. Complete a monthly report to keep all members informed.	

REFERENCES:

Aged Care Standards Agency. *Accreditation Guide* 1998.

Australian Council on Healthcare Standards (2012), *EQuIP National Standards,* ACHS Publications Service, Sydney.

Australian Commission on Safety and Quality in Healthcare (2012), *National Safety and Quality Health Service Standards*, Sydney.

Australian Commission on Safety and Quality in Healthcare (2012), *National Safety and Quality Health Service Standards Guide for Small Hospitals*, Sydney.

Department of Health (2013), *Victorian Quality Improvement Framework for Healthcare 2013-2022*, Melbourne.

Department of Health (2013), *Accreditation – Performance Monitoring and Regulatory Approach, Business Rules*, Melbourne.

AS/NZS ISO 3100:2009, *Risk management- principles and guidelines,* Sydney.