Orbost Regional Health
Outstanding Rural Healthcare
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Mr Iain T West
Deputy State Coroner
Coroners Court of Victoria
Level 11, 222 Exhibition St
Melbourne Vic 3000

5th September 2011

Re: Mrs Marlene Kenny, Court reference 1090/07

Following the death of Mrs Marlene Kenny at Orbost Regional Health in February 2007, a Root Cause Analysis (RCA) was conducted as indicated in your findings. The final report included recommendations in the form of a Risk Reduction Action Plan. All recommended actions were undertaken and a final report against the Action Plan was presented to Orbost Regional Health's Clinical Standards Committee (previously Clinical Risk Committee) in November 2008.

Following the handing down of the finding into the death of Mrs Marlene Kenny by you on the 29th July 2011, the Risk Reduction plan was again reviewed to ensure we have complied with all of the recommendations. Some minor amendments were made and we believe we have fully complied and completed the agreed actions. We welcome your comments where you concluded that the recommendations contained within the RCA were "appropriate" as we believe that it was thorough and self-critical to ensure that we understood where the improvements in our systems should occur.

Many of the actions undertaken in 2008 to implement the recommendations, such as the development of policies or procedures, have since undergone further review as part of usual quality cycle. Therefore the most recent documents and the action spread sheet are attached as proof of compliance with the recommendations.

Some of the July 2007 timeframes in the initial Action Plan did prove to be optimistic however all of the actions were very comprehensively completed in 2008.

If you require any clarification please do not hesitate contacting me on 51546615 or therese.tierney@orh.com.au. An electronic copy has also been forwarded.

Yours sincerely

Therese Tierney

Therese Tierney
Chief Executive Officer
Orbost Regional Health

RISK REDUCTION ACTION PLAN

Risk	Risk rating level	Recommended Actions from RCA	Person responsible	Expected date of completion	Outcome & Date completed	Risk Rating after implementation *
Risk of clinically relevant symptoms not being recognised.	High	▪ The hospital, develop and implement guidelines for reportable observations and include them as prompts on observation charts.	Director of Nursing.	July 2007	Clinical instability criteria and policy developed, R\v by all GP's and accepted by Clinical Standards Committee (previously the Clinical Risk Committee) - see attached. http://orhpps/PolicyProtocol/display.asp?guidRevisionID=7F8A772CF24A4181B915360F024DD1D6 • Criteria displayed in ED & ward, compliance is regularly audited and presented to the Clinical Standards Committee • Clinical instability criteria included on special observation charts • Communicated to staff at nurses meetings **Competed July 2007. Reviewed May 2008, on-going audit undertaken.**	Medium
Risk of adverse clinical events occurring due to lack of documentation.	High	▪ The hospital, develop and implement key performance indicators on the completion of medical documentation reportable Director of Medical Services, and to the Clinical Risk Review Committee of the hospital.	Director of Medical Services.	July2007	• Medical documentation audited via LAOS program. Further internal audits carried regularly and reported to the Clinical Standards Committee (previously the Clinical Risk Committee). **Completed Nov 2008, on-going 6 monthly audits**	Low

RISK REDUCTION ACTION PLAN

Risk	Risk rating level	Recommended Actions from RCA	Person responsible	Expected date of completion	Outcome & Date completed	Risk Rating after implementation *
	High	▪ The hospital, develop and implement key performance indicators on the completion of nursing documentation reportable Director of Nursing, and to the Clinical Risk Review Committee of the hospital.	Director of Nursing. Director of Nursing.	July 2007	• Nursing Documentation policy developed which includes KPI's. General documentation audits have been completed (see attached) against this policy and results reported to Continuum of Care Committee previously (Client outcomes committee) and to the monthly General Nurses meeting. There have been steady continual improvements in documentation. **Completed September 2008, on-going regular audits** • Mandatory education with 100% attendance at documentation in-service in November 2008 and repeated in August 2011.	Medium
	High	▪ The hospital develops and implements a stroke/TIA care pathway to assist with improving nursing assessment and documentation.		July 2007	• A CVA\TIA clinical pathway was developed based on the National Stroke Guidelines. ..\..\NURSING\All Charts & Forms\Clinical Pathways\Conscious Cerebrovascular Accident-TIA.pdf • A policy to support this pathway has been, both completed in **Sept 2007 and updated in 2008 and then again in April 2011** http://orhpps/PolicyProtocol/display.asp?guidRevisionID=F4F3538E70484A55BC900893A58ED45	Medium

RISK REDUCTION ACTION PLAN

Risk	Risk rating level	Recommended Actions from RCA	Person responsible	Expected date of completion	Outcome & Date completed	Risk Rating after implementation *
					2 • During 2011 Orbost Regional Health has participated in the Gippsland Stroke Network meetings to further improve the process of direct transfer of patients with specific symptoms to a Stroke Unit.	
Risk of patients not receiving optimum medical management if they are discharged prior to planned medical review	High	▪ The hospital, develop and implement guidelines for the recall or follow-up of patients which have been discharged without medical review.	Director of Medical Services.	July 2007	A 'Discharge from the Acute Ward and Emergency Department Protocol has been developed and incorporates the recommended action from the RCA. http://orhpps/PolicyProtocol/display.asp?guidRevisionID=2408CA5A860B4AF18D0FE34DBCE615FA **Completed May 2008, revised July 2011**	Low
Risk of delay in transport to facilities that provide he optimum investigative and treatment options	High	▪ Hospital , RAV an AAV services to work collaboratively to develop and implement a standardised , structured, clinical handover process to standardise communication between all agencies which includes Options for providing information on the	Hospital Director of Nursing RAV – Senior Operations Officer logistics support. AAV – Air Base	December 2007	RAV transfer form updated to include greater number of transfer options including ▪ Time critical ▪ Urgent ▪ High acuity ▪ Medium acuity ▪ Low acuity	

RISK REDUCTION ACTION PLAN

Risk	Risk rating level	Recommended Actions from RCA	Person responsible	Expected date of completion	Outcome & Date completed	Risk Rating after implementation *
		- Maximum number of hours transfer can take for optimum patient management - Maximum time patient can be outside hospital environment for optimum patient management Systems to ▪ Provide the transferring agency with the expected time frame for transfer ▪ Notify all agencies of change in condition and or change to expected time frames for transfer. ▪ Provide transferring agencies with clinical information prompts ▪ Hospital, RAV and AAV services to work collaboratively to develop a new classification guideline which includes, definitions and descriptors, to expand the options from the current limited non urgent and time critical options for	Manager As above	December 2007	▪ Mental health The reverse side of the form contains 'Guidelines to Assist Health care staff requesting patient transport" (transfer guidelines). **Completed April 2008** • 'Ambulance Retrieval and Transfer of Patients' policy instructs nursing staff to update Ambulance Victoria (AV) regarding condition changes http://orhpps/PolicyProtocol/display.asp?guidRevisionID=67B20AF395494821BD340401B9B49045 **Completed Dec 2008, reviewed 2011** As above	Medium

RISK REDUCTION ACTION PLAN

Risk	Risk rating level	Recommended Actions from RCA	Person responsible	Expected date of completion	Outcome & Date completed	Risk Rating after implementation *
		transfer				
		▪ RAV review operations centre guidelines for contingency planning for transport arrangements ▪ RAV review operations centre policies and procedures regarding the requesting of aircraft for routine and time critical requests ▪ RAV develop and implement a process to audit clinical decision making processes made y staff working in the operations centre	RAV – Senior Operations Officer Logistics Support	August 2007 June 2007 June 2007	RAV (now Ambulance Victoria) to complete	
		▪ The hospital develop guidelines for the optimum time to transfer high risk patients which take into consideration the location of the hospital and the time taken to activate resources and effect a transfer if the patient's condition deteriorates	Director of Nursing	July 2007	These guidelines have been incorporated into the 'Ambulance Retrieval and Transfer of Patients' Policy http://orhpps/PolicyProtocol/display.asp?guidRevisionID=67B20AF395494821BD340401B9B49045 Completed Nov 2008 and updated again in 2011	Medium

RISK REDUCTION ACTION PLAN

Risk	Risk rating level	Recommended Actions from RCA	Person responsible	Expected date of completion	Outcome & Date completed	Risk Rating after implementation *
		▪ The Hospital implement an evidenced based risk screening tool for the management and transfer of patients with transient ischaemic attacks	Director of Nursing	Aug 2007	A screening tool has been incorporated into the conscious CVA\TIA clinical pathway and policy which is based on the National Stroke Guidelines. ..\..\NURSING\All Charts & Forms\Clinical Pathways\Conscious Cerebrovascular Accident-TIA.pdf(Completed Sept 2007) Reviewed Nov 2008 and updated again in 2011 A policy to support this pathway has been completed http://orhpps/PolicyProtocol/display.asp?guidRevisionID=F4F3538E70484A55BC900893A58ED452	Low
			Director of Nursing	July 2007	During 2011 Orbost Regional Health has participated in the Gippsland Stroke Network meetings to further improve the process of direct transfer of patients with specific symptoms to a Stroke Unit. Updated June 2011	Low
		▪ The hospital review the Medical Officer orientation program to include - Circumstances where they may have to escort patients with the ambulance services.	Director of Medical Services.	July 2007	Review of the medical officer orientation program has occurred and includes Escorting of Patients Was in place July 2007; complete review August 2010, Reviewed August 2011	Low

RISK REDUCTION ACTION PLAN

Risk	Risk rating level	Recommended Actions from RCA	Person responsible	Expected date of completion	Outcome & Date completed	Risk Rating after implementation *
		- The most time effective means of arranging beds in higher level facilities and time critical transfer ▪ DHS consider developing a process where rural facilities can determine bed availability for medical patients requiring urgent transfer to tertiary facilities through a central point reducing the time and resources required to find a bed.	DHS.	July 2007	Adult Retrieval Victoria (ARV) met with ORH in 2008 and this system has been used as a first priority when we have had difficulty in obtaining appropriate transfer of clinically unstable patients See above	
Risk of patients and family not being adequately informed	Medium	Hospital and ambulance service staff be reminded of the importance of the patient, family members and carer's receiving information and support throughout care delivery.	Director of Nursing. RAV AAV –Air Base Manager	. July 2007	▪ Nursing staff at ORH are already aware of the importance of communication to patients and families ▪ Information discussed with nursing staff at staff meetings ▪ Included into transfer by ambulance policy **Completed June 2008**	Low

CLINICAL INSTABILITY CRITERIA

For Urgent Medical Assistance Press the Emergency Call Button on the Wall

RESPIRATORY	All respiratory arrests	Respiratory rate < 12 or > 24	Oxygen saturation < 90% on room air	Stridor / upper airway obstruction / threatened airway		
HAEMODYNAMIC	All cardiac arrests	Systolic BP <90 MMHG	Systolic BP > 170 Diastolic BP > 90	Pulse rate < 50 beats / minute	Pulse rate > 120 beats / minute	Urine output < 30 mls / hour or < 100 mls / 6 hours
CONSCIOUS STATE	Sudden decrease in the level of consciousness or mental state.	Repeated or prolonged seizures	Glascow coma score drop of 2 or score < 13			
Those patients who may not meet the above criteria but have a sudden deterioration in their medical condition require urgent medical review						

The criteria act as a guide only. Patients are not to be discharged from the Emergency Department without consultation with the GP and all observations reported

Stroke/TIA Management Protocol

Protocol:

At Orbost Regional Health all patients who have been diagnosed with an acute stroke will be managed according to National Clinical Guidelines for Stroke Management.

The stroke score tool (ABCD Score) will be used to assist in rapid accurate assessment for all people with stroke.

Patients diagnosed with acute stroke, when possible, will be transferred to an acute stroke unit. Those patients who are not transferred will be managed as closely as possible to the criteria for stroke care unit.

ASSESSMENT AND MANAGEMENT OF TIA (Transient Ischaemic Attack)

Patients with suspected TIA are to have a rapid assessment and treatment is to be undertaken in 24 – 48 hours of symptom onset.

- Those identified at high risk (ABCD score > 4) should be admitted to a stroke unit (or where available referred to a specialist TIA clinic if the person can be assessed within 24-48 hours) to facilitate rapid assessment and treatment.
- Those identified at low risk (ABCD score < or = 4) may be managed in the community or at ORH, or where possible referred to a specialist TIA clinic and seen within 7 – 10 days.

ABCD Score

- **A** (age; 1 point for age ≥60 years),
- **B** (blood pressure; 1 point for hypertension at the acute evaluation BP >140/90),
- **C** (clinical features; 2 points for focal weakness, 1 for speech disturbance without weakness), and
- **D** (symptom duration; 1 point for 10–59 minutes, 2 points for ≥60 minutes, other = 0 points).

The following investigations should be undertaken routinely for all patients with suspected TIA:

- FBE, U&E, fasting Cholesterol level, Glucose level, ESR, C – reactive protein
- ECG
- Patients classified as high risk (ABCD > 4) should have an urgent CT brain (urgent is considered as soon as possible, but certainly within 24 hours).
- Carotid duplex ultrasound should also be undertaken urgently in patients with carotid territory symptoms who would potentially be candidates for carotid re-

vascularisation.
- Patients classified as low risk (ABCD < 4) should have CT brain and carotid ultrasound (where indicated) as soon as possible (within 48 – 72 hours).

ACUTE MEDICAL MANAGEMENT OF ISCHAEMIC STROKE AND TIA

Antithrombotic therapy

- Aspirin (150-300mg) should be given as soon as possible after the onset of stroke symptoms (i.e. within 48 hours) if CT/MRI scans excludes haemorrhage.

Blood pressure lowering therapy

- If extremely high blood pressure (e.g. BP> 220/120) exists, instituting antihypertensive therapy may be started, but blood pressure should be cautiously reduced (e.g. by no more than 10 – 20%) and the patient observed for signs of neurological deterioration.
- Pre-existing antihypertensive therapy may be continued provided there is no symptomatic hypotension or other reason to withhold treatment.

GENERAL ACUTE STROKE CARE

Vital signs: Patients should have their neurological status (including Glasgow Coma Scale) and vital signs including pulse oximeter, blood pressure, temperature, oxygen saturation, glucose, and respiratory pattern monitored and documented four hourly during acute phase. If the patient's condition is unstable more frequent observations may be required e.g. 1/2 hourly - hourly observations may be required until the patient's condition is considered stable by the doctor.

ECG: An ECG is to be taken on admission and at other times as requested by the doctor or if there are changes in the patient's condition.

Dysphagia: Patients should be screened for swallowing deficits before being given food, drink or oral medications. Screening should be undertaken by personnel specifically trained in swallowing screening. Patients should be screened within 24 hours of admission. (Refer to attachment Screening Assessment tool). Patients who fail the swallowing screening should be referred to a speech pathologist for a comprehensive assessment.

Nutrition: Close monitoring of hydration status. All patients should be screened for malnutrition. Those at risk of malnutrition, including those with dysphagia, should be referred to a dietician for assessment.

Early mobilisation: Patients should be mobilised as early as possible. Referral to the physiotherapist is required.

Activities of daily living (ADL): Patients with difficulties in occupational performance in daily activities should be treated by an occupational therapist.

Cognition and perception: All patients should be screened for cognitive and perceptual deficits.

Communication: All patients should be screened for communication deficits. Those with

suspected communication difficulties should be referred to the speech pathologist.

Incontinence: Patients with confirmed continence difficulties should have a continence management plan. Patients should be referred to the continence nurse, when necessary. The use of an indwelling catheter should be avoided as an initial management plan.

Mood: Patients with suspected altered mood (e.g. depression, anxiety, emotional liability) should be assessed by trained personnel. Referral to a counsellor, neuropsychologist or psychiatrist should be considered. Routine use of antidepressants to prevent post stroke depression is not recommended. Antidepressants may be used with people with emotional liability, depression or anxiety.

Deep Vein Thrombosis (DVT) and Pulmonary Embolism (PE): early mobilisation and hydration should be encouraged to prevent DVT and PE.

Antiplatelet therapy should be used for people with ischaemic stroke to prevent DVT/PE. The following interventions may be used with caution for selected people with acute ischaemic stroke at high risk of DVT/PE:

- Low molecular weight heparin or heparin in prophylactic doses.
- Thigh length antithrombotic stockings.

CARE PATHWAYS

All stroke patients admitted to ORH may be managed according to the Conscious Cerebrovascular Accident / TIA clinical pathway.

- The pathway is to remain part of the patient's health record.
- A copy is to be made and sent to receiving health provider at time of patient transfer or discharge.
- The pathway is an interdisciplinary tool to be used and recorded on by the appropriate discipline involved in the specific care and treatment.

SECONDARY PREVENTION

Every person with stroke should be assessed and informed of their risk factors for a further stroke and possible strategies to modify identified risk factors. The risk factors and interventions include:

- Smoking cessation: nicotine patches
- Improving diet: a diet that is low in fat and sodium, high in fruit and vegetables.
- Increasing regular exercise.
- Avoiding excessive alcohol.

REHABILITATION

If ongoing rehabilitation is needed, care should be provided in either a stroke rehabilitation unit or a general rehabilitation unit.

PRE-DISCHARGE

- Before discharge, patients with stroke and their carers are to have the opportunity to identify and discuss their post discharge needs.
- Before discharge all patients are to be assessed to determine the need for a home

for a home visit prior to discharge from hospital.
- If needed a home assessment should be carried out to ensure safety and community access.
- Training of carers may be required e.g. personal care techniques, ongoing prevention and other specific stroke related problems.

Appendices:

- Stroke Fact Sheets

Standard:

ACHS Criterion 1.1.1 The assessment system ensures current and ongoing needs of the consumer / patients are identified.

ACHS Criterion 1.1.2 Care is planned and delivered in partnership with the consumer / patient and where relevant, the carer, to achieve the best possible outcomes.

References:

Stroke Foundation. Clinical Guidelines for Acute Stroke Management. National Stroke Foundation 2007.

Rothwell P M., Giles M F., Flossman E.M., Lovelock C E., Redgrave J N E., Warlow C P, Mehta Z. A Simple Score (ABCD) to identify individuals at high early risk of stroke after transient ischaemic attack. The Lancet Vol 366. July 2nd 2005.

Stroke Care Pathway. West Gippsland Hospital Warragul. 2006

Additional Resources:

Better Health Channel, Fact Sheet 'Stroke - Signs and Symptoms' http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Stroke_signs_and_symptoms?open (current 16/01/09)

- other fact sheets on stroke also available http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/AToZ?Openview&RestrictToCategory=S&Count=500

Stroke SA 'Frequently Asked Questions' http://stroke.org.au/wordpress/?page_id=16 (current 16/01/09)

Revision History:

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Admission and Discharge from Acute Ward and the Emergency Department Protocol

Protocol:

To ensure that all patient admissions to Orbost Regional Health are performed in a timely and streamlined manner to optimise clients outcomes, reduce required length of stay, and to prevent unplanned readmission.

Patients are admitted to Orbost Regional Health following consultation between the VMO's and the Nurse Unit Manager, senior nurse or After Hours Hospital Co-coordinator. If a doctor from another establishment wishes to admit a client to ORH, they are required to liaise with the VMO's from Orbost Medical Clinic, who will then discuss admission with the Nurse Unit Manager or senior nurse.

To ensure all community needs are assessed, and appropriate services are in place prior to discharge to ensure the transition between hospital and home is uneventful and adequately meets the needs of the patient and their family.

1. Acute Admissions

a) Inclusion Criteria for Admission:

- The client's condition requires clinical management and/or facilities not available in their usual residential environment.
- The client requires observation in order to be assessed or diagnosed.
- The client requires at least daily assessment of their medication needs.
- The client requires a procedure/s that cannot be performed in a stand-alone facility, such as a doctor's room without specialised support facilities and/or expertise available.
- There is a legal requirement for admission (e.g., under child protection legislation).

b) Exclusion Criteria:

If staff are unsure of a client's appropriateness for admission, discussion should take place between VMO, Nurse Unit Manager/After Hours Co-coordinator and Director of Nursing if necessary.

The following list includes examples of exclusion criteria that apply when considering clients for admission to ORH:

- Client requires invasive positive pressure ventilation
- Client who has ongoing chest pain following thrombolytic therapy

- Any child requiring specialist paediatric services
- Moderate and high risk obstetric clients (refer to the Safe Birthing Framework)
- Clients deemed to be at high risk of harm to self or others
- Any client with suspected neck, head and\or neurological injuries requiring diagnostic evaluation and treatment
- Clients recommended as involuntary patients under Mental Health Act, unless in direct consultation with Gippsland Psychiatric Services.
- Children under the age of 1 year requiring general anaesthetic – see anaesthetic policy - unless in an emergency situation

2. Role Delineation:

Staff on the acute ward

On any given shift there is a senior Division 1 nurse nominated as 'in-charge'. The senior Division 1 nurses have additional skills including:

- Advance life support training,
- IV cannulation
- ECG interpretation.
- On top of these skills, many of the nursing staff have additional qualifications in areas such as:
- midwifery,
- perioperative,
- coronary and intensive care,
- accident and emergency,
- dialysis and
- obstetric advanced life support.

The senior nurse is responsible for ensuring that the acutely unwell patients are cared for by staff with appropriate skills, as well as being responsible for triaging any new patients to be seen in the Emergency Department.

3. Care Planning process:

- Care planning commences on admission.
- Complete required documentation - Admission/Discharge form, Daily care plan and No Lift care plan. Other forms of care plans will be used according to admission history and clinical requirements e.g. FRAT form, VTE assessment, Peri-operative Record, Maternity & Newborn Care Pathways, and other clinical pathways according to clinical need e.g. CVA\TIA
- Identify consumer involvement in care plan on Admission/Discharge form.
- Document a management plan in patient's clinical notes.
- Provide information on care plan at Clinical Handover.
- The second Division 1 nurse (except for night duty) will report any change in patient condition to the senior nurse.
- Medication-endorsed Division 2 nurses may work in the acute ward. The endorsed Division 2 nurses act within their extended scope of practice (http://www.nbv.org.au/) to provide care to medically stable patients, and discuss care planning and any change in condition with the Division 1 nurse.
- VMOs are to be involved in care planning decisions during doctors rounds. Document changes in care plan in patients clinical notes.
- Update Care Plan daily according to needs.

4. Admission Procedure:

- Ward allocation is made by the Senior RN.
- Booking of all admissions to be referred to Senior RN.
- RN notifies the VMO of the patient's admission (unless previous arrangements made).
- Ward clerk collects patient history, X-Rays and pathology results from medical records (if applicable).
- Identification - identification bands to be placed on right wrist (unless contraindicated)
- Notify next-of-kin of patient's admission if patient unaccompanied and provides consent.

N.B. If the patient has a known allergy use red identification band.

- Complete Admission / Discharge form
- Commence Clinical Pathway (if applicable)
- Complete admission notes in nursing history
- Formulate Nursing Care Plan
- Inform relevant services provided to patient at home of admission so that services can be withheld whilst patient is in hospital e.g. Meals on Wheels, Community Health, Home Care.
- Take, record and report relevant observations e.g. blood pressure, temperature, pulse, respirations, weight, urinalysis and other specific observations as ordered.
- Commence any additional paperwork including FRAT, skin assessment and fluid balance chart.
- If clothing and valuables are to be retained in hospital - all valuables and money to be entered in valuables book, checked with two registered nurses. Patient or next of kin is given receipt. Forward valuables to front office during hours, after hours to Nursing Supervisor.

N.B. If recording jewellery, describe by colour, e.g. blue stone on yellow band, not gold band.

Medications - any medications brought in by patient must be either:

- Taken home by relatives after being reviewed by the VMO
- Labelled and stored in ward medication box in nurses annexe
- Medications are returned to patient on discharge following review of medications by VMO

N.B. If patient's own medications include S4 or S8 drugs, these are to be stored in locked cupboard.

Orientation To Ward:

- All patients and their carers should be shown around ward, where to obtain coffee/tea, location of pay phone, nurse's station, public toilet and so on.
- Inform all patients and visitors that smoking is not permitted within the hospital grounds.
- Give all clients a copy of patient/client information book and information directory and ensure that they are aware of their rights and responsibilities as an in-patient at ORH and how they can make complaints or provide compliments.

Private Patients:

(Additional ward clerk responsibilities)

- When a client elects to be admitted as a private patient the ward clerk will collect health insurance details including fund name and number from client.
- The client should be given a brochure outlining private health admissions to ORH. The kitchen should be notified that the client is admitted as private patient.
- Senior nurse should be notified prior to allocating bed to enable admission to single room if appropriate.

5. Discharge Planning and discharge of patient from the ward:

- Talk to client and/or carer about discharge needs or concerns on day of admission and throughout the patients stay.
- The patient will be visited and assessed by the Community Links nurse who will participate with the nursing staff in arranging required services and other relevant requirements for discharge.
- E-mail any relevant S2S referrals to appropriate area, and document these referrals on Admission/Discharge form. Referrals should be sent at least 48 hours prior to discharge.
- Identify key worker on Admission/Discharge form.
- Patients with complex needs may require a case meeting which will be arranged by the Nurse Unit Manager or senior nurse.
- When transferring a patient to another facility a Patient Transfer Form is to be completed.
- Post Acute Care documentation will be completed by the Intake Worker in consultation with nursing staff.
- Nursing staff are to ensure all valuable, medications have been returned to the patients.
- Nursing staff are to ensure the patients have all the relevant information they require about medications, appointments and how to care for themselves when they are home.
- A follow up phone call will be made to the patient 3 days post discharge to ensure discharge needs have been met.
- Nursing staff are to complete the discharge documentation on the Admission/Discharge form when the patient is discharged.

Discharge from the Emergency Department:

- Patients who have been seen by the doctor are not to be discharged from the Emergency Department until they are reviewed again or the doctor has given instructions relating to discharge.
- If the patient discharges themselves they must complete the Discharge at Own Risk form, see below; (Aboriginal and Torres Straight Islanders who DAOR require special follow up - see below also).
- When a patient is discharged all documentation must be completed including time of discharge, a set of observations recorded, doctors' orders, advise given and any follow up required.

Discharge at own risk:

If a patient wishes to discharge themselves against medical advice;

- Doctor must be informed and advice sought.

- Every attempt should be made by the nursing staff to convince the patient to remain in hospital.
- Other support services may need to be contacted to assist in advising the patient to remain in hospital e.g. Mental Health services, Social Worker, Koori Health Liaison, family members with the patients permission
- The patient is to sign a Discharge At Own Risk form.
- In the Emergency Department the patient must sign the 'Discharge at own Risk' section of the Accident & Emergency Form.
- Document in the patient's medical file all avenues that were taken to prevent the patient from discharging themselves and advice given to the patient regarding their medical care.

Staff Alert

The signing of the 'Discharge at own Risk' form may not in fact release the health service from all legal responsibility in every case and diminished capacity must be considered in all cases. The VMO must always be notified and the Director of Nursing and Midwifery or the CEO should be contacted if staff are concerned about the capacity of the patient or representative to make the decision.

6. Follow up of patients who leave before being seen:

Whilst most people who leave the Emergency Department prior to being seen have non-urgent health problems, some may leave with unmet needs that put them at risk of an adverse health outcome. Follow up of patients who leave the Emergency Department prior to treatment has two main purposes.

1. To ensure the person has been able to access appropriate care since leaving the Emergency Department, and if not, to assist them to access an appropriate service.
2. To seek information about the reasons they left the Emergency Department prior to treatment.

Which Patients to follow up:

1. Aboriginal and Torres Strait Island people who present to the Emergency Department, and are triaged, but then either:

- leave prior to assessment/treatment commencing; or
- leave prior to treatment being completed.

2. Any person you are concerned about

During business hours the Koori Health Liaison Officer is responsible for following up Aboriginal and Torres Strait Island people. The Koori Liaison Health worker is notified by the ward clerk and she also reviews the A&E register each day on Monday mornings, to identify any Koori patients that may have left before being seen.

The Community Links nurse and the Division 1 nurses are responsible for following up any other patient.

Follow up of all events is recommended. Particularly for those people who are at risk such as people with mental illness.

When to follow up.

The next business day following presentation (sooner if staff are very concerned about the persons

well being), preferably within 48 hours. At least three attempts should be made to contact the patient at different times of the day. Patients should not be followed up if more than 14 days has passed since their presentation.

Patients can be followed up via telephone where this is appropriate, however the Koori Health Liaison Officer may recommend a home visit or face to face meeting depending on the circumstances, or pre-existing knowledge of the individual involved.

What information to collect: see attachment

Who post follow -up finding be reported to:

The Continuum of Care Committee.

7. Postnatal Transfers from other organisation:

If a woman and her baby are being transferred to ORH from another organisation the rostered midwife must approve the transfer after liaison with VMO. If no midwife on duty, the community midwife on call will come to ORH to assess/admit woman and baby upon their arrival back to ORH. It will be the midwife's responsibility to ensure that a plan of care is devised, and that appropriate midwifery cover is available at all times.

8. Respite Patients:

- The same admission process applies
- Patients booked for admission are required to bring own medications to be used during respite stay.
- Payment arrangements should have been already attended to prior to admission, if not, family/carer to be directed to Main Reception desk during business hours.

9. Elective Admission of children:

In addition to the procedure for adults, the following considerations are necessary:

- Preparation of the unit will be influenced by the child's age and condition.
- Introduce yourself to parents/carer and child.
- Orientate parents and child to ward layout, and routines.
- Inform parents of items to bring into hospital for themselves and child e.g. baby formula, favourite toy, toiletries, and labelled pyjamas.
- As children are generally apprehensive in their new surroundings, encourage parents/carer to stay with the child and participate in their care.
- Observations – take, record and report:-
    - Temperature, using tympanic thermometer or digital thermometer per axilla
    - Pulse (radial in larger children, apex heart rate for smaller children and babies)
    - Baseline B.P. to be taken for all children over 10 years
    - Respirations, note rate and describe
    - Urinalysis
    - Height
    - Weight – bare weight for babies plus minimal clothes (e.g. underwear) for children
    - Head circumference of child up to 18 months of age or if ordered by VMO.

10. End of Life Wishes:

All patients / clients have the right to make decisions about their health care, now and for the future. Medical treatment should only be given with the patient / clients fully

informed consent and they have the right to refuse treatment. An Advanced Care plan gives the patient / client the opportunity to record ahead of time, their choices for medical treatment.

The three ways to record choices in an Advance Care Plan are:

1. Appointing a Medical Enduring Power of Attorney (MEPOA)
2. Documenting a Statement of Choices
3. Completing a Refusal of Certificate.

Before completing an Advanced Care Plan, the patient / client, must take the time to read the information carefully. It is important that they discuss their values and beliefs and the content of the Advanced Care Plan with the person whom they wish to appoint as their MEPOA, and they discuss the Advance Care Plan together so they understand and respect the choices made.

Who should be given the opportunity to complete an Advanced Care Plan?

1. Palliative care patients / clients
2. People admitted into residential aged care
3. Any person who has a chronic illness that impacts on their ability to lead an independent fulfilling life
4. Any person who requests an Advance Care Plan

Who should have a copy of the Advance Care Plan?

1. The patient / client
2. Family members / carers
3. Patient / client medical record file
4. Ambulance
5. Medical clinic / Dr

Definitions:

Admission - An admission is a process whereby the hospital accepts responsibility for the patient's care and/or treatment. Admission follows a clinical decision based upon specific criteria that a patient requires same-day or overnight care or treatment.

Admitted Patient – A patient who undergoes a hospital's admission process to receive treatment and/or care. This treatment and/or care is provided over a period of time and within an expected time frame.

Discharge planning: The process by which the patient and health care professionals collaborate in an interdisciplinary manner to ensure that patients have access to necessary and/or continuing appropriate services after discharge.

Appendices:

- Discharge at own risk
- Election of Admission Form

Standard:

ACHS Criterion 1.2.2 Access and admission to the system of care is prioritised

according to clinical need.

Evidence of Compliance:

- Regular reviews of patient admission history to ensure appropriate details are recorded.
- Review of patient satisfaction surveys to assess client response to admission process.

References:

DHS Hospital Admission Policy 2003-04: Incorporating Admission Criteria, Leave and Separation Issues. Victorian Government Department of Human Services Melbourne, Victoria: http://www.health.vic.gov.au/hdss/vaed/admpol0304.pdf.

Nurse Board of Victoria: http://www.nbv.org.au/.

Department of Human Services Effective Discharge Strategy: http://www.health.vic.gov.au/discharge/

Ambulance Retrieval and Transfer of Patients Policy

Policy Statement:

At Orbost Regional Health we recognise that early notification and planning for the transport/transfer of patients are key factors in timely, safe patient transport management to ensure appropriate ongoing management and improve patient outcomes.

TRANSFER BY AMBULANCE:

1. Essential factors that must be considered:

- Provide clear and concise communication of the patient condition to ensure appropriate transport and personnel are dispatched for the retrieval or transfer.
- When arranging transport consider the likelihood of possible time delays (for whatever reason) that may affect timeliness of ongoing care.
- Contact receiving health service to discuss patient condition and ETA once client has left ORH.

2. Booking of Ambulance:

- As soon as it is recognised that a patient is to be transferred via ambulance to another health service facility the ambulance booking office must be notified immediately.
- Complete the required Hospital Transport Booking form and fax to the number on the form.
- Refer to "Guidelines to Assist Health Care Staff Requesting Patient Transport" located on the reverse side of Hospital Transport Booking form to assist with identifying the urgency of transport
- **If the transport requirements are Time Critical or Urgent ring Triple 000 to make the booking. This way preparation can start immediately. A form does not have to be faxed for time critical or urgent transports.**
- For access to adult emergency retrieval and critical care beds telephone ARV 1300 36 86 61
- To contact PERS or NETS telephone 1300 137 650
- **If the ambulance booking office has not confirmed an approximate patient pick up time within 30 minutes phone the booking office to get confirmation of booking.**

NB: If the patient's condition changes then notify the ambulance booking

office immediately to update the urgency of transfer.

3. Question you may be asked by the ambulance booking office:

- Patients name and date of birth.
- Name of doctor requesting transfer.
- Urgency of transfer.
- Patient assessment / diagnosis - this may be definitive or provisional diagnosis.
- What treatment/management has been implemented.
- What equipment is currently being used.
- Why the patient needs transfer and which health service they are being transferred to.

4. Preparation of Patient requiring urgent transfer:

Anticipate problems prior to departure and ensure management strategies are in place.

a) Airway

- Ensure airway patent. If artificial airway required, ensure correctly inserted **and secured.**
- Maintain spinal immobilisation as required.

b) Breathing

- Ensure adequate O2 flow
- Ensure adequate patient ventilation as required
- Ensure appropriate monitoring of respiratory status as required e.g. AGB's, oxygen saturation, respiratory rate

c) Circulation

- Two patent, well secured large bore IV lines
- Control any haemorrhage using direct pressure and dressings
- Immobilise any suspected fractures (to reduce pain and further bleeding)
- IV's not in use bunged off with a 3 - way tap
- Keep patient warm and dry
- Insertion of IDC and monitoring of urinary output
- Adequate monitoring of circulatory status as required e.g. ECG, continuous cardiac monitoring, peripheral circulatory observations.

d) Additional considerations

- Consideration of analgesia / antiemetics PRN
- Neurological observations as required
- Insertion of NGT for IPPV patients

5. Documentation:

- Complete all details on the required Hospital Transfer Booking form (Rural Ambulance Victoria Hospital Transport Booking Form) or (Advanced Medical Transport - Non-Emergency Transport Booking Sheet) or (Health Select - Non-Emergency booking form).
- Information provided to patients prior to transfer must be documented on their record and transfer/transport form/letter.

- Complete all required details in the Ambulance Transfer Booking log book in the nurses' station
- Document all communication with the Ambulance service in the patient's medical file.
- Have all the required patient information ready and available to hand over to ambulance officers.

6. Patient Information:

- Inform patient being transferred from ORH to other facilities their rights and liabilities.
- Patients being transferred or transported to any other facility, where circumstances allow, must be informed of their status in regard to financial liability.
- Patients awaiting confirmation of third party insurance claim (e.g. Public Liability) will be liable for expenses and must be made aware of this.
- Keep the patient, family and or carers up to date at all times regarding the transport arrangements.

7. Payment Responsibilities:

- Patients transferred or transported as a direct result of a road accident generally have their ambulance costs paid for by the Traffic Accident Commission.
- A patient deemed to have an accident related to a Workcover claim, which has been authorised, will generally have ambulance costs paid by Workcover Victoria.
- Ambulance costs will be paid by the Health Service if the patient is FULLY admitted and being transferred to another Health Facility for treatment, and only as a result of a directive by the Visiting Medical Officer
-
- The patient is liable for ambulance costs where the transfer is as a result of patient requests or transport is required from Accident & Emergency to another Health Service and the patient is not a paid up member of the Ambulance Service.
- The patient is liable for ambulance costs (if not a paid up member of the Ambulance Service) in the case of an emergency (life threatening situation) where there is no choice for the patient to consent and the attending doctor deems it necessary to transport to another facility, from the Outpatient Department.

TRANSPORTATION OF PATIENTS USING HOSPITAL VEHICLES:

- Registered and enrolled nurses may transfer patients/clients using MPS pool vehicles in appropriate situations
- Permission must be sought from the VMO and approval given by the Nurse in charge prior to transport.
- Children under the age of 12 may only be transported with the written permission of a parent or guardian and in approved child restraints (see below).
- Documentation and patient information should be as above

Safety Consideration:

- Babies under six months must be restricted in the back seat in a baby capsule or other approved form of infant restraint. the only vehicle in the ORH fleet with this restraint is the Maternal & child Health Nurses car
- Children over 12 months must also be restrained in the child appropriate restraint or they cannot be transported in an ORH vehicle.
- Children under 6 should not be transported in the front seat and must also be transported in the appropriate restraint seat (booster seat).

- Patients who are unable for medical reasons or size, condition, build or other physical characteristics to wear a seat belt should be transported by ambulance or medical transport.

Definitions:

Inpatient – one who is fully admitted to a ward for treatment and/or observation for more than four (4) hours and who is deemed to be a patient requiring ongoing care in the hospital.

Outpatient – one who is admitted to Casualty/Outpatient Department for treatment by the Visiting Medical Officer for the purpose of observation or stabilisation prior to transport to another Health Service or any other location.

Transfer – any fully admitted patient moved from one Health Facility to another Health Facility.

Transport – anyone who is NOT a fully admitted patient within a Health Facility who is moved to another location.

Appendices:

- Guide to Completing the Rural Ambulance Victoria Hospital Transport Booking Form
- Instructions for Time Critical/Emergency Transports and Routine Response Transports
- Non-Emergency Patient Transport Booking Sheet

Standard:

ACHS Criterion 1.1.5 Processes for clinical handover, transfer of care and discharge address the needs of the consumer / patient for ongoing care.

Evidence of Compliance: No complaints regarding transfer of patients/clients.

References:

Rural Ambulance Victoria, 1999 (Ballarat, Management and Planning Department)

Orbost Regional Health

CONSCIOUS CEREBROVASCULAR ACCIDENT / TIA

Clinical Pathway – Conscious Cerebrovascular Accident / TIA

Clinical Pathway – Conscious Cerebrovascular Accident / TIA

Post TIA Screening for Stroke

The risk of stroke occurring within 7 days of a patient who presents with TIA can be estimated by using this tool.

Please complete for all TIA's or suspected TIA's.

Patient total score using matrix below	RISK OF STROKE at 7 days
< or equal to 3	Very Low
4	2%
5	16%
6	35%

Circle score for each criteria. The total score will provide an estimate of the probability of a stroke occurring within the following 7 days

Clinical Parameter		Score
Age	Age > 60 years.	**1**
Blood pressure	Systolic blood pressure > 140 mmHg and / or Diastolic blood pressure > 90mmHg	**1**
Clinical history	Unilateral weakness Speech involvement (without weakness) Other symptoms	**2** **1** **0**
Duration of the symptoms in minutes	Duration > 60 minutes Duration 10 – 59 minutes Duration < 10 minutes	**2** **1** **0**
TOTAL SCORE		

*Other symptoms such as "numbness", "clumsiness", "tingling" or "heavy" are not helpful, or predictive.

SCORES OF 5 OR ABOVE MUST BE COMMUNICATED TO THE DOCTOR IMMEDIATELY

Orbost Regional Health

FIX UR LABEL HERE

Clinical Pathway
Conscious Cerebrovascular Accident / TIA

This clinical pathway is intended as a guide. Care provided must always be based on the specific assessed needs of the patient.

1. Sign signature page	2. Tick appropriate box for intervention performed
3. Sign in appropriate shift column	4. Document variances on variance page

CLINICAL RISK ASSESSMENT	CLINICAL RISK MANAGEMENT

All staff, including Doctors, please print name, sign usual signature, and initial.

Name	Signature	Initials	Name	Signature	Initials

Clinical Pathway – Conscious Cerebrovascular Accident / TIA

SCREENING TOOL – Acute Screening of Swallow in Stroke / TIA

Completion of this screening tool is recommended in the presence of persisting acute stroke symptoms by personnel that have undergone and successfully completed approved dysphagia screening training.

DATE: ...../...../..... Time of Screen: ..... (Please use 24 hour clock time)

1. Is the patient able to:-	
• Maintain alertness for at least 20 minutes?	Yes ☐ No ☐
• Maintain posture/positioning in upright sitting?	Yes ☐ No ☐
• Hold head erect?	Yes ☐ No ☐

STOP HERE if you answered NO to ANY part of Q1. Place patient Nil by Mouth and review when all of the parameters in section 1 are answered YES. Consider alternative means for nutrition, hydration and medication in consultation with treating medical team and dietitian.

2. Does the patient have any of these?	
• Suspected brainstem stroke	Yes ☐ No ☐
• Facial weakness/droop	Yes ☐ No ☐
• Slurred/absent speech	Yes ☐ No ☐
• Coughing on saliva	Yes ☐ No ☐
• Drooling	Yes ☐ No ☐
• Hoarse/absent voice	Yes ☐ No ☐
• Weak/absent cough	Yes ☐ No ☐
• Shortness of breath	Yes ☐ No ☐
• Pre-existing swallowing difficulty	Yes ☐ No ☐

STOP HERE if you answered YES to ANY part of Q2. Place patient Nil by Mouth and refer to Speech Pathology or VMO and follow up plan over page.

3. Test the patient with a sip of water and observe:	
• Any coughing/throat clearing	Yes ☐ No ☐
• Change in vocal quality	Yes ☐ No ☐
• Drooling	Yes ☐ No ☐
• Change in respiration/shortness of breath	Yes ☐ No ☐

STOP HERE if you answered YES to ANY part of Q3. Place patient Nil by Mouth and refer to Speech Pathology or VMO and follow up plan over page.

4. Observe the patient drink a cup of water:	
• Any coughing/throat clearing	Yes ☐ No ☐
• Change in vocal quality	Yes ☐ No ☐
• Drooling	Yes ☐ No ☐
• Change in respiration/shortness of breath	Yes ☐ No ☐

STOP HERE if you answered YES to ANY part of Q4. Place patient Nil by Mouth and refer to Speech Pathology or VMO and follow up plan over page.

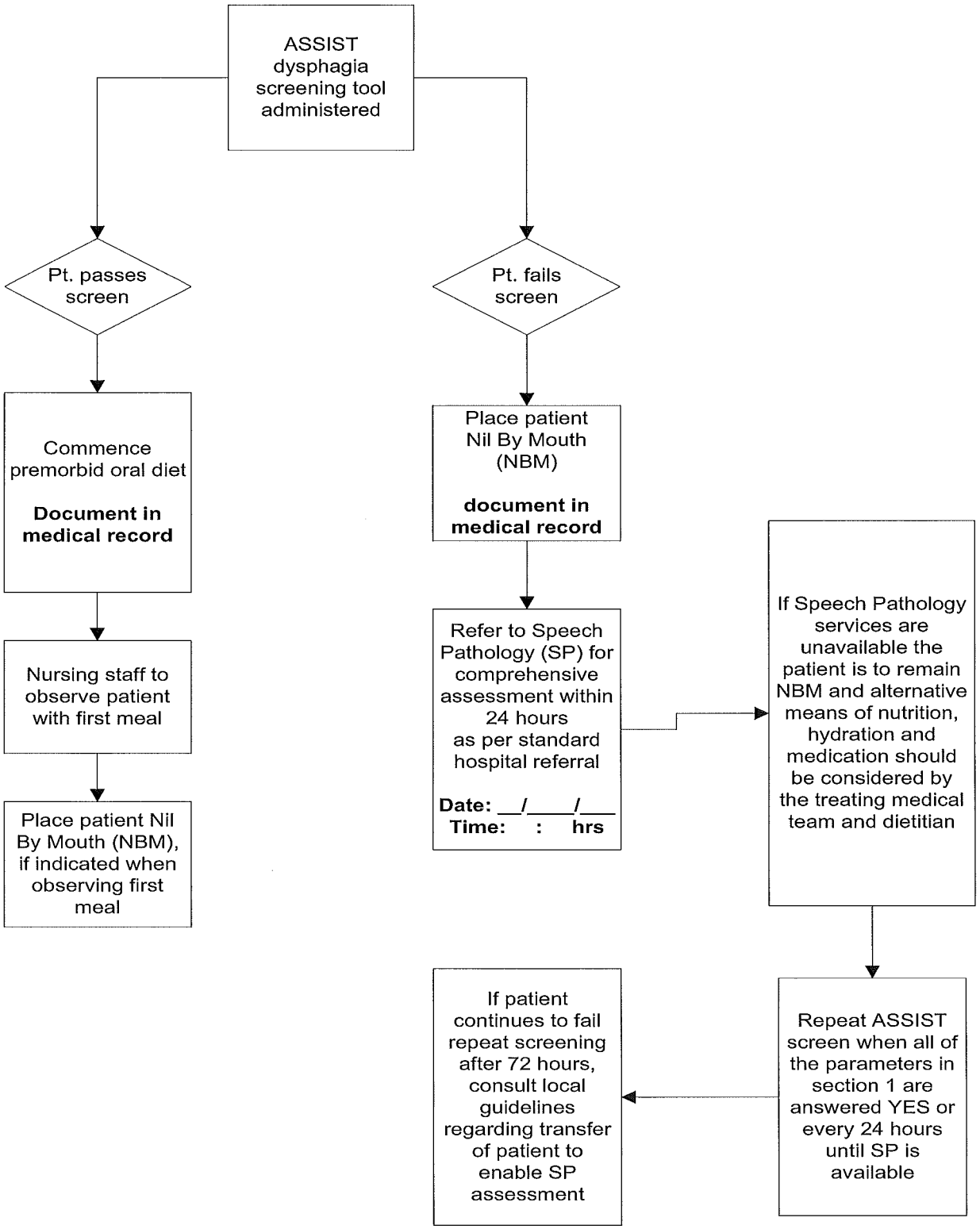
5. Commence premorbid oral diet
- Nursing staff to observe patient with first meal
- Staff Member reviewing first meal: _____

Time: _____ Date: _____

A spike in temperature and/or deterioration in chest condition may indicate silent aspiration. Place patient NBM and refer to Speech Pathology or VMO.

Clinical Pathway – Conscious Cerebrovascular Accident / TIA

Follow Up Plan



Clinical Pathway – Conscious Cerebrovascular Accident / TIA

ADMISSION DAY:	DATE:	AM	PM	ND
Admission Assessment	VMO Admission completed Admission and Discharge Form completed Yes\No			
Observations	BP sys 100 – 140, diastolic 60-95, HR reg 60 -100b\m, RR 16-22 Afebrile Neuro observations recorded and within normal limits Urinalysis – NAD Wt attended where possible using chair scales BSL Recorded			
Discharge Planning	Discharge Planning commenced as per A&D Form Pre-admission support services notified of patients admission			
Patient/Relative Education	Relatives aware of admission Yes [ ] No [ ] Reassurance and explanation of care given to patient/family			
Allied Health **Physio** **OT** **Speech Pathologist** **Social Worker**	Referral notification to Allied Health Professionals Physio [ ] OT [ ] SP [ ] Dietician [ ] **Assessments / review with 24 hours of receiving referral**			
Medications	Given as per MO orders on Treatment Sheet **Tolerating Medications** **Allergies noted**			
Test Procedures & Treatment	± CT Scan Date_____ Time _____ FBE, U&E Other _____ MSU Yes [ ] No [ ] ECG Yes [ ] No [ ] NG Tube Yes [ ] No [ ] O2 Therapy _____ Yes [ ] No [ ] **Other:**			
Oral Intake Fluids	Dysphagia Screening undertaken by nursing staff Swallowing assessment completed by – Medical Officer [ ] Speech Pathologist [ ] Nil Orally Yes [ ] Fluids: Consistency Normal [ ] Thickened [ ] Diet _____ **Tolerating diet and fluids** **Variance = Not tolerating diet / fluids** **Document reason why in the progress notes** Fluids IV [ ] Check site each shift [ ]			
Elimination	IDC [ ] Yes [ ] No [ ] Toilet – Independent [ ] Assistance [ ] Aids _____ Fluid Balance Chart Yes [ ] No [ ] Bowel Chart [ ] or Record on Obs Chart [ ] **Assess continence status**			
Hygiene **Comfort** **Skin Integrity**	Sponge [ ] Mouth Care Attended NAD Yes [ ] No [ ] Skin Integrity Intact Yes [ ] No [ ] Wounds –**wound chart completed Yes [ ] No [ ]**			
Activity **Safety**	Falls Risk Assessment Completed Yes [ ] No [ ] Client Risk Assessment Form Yes [ ] No [ ] Bedrails required Yes [ ] No [ ] If yes Restraint Form Completed Yes [ ] No [ ]			

Name, Signature, Designation	

CLINICAL PATHWAY CVA / TIA

Clinical Pathway – Conscious Cerebrovascular Accident / TIA

DAY 2:	DATE:	AM	PM	ND
Assessment	**S/B VMO [ ] Pathway continued [ ]**			
Observations	BP, HR, RR, T, WNL (within normal limits) as above Neuro obs recorded and within normal limits BSL Yes [ ] No [ ] Frequency _____ **Other**			
Discharge Planning	Discharge Plan Commenced / Discharge Date identified			
Patient/Relative Education	Education provided to patient/family			
Allied Health: **Physio** **OT** **Speech Pathologist** **Social Worker**	 Yes [ ] No [ ] Document in progress notes **Variance = Not S/B Physio/Referral not sent [ ] Physio unavailable [ ]** Yes [ ] No [ ] Document in progress notes Yes [ ] No [ ] Document in progress notes Yes [ ] No [ ] Document in progress notes			
Medications	**Medication as per chart Changes Yes [ ] No [ ]** **Tolerating Medications**			
Test **Procedures** **&** **Treatment**	As Requested by Medical Officer ± CT Scan Date_____ Time _____ FBE, U&E [ ] MSU Yes [ ] No [ ] ECG Yes [ ] No [ ] O2 Therapy _____ Yes [ ] No [ ] **Other:**			
Oral Intake **Fluids**	As assessed by – Medical Officer [ ] Speech Pathologist [ ] Nil Orally Yes [ ] No [ ] Fluids: Consistency Normal [ ] Thickened [ ] Diet _____ **Tolerating diet and fluids** Fluids IV **Yes [ ] No [ ]** Check site each shift Yes [ ] No [ ]			
Elimination	IDC [ ] Yes [ ] No [ ] IDC care if required Toilet – Independent [ ] Assistance required [ ] Fluid Balance Chart Yes [ ] No [ ] Record Bowel motions daily [ ] Obs Chart [ ] Incontinent – Urine [ ] Faeces [ ] **Incontinence Aids**_____			
Hygiene **Comfort** **Skin Integrity**	Sponge [ ] Shower with assistance [ ] Independent [ ] Mouth Care _____ PAC Devices _____ Skin Integrity Intact Yes [ ] No [ ] Wound – Yes [ ] no [ ] refer to wound chart			
Activity **Safety**	Activities as assessed by physio: **Refer to progress notes** Safety Aids and \or Restraint Form completed			

Name, Signature, Designation	

CLINICAL PATHWAY CVA / TIA

Clinical Pathway – Conscious Cerebrovascular Accident / TIA

DAY 3:	DATE:	AM	PM	ND
Assessment	**S/B MO [ ] Pathway continued [ ]** **Nursing Assessment = Stable [ ]**			
Observations	TPR / BP_____ **within normal limits** BSL Yes [ ] No [ ] Frequency _____ **Other**			
Discharge Planning				
Patient/Relative Education	Care Plan discussed with the patient / family			
Allied Health **Physio** **OT** **Speech Pathologist** **Social Worker**	**Documentation in the progress notes** **Physio – Assess Rehabilitation status**			
Medications	**Medication as per chart Changes Yes [ ] No [ ]** **Tolerating Medications**			
Test **Procedures** **&** **Treatment**	As Requested by Medical Officer (document tests performed)			
Oral Intake **Fluids**	As assessed by – Medical Officer [ ] Speech Pathologist [ ] Nil Orally Yes [ ] No [ ] Fluids: Consistency Normal [ ] Thickened [ ] Diet _____ **Tolerating diet and fluids** **Variance = Not tolerating diet / fluids** **Document reason why in the progress notes** Fluids IV **Yes [ ] No [ ]** Check site each shift Yes [ ] No [ ]			
Elimination	IDC [ ] Yes [ ] No [ ] IDC care if required Toilet – Assistance Required [ ] Fluid Balance Chart Yes [ ] No [ ] Record Bowel motions daily [ ] Obs Chart [ ] Incontinent – Urine [ ] Faeces [ ] **Record incontinence aids used in progress notes** Aperient if BNO × 2 days			
Hygiene **Comfort** **Skin Integrity**	Sponge [ ] Shower with assistance [ ] Independent [ ] Mouth Care _____ PAC Devices _____ Skin Integrity Intact Yes [ ] No [ ] Dressing – **refer to wound chart** TED / Support Stockings Yes [ ] No [ ]			
Activity **Safety**	Activities as assessed by physio: **Refer to progress notes** Client Risk Assessment Form Completed Restraint required Yes [ ] No [ ] Type:			

Name, Signature, Designation	

CLINICAL PATHWAY CVA / TIA

Clinical Pathway – Conscious Cerebrovascular Accident / TIA

DAY 4:	DATE:	AM	PM	ND
Assessment	**S/B MO [ ] Pathway continued [ ]** **Nursing Assessment = Stable [ ]**			
Observations	TPR / BP_____ **within normal limits** BSL Yes [ ] No [ ] Frequency _____			
Discharge Planning	Review length of stay Yes [ ] No [ ]			
Patient/Relative Education	Care needs discussed with the patient / family Concerns addressed regarding care needs = **documented in the progress notes**			
Allied Health **Physio** **OT** **Speech Pathologist** **Social Worker**	**Documentation in the progress notes** **S/B Physio [ ]** S/B OT Home Assessment Yes [ ] N/A [ ] S/B Speech Pathologist Yes [ ] No [ ]			
Medications	**Assessed by Medical Officer Changes Yes [ ] No [ ]**			
Test **Procedures** **&** **Treatment**	As assessed by Medical Officer (document tests performed)			
Oral Intake **Fluids**	As assessed by – Medical Officer [ ] Speech Pathologist [ ] Nil Orally Yes [ ] No [ ] Fluids: Consistency Normal [ ] Thickened [ ] Diet _____ **Tolerating diet and fluids** Fluids IV **Yes [ ] No [ ]** Check site each shift Yes [ ] No [ ]			
Elimination	IDC [ ] Yes [ ] No [ ] IDC care if required Toilet – Assistance Required [ ] Fluid Balance Chart Yes [ ] No [ ] Record Bowel motions daily [ ] Obs Chart [ ] Incontinent – Urine [ ] Faeces [ ] **Record incontinence aids used in progress notes** Aperient if BNO × 2 days			
Hygiene **Comfort** **Skin Integrity**	Assistance [ ] Independent [ ] Mouth Care _____ PAC Devices _____ Skin Integrity Intact Yes [ ] No [ ] = wound chart = **referred to wound consultant**			
Activity **Safety**	Activities as assessed by physio: **Refer to progress notes** Client Risk Assessment Form Completed Ambulatory Aids required Yes [ ] No [ ] Restraint required Yes [ ] No [ ] Type:			

Name, Signature, Designation	

CLINICAL PATHWAY CVA / TIA

Clinical Pathway – Conscious Cerebrovascular Accident / TIA

DAY 5:	DATE:	AM	PM	ND
Assessment	**S/B MO [ ] Pathway continued [ ]** **Nursing Assessment = Stable [ ]**			
Observations	TPR / BP_____ **within normal limits** BSL Yes [ ] No [ ] Frequency _____			
Discharge Planning	Discharge Date: _____ Support Services Identified: Community Nurse [ ] HACC [ ] MOW [ ] Post Acute Care [ ]			
Patient/Relative Education	Care needs discussed with the patient / family Concerns addressed regarding care needs = **documented in the progress notes** Discharge date discussed with patient Yes [ ] No [ ] **Referrals to support services discussed with patient / family**			
Allied Health **Physio** **OT** **Speech Pathologist** **Social Worker**	**Documentation in the progress notes** **S/B Physio [ ]** S/B Occupational Therapist [ ] S/B Speech Pathologist [ ]			
Medications	**Medication as per charge Changes Yes [ ] No [ ]** **Discharge Medications reviewed [ ] Scripts required [ ]**			
Test Procedures & Treatment	As assessed by Medical Officer (document tests performed)			
Oral Intake Fluids	As assessed by – Medical Officer [ ] Speech Pathologist [ ] Nil Orally Yes [ ] No [ ] Fluids: Consistency Normal [ ] Thickened [ ] Diet _____ **Tolerating diet and fluids** Fluids IV **Yes [ ] No [ ]** Check site each shift Yes [ ] No [ ]			
Elimination	IDC [ ] Yes [ ] No [ ] IDC care if required Toilet – Assistance Required [ ] Fluid Balance Chart Yes [ ] No [ ] Record Bowel motions daily [ ] Obs Chart [ ] Incontinent – Urine [ ] Faeces [ ] **Record incontinence aids used in progress notes**			
Hygiene **Comfort** **Skin Integrity**	Assistance [ ] Independent [ ] Mouth Care _____ PAC Devices _____ Skin Integrity Intact Yes [ ] No [ ] = wound chart = **referred to wound consultant**			
Activity **Safety**	Activities as assessed by physio: **Refer to progress notes** Client Risk Assessment Form Completed Aids required _____			

Name, Signature, Designation	

CLINICAL PATHWAY CVA / TIA

Clinical Pathway – Conscious Cerebrovascular Accident / TIA

DAY 6:	DATE:	AM	PM	ND
Assessment	**S/B MO [ ] Pathway continued [ ]** **Nursing Assessment = Stable [ ]** **Variance = Condition unstable** **If Pathway Ceased [ ] Document reason in the progress notes**			
Discharge Planning	Discharge Date: _____ Referrals required: Community Nurse [ ] HACC [ ] MOW [ ] Post Acute Care [ ] **48 hours notice required for Community Nurse / HACC / MOW referrals**			
Patient/Relative Education	Care needs discussed with the patient / family Concerns addressed regarding care needs = **documented in the progress notes** Discharge date discussed with patient Yes [ ] N/A [ ] **Referrals to support services discussed with patient / family**			
Allied Health **Physio** **OT** **Speech Pathologist** **Social Worker**	**Date OT Home assessment** _____ **Equipment required [ ]** **Outpatient appointments required:** **Physio [ ]** **Speech Pathologist [ ]** **Dietician [ ]** **Document times in the progress notes**			
Observations	TPR / BP_____ hrly **within normal limits** BSL Yes [ ] No [ ] Frequency _____ **Variance = Observations unstable / febrile**			
Medications	**Medication as per chart Changes Yes [ ] No [ ]** **Discharge Mediations Reviewed [ ] Scripts Required [ ]**			
Test Procedures & Treatment	As assessed by Medical Officer (document tests performed)			
Oral Intake Fluids	As assessed by – Medical Officer [ ] Speech Pathologist [ ] Nil Orally Yes [ ] No [ ] Fluids: Consistency Normal [ ] Thickened [ ] Diet _____ **Tolerating diet and fluids** **Variance = Not tolerating diet / fluids** **Document reason why in the progress notes** Fluids IV **Yes [ ] No [ ]** Check site each shift Yes [ ] No [ ]			
Elimination	IDC [ ] Yes [ ] No [ ] IDC care if required Toilet – Assistance Required [ ] Fluid Balance Chart Yes [ ] No [ ] Record Bowel motions daily [ ] Obs Chart [ ] Incontinent – Urine [ ] Faeces [ ] **Record incontinence aids used in progress notes** Aperient if BNO × 2 days			
Hygiene **Comfort** **Skin Integrity**	Assistance [ ] Independent [ ] Mouth Care _____ PAC Devices _____ Skin Integrity Intact Yes [ ] No [ ] = wound chart = referred to wound consultant			
Activity **Safety**	Client Risk Assessment Form Completed Aids required _____			

Name, Signature, Designation	

CLINICAL PATHWAY CVA / TIA

DAY 7:	DATE:	AM	PM	ND

Clinical Pathway – Conscious Cerebrovascular Accident / TIA

Assessment	**S/B MO [ ] Pathway continued [ ]** **Nursing Assessment = Stable [ ]** **Variance = Condition unstable** **If Pathway Ceased [ ] Document reason in the progress notes**			
Observations	TPR / BP_____ **within normal limits** BSL Yes [ ] No [ ] Frequency _____			
Discharge Planning	Review patient classification Acute Pathway continued [ ] Rehab [ ] GEM [ ] **Pathway ceased** [ ] For discharge today [ ] Discharged Time: _____ **Discharge Plan Completed** [ ] Referrals required: Community Nurse [ ] HACC [ ] MOW [ ] Post Acute Care [ ] **48 hours notice required for Community Nurse / HACC / MOW referrals**			
Patient/Relative Education	Care needs discussed with the patient / family Concerns addressed regarding care needs = **documented in the progress notes** Discharge date discussed with patient Yes [ ] N/A [ ] **Referrals to support services discussed with patient / family**			
Allied Health **Physio** **OT** **Speech Pathologist** **Social Worker**	**S/b Physio [ ]** **S/B Speech Pathologist [ ]** **S/B Dietician [ ]** **Document times in the progress notes**			
Medications	**Medication as per chart Changes Yes [ ] No [ ]** **Discharge Mediations Reviewed [ ] Scripts Required [ ]**			
Test Procedures & Treatment	As assessed by Medical Officer (document test performed)			
Oral Intake Fluids	As assessed by – Medical Officer [ ] Speech Pathologist [ ] Nil Orally Yes [ ] No [ ] Fluids: Consistency Normal [ ] Thickened [ ] Diet _____ **Tolerating diet and fluids** **Variance = Not tolerating diet / fluids** **Document reason why in the progress notes** Fluids IV **Yes [ ] No [ ]** Check site each shift Yes [ ] No [ ]			
Elimination	IDC [ ] Yes [ ] No [ ] IDC care if required Toilet – Assistance Required [ ] Fluid Balance Chart Yes [ ] No [ ] Record Bowel motions daily [ ] Obs Chart [ ] Incontinent – Urine [ ] Faeces [ ] **Record incontinence aids used in progress notes** Aperient if BNO × 2 days			
Hygiene **Comfort** **Skin Integrity**	Assistance [ ] Independent [ ] Mouth Care _____ PAC Devices _____ Skin Integrity Intact Yes [ ] No [ ] = wound chart = referred to wound consultant			
Activity **Safety**	Client Risk Assessment Form Completed Aids required _____			

Name, Signature, Designation	

Clinical Pathway – Conscious Cerebrovascular Accident / TIA

Variation Page

Clinical	**C**	Complications, changes in clinical management/condition
Internal	**I**	No physio, equipment breakdown
External	**E**	No stroke bed available, transport unavailable, delayed
Social	**S**	Social supports, family

REFERRALS				
Date/Time	**Mode**	**To**	**From**	**Outcome**

VARIATIONS					
Variation type	**DATE TIME**	**What variance occurred? What was the issue**	**Action taken What did you do?**	**Outcome Did your action solve the problem?**	**Reported by (signature)**

Clinical Pathway – Conscious Cerebrovascular Accident / TIA

Variation Page

Clinical	**C**	Complications, changes in clinical management/condition
Internal	**I**	No physio, equipment breakdown
External	**E**	No stroke bed available, transport unavailable, delayed
Social	**S**	Social supports, family

REFERRALS				
Date/Time	**Mode**	**To**	**From**	**Outcome**

VARIATIONS					
Variation type	**DATE TIME**	**What variance occurred? What was the issue**	**Action taken What did you do?**	**Outcome Did your action solve the problem?**	**Reported by (signature)**

Clinical Pathway – Conscious Cerebrovascular Accident / TIA

Variation Page

Clinical	**C**	Complications, changes in clinical management/condition
Internal	**I**	No physio, equipment breakdown
External	**E**	No stroke bed available, transport unavailable, delayed
Social	**S**	Social supports, family

REFERRALS				
Date/Time	**Mode**	**To**	**From**	**Outcome**

VARIATIONS					
Variation type	**DATE TIME**	**What variance occurred? What was the issue**	**Action taken What did you do?**	**Outcome Did your action solve the problem?**	**Reported by (signature)**

Medical Emergency Team Call (MET Call) Policy

Policy Statement:

PURPOSE AND SCOPE

The primary goal of this policy is to outline the expected response to patient's warning signs before cardiac or respiratory arrest occurs. This policy sets out the criteria to determine clinical instability warranting a MET Call

POLICY

Nursing staff are able to initiate a MET call using the set criteria for Adult and Paediatric patients to facilitate rapid response by medical staff for patients deemed to be at risk.

A MET call does not replace:

- **The usual communication between nursing and medical staff in relation to patient care at other times;**
- **The emergency RESPOND BLUE**

PROCEDURE

ASSESSMENT

In the presence of one or more of the below criteria, any member of nursing staff may request urgent medical review of the patient.

Criteria for Adult Patients

1. Deterioration in conscious state of GCS 2 or more
2. Systolic blood pressure less than 90mmHg
3. Heart rate less than 40 beats per min.
4. Heart rate greater than 140 beats per min.
5. Respiratory rate less than 10 breaths per min.
6. Respiratory rate greater than 30 breaths per min.
7. Difficulty breathing
8. Prolonged convulsions (> 2 minutes)
9. Uncontrolled pain
10. Nurse worried 'The patients' condition is worsening and needs medical

assessment, but I'm not quite sure what the problem is'.

Criteria for Paediatric Patients

1. Nurse worried: 'the patient's condition is worsening and needs medical assessment, but I'm not quite sure what the problem is'.
2. Deterioration in conscious state of GCS 2 or more
3. Significant change in vital signs.

IMPLEMENTATION

To gain urgent medical review of a patient (including paediatric)

During business hours (0930 - 1730)

1. the on-call VMO at the Medical Clinic either by direct line to their consulting room or by contacting the receptionist and asking them to inform the on-call doctor of the emergency

After Hours (including weekends/public holidays) contact the doctor on call.

Medical officers have 30 minutes in which to attend, if after this time they have not attended a second call should be made to provide a progress report of the patient's condition

Where time permits it is advisable to discuss the clinical situation of acutely unwell patients with the Nursing Unit Manager or After Hours Supervisor before making the call to the Medical Officer.

The Nursing Supervisor must be kept informed of the medical response and potential outcomes.

DOCUMENTATION

Document the details of the situation, medical response and patient outcome in the patients' progress notes.

Appendices:

- Clinical Instability Criteria

Departments:

- Clinical

Documentation Policy

Policy Statement:

- Medical records must be sufficiently detailed to clearly identify the patient, patient assessment, planning of care, implementation of care and evaluation of care, but not contain repetitive and/or redundant information.
- Medical records must be sufficiently detailed to facilitate continuity of care, education, quality improvement, and research and casemix funding (where required) and to meet Medico legal and statutory requirements.
- Each health profession involved in the patient's episode of care is responsible for documenting in the medical record according to the specifications outlined according to the specifications below in compliance with ACHS and/or hospital standards, relevant professional guidelines and statutory requirements.
- All entries in the medical record shall be made only by persons authorised by Orbost Regional Health. These shall include authorized employees, as well as other health professionals who are requested to consult or who are otherwise involved in the care of the client. Any entry recorded by a student on clinical placement shall be counter signed by the supervisor or preceptor.
- Entries made in the medical record shall be the responsibility of the individual health care provider
- Medical notes are integrated with nursing and allied health documentation for continuity of care.

Documentation standards

- All entries shall be timed using the 24 hour clock, dated including year, and signed with printed name and designation following signature. Stamps or stickers denoting designation and name can be used whenever possible.
- The patient's name and medical record number shall be included on each sheet of the record.
- All significant changes and events shall be recorded.
- Patient quotes shall be identified.
- The progress notes shall be made by exception and at a minimum as follows:
    - In acute settings at least once every 24 hours.
    - For psychiatric patients at least once per shift.
    - In residential aged care (high and low) at least once per month.
- Where notes are continued over to a new page the bottom of the first page shall be signed and 'continued' written at next entry.
- All entries in the medical record shall be recorded on approved hospital

forms or stationary.

- All entries including alterations shall be legible and made with permanent blue or black ink.
- No "white out" substances shall be used.
- Alterations to the record shall be made by ruling one line through the mistake and "written in error" noted and signed. Medical record entries must not contain gaps and empty lines between them. A single line shall be ruled through any blank spaces.
- Do not amend any previously written notes.
- Information is not to be removed from the medical record.
- A registration form must be completed for all patients admitted to ORH
- An alert notation for allergic response or drug sensitivity shall be prominently displayed in the record.
- Only abbreviations from the ORH's *Accepted Abbreviations Policy* may be used.
- Enter treatment orders, as it occurs, not in advance.
- Entries shall not be made retrospectively unless clearly documented that they have been done so.
- Keep all patient data strictly confidential and keep the names of other patients out of your notes.
- Documentation of medicines given under Standing Orders should comply with the *Standing Orders* policy

Documentation frequency:

- **Medical staff:** The minimum frequency of documentation is daily for acute patients and twice weekly for aged care residents.
- **Nursing staff:** The minimum frequency of documentation should be once per shift. Care should be documented as it occurs. The frequency is not limited to these intervals, but should be based on the condition of the patient.
- **Allied Health staff:** The initial assessment will be documented on the day of assessment on the progress notes, in both inpatient and ambulatory settings. Every patient contact thereafter will be documented and will include the ongoing care plan.

Content of Medical Record:

Admission information

- Presenting health problem
- Relevant past history
- Current treatment including medications, other treatments and services
- Assessment including physical, cognitive, psychosocial, social and cultural, functional status both prior to this illness and current.
- Risk screen/assessment including allergies and alerts.
- Management plan
- Expected date of discharge and designation
- Relevant contacts e.g. Family, other nominated person(s), general practitioner, other health professional
- Evidence of informed consent from patient or patient's next of kin/legal guardian
- Documented diagnosis on admission (may be provisional)

Progress information

- Management plan
- Planned and achieved outcomes
- Care requested, delivered and ceased
- Response to treatment
- Patient observations
- Significant events such as change in condition, adverse events
- Variations from planned care
- Patient education
- Referral details
- Review and update of discharge plan including referrals to community services and reasons for delay in discharge.
- Investigations ordered and results noted.
- Any telephone conversations with the duty GP re on going care

Surgical requirements

- Written consent for surgery, which complies with ethical and legal obligations (patient or patient's next of kin/legal guardian)
- Pre-anaesthetic assessment
- Anaesthetic record – personnel involved, anaesthetic agents and medications, access, technique, airway, monitoring and interventions, time-line and adverse events.
- Operative record – diagnosis, findings, procedure performed, prosthetic details and tissue removed.
- Operative room count
- Recovery record – appropriate monitoring of vital signs, status of the patient and post – operative orders.

Admission to Emergency Department

- Complete all required fields on Accident and Emergency form
- Document triage score, time, date, all nursing treatments and signature.
- VMO is responsible for documenting clinical notes and sign treatment orders.
- Attach all other relevant documentation to form. E.g. ambulance sheet, doctors letter, ECG
- Enter patient's details and triage score in A&E register.
- If a sterile procedure performed, place all validation stickers on patient records corresponding with treatment.
- Photocopy patient's records and place in ward history.
- Records to be placed in completed basket unless ongoing care i.e. daily dressings.

Inter-department transfer

- Summary of care
- Ongoing plan
- Notification of transfer to relevant contact e.g. Family, health carer or other nominated person.
- Transfer destination
- Date and time of transfer

Discharge and Inter-hospital transfer

- Discharge plan including arrangements for continuing management,

follow up instructions and education to patient and carer(s).
- Notification of transfer or discharge to relevant contact e.g. Family, health carer or nominated person.
- Discharge and transfer destination.
- Date and time of separation.
- Reason for transfer.
- Discharge summary to be completed.
- Inter-hospital Transfer Form must be completed.

Death Information

- Date and time of death
- Events and details relevant to death
- Notification of relatives and/or next of kin
- Other details e.g. Autopsy, coronial reporting
- Discharge Summary must be completed for all deceased patients
- Death certificates to be completed (excludes cases referred to coroner)
- Notification of GP
- If verifying death, please refer to the *'Nurse Verification of Death Policy'*.

Legal Information

- Details regarding guardianship
- Details regarding competency
- Reasons and details for restraint
- Refusal of treatment
- Limitation of treatment
- mandatory reporting of child abuse should be documented according to the *Child FIRST and Child Abuse Reporting (including Mandatory Reporting) Policy*.

Outcome:

The medical record is a medico-legally sound document and correctly reflects what was communicated or decided or what action was taken. It is able to support the needs of the business to which it relates and be used for accountability.

The Australian Standard ISI15489 for documentation.

Definitions:

Medical record - is the document in which all health care providers contributing to care of the client record all details of care planned and delivered.

Standard:

ACHS Std 1.1.8. The health record ensures comprehensive and accurate information is collaboratively gathered, recorded and used in care delivery.

Review circulation: Quality Facilitator, Information Management Manager, MPS Management Committee

Evidence of compliance: Six monthly audits, to check compliance with this policy.

References:

Latrobe Regional Hospital Documentation policy 2005

ACHS EQuIP Guidelines – Information Management. 2006.

Northern Hospital Medical records Documentation Standards (Including standards for clinical documentation) 2004

Linked PP:

- Accepted Abbreviations Policy
- Child FIRST and Child Abuse Reporting (including mandatory reporting) Policy
- Nurse Verification of Death Policy
- Standing Orders Policy

Departments:

- Clinical

Orbost Regional Health

Hollands Wing Nursing Documentation Audit

Descriptor	Compliant / Not compliant	Comments
1. Writing is legible.		
2. Writing is in ink.		
3. Signed by author.		
4. Dated by author.		
5. A straight line has been drawn through mistakes.		
6. Reason for error identified.		
7. Initial used to identify who made correction.		
8. Designation of author identified.		
9. All pages are identified with patient name.		
10. Documentation is factual of observations and actions.		

Audit completed by (print name): _____ **Designation:** _____

Date: _____/_____/_____

QUALITY USE ONLY

Outcome	Tick	Action Plan
Documentation incomplete. Further action required.		

Medical Officer Orientation

Developed December 2006: Reviewed November 2010: August 2011
I:\Area Managers\ORH Sentinel Event 2007\Response to the Coroners Report\Medical Officer Orientation.docx

CONTENTS

ORBOST REGIONAL HEALTH

At Orbost Regional Health we are proud that this innovative Multi Purpose Service has the capacity, through our flexible funding, to embrace a holistic approach to the health and wellbeing of our communities. We provide acute and residential aged care facilities (Waratah Lodge our high level care nursing home and Lochiel House our residential hostel) and many other services including the Orbost Medical Clinic, allied health services and community health services.

Through regular community consultation, a Community Needs Survey, forums, patient satisfaction surveys etc we are able to provide the services that the community considers are most important to them.

Services are provided over a vast area from Nowa Nowa to just east of Orbost at Mallacoota, and inland to Buchan and as far as the remote areas of Tubbut, Bendoc and Bonang, covering some 1 million square hectares.

CONTACT NUMBERS FOR URGENT TRANSFER

Numbers to call for urgent transfer:

Adult Retrieval Victoria	1300 36 86 61
Perinatal Emergency Referral Service:	1300 137 650
Newborn and Paediatric Emergency Transport Service:	1300 137 650

Please note there are times when transfer of patients is difficult due to lack of retrieval services availability; therefore Visiting Medical Officers may be required to escort critically ill people part, or all, of the way to the receiving facility in order to expedite transfer and subsequent treatment.

MEDICAL RECORDS

During business hours the ward clerk will obtain hospital records for any patient. After hours, or on weekends, ask either the ward clerk or senior nurse who will access the record for you. Patients have a medical history at Orbost Medical Clinic that is separate to the medical record which is stored at Orbost Regional Health.

DAILY ROUTINE

Weekdays

8.30am – Ward round in acute ward. This is attended by medical staff (where appropriate), nursing staff and allied health professionals if required.

Following ward round see urgent outpatients who may present at the hospital.

Also do venesections, chemotherapy etc. which may have been organised by you or for you.

10.00am – Surgery starts

- Bookings from 10am – 12pm and 2pm – 4.45pm

Monday and Friday Mornings

Acute ward round is followed by Waratah Lodge round. All nursing home residents are seen and medical report written in resident's history using the electronic WeCare system (hand palm or lap top). Any scripts, pathology etc. for nursing home residents written up at this time.

Thursday Morning

General anaesthetics followed by lumps and bumps. Consultations at surgery are dependent upon time commitment at the hospital.

Home Visits

If a home visit is requested, it is fitted in between hospital and surgery, during lunch time, or during consultation time if there is a break.

Weekends

Saturdays 8.30am – ward round by doctor on call

10am – surgery, then on call, patients seen in Outpatients department.

You may choose to either allocate a time to return and see non-urgent outpatients, or be phoned for each patient and return to the hospital as required.

Sunday Approx. 9.30am – ward round and see outpatients

Patients requiring semi-urgent attention are encouraged to arrive at the hospital at 10am on Sundays. The VMO is then on call after the ward rounds and outpatient consultations.

Other Services

A doctor from Orbost Medical Clinic attends Cann River Bush Nursing Centre every Wednesday; Buchan Bush Nursing Centre every three weeks on a Wednesday; and Moogji Aboriginal Clinic every Tuesday afternoon.

PAP SMEARS

Cervical cytology is sent to Victorian Cytology Service.

It can also be sent to Gippsland Pathology, however this is not a free service. Use the normal Pathology form for Gippsland Pathology Service.

Samantha Osborn, Women's Health Nurse, sees women at the Clinic on Wednesday's via appointments. Can perform pap smears during this time.

RADIOLOGY

Non-Urgent X-Rays

Doctors are **not** permitted to perform any X-Rays unless they are registered with the radiation safety unit, Department of Health.

Radiographer from Bairnsdale visits Orbost Regional Health on Mondays 9am – 3pm

The Radiographer does all non-urgent X-Rays (backs, necks, routine chests, etc.) including IVP's (usually booked for 9 am or 1.30 pm, as we have to give the contrast and stay around for a few minutes afterwards). We charge a consult to the patient, bulk-billed if appropriate.

To make appointments for non-urgent X-Ray's, contact Orbost Regional Health reception (phone 5154 6666) during business hours. Fill in X-Ray slip and give to patient to present to Reception. Results will be sent to you via Medical Director.

If the requesting practitioner specifically wants the results of radiology requests to be provided direct to them, the doctor is to make a note on the request form.

Barium studies, ultrasound, CT mammography and echocardiograms are done in Bairnsdale. Book on 5150 3470.

Nuclear medicine done in Sale. Book on 5149 6620. CT's, ultrasounds, etc. can be done in Sale also.

Prep kits for barium enemas, ultrasounds are kept in the clinic (in the cupboard above the sink in the back room).

Routine mammograms can be booked by the patient by phoning the number in the Breast Screen pamphlet at the surgery.

PATHOLOGY

Local provider is Gippsland Pathology Service and their laboratory is in Bairnsdale. Results can be obtained by phoning the laboratory on 5150 3300, 5150 3405, 5154 3475 or 5154 3476.

Only urgent bloods are to be ordered on the weekend. They have to go via V-Line bus and Pathology in Bairnsdale must be notified prior to their arrival.

Routine service here is Monday to Friday 8 am – 10.30 am. No appointments are required. Courier also picks up bloods and microbiology from that morning, or the day before, from the hospital reception desk and the clinic at 10.45 am.

The laboratory does not like most specimens to be more than a few hours old – do not take FBE, E&U, LFT etc. after the courier has left for the day.

Urgent investigations can be taken and transport can be organized, however discuss it with the Nurse Unit Manager or Senior Nurse if you want these done.

If the requesting practitioner specifically wants the results of pathology requests to be provided direct to them, the doctor is to make a note on the request form.

Results are downloaded daily from Bairnsdale to us at 8.30 & 11.30 am and 1.30 and 4.30 pm.

Urgent results are faxed or phoned through by the laboratory if requested, or if they consider it appropriate.

Pathology Forms

Fill in all the details including patient's file number. ID labels are obtained from clients history.

Pension/Healthcare Card Holder

In order for Medicare to bulk bill pensioners or health care card holders, you must ensure that they sign the assignment for section of the computer generated pathology request form. If a pathology slip is written manually, ensure that a pathology Medicare chit is completed. This process is the same for outpatients or clinic patients.

Transport Accident Commission

All drivers involved in motor vehicle accidents are required to have blood alcohols taken by the doctor seeing patient in outpatients department. Tubes in cupboard behind door in outpatients annexe. Patient to keep a sample in case of future dispute.

Most car accidents are billed direct to TAC.

In addition to patients name and address, we need:

- Date of birth
- Car registration number
- Attending Police - Orbost, Cann River, etc.

It is important to document type of consultation, any X-Rays and procedures performed for billing purposes.

Patient needs to ring TAC to obtain a claim number. There are cards supplied by TAC for this purpose kept at the hospital and the patient can ring TAC from the hospital.

WORKCOVER

Carefully document history, including mode of injury, date and time.

Examination findings, assessment and management plan must also be clear, as you may have to justify it years later in court.

Note the name and address of employer.

Fill our WorkCover certificate. The first certificate can only be for a maximum of 2 weeks. Subsequent certificates can be for 4 weeks.

Note type of consultation, any X-rays (we bill for these) and any procedures so that the receptionist can work out what to bill without annoying you.

Let receptionist know if any consultation is WorkCover to ensure correct billing.

NURSING STAFF

Admission

Contact the Nurse Unit Manager or Senior Nurse in charge to discuss bed availability and reason for admission. The Nurse Unit Manager or Senior Nurse in Charge may at times discuss the appropriateness of the admission to Orbost Regional Health if the patient is a psychiatric patient requiring one to one management, or the patient is very unstable.

If a bed is not available, or only the HDU bed is available, you may need to discharge another patient, or arrange transfer to another facility.

Admission assessment documentation and medication chart are to be completed on admission.

Nursing

The acute ward is staffed by 2 Division1 nurses and on some morning and evening shifts, 3 Division 1 nurses. The Nurse Unit Manager works Monday to Friday 0800 – 1630 and is in charge during that time. In the evening there is a Grade 5 nurse rostered in charge of the shift. All Grade 5 nurses have ALS qualifications. Most Division1 nurses can cannulate.

On night duty there is a 1 Division 1 nurse and 1 Enrolled Nurse on duty.

Waratah Lodge is staffed by 2 Enrolled Nurses, a PCA and a Lifestyle and Leisure co-ordinator.

MATERNITY PATIENT SERVICES

Orbost Regional Health, in conjunction with Orbost Medical Clinic, has an established antenatal, intrapartum and post-natal care program for low risk women.

An enormous amount of work and effort has gone in to sustaining maternity services for the Orbost community. The Department of Health is very supportive of our initiatives and will continue to support us PROVIDED THAT we continue to use evidence-based practice that results in cost-effective, consumer focused care that is of a high standard.

Through this program and in conjunction with Monash University and the Bairnsdale Rural Medical School, we use this model of care to provide clinical teaching to medical students and post-graduate midwifery students. They need every opportunity to liaise with women early to establish a number of cases which they are able to 'follow through' the continuum of pregnancy, birth and postnatal care to complete their educational requirements.

The Department of Health's Rural Maternity Initiative has provided us with substantial funds to support our program, which despite our small numbers, demonstrates outcomes comparable with larger centres. There is sound evidence to support that better birth outcomes will result where the carer in labour has had significant involvement in a woman's pregnancy care and is well known to the mother.

Much of the current philosophy around pregnancy care is that women are given the correct information so that they are able to make an INFORMED CHOICE. We encourage the women to assume responsibility for their pregnancy care with the knowledge that they are guided by expert practitioners using the best available evidence (such as the 3 centres consensus guidelines on antenatal care).

All our midwives and doctors participate in inter-professional education in pregnancy care, Advanced Life Support in obstetrics and other programs to ensure contemporary practice.

We therefore ask that you consider carefully what is in the best interests of a woman if they present to you in early pregnancy. It is preferable that you refer them immediately to Community Maternity Care Program - a collaborative team of midwives, GP obstetricians and Obstetricians at Sale. The benefits of early referral to the program are:

- commencement of the Victorian Maternity Record;
- reduction in unnecessary investigations;
- early identification of moderate to high risks pregnancies and intervention and referral as necessary (as per the Orbost Regional Health's Safe Maternity Care Framework);
- pregnancy care education commences at appropriate times so that women can make informed choices and are not overwhelmed;
- women are able to establish relationships with the staff who will provide their intrapartum care; and
- medical and midwifery students have full access to our small number of women for teaching purposes.

The sustainability of maternity services for our local community relies on the participation of women from our community, good outcomes and maximum collaboration between health professionals.

For more information please speak to the GP Obstetrician, Orbost Medical Clinic, or Jo Marshall (Manager of Maternity Services, Orbost Regional Health).

ISOLATED PATIENT TRAVELLING ALLOWANCE

Any patient travelling more than 100km to see the nearest specialist for is or her specialty is entitled to claim under this scheme. They receive a travelling allowance and accommodation allowance if appropriate, e.g. those attending Peter MacCallum for radiotherapy, or dialysis patients seeing nephrologists. The patient fills in the first part of the form and the specialist completes it.

OPERATIONS

Operating day for non-urgent procedures is Thursday morning at the hospital.

Minor Procedures

Write name of patient and type of procedure in the appointment book on the Thursday that the patient wants it done. Tell the patient to ring the clinic the day before for the time of their appointment (we work out the order and the approximate timing on the Wednesday morning).

Procedures under General Anaesthetic

Same method of booking, but discuss it with the anaesthetist before booking, until you are sure that the procedure is appropriate for us to be doing.

Ensure appropriate informed consent is obtained and form is signed.

Decide with the patient whether it is a day case and they are to be admitted by 7.15 am on the day of surgery (and fasting), or admitted the night before.

Ask the patient to ring the Orbost Medical Clinic (ph 5154 6777) to make appointments to see the doctor (anaesthetist) and the clinic nurse preferably on the **TUESDAY** prior to their surgery which will be done on the Thursday.

- The patient will need a pre-anaesthetic check carried out by the anaesthetist.
- The patient will also need to have a pre-anaesthetic check completed by the clinic nurse.
- The patient will need to book in at the hospital at least the day prior to admission. The clinic nurse will send the patient over to the hospital reception in order to do this, after they have finished at the clinic.

ACCESS TO THE ORBOST REGIONAL HEALTH POLICY SYSTEM

http://orhpps

Clinical policies are approved by the Clinical Standards Committee and Medicines Advisory Committee.

Committee membership

As a Visiting Medical Officer you are invited to be part of the Clinical Standards Committee which meets monthly at lunchtime.

Director of Medical Services

Our Director of Medical Services is on site every eight weeks and is happy to meet with you on those days.

VISITING MEDICAL OFFICER PROTOCOLS

The VMO protocols have been established to define the role and responsibilities of the Visiting Medical Officers of Orbost Regional Health. They include direction for inpatient care and after hours care in the Emergency Department, billing and professional development.

VMO Protocols are a fixed agenda item at the Clinical Standards Committee meetings where doctors or other Committee members may raise issues that relate to those Protocols.

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VISITING MEDICAL OFFICER PROFESSIONAL DEVELOPMENT

The goal of Visiting Medical Officer professional development is to inform and support organisational clinical governance processes including credentialing, assisting doctors to meet their continuing professional development requirements and maximise patient outcomes.

CREDENTIALING AND SCOPE OF PRACTICE

Orbost Regional Health has a clearly defined policy for credentialing and the determination of scope of practice which complies with all applicable legislation, regulations and standards and is viewed as a risk management tool.

You will have your credentials confirmed initially by our Director of Medical Services, who will also advise your scope of practice provisionally prior to you commencing work as a Visiting Medical Officer.

A formal process to credential and affirm scope of practice is conducted through our Sub Regional Credentialing Committee and Clinical Standards Committee on an annual basis.

A recommendation is made by the Clinical Standards Committee to the Orbost Regional Health Board of Management for endorsement.

Any change to scope of practice must be applied for and approved in the same way.

It is also a requirement that you submit on an annual basis, evidence of current medical indemnification, registration with the Australian Health Practitioner Regulation Agency, current X-ray licence, and evidence of participation in professional development activities.

MEDICAL STAFF RULES AND REGULATIONS

All Visiting Medical Officers will be provided with a copy of the Medical Staff Rules and Regulations contained in the Orbost Regional Health Administration Orders. It is in your interests to familiarise yourself with this document.

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REFERRALS

See **Appendix 1** for a guide to specialists. The list will be updated bi-annually.