Safety and Quality Account Report

Limestone Coast Local Health Network

2022 / 2023

Contents

Introduction

Annually, the Limestone Coast Local Health Network (LCLHN) will complete a Safety and Quality Account to demonstrate its achievement and ongoing commitment to improving and integrating safety and quality activity. This approach places safety and quality reporting on the same level as financial reporting as an accountability mechanism with public transparency. The account will provide information about the safety and quality of care delivered by the LHN, including performance against key quality and safety measures and patient safety priorities, service improvements and integration initiatives.

The Safety and Quality Account seeks to ensure that structures, systems and processes are in place that require and foster quality service delivery and ongoing improvement.

The Safety and Quality Account will cover the five (5) components of the National Clinical Governance Framework as follows:

1. Governance, leadership and culture

   Integrated corporate and clinical systems are established and used to improve the safety and quality of health care for patients.

2. Patient safety and quality systems

   Safety and quality systems are integrated with governance processes to actively manage and improve the safety and quality of health care for patients.

3. Clinical performance and effectiveness

   The workforce has the right qualifications, skills and supervision to provide safe, high quality health care to patients.

4. Safe environment for the delivery of care

   The environment promotes safe and high-quality care for patients.

5. Partnering with consumers

   Systems are designed and used to support patients, carers, families and consumers to be partners in healthcare planning, design, measurement and evaluation.

Annual report submission

Annual report endorsed by the Limestone Coast Local Health Network Governing Board, and submitted to Department for Health and Wellbeing, 22 May 2023.

Acknowledgement of the Traditional Custodians

Limestone Coast Local Health Network acknowledges the Traditional Custodians of Country throughout the region and Australia. We acknowledge their connections to land, sea, waters and community and acknowledge this land was never ceded and the ongoing impacts of colonisation.

We recognise the history of First Nation Peoples vast knowledge in traditional holistic healing ways.

They were our first health care workers.

We pay our respects to Elders past, present and emerging, and extend that respect to all First Nation peoples today.

1. Governance, Leadership and Culture

1.1 Clinical governance

The Limestone Coast Local Health Network (LCLHN) is committed to excellence in care and providing the highest levels of patient and client safety. The LCLHN covers a large geographical area, and delivers a range of in-hospital, aged care, community, disability, and mental health services to the Limestone Coast community through a number of public hospitals and other health service sites located at Bordertown, Keith, Kingston, Lucindale, Millicent, Mount Gambier, Naracoorte and Penola.

The LCLHN Governing Board is responsible and accountable to the Minister for Health and Wellbeing for local decision-making. The role of the LCLHN Governing Board includes setting strategies and priorities for health services in the region, as well as ensuring the LHN achieves the performance indicators in its Service Agreement. The Rural Support Service (RSS) provides a clinical and corporate advisory service to the regional LHNs (rLHN), which is hosted by Barossa Hills Fleurieu LHN. The Governing Board is accountable to the Minister for Health and Wellbeing.

The LCLHN Strategic Plan 2021-2025 highlights our priorities as we seek to draw upon the benefits of the localized governance and management of public health care services and the vast opportunities this presents for our region and our community.

Purpose

Our core purpose is to partner with our community in delivering best practice care and services that contribute to improving the health and wellbeing of our communities and region.

Vision

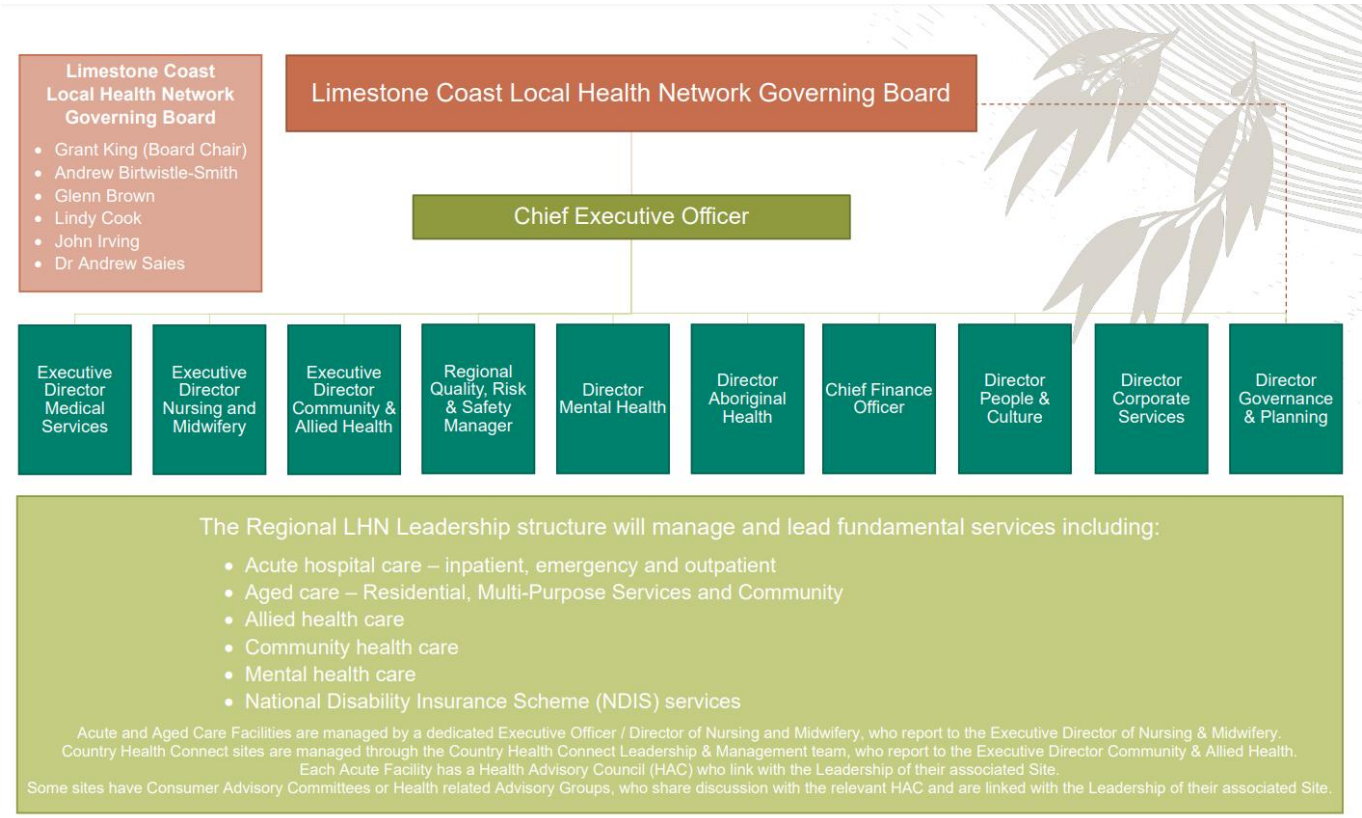
Our vision to be a trusted leader and partner in the provision of safe, high-quality, progressive, consumer directed care and services.

Key Priorities

Our focus between now and 2025, will be on five key priorities. We see these as the building blocks for delivering safe, high-quality, progressive, consumer-directed care and services. Following through on our commitments will be vital in the coming period, and we will actively measure and regularly report progress on the actions identified for each priority. We look forward to continuing to serve the diverse communities of the Limestone Coast by delivering the best and safest health care and services for our region.

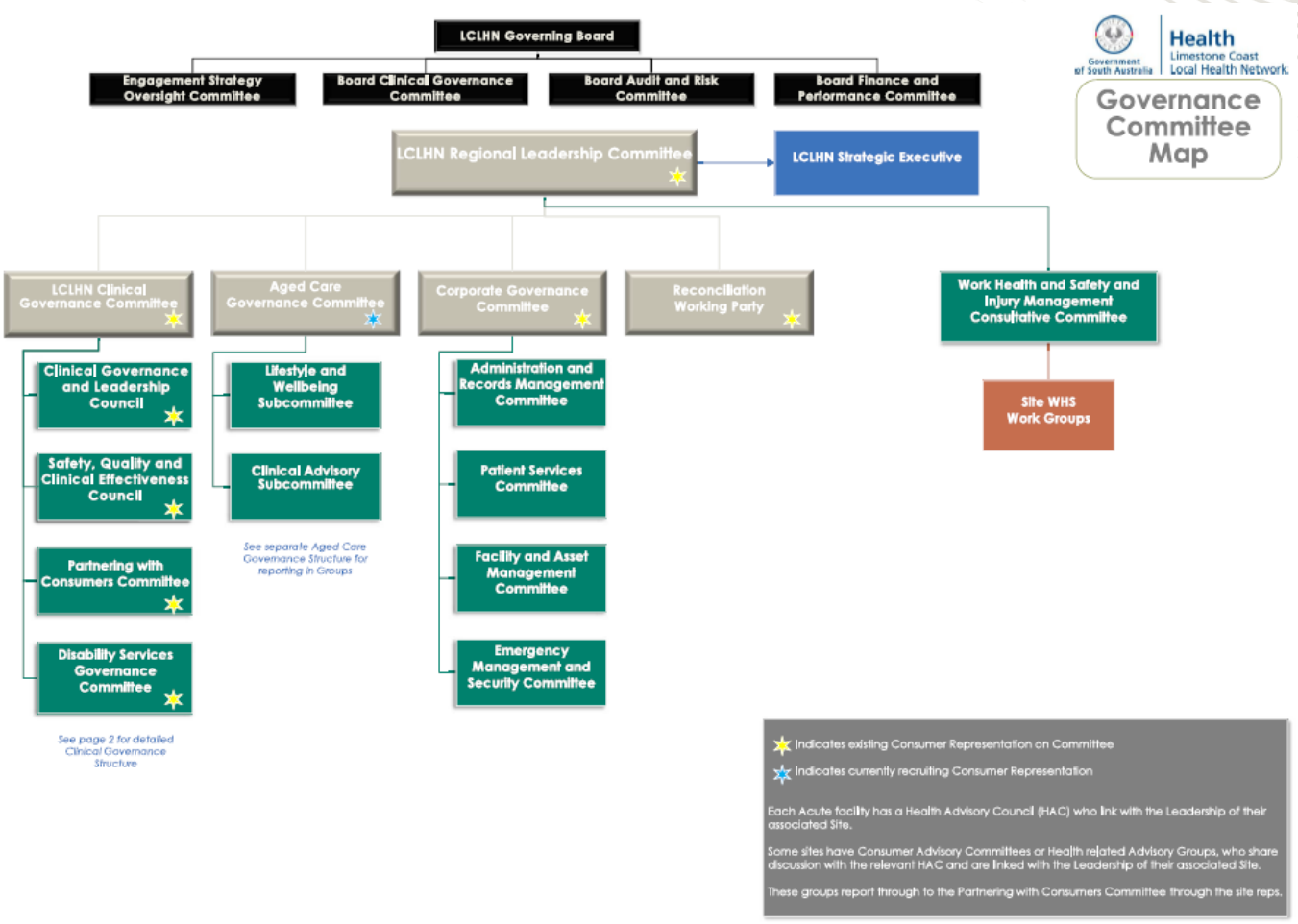
We are guided by and committed to five key **values:**

LCLHN is governed by the skills-based Governing Board and runs operationally under the direction of a Chief Executive Officer and comprehensive Executive Management team. The LCLHN leadership structure manages and lead fundamental services including acute hospital care (inpatient, emergency and outpatient), aged care (residential, multi-purpose services and community), allied health care, community health care, disability care and mental health care.



The following Board Committees are established: Clinical Governance Committee, Audit and Risk Committee, Finance and Performance Committee, and the Engagement Strategy Oversight Committee.

The LCLHN Regional Leadership Committee is the peak operational governance committee. Directly reporting into this Committee are the peak Governance Committees for the LCLHN: Clinical Governance Committee, Aged Care Governance Committee, Corporate Governance Committee.



The LCLHN Regional Leadership Committee is the peak LCLHN operational decision-making body. The LCLHN Regional Leadership Committee meet weekly under the Management Operating System (MOS) format, and formally monthly to monitor and review the effectiveness of LHN performance, ensure sound financial performance, and establish strategies and processes to ensure continuous improvement. The MOS is the weekly leadership oversight system for management of the LHN. The Business As Usual area identifies any key issues or risks, and celebrates achievements/positives, and any events occurring across the LHN.

The intent of the LCLHN Strategic Executive is developing and implementing overarching strategies impacting the LHN, identifying strategic improvements required to be a high performing organisation; driving, inspiring and maintaining a positive approach to transforming best practice within the workplace, and providing leadership for best practice outcomes across the LCLHN.

The LCLHN Operational Governance Committees are the peak operational points of governance within our LHN, with input and oversight of all new program development, new service initiatives, and existing program governance and monitoring, and have a direct reporting relationship to the LCLHN Regional Leadership Committee. These Governance Committees include active and engaged consumer representatives, and include the LCLHN Clinical Governance Committee, LCLHN Corporate Governance Committee, and LCLHN Aged Care Governance Committee.

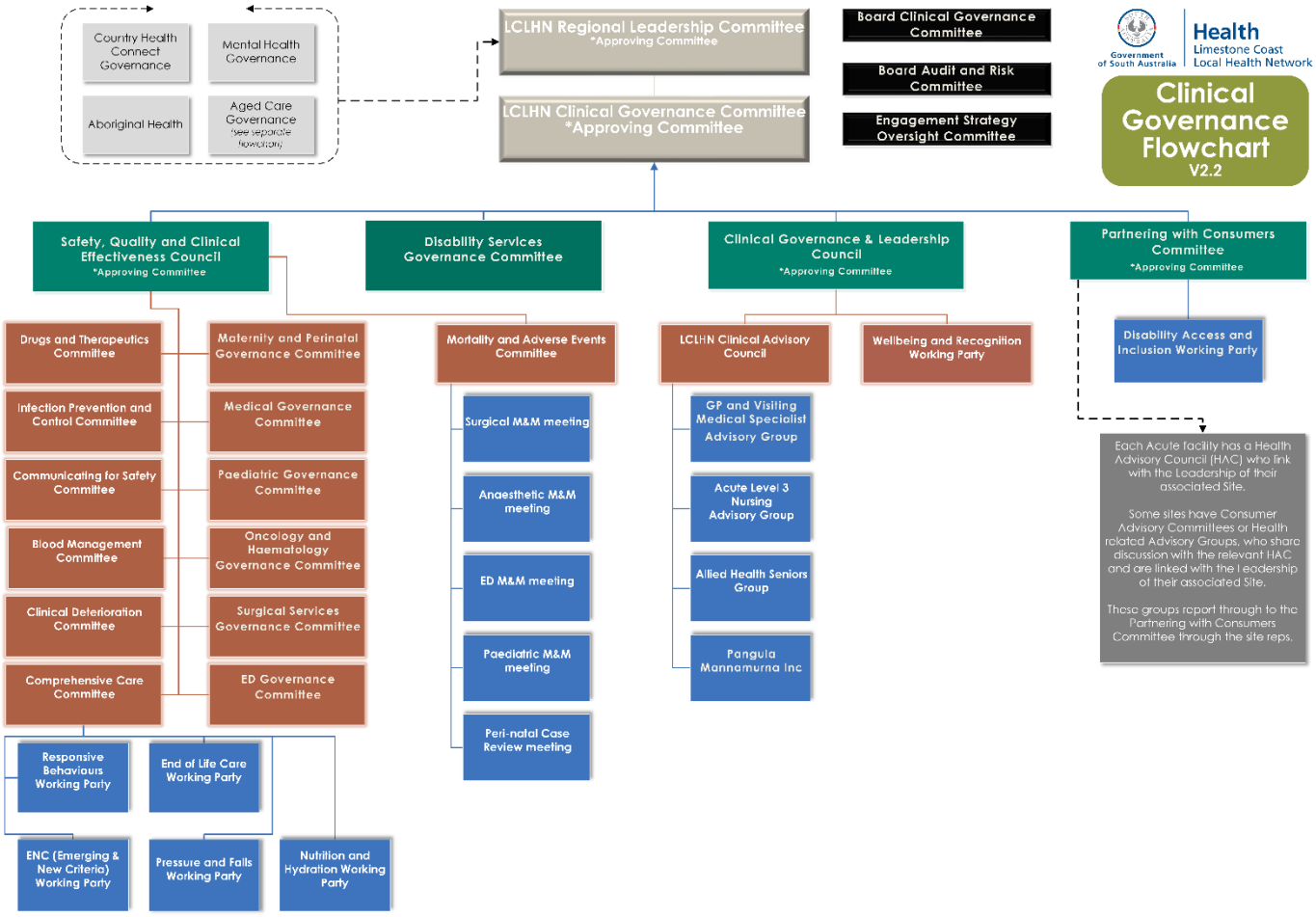
Each Health Unit holds regular site management/leadership meetings, to provide operational and clinical management across each site. Each Health Unit lead is a member of the Regional Leadership Committee, and escalates site-based issues and risks through our MOS.

LCLHN formally adopted the Australian Commission on Safety and Quality in Health Care (ACSQHC) National Model Clinical Governance Framework (the Framework) in September 2019. The LCLHN Clinical Governance Framework has been developed and implemented to ensure that patients and consumers receive safe and high-quality health care. The Framework is based on the National Safety and Quality Health Service (NSQHS) Standards (second edition), particularly the Clinical Governance Standard and the Partnering with Consumers Standard. As part of the complete set of NSQHS Standards, these two standards constitute a complete and robust clinical governance framework. Requirements have also been incorporated from the Aged Care Quality Standards and the National Disability Insurance Scheme (NDIS) Practice Standards.

The LCLHN Clinical Governance Framework describes the systems and processes that LCLHN facilities have in place to support the implementation and monitoring of effective performance monitoring and accountability. The LCLHN Quality, Risk and Safety Action Framework aims to provide an integrated QRS management system allowing health units to develop localised solutions to quality and risk problems and ultimately inform the Operational Plan.

The success of the LCLHN Clinical Governance Framework relies on leadership and culture that supports the LCLHN workforce to prioritise safe and high-quality care. The LCLHN Regional Leadership Committee sets the tone for and maintains a key focus on a 'just' and restorative organisational culture.

The LCLHN Clinical Governance structure is reviewed annually and has been further improved throughout 2022-2023, with the consolidation and streamlining of committees, strengthening of governance processes and accountability and ensuring contributions and ownership by individuals and teams at all levels across the organisation. The Disability Services Governance Committee has been escalated from a working party reporting into the Safety, Quality and Clinical Effectiveness Council, to a Governing Committee directly reporting to the Clinical Governance Committee.



Under the Health Care Act, the LCLHN Governing Board has developed the Clinician and Staff Engagement strategy, and consulted with the community and consumers in development of the LCLHN Consumer, Carer and Community Engagement Strategy. A number of aligning LCLHN key strategies have been developed and implemented including: People & Culture Strategy, Aboriginal Health Strategy, Reconciliation Action Plan, and Disability Access and Inclusion Plan.

Key improvement initiatives:

- Strengthening of the LCLHN Clinical Governance Framework to reflect LCLHN processes and system updates, inclusion of mandatory reporting requirements under Aged Care and NDIS, inclusion of Cultural Awareness as a key function
- Clinical Governance Structure improvements:
    - Escalation of the Disability Services Governance Committee from a working party, to a Governance Committee reporting directly to the Clinical Governance Committee. This ensures focus on quality service provision and performance of our disability services
    - Streamlining of working parties under Comprehensive Care, reducing duplication of discussion and direct point of escalation for working party discussion
    - Continued focus on the LCLHN Safety, Quality and Clinical Effectiveness Council (SQCEC). The purpose of the LCLHN SQCEC is to provide high level assurance and assistance to the Clinical Governance Committee regarding the Safety and Quality of our Clinical Service. This is achieved by oversight of all clinical safety and quality matters within the service, oversight of all current clinical initiatives and issues and ensuring all underpinning Committees and Working Groups are effectively reviewing performance and practice.
    - Revitalisation of the Clinical Advisory Council, being informed from specialised clinical advisory groups and staff, and reporting into the Clinical Governance and Leadership Council
    - Creation of the Wellbeing and Recognition Working Party under the Clinical Governance and Leadership Council to ensure a focus on supporting and celebrating our staff
- Strengthening the Corporate Governance Structure with the formalisation of the Administration and Records Management Committee, Patient Services Committee, Facility and Asset Management Committee, and the new Emergency Management and Security Committee
- Implementation planning and monitoring for the Consumer, Carer and Community Engagement Strategy through the Partnering with Consumers Committee
- Aged care provision, including co-located aged care facilities make up a sizeable proportion of the LCLHN business. LCLHN Aged Care Governance Committee structure has been reviewed and improved, and reports through to Regional Leadership Committee. The committee works in partnership with the Clinical Governance Committee, and reports through to the Board Clinical Governance Committee.

1.2 Monitoring and review of safety and quality performance

The LCLHN is currently accredited through the Australian Council on Healthcare Standards (ACHS) against the National Safety and Quality Health Service Standards (NSQHS) until 5 January 2024, with a planned assessment to commence in June 2023, noting that from July 2023 the process will move to no-notice assessments.

The LCLHN is a registered NDIS provider with current accreditation until 20 January 2023, and is currently in process for reaccreditation - Stage 1 audit was undertaken in March 2023 and Stage 2 audit in April 2023. We are currently addressing actions with final assessment scheduled for July 2023.

The LCLHN operates three Residential Aged Care Facility (RACF) sites, accredited under the Aged Care Quality Standards:

- Charla Lodge in Bordertown is fully compliant and current accreditation is due to expire on 31 October 2025.
- Sheoak Lodge in Millicent is accredited and is due to expire on 10 September 2024. An unannounced contact assessment was completed on 4 January 2023. The Performance Report was received 31 January 2023 with all Requirements assessed as meeting the standards.
- Moreton Bay House in Naracoorte is accredited and is due to expire on 4 February 2024. Following an unannounced contact assessment in May 2022 sanctions and a Notice to Agree were imposed by the Aged Care Safety and Quality Commission (ACSQC) and the LCLHN immediately commenced work to address the recommendations made. In August 2022 re-accreditation was provided, and regular monitoring by the ACSQC continues with the most recent reassessment undertaken in January 2023. The Performance Report dated 7 March 2023 found 2 requirements non-compliant, which are being actively worked on to meet standards.

Aged Care facilities at Multi-Purpose Services (MPS) sites at Kingston and Penola are included in the LCLHN organisation wide NSQHS accreditation and will include assessment against the Aged Care Module for Multi-Purpose Services in June 2023.

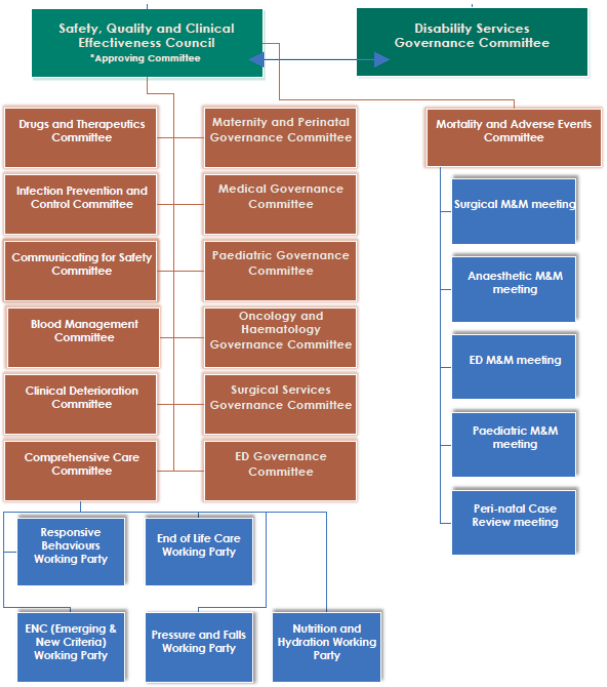
The Mount Gambier and Districts Health Service is accredited under the Diagnostic Imaging Accreditation Scheme until 3 May 2024.

Monthly Dashboard reports highlighting key performance data are collated and analysed for targeted business areas: Acute, Aged Care, Mental Health, Country Health Connect, Disability Services, Aboriginal Health and Infection Prevention & Control. The monthly dashboards highlight a variety of key performance areas, including (but not limited to): Finance & Activity, Patient Safety and Incident Management, Consumer Feedback, Audit results, Benchmarking indicators, Performance and Capacity information (including PPAs, ALOS, Separations, Readmissions, NEAT, HACs, Infection Control Surveillance, Discharge information, Consumer Self Identification, LOCUM usage, Residential bed occupancy, Referrals, Wait list summary information, Hand Hygiene data), and a summary of current Quality Improvements for each business area. The Dashboard reports are analysed monthly at the LCLHN SQCEC alongside the monthly reports from the specialised Committees / Working Parties who identify and drive LHN wide quality improvement. Areas for action which cannot be addressed at the local level are escalated through to the LCLHN Clinical Governance Committee. The Dashboard reports are shared and analysed at the quarterly Board Clinical Governance Committee.

The LCLHN KPIs are monitored through Regional Leadership, Governance Committees, and the LCLHN Board. LCLHN has a Service Agreement with SA Health with Tier 1 and Tier 2 KPIs identified. KPIs include a broad variety of measures from clinical performance (including ALOS, PPAs), through to HR areas (including PRD compliance, mandatory training compliance). These KPIs are reported to the Board on a monthly basis. LCLHN performance is also monitored by SA Health in quarterly performance meetings with the LCLHN.

Quality, Risk and Safety data is reviewed regularly to inform improvement opportunities at all Health Units Unit (split reports for Acute, Aged Care, Country Health Connect and combined site reports for the Multi Purpose Sites (MPS) including data for their Acute, Aged Care and Community areas). Detailed Health Unit specific data is presented quarterly for review and action under the following headings: Patient Incident data, Audits, Consumer Feedback, Quality Actions/Improvements, and Risk.

QRS subject specific data (including Patient Incident data and trending, Clinical Audit results, Benchmarking, Risk and Consumer Feedback) is presented to the Clinical 'reporting-in' Committees and Working Parties under SQCEC in the form of a detailed regular QRS report. This information is presented and discussed at the content specific Committees and Working Parties to inform and drive region wide improvements, including: Drugs & Therapeutics Committee, Communicating for Safety Committee, Clinical Deterioration Committee, Blood Management Committee, Infection Prevention & Control Committee, Comprehensive Care Committee and its working parties (Responsive Behaviour Working Party, End of Life Care Working Party, Pressure & Falls Working Party, Nutrition & Hydration Working Party, and Emerging & New Criteria Working Party). Safety & Quality data is also monitored and used to drive improvement through the Disability Services Governance Committee, and the Aged Care Governance Committee and reporting in Sub-Committees. The LCLHN QI/PCI module of Moving on Audits is the system used to document and track quality improvement action progress.



Monthly medical departments Scorecards are produced for the following specialities: Anaesthetics, Oncology & Hematology, ED, General Medicine, Obstetrics & Gynaecology, Paediatrics and the Surgical team. These Scorecards highlight departmental performance and include financial and activity indicators, patient incident and consumer feedback data, HR related information and key KPIs such as discharge summary completion. The Scorecards are utilised by the Heads of Unit to review departmental performance and identify key areas for improvement.

The Safety Learning System (SLS) is an integrated multi-module web-based system used for the reporting of patient incidents, consumer feedback (complaints and compliments) worker incidents and security incidents. All incidents reported within the LCLHN are monitored, trended and analysed. All serious adverse events are immediately coordinated through the LCLHN PitSTOP process and undergo a comprehensive clinical case review and open disclosure supported by the LCLHN Clinical Risk Manager, and are reviewed by the LCLHN Mortality & Adverse Events Review Committee (MAERC). All medically based case review meetings report into the MAERC. Shared learnings are fed through to LCLHN SQCEC, distributed by MAERC and shared with all staff. All items for escalation are escalated to the LCLHN Clinical Governance Committee. An action plan is created for any recommendation arising from review and this is then included on the QI/PCI.

Quality improvement auditing processes have the intent to improve consumer care and outcomes through systematic review of care against explicit criteria and identification, from the review of action to improve clinical practice and the implementation of those actions. A number of audits are conducted across LCLHN for a number of target groups, with results collated and reported in a timely manner to Health Units and relevant Committees who analyse the results, develop actions and monitor improvement. This includes specific audits for Acute, Aged Care, Community & Allied Health, and NDIS. The Daily Care Audit is utilised in Acute to gather real-time and retrospective information to confirm the quality of care provided as well as identify improvement activities to ensure a safe environment for consumer care and outcomes. A suite of Acute care audits are scheduled across the year, with results informing improvement activities. The Moving on Audits electronic system is utilised for all Acute, Home Care, Residential Aged Care Facilities, Multi-Purpose Sites (MPS), and NDIS services to ensure detailed monitoring and review of performance, consumer outcomes, systems, procedures and protocols, staff practice, and consumer experience. The suite of audits are being continuously added to ensure they meet the organisational needs. The QRS team continue to work with the Moving on Audits team to create bespoke reporting to meet our requirements.

The LHN participates in benchmarking activities, monitoring performance against a number of clinical indicators. The Mount Gambier and Districts Health Service is a member of the Health RoundTable. In 21-22, Millicent and Districts Hospital and Health Service and Naracoorte Health Service trialed membership with Health RoundTable, but due to the low activity levels comparatively against member hospitals it was decided to remain with MGDHS membership only as the HUB hospital for the LHN, with utilisation of the data and learnings to drive improvement across the LHN. Data is reviewed by the relevant LHN Committees and Working Parties to inform and drive region wide improvements. Areas for improvement are recorded through QI/PCI. We continue monthly reporting to the South Australian Audit on Surgical Mortality (SAASM) audit, and actively respond with any information requested.

Mandatory Aged Care Quality indicators are collected, reported and improvements actioned by all sites with Aged Care, Residential Aged Care (RAC) sites submitting through Moving on Audits electronic system to the My Aged Care Portal, and reported to the SA Health Commissioning and Performance Branch as per the SA Health Performance Framework. The MPS sites collect and report through the Moving on Audits system.

LCLHN is a member of the Australian Council on Healthcare Standards (ACHS) and has access to the Clinical Indicator program. Selected health units collect different sets of acute clinical indicators to measure performance, enabling peer group comparison.

The Pregnancy Outcome Unit undertakes state-wide monitoring of pregnancy characteristics and outcomes to identify population groups most at risk and determine preventive interventions. LCLHN birthing sites collect maternity indicators using the supplementary birth record and submitting data using the Obstetric Reporting Collection and Database System (ORChiDS).

The LCLHN has a Service Agreement with SA Health with Tier 1 and Tier 2 KPIs identified. These KPIs are reported to the Board on a monthly basis. LCLHN performance against the Service Agreement is also monitored by SA Health in quarterly performance meetings with the LCLHN.

Health Acquired Complications (HAC) are reported on the Infection Prevention and Control Dashboard, and the monthly rate is also reported to the LCLHN Governing Board.

Key improvement initiatives:

- Continuous improvement of the monthly LHN Dashboards for Acute, Aged Care, Mental Health, Country Health Connect, Aboriginal Health and Infection Prevention & Control, and Disability services
- Improvement project focusing on QRS site and committee data reporting
- Continued expansion to electronic auditing software Moving on Audits for Acute, now being used for all Acute, Home Care, RAC Facilities, MPS, and NDIS services to ensure detailed monitoring and review of performance, consumer outcomes, systems, procedures and protocols, staff practice, and consumer experience
- Ongoing work with the Moving on Audits team to create bespoke dashboard reporting that meets LCLHN requirements
- Use of risk management software RIAM (Risk Identification Analysis Management) is in progress of being rolled out across all Residential Aged Care Facilities within LCLHN

1.3 Addressing health priorities for Aboriginal and Torres Strait Islander people

The LCLHN has a strong commitment to address the health priorities for Aboriginal and Torres Strait Islander people. LCLHN Strategic Risk: Aboriginal Health explores and addresses the controls required with respect to failing to sustainably improve Aboriginal health outcomes and close the gap in life expectancy for Aboriginal people living in Limestone Coast.

The Director Aboriginal Health position drives cultural reform to build the capacity of LCLHN to improve health outcomes for Aboriginal people and communities. The core elements of this role include strategic partnerships, cultural advice and advocacy. The Director Aboriginal Health facilitates the improvement of accessibility and design of health services for Aboriginal people in the Limestone Coast. A project officer position has been created and implemented to focus on Close the Gap Chronic Disease Project (up until June 2024), support the Director Aboriginal Health, the delivery of local strategies and improvements, and the review and development of care pathways.

The LCLHN Aboriginal Strategic Operating Plan identifies improvement areas within the LCLHN, and is implemented to assist creating a safe and culturally appropriate environment for all. The LCLHN Aboriginal Workforce Plan has been developed and implemented. A Memorandum of Understanding (MOU) between the LCLHN and the local Aboriginal Health Corporation, Pangula Mannamurna Inc, is in place to strengthen our partnership and improve health outcomes of our local community.

The continuous improvement of the monthly Aboriginal Health Dashboard highlights our key performance in the provision of services to our local community. This Dashboard is reviewed at multiple Operational and Board Governance Committees.

Aboriginal Health Impact Statements (AHIS) provide a central lens and context across policy, procedures, processes and planning as it relates to improving Aboriginal health outcomes.

The LCLHN Reconciliation Action Plan (RAP) aims to build a foundation to achieve an optimal health care system in LCLHN, a foundation based on strong relationships and cultural respect for Aboriginal and/or Torres Strait Islander peoples. For the relationship to be strengthened between Aboriginal and/or Torres Strait Islander and non-Aboriginal Australians, it is important that every LCLHN staff members develop an appreciation of how historical government policies and practices have impacted on Aboriginal and/or Torres Strait Islander peoples and cultures, and how their impact reverberates across generations and continues to create barriers and disadvantage today. All staff are obligated to learn as much as they can about Aboriginal and/or Torres Strait Islander cultures, for being informed about history and culture is key to moving forward and developing and delivering health services that are culturally sensitive and safe.

The LCLHN Reconciliation Working Party meets monthly to address the needs of our Aboriginal and Torres Strait Islander communities. The LCLHN Reconciliation Working Party promotes and supports the implementation of activities associated with Aboriginal and Torres Strait Islander significant celebrations, through a process of engagement and consultation with Aboriginal community members.

LCLHN is committed to providing safe and culturally appropriate care for our Aboriginal and Torres Strait Islander consumers. Three levels of Cultural Awareness training are undertaken for the LCLHN: Individual Level: Knowledge and Awareness (Online Level 1 [mandatory, all staff]), Work Practice or System Level (two-day face to face Level 2

[all staff]), Organisational level (Level 3 Immersion [Board, Executive and Managers]). These three levels are formed by key topics that outline essential knowledge, skills and values that staff require in order to demonstrate cultural sensitivity in their work practice when interacting with Aboriginal people.

A number of LCLHN resources and guiding documents have been created to guide staff including: LCLHN Guide for engaging with Aboriginal People, LCLHN Patient Care Guidelines for Staff – Aboriginal and Torres Strait Islander, Aboriginal and Torres Strait Islander Origin – recording of Information of Patients and Clients, Protocol Australian Aboriginal Flag.

'Asking the question training' has been developed and rolled out across LCLHN.

All LCLHN meeting rooms are in the process of being re-named into language. Signs with 'chatter-box' recordings will be installed outside each room, with correct pronunciation of the room name in language.

Reconciliation boards have been created and are displayed in each health unit.

Key improvement initiatives:

- Cultural awareness and competency - development and improvement of Level 2 training
- LCLHN Guide for engaging with Aboriginal People developed and implemented
- Development of Patient Care Guidelines for Staff – Aboriginal and Torres Strait Islander
- Naming of LCLHN meeting rooms in language – implementation of signs and chatter boxes
- Creation of Australian Aboriginal Flag Protocol for sites
- Procedure developed Aboriginal and Torres Strait Islander Origin – recording of Information of Patients and Clients
- LCLHN Aboriginal Health Strategic Operational Plan
- LCLHN Aboriginal Workforce Plan
- LCLHN Reconciliation Action Plan
- Reconciliation boards created and are on display in each health unit
- Aboriginal Health Impact Statements (AHIS) are completed for all new or changed programs or procedures
- MOU between LCLHN and Pangula Mannamurna Inc
- Aboriginal Artwork and posters commissioned, and are on display in waiting rooms and entrances, making a welcoming environment.
- Each building entrance across the LCLHN has been wrapped with artwork designed by local Elder group.
- Racism can now be specifically reported on SLS, this has been promoted to all staff through a CE Check.

2. Patient safety and quality systems

All health units within the LCLHN provide a range of services to the community and a range of internal business support services. The LCLHN Quality, Risk and Safety (QRS) Action Framework provides an integrated QRS management system for all Health Units, operationalising the requirements outlined in the LCLHN Clinical Governance Framework. The Action Framework supports the achievement of the overarching objectives set out in the LCLHN Operational Plan, demonstrating compliance with QRS related legislation, standards, quality management, and risk management for LCLHN.

The Aims of the framework are to support:

- A consumer centred health service
- Reliable evidenced based best practice care
- A positive culture that values effective, high-quality care
- Consumer participation in the delivery and governance of care
- Clinical risks and causes of harm are systemically addressed
- Staff, managers and consumers understand and act to improve quality

The QRS Action Framework Plan is written under the key areas of:

- Consumer Centred: with actions under the following key headings – Partnering with Consumers, Consumer Feedback, Consumer Experience Surveys, Patient Information, Consumer Rights and Responsibilities, Open Disclosure
- Driven by Information: with actions under the following key headings – Policy directive and guidelines, Strategic plan, Safety Learning System data (SLS), Clinical Audits / Indicators, Medical Records Audits, KPIs, Recording of Quality Improvements, Infection Prevention and Control data, QRS Reporting
- Organised for Safety: with actions under the following key headings – QRS Structure, Risk Management, Business Continuity Plans, Safety Learning System Reporting and Investigation, Morbidity and Mortality Review, Critical Incident Review, Accreditation, Safety and Quality Alerts

The regional QRS team are allocated with key areas to provide consistent advice and support across all Health Units: Clinical Governance, Consumer feedback, Quality Improvements, Patient Incidents, QRS clinical Audits, S&Q Alerts / TGA Recalls, Clinical and Operational Risk, Information Requests / Sharing, Medico-Legal and Research. Each site within LCLHN has been allocated with a QRS Coordinator who supports the site on a regular basis.

Detailed Quality Risk and Safety data is presented and reviewed through multiple mechanisms, at departmental level, health unit level, across LHN level, through to the Governing Board.

SharePoint is utilised as the mechanism for sharing information, including policies, procedures and guidelines. The LCLHN QRS HUB includes links to key information, including: Patient Safety HUB, Consumer Feedback Management HUB, LCLHN Policy & Procedure search function (LC/DC) and Document Control HUB, Risk Management, Clinical Governance Committees, and detailed information on Quality systems such as Audits, Quality Improvement and LEAN. The Aged Care SharePoint page provides guidance and links to key information. The Country Health Connect SharePoint HUB includes information and links to all community-based information including NDIS specific information and procedures.

Detailed audit schedules are in place for Safety & Quality, Infection Prevention & Control, and Work Health Safety & Injury Management. Improvement actions are addressed and monitored through the QI/PCI, or the Work Health & Safety Corrective Action Plan (CAP). A clinical safety alert and recall process is in place.

Patient incidents, consumer feedback, work health and safety and security incidents/hazards are all reported and managed through the Safety Learning System (SLS). Patient incident reporting and management, patient centred care, partnering with consumers, work health and safety, hazard identification and management, and emergency procedures are all required training for staff.

Quality, Risk and Safety training is provided in a number of ways across all staff. The fortnightly Quali-TEA education sessions provide a learning platform and a forum for all staff to be involved in regular safety and quality conversations and educational opportunities. The QRS Manager and Team Leader study days provide education in quality, risk and safety domains in a ‘skills station’ format, which allows for the attendees to interact and actively ask system or functional questions or seek specific guidance in small group format. The topics of the ‘skills stations’ are: Consumer Feedback Management, Quality Improvement, Patient Safety, Risk Management, Document Control and SharePoint, and Clinical Governance.

Consumer representatives are active members of our Governance Committees where safety and quality performance issues are discussed. The Health Advisory Councils (HACs) are an important conduit to the community and contribute to quality improvement activities.

LCLHN is governed by the State Records Act 1997 and SA Health requirements. There is an Administration & Records Management Committee which reports to LCLHN Corporate Governance Committee. Clinical records are available at the point of care and procedures are in place for transport and release of information. Freedom of Information (FOI) processes are in place across the LHN.

Key overarching improvement initiatives:

- Development and implementation of QRS Manager and Team Leader study day training, focusing on: Consumer Feedback Management, Quality Improvement, Patient Safety, Risk Management, Document Control and SharePoint, and Clinical Governance
- Implementation of fortnightly Quali-TEA education sessions for all staff
- Significant improvement of staff information available through the QRS SharePoint HUB, including: Patient Safety HUB, Consumer Feedback Management HUB, LCLHN Policy & Procedure search function (LC/DC) and Document Control HUB, Risk Management, Clinical Governance Committees, and detailed information on Quality systems such as Audits, Quality Improvement and LEAN. The Aged Care SharePoint page

provides guidance and links to key information. The Country Health Connect SharePoint HUB includes information and link to all community-based information including NDIS specific information and procedures

- Creation of Nursing Director position at MGDHS with a Safety & Quality focus
- Creation of a Level 4 nursing Project position

2.1 Compliance with legislation and regulation

The SA Health System-wide Integrated Compliance Policy Directive provides an overarching framework encompassing all SA Health compliance activities, including policy, financial management and legislative compliance. This Policy Directive and associated key activities ensure legislative compliance activities are embedded across SA Health and that legislative obligations are understood, risk assessed, and compliance monitored.

An Integrated Compliance Community of Practice has been established, represented by each SAH entity. An annual certification process is completed. The LCLHN is supported by the RSS Risk Management Unit who have established a rLHN Integrated Compliance Community of Practice to support the certification process.

The LCLHN has a subscription to the Law Compliance legislative compliance system, which provides updates when there are changes to legislation. A baseline audit has been conducted across the LCLHN to identify key legislation. Relevant changes are incorporated into policies and procedures as appropriate.

The LCLHN has established a legislative obligations register and is certified against this consistent with the Legislative Compliance Framework created by the Department for Health & Wellbeing (DHW).

The Clinical Risk Manager presents and discusses any findings, action recommendations or shared learnings at the LCLHN Mortality and Adverse Event Review Committee. A regular Shared Learnings report is created and shared with all staff.

A Coordinator Audit, Risk and Compliance Role is in place within LCLHN to support these important functions.

2.2 Coroners findings of inquest recommendations and actions

Any Coronial recommendations are received through the Clinical Risk Manager and entered onto the LCLHN Recommendations Register. These are forwarded through to the appropriate Medical Governance Committee for review and discussion, and action planning. The appropriate Committee will review the Coroners recommendations, and provide a LCLHN response and any actions for consideration. These are discussed at the Mortality and Adverse Event Review Committee, and upon finalisation, these are forwarded for endorsement to the Clinical Governance Committee.

Recommendations from the local 2016 finding of Coronial inquest have been actioned at the Mount Gambier site
Paxford, Mathew George.pdf (courts.sa.gov.au)

2.3 Measurement of quality improvement

The LCLHN embraces and promotes a culture of continuous improvement, delivering high quality and innovative health services to improve health outcomes of Country South Australians. The online QI/PCI module of Moving on Audits has been implemented for the documentation of LCLHN continuous improvement, knowledge and information management. The system has been designed to encourage all staff to be involved in identifying and managing opportunities for improvement. Action owners are allocated, and regular email reminders are sent to ensure items are completed, evaluated and up to date.

Quality Improvement resources have been developed for LCLHN including: fact sheet for staff on ‘Identifying Improvements’, ‘Evaluating Improvements’ fact sheet and evaluation templates, PDSA fact sheet, Quality Improvement entry on QI/PCI, QI/PCI and MOA user guides.

The LCLHN has offered two rounds of 5 day LEAN training to groups of key staff across the organisation. A suite of LEAN guiding resources and templates have been developed and are utilised to support and coach staff in the

improvement process, including the A3 model: Clarify, Understand, Analyse, Set Goal Improve, Implement, and Sustain and Continuously Improve. Templates are available for tools such as Values stream mapping, Swimlane map, Fishbone problem analysis, and Pareto graph. All resources are available to all staff through the Quality Improvement page of the QRS SharePoint HUB.

Quality Improvement training, support and guidence occurs on a 1:1 and group setting dependent on activity. The fortnightly Quali-TEA education sessions provide a relaxed space for staff to join in on quality, risk and safety conversations – driven by staff, supported by QRS, and reinforced through best practice. Quality Improvement is a key topic for discussion. The QRS Manager and Team Leader study days have been developed and implemented provide education in quality, risk and safety domains in a 'skills station' format, which allows for the attendees to interact and actively ask system or functional questions or seek specific guidance in small group format. One of the key topics of the 'skills stations' is: Quality Improvement. The 'skills stations' are manned by one or more members of the QRS team who support sites with that portfolio.

Quality improvement items are reported to Committees and Health Units within the detailed QRS reports and summarised on the Dashboards and Scorecards. The reporting template utilised to 'report up' within the Clinical Governance structure includes Quality Improvement activities identified / in progress.

The LCLHN Quality Improvement Community of Practice has been formed to bring quality improvement champions and staff members trained in LEAN methodology together on a monthly basis to share improvement activities and learnings, provide a platform for QI training, and knowledge sharing.

To highlight and share the great quality improvement work across the LCLHN, selected QIs are promoted and celebrated across the LHN as a LCLHN LimeLIGHT 'shining the light on quality improvement in the Limestone Coast LHN'. There is at least one LimeLIGHT promoted to staff through the staff newsletter each week. All LimeLIGHTs are available on SharePoint, and are printed and promoted at sites as appropriate. Each LimeLIGHT indicates the QI/PCI number if any staff would like more detailed information on the improvement.

The LHN participates in benchmarking activities, monitoring performance against a number of clinical indicators. The Mount Gambier and Districts Health Service is a members of the Health Round Table, and this information is being utilised to drive improvement. Monthly Quality Indicators are collected for each Residential Aged Care Site and benchmarked against other like services through the Moving on Audits System. Data is reviewed by the relevant LHN Committees and Working Parties to inform and drive region wide improvements.

Key improvement initiatives:

- Strengthened Clinical Governance structure with a focus on quality improvement activities
- Development of local resources for quality improvements
- Development of group Quality Improvement training options: Quali-TEA sessions, and the QRS Manager and Team Leader study day
- Inclusion of Quality Improvement sections on the Dashboards and Scorecards, making QI part of 'every day' business
- Introduction of LimeLIGHTs
- Expanding utilisation of the PCI module on the electronic Moving on Audits system to capture improvements across the LHN – incorporating corporate service improvements
- Strengthened utilisation of benchmarked data across the LHN to inform quality improvement
- Creation of the LCLHN Quality Improvement Community of Practice

2.4 Risk Management

The LCLHN Risk Management Procedure is implemented for the LCLHN. Risks are identified, assessed and treated in accordance with the procedure. This procedure provides staff with a consistent approach to risk management decision making and establishes a structured approach to risk identification, analysis and the management of all types of risk within the organisation. Responsibilities are defined within the procedure, Risk Types explained (consumer, clinical, corporate), and it describes in detail the Risk Management Process. It builds in the Business As Usual (BAU) Management Operating System (MOS) at the LHN level as the initial point for current risk and issue management. It defines criteria against which risks will be assessed and provides guidance on the LCLHN Risk

Appetite. It works through Identifying, Analysing, Evaluating, Treating, and the Monitoring and Review system. It describes the LCLHN Risk Escalation process in detail. A simple flowchart has been developed to highlight the key points for all staff to understand the escalation pathway for identified risks and management of issues.

The LCLHN has created the LCLHN Risk Appetite Statement. Any risk considered to be serious or systemic outside of the organisations risk appetite and tolerance or having potential system-wide application is escalated to the Governing Board via the LHN Audit and Risk Committee to consider if escalation to the System Leader is required.

The LCLHN Audit and Risk Committee (ARC) meets quarterly, in accordance with its agreed Terms of Reference and the Board Charter. ARC monitors Risk compliance against the SA Health Risk Management Policy and Framework. The ARC has an agreed Annual Reporting Calendar to ensure all requirements are reviewed and discussed across the calendar year in a systematic and timely fashion, including detailed risk reports. The ARC has focused discussion on one or more Strategic risks per meeting. The topic 'Emerging Risks' is included on the standing agenda items for each meeting. The Board Clinical Governance Committee additionally reviews clinically based strategic risks and, also has a standing agenda item that includes 'Emerging Risks'.

The LCLHN's Management Operating System (MOS) framework significantly increases understanding and positively influences culture for Risk Management within the organisation. The framework provides the LCLHN with oversight of current and emerging risks within our business, detailing the concern, cause and countermeasures. It provides us with the framework to consider whether a risk is Business as Usual (BAU), short-term, or requires escalation as longer term operational or strategic risks to the risk register. Regional Leadership meets weekly under the MOS framework, with all Health Units implementing this management structure.

The LCLHN Clinical Governance structure has undergone annual review resulting in a strengthened and improved structure during 2022-2023. The LCLHN Corporate Governance structure has been reviewed and strengthened. The Aged Care Governance structure has been reviewed and strengthened. The improved structures strengthen the operational process for review and maintenance of risks, each risk is assigned to an overall responsible risk owner, and the relevant Committee for oversight of treatment completion and control effectiveness. Controls and treatments are allocated to appropriate owners for action and review. The 'reporting up' templates prompt identification and escalation of risks and issues.

The LCLHN utilises the electronic Risk Management System - Risk Console (SAiCORP) which is utilised across multiple South Australian government agencies. Benefits realised since implementation include: each 'Owner' having individual access to update Risks in the 'Live' environment, development and utilisation of the Stakeholder field to allocate an oversight committee for active monitoring, and greatly improved reporting.

A Risk Management Key Performance Indicator (KPI) report is reviewed by the Governing Board at each Board meeting. This report summarises Risk Management Highlights, Emerging Issues, Top Issues, Strategies for Improvement, any items For Approval, and provides a detailed dashboard report including:

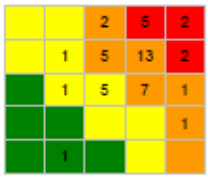
- Strategic Risk Profile (graphically indicating Inherent Risk Level, Controlled Risk Level and Treated Risk Level)
- Total number of Risks by Consequence type (for both Strategic and Operational Risks)
- Health Check:
    - Key Statistics (for the Period): New risks identified, Retired risks, % Controlled risks (Moderate or Low), Risks rated as Extreme or High post controls without treatments, Risks with 'ineffective' or 'partially effective' controls and no treatments (all categories reported by: count, trend, traffic light status, and Commentary)
    - Risk Mitigation Progress (for the Period): Treatments converted to controls/closed, Treatments with dates pushed out, Treatments reported as Overdue, Treatments classified as "Issue", Treatments classified as "At Risk" (all categories reported by: count, trend, traffic light status, and Commentary)
- New risk detail (including detail: Risk #, Register – Strategic or Operational, Risk Title, Risk Owner, Controlled Risk Rating, Commentary)
- Retired risk detail (including detail: Risk #, Register – Strategic or Operational, Risk Title, Risk Owner, Controlled Risk Rating, Commentary)
- Listing of Extreme and High Risks grouped by Register (including detail: Risk #, Register – Strategic or Operational, Risk Title, Risk Owner, Controlled Risk Rating, # of Controls, # of Treatments)

OFFICIAL

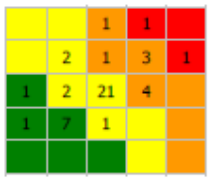
Snapshot Report

Government of South Australia | Health Limestone Coast Local Health Network

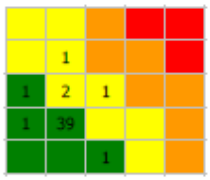
Inherent Risk Map



Current Risk Map



Target Risk Map



Reference	Risk Name	Risk Owner	Business Unit	Directorate	Inherent	Current	Target	# Ctrls	# Trtmnts
R-1003802	Safe and Quality Health Service Delivery and Outcomes	Executive Director of Medical Services	LCLH Medical Services	LCLH Medical Services	High	Medium	Low	22	2
R-1003803	Commonwealth Programs Funding - Reforms in a Competitive Market	Executive Director Community & Allied Health	LCLH Community and Allied Health	LCLH Community and Allied Health	Extreme	High	Low	8	
R-1003804	Aboriginal Health	Director Aboriginal Health	LCLH Aboriginal Health	LCLH Aboriginal Health	High	Medium	Low	6	1
R-1003806	Applications and Software	Director Corporate Services	LCLH Corporate Services	LCLH Corporate Services	High	Medium	Low	6	3
R-1003807	Attraction and Retention	Director People & Culture	LCLH People and Culture	LCLH People and Culture	Extreme	Extreme	Low	22	7
R-1003808	Budget and Cost Management	Chief Finance Officer	LCLH Finance	LCLH Finance	High	Medium	Low	11	1
R-1003809	Infrastructure	Director Corporate Services	LCLH Corporate Services	LCLH Corporate Services	High	Medium	Medium	9	2
R-1003810	Safe Systems of Work	Director People & Culture	LCLH Corporate Services	LCLH Corporate Services	Extreme	Medium	Low	18	3
R-1003812	Clinical Services Commissioning	Chief Executive Officer	LCLH Limestone Coast LHN		Extreme	High	Low	5	
R-1003813	Aged Care Services	Executive Director of Nursing & Midwifery	LCLH Nursing and Midwifery	LCLH Nursing and Midwifery	Extreme	High	Low	17	2
R-1003814	Accreditation	Regional Quality, Risk & Safety Manager	LCLH Quality Risk and Safety	LCLH Quality Risk and Safety	High	Medium	Low	13	

Reference	Risk Name	Risk Owner	Business Unit	Directorate	Inherent	Current	Target	# Ctrls	# Trtmnts
R-1003815	Credentialing	Executive Director of Medical Services	LCLH Medical Services	LCLH Medical Services	Extreme	Low	Low	5	1
R-1003816	Employee Misconduct	Director People & Culture	LCLH People and Culture	LCLH People and Culture	High	Low	Low	8	1
R-1003817	Emergency Response and Management	Director Corporate Services	LCLH Corporate Services	LCLH Corporate Services	High	Low	Low	8	1
R-1003818	Business Disruption	Director Corporate Services	LCLH Corporate Services	LCLH Corporate Services	High	Medium	Low	7	
R-1003819	Consumer Feedback	Regional Quality, Risk & Safety Manager	LCLH Quality Risk and Safety	LCLH Quality Risk and Safety	High	Low	Low	7	
R-1003820	Centralised Support Services (Clinical & Administrative)	Director Corporate Services	LCLH Corporate Services	LCLH Corporate Services	Medium	Medium	Low	3	
R-1003821	Disability Service Provision	Executive Director Community & Allied Health	LCLH Limestone Coast LHN		High	Low	Low	13	
R-1003822	Incident Management & Open Disclosure	Executive Director of Medical Services	LCLH Medical Services	LCLH Medical Services	High	Medium	Low	7	1
R-1003823	Medication Safety and Management	EO/DONM Naracoorte & Penola	LCLH Nursing and Midwifery	LCLH Nursing and Midwifery	High	Medium	Low	5	
R-1003824	Blood and Blood Products Management	Executive Director of Nursing & Midwifery	LCLH Nursing and Midwifery	LCLH Nursing and Midwifery	High	Medium	Low	7	
R-1003825	Falls	EO/DONM Millicent	LCLH Quality Risk and Safety	LCLH Quality Risk and Safety	High	Medium	Low	11	
R-1003826	Clinical Records Management	Executive Director of Medical Services	LCLH Quality Risk and Safety	LCLH Quality Risk and Safety	Medium	Low	Low	9	1
R-1003827	Clinical Handover and Discharge Planning	Executive Director of Nursing & Midwifery	LCLH Nursing and Midwifery	LCLH Nursing and Midwifery	High	Medium	Low	14	1
R-1003828	Restrictive Practices	EO/DONM Mt Gambier	LCLH Mental Health	LCLH Mental Health	Medium	Medium	Low	7	1
R-1003829	Child Safety Framework	Executive Director of Medical Services	LCLH Medical Services	LCLH Medical Services	Extreme	Low	Low	4	
R-1003830	Maternity and Birthing Services	EO/DONM	LCLH Nursing and Midwifery	LCLH Nursing and	High	High	Low	14	5

		Naracoorte & Penola		Midwifery					
R-1003831	Bio-Medical Equipment	Director Corporate Services	LCLH Corporate Services	LCLH Corporate Services	High	Medium	Medium	6	
R-1003832	Consumables and Inventory	Director Corporate Services	LCLH Corporate Services	LCLH Corporate Services	High	Medium	Medium	3	
R-1003833	Research	Executive Director of Medical Services	LCLH Medical Services	LCLH Medical Services	Low	Low	Low	2	
R-1003835	Failure to Reduce HAI's	Executive Director of Nursing & Midwifery	LCLH Nursing and Midwifery	LCLH Nursing and Midwifery	Medium	Medium	Low	7	
R-1003836	Clinical Services Planning	Director Governance and Planning	LCLH Governance and Planning	LCLH Governance and Planning	Medium	Low	Low	10	
R-1003837	Third Party Partnership	Director Corporate Services	LCLH Corporate Services	LCLH Corporate Services	Medium	Medium	Medium	3	1
R-1003839	Identification and management of the deteriorating patient	EO/DONM Millicent	LCLH Nursing and Midwifery	LCLH Nursing and Midwifery	High	Medium	Low	16	1
R-1004320	CHIRON (Patient Administration System)	Executive Director of Nursing & Midwifery	LCLH Limestone Coast LHN		Extreme	Extreme	Low	3	
R-1004346	Document Control	Regional Quality, Risk & Safety Manager	LCLH Limestone Coast LHN		High	High	Low	4	
R-1005041	Response to Pandemic	Executive Director of Nursing & Midwifery	LCLH Nursing and Midwifery	LCLH Nursing and Midwifery	Extreme	Medium	Low	15	
R-1005341	Surgical Services	Executive Director of Medical Services	LCLH Medical Services	LCLH Medical Services	High	High	Low	6	3
R-1005397	Implementation of Electronic Medical Record in Acute facilities (Sunrise)	Executive Director of Nursing & Midwifery	LCLH Limestone Coast LHN		High	Medium	Low	11	2
R-1005779	Security system at MGDHS site	EO/DONM Mt Gambier	LCLH Limestone Coast LHN		High	High	Low	6	3
R-1005861	Challenging Behaviour Strategic Framework	EO/DONM Mt Gambier	LCLH Nursing and Midwifery	LCLH Nursing and Midwifery	Medium	Medium	Low	14	
R-1006321	Climate Change	Regional Quality, Risk & Safety	LCLH Limestone Coast LHN		High	Medium	Low	4	1
R-1006456	AS/NZ 4187 Advisory 18/07 (Infection Prevention and Control)	Nurse Consultant Infection Prevention & Control	LCLH Nursing and Midwifery	LCLH Nursing and Midwifery	High	High	Low	3	1
R-1006487	Records Management	Director Corporate Services	LCLH Corporate Services	LCLH Corporate Services	High	High	Low	12	2
R-1006492	Mental Health	Director Mental Health	LCLH Mental Health	LCLH Mental Health	High	Medium	Low	4	
R-1006552	Keith and District Hospital Transition Project	Chief Executive Officer	LCLH Limestone Coast LHN		High	Medium	Low	17	

Across July 2022-April 2023, the following Internal Audits were conducted by the rLHN RSS Internal Audit Team:

Audit title	Number of improvement actions identified	Number closed at 30/4/23	Number in progress at 30/4/23
Credentialing and Scope of Clinical Practice Audit	25 (11 applicable to LCLHN)	6	5 (none overdue)
Consumer feedback and management processes	4		4 (none overdue)

Key improvement initiatives:

- Continuous improvement of electronic risk management software ‘Risk Console’. Benefits realised since implementation include: each 'Owner' has individual access to update Risks in the 'Live' environment, development and utilisation of the Stakeholder field to allocate oversight committee for active monitoring, and greatly improved reporting.
- Development of LCLHN Risk Appetite Statement
- Improvement of the LCLHN Risk Management Procedure and simple flowchart
- Development and ongoing improvement of Risk Management reporting and system
- Formal risk escalation process within Clinical Governance structure
- Risks allocated for monitoring and update to the appropriate Governance Committees, alongside allocation of an owner

2.4 Incident management systems

Incident management includes all the activities involved in the reporting, notification or documentation of an incident or near miss; and the review, investigation and analysis of the individual incident or groups of incidents, for the purpose of improving the safety and quality of the health service and the care provided.

The LCLHN SharePoint HUB provides specific portals for information on incident management, for both Patient and Worker. The LCLHN Patient Safety HUB has been developed as a consolidated information sharing point for staff to find supporting resources, flows and contact information for patient safety events.

Everyone providing services on behalf of SA Health must record all consumer related incidents, including near misses, into the Safety Learning System (SLS). All incidents reported into SLS are reviewed and serious incidents undergo more detailed investigation. Incident management and review is a requirement under SA Health policy, the National Safety and Quality Heath Service Standards (NSQHS), Aged Care Quality Standards and the Disability Service Standards. Serious Incident Response Scheme (SIRS) reporting is conducted as required for Aged Care consumers, as well as NDIS Mandatory Reporting for reportable incidents for NDIS consumers.

SA Health promotes an open and positive approach to incident management and recognises that most incidents occur because of problems with systems, rather than with individuals. The Patient Incident Management toolkit includes resources that have been developed for staff to report, investigate, analyse and take action to prevent recurrence of an incident.

All incidents reported within the LCLHN are monitored, trended and analysed. All serious adverse events are immediately coordinated through the LCLHN PitSTOP process and undergo a comprehensive clinical case review and open disclosure supported by the LCLHN Clinical Risk Manager, and QRS coordinators. For the year 1 July 2022 up to and including 30 April 2023, across the LHN there have been 4 ISR 1's, and 23 ISR 2's. Findings are discussed by the LCLHN Mortality and Adverse Events Review Committee. External reporting is undertaken as required – SIRS for Aged Consumers, and NDIS Mandatory Reporting for consumers with Disability. Shared learnings and recommendations are shared through the Safety, Quality and Clinical Effectiveness Council (SQCEC) to the LCLHN Clinical Governance Committee. Shared learnings are promoted to all staff, and available on the QRS SharePoint HUB. Serious incidents are escalated through the RSS Regional Adverse Events Committee for further review as required.

Quality, Risk and Safety data, including detailed Patient Incident data analysis, is presented and reviewed through multiple mechanisms including the monthly Dashboards, Scorecards, QRS detailed reports to Health Units and LHN Committees. Safety & Quality performance reports are presented monthly to the Board, with detailed Clinical Risk reports presented and discussed at the Board Clinical Governance Committee.

Key improvement initiatives:

- Development of LCLHN Patient Safety SharePoint page for staff
- Formalisation of LCLHN Serious Incident Review Process: PitSTOP huddle – an immediate huddle of the key stakeholders and executive to be informed of events, determine immediate actions, allocate responsibility for review and investigation
- Development of resources for local LCLHN staff such as 'LCLHN Guide to Patient Incident reporting'
- Allocation of QRS Coordinator to support each site has resulted in a greater model of support for completion of clinical case review process, in partnership with the Clinical Risk Manager.
- Development and implementation of QRS Manager and Team Leader study day training, focusing on: Consumer Feedback Management, Quality Improvement, Patient Safety, Risk Management, Document Control and SharePoint, and Clinical Governance
- Ongoing SLS training undertaken at each site, during these sessions there is emphasis on staff being in a key position to improve the quality of care delivered by reporting incidents. We promote a no blame culture with the clear aim of identifying system issues rather than apportioning blame on individuals involved in an incident. Any system issues identified are entered onto the QI/PCI for implementation to ensure appropriate action is taken to prevent future harm.
- Teaching on adverse events that have been reviewed and shared learnings that have arisen from these reviews are communicated by the Regional Clinical Risk Manager. This is part of promoting the fundamental purpose of reporting on SLS, which is to learn from incidents.
- Inclusion of medical staff in review and accountability of management of SLS and incidents

2.6 Open disclosure

The open disclosure of incidents is an important part of the incident management process and is essential to a person-centred approach to care. The open disclosure toolkit is available to all staff and includes resources for staff to manage the open disclosure process for level 1 (ISR 1 and 2) and level 2 (ISR 3 and 4) incidents. Consumer information and resources are also available.

Key Performance Indicators (KPIs) including Open Disclosure rates are reported regularly to all levels within the organisation (Health Unit through to Board) for monitoring. For the 27 ISR 1 & 2 Patient Incidents reported for the period 1/7/22-30/4/23, we sit at a 96% rate for Open Disclosure.

Patient incident management and open disclosure training is mandatory for all staff on induction and refresher training is provided regularly. A number of staff across the LCLHN have received masterclass and expert training in open disclosure. A listing of trained staff is available on the LCLHN Patient Safety HUB on SharePoint. The LCLHN Clinical Risk Manager is a key support in Incident Investigation and Open Disclosure processes.

2.7 Feedback Systems and Complaints Management

The LCLHN values feedback from consumers, carers, advocates, family members, friends and the community as it provides an opportunity to observe the quality of health care from the of consumer/carer perspective. It assists us in directing improvements in the quality of our services and in the continuous improvement and delivery of safe, high quality health care.

For the year 1 July 2022 up to and including 30 April 2023, LCLHN had received: 436 compliments, 268 complaints, 1 advice, and 44 suggestions.

A suite of LCLHN branded promotional materials has been launched to encourage consumer feedback across all of our sites. As part of the relaunch, the external ‘Contact us’ webpage has been improved to incorporate comprehensive information about how consumers can submit feedback. Both an online feedback form and printed feedback form have been made available for consumers to access. Following community consultation, the LCLHN has also implemented a 1800 number for consumer feedback which is monitored by the new LCLHN Consumer Advisor position. Regular external promotions are published to encourage feedback including on the LCLHN Facebook page and through the quarterly LCLHN Community Update Newsletter.

The Consumer, Carer and Community Feedback and Complaints Management Strategic Framework, Guide and Resources assists in addressing consumer feedback and complaints. This framework, guide and resources along with several other tools, have informed the development of LCLHN feedback process flowchart, a LCLHN Complaints Management Guide, and additional localized resources, ensuring a consistent approach to feedback and complaints management. The LCLHN Consumer Advisor assists all health units with feedback systems and processes. Training is provided 1:1 with managers, and also as a skills station at the QRS Manager and Team Leader study day.

Consumer feedback is recorded in SLS, including compliments, complaints and suggestions. All complaints are acknowledged, investigated and responded to with SLS utilised as the system to document this process. Key Performance Indicators (KPIs) are reported on including the timeliness of responding to consumers to resolve their concerns.

The Health and Community Services Complaints Commissioner (HCSCC), Aged Rights Advocacy Service and Disability Commission help people, service users, carers and service providers to resolve complaints about health and community services, when a direct approach to the service provider is either unreasonable or had not succeeded.

A number of resources are available for consumers to assist them to provide feedback and have any concerns managed appropriately.

South Australian Consumer Experience Surveillance System (SACESS) is an epidemiological surveillance system involving a representative, randomly selected, monthly sample of South Australian adults, aged 16 years or more who have received inpatient care. This is conducted for the Mount Gambier and Districts Health Service (MGDHS),

the Acute Hub site for LCLHN. The Measuring Consumer Experience SA Public Hospital Annual Report details key findings and further analysis of the consumer's experiences to ensure that we meet the best standards for our consumers. For 22-23 year we are pleased to be projected to receive an average overall quality score of 83% from consumers who accessed our Service. A projected 82% consumers felt they were kept informed, and 87% of consumers felt cared about by staff. 78% felt involved in treatment and care, and 79% responded satisfaction with being heard.

In addition to SACESS, the LCLHN Consumer experience surveys (Acute, Aged Care, Community and NDIS) have been developed to capture consistent information from consumers for the different areas of health care provided. A variety of surveys are conducted, including (but not limited to): service participant annual and monthly 'pulse' surveys through Moving on Audits for Residential Care, Community Home Care and NDIS programs, and snapshot surveys.

Consumer feedback and consumer experience trends and data are reported to the Governing Board, through monthly LHN Dashboards, Departmental Scorecards, QRS site based and Committee detailed reports, and the Partnering with Consumers working party.

Key improvement initiatives:

- Implementation of LCLHN Consumer Advisor position
- Development of LCLHN feedback process flowchart and localized guiding documents such as Complaints Management guide for managers, and 'A guide to receiving feedback' for all staff
- Re-brand of a suite of LCLHN Consumer Feedback promotional materials
- Regular external promotion of materials encouraging feedback such as through the LCLHN facebook, and the LCLHN Community newsletter
- Update of LCLHN website to encourage feedback through online feedback form or satisfaction questionnaires
- Development and implementation of QRS Manager and Team Leader study day training, focusing on: Consumer Feedback Management, Quality Improvement, Patient Safety, Risk Management, Document Control and SharePoint, and Clinical Governance
- Review of consumer experience survey tools
- Featuring a consumer feedback section in the weekly staff newsletter 'Across the Coast'
- We have implemented a number of service and quality improvements arising from consumer feedback. Some examples include:
    - Re-design of 'You are leaving hospital' passport information
    - Service areas re-design across the LHN sites
    - Implementation of mealtime support volunteer program at MGDHS
    - LCLHN model for identification and management of cognitive impairment, dementia and delirium in hospitalised patients
    - Continued focus on the DONNA project – an end-of-life patient and family centred care approach

2.8 Diversity and high risk-groups

Procedures are in place to ensure screening occurs relevant to the patient/presentation such as falls risks, nutrition and hydration, dementia and delirium, pressure injuries and maternal body mass index (BMI). Specialist committees and Working Parties across the LHN guide consistent best practice in the management of high-risk groups across the LHN, as outlined above in item 1.2.

The Comprehensive Care Committee, the Aged Care Nursing Advisory Group, and the Disability Services Governance Committee (previously NDIS Working Party) have been developed and implemented to ensure a consistent approach and overarching monitoring of risks and improvements across the LHN. The Responsive Behaviours Working Party is implementing the Cognitive Impairment and Care Planning Model of Care/Framework, which is an important person centred care initiative to improve the patient journey of our vulnerable older population. The Cognitive Impairment and Care Planning Framework outlines the LCLHN Procedure for Cognitive Impairment and Delirium Identification and Management, which outlines the process for cognitive screening of patients

presenting, and/or admitted, to LCLHN hospitals either with or at risk of cognitive impairment (including delirium and/or dementia) and details the use of the Cognitive Impairment Identifier (CII).

Vulnerable client lists are maintained by Country Health Connect and clients contacted on days of extreme weather.

The LCLHN Interpreter and Translator Procedure is in place to guide and facilitate culturally appropriate information sharing.

The LCLHN Reconciliation Committee meets monthly to address the needs of our Aboriginal and Torres Strait Islander communities. The LCLHN collaborates with our valuable Experts by Experience for consultation and community engagement through our Director of Aboriginal Health. Experts by Experience members are inducted to our organisation and receive regular communications and updates. The LCLHN has a formalised relationship with Pangula Mannamurna Inc – our local Aboriginal Health organisation to improve the patient journey and outcomes for our local population, as discussed in item 1.3 above.

Key improvement initiatives:

- Memorandum of Understanding (MOU) between LCLHN and Pangula Mannamurna Aboriginal Corporation Inc
- Implementation of Cognitive Impairment and Care Planning Project
- Development and implementation of the Aged Care Diversity Action Plan
- Continued support of the Donna project – an end-of-life patient and family centred care approach which was identified through consumer experience.
- The LCLHN has implemented the Diversity and Inclusion Plan 2020-2023 to help staff feel valued and respected for who they are, feel connected to and accepted by their co-workers, have equal opportunities to develop their career and progress, can contribute their full talents to the public sector and feel safe to freely talk about physical and mental health challenges.
- The LCLHN has also implemented the Disability Access and Inclusion Plan 2021-2023

3. Clinical performance and effectiveness

3.1 Safety and Quality training

Quality, Risk and Safety training is provided in a number of ways to all staff. The fortnightly Quali-TEA education sessions provide a relaxed space for staff to join in on quality, risk and safety conversations – driven by staff, supported by QRS, and reinforced through best practice. Focus topics include: Person-Centred Care, Open Disclosure, 'Bridge of Satisfaction', Incident Management, Patient Experience, Reporting Incidents, Quality Improvement, Reporting Consumer Feedback, Document Control, Safety and Quality Culture, Reporting Incidents – SLS Classifications, Clinical Risk, and Open sessions.

The QRS Manager and Team Leader study days provide education in quality, risk and safety domains in a 'skills station' format, which allows for the attendees to interact and actively ask system or functional questions or seek specific guidance in small group format. The topics of the 'skills stations' are: Consumer Feedback Management, Quality Improvement, Patient Safety, Risk Management, Document Control and SharePoint, and Clinical Governance. The 'skills stations' are manned by one or more members of the QRS team who support sites with that portfolio.

Extensive staff training and development is available and used to support safe practice and high-quality health care. The LCLHN Mandatory and Required Training schedule includes as required trainings: Patient incident management and open disclosure (training compliance at April 2023 75%), Partnering with Consumers and Community (training compliance at April 2023 67%), Aboriginal cultural awareness (training compliance at April 2023 91%), specific modules for at risk groups including Disability Awareness (training compliance at April 2023 97%), varied Aged Care modules, work health and safety for managers (training compliance at April 2023 76%), various WHS trainings for staff, and emergency awareness (training compliance at April 2023 72%).

The LCLHN conducts regular corporate orientation sessions, inclusive of key Quality, Risk and Safety information. An orientation program inclusive of Quality Risk and Safety training is additionally in place for the Governing Board, Health Advisory Council members, Volunteers and Consumer representatives.

Education sessions in Quality Improvement systems and methodology are provided regularly, and on an as-needs basis. SLS training is undertaken within departments, and on a 1:1 basis with staff and management. Training in accessing and utilising benchmarked information is held as required.

A LCLHN Nursing education team has been implemented to support nurse education and a significant increase in TPPP nurses. Locally based 'Working with Wisdom' positions have been developed as wrap around support to the junior workforce.

Sites have dedicated spaces set up for education (practical and computer based)– varying across each site.

Key improvement initiatives:

- Development and implementation of QRS Manager and Team Leader study day training, focusing on: Consumer Feedback Management, Quality Improvement, Patient Safety, Risk Management, Document Control and SharePoint, and Clinical Governance
- Implementation of fortnightly Quali-TEA education sessions for all staff
- Continuous improvement of LCLHN QRS SharePoint pages for staff easy access of information
- Health RoundTable benchmarking system training
- Multiple Moving on Audits training sessions held
- Ongoing support and training provided through the LCLHN Clinical Risk Manager
- Development of LCLHN nursing education team

3.2 Cultural competency and awareness

The LCLHN Reconciliation Action Plan (RAP) aims to build a foundation to achieve an optimal health care system in the LCLHN, a foundation based on strong relationships and cultural respect for Aboriginal and/or Torres Strait Islander peoples. For the relationship to be strengthened between Aboriginal and/or Torres Strait Islander and non-Aboriginal Australians, it is important that every LCLHN staff member develops an appreciation of how historical government policies and practices have impacted on Aboriginal and/or Torres Strait Islander peoples and cultures, and how their impact reverberates across generations and continues to create barriers and disadvantage today. All staff are obligated to learn as much as they can about Aboriginal and/or Torres Strait Islander cultures, as being informed about history and culture is key to moving forward and developing and delivering health services that are culturally sensitive and safe. Cultural competency training is included in the LCLHN Mandatory Training procedure and schedule, and our intent is to continue to strengthen relationships and work in partnership with our Aboriginal community.

Three levels of Cultural Awareness training are undertaken for the LCLHN: Individual Level: Knowledge and Awareness (Online Level 1 [mandatory, all staff]), Work Practice or System Level (two-day face to face Level 2 [all staff]), Organisational level (Level 3 Immersion [Board, Executive and Managers]). These three levels are formed by key topics that outline essential knowledge, skills and values that staff require in order to demonstrate cultural sensitivity in their work practice when interacting with Aboriginal people. Level 1 – Aboriginal Cultural Awareness training compliance at April 2023 is 91%.

A number of LCLHN resources and guiding documents have been created to guide staff including: LCLHN Guide for engaging with Aboriginal People, LCLHN Patient Care Guidelines for Staff – Aboriginal and Torres Strait Islander, Aboriginal and Torres Strait Islander Origin – recording of Information of Patients and Clients, Protocol Australian Aboriginal Flag.

'Asking the question training' has been developed and rolled out across LCLHN.

The development and implementation of a monthly Aboriginal Health Dashboard highlights our key performance in the provision of services to our local community. This Dashboard is reviewed at multiple Operational and Board Governance Committees.

Key improvement initiatives:

- Development of Cultural Awareness training level 2 (two day face to face, all staff) in a co-design process with local Elders
- Memorandum of Understanding (MOU) between LCLHN and Pangula Mannamurna Aboriginal Corporation Inc
- LCLHN Guide for engaging with Aboriginal People developed and implemented
- Development of Patient Care Guidelines for Staff – Aboriginal and Torres Strait Islander
- Naming of LCLHN meeting rooms in language – implementation of signs and chatter boxes
- Procedure developed Aboriginal and Torres Strait Islander Origin – recording of Information of Patients and Clients
- LCLHN Aboriginal Health Strategic Operational Plan
- LCLHN Aboriginal Workforce Plan
- LCLHN Reconciliation Action Plan
- Reconciliation boards created and are on display in each health unit
- Aboriginal Health Impact Statements (AHIS) are completed for all new or changed programs or procedures
- Aboriginal Artwork and posters commissioned, and are on display in waiting rooms and entrances, making a welcoming environment.
- Each building entrance across the LCLHN has been wrapped with artwork designed by local Elder group.
- Racism can now be specifically reported on SLS, this has been promoted to all staff through a CE Check.
- Quarterly update from Director Aboriginal Health in the LCLHN Community Newsletter

3.3 Workforce

LCLHN employ approx. 1,600 staff across Acute, Aged Care, Community, Disability and Mental Health services.

Performance management is managed through a 12 monthly Performance Review and Development (PRD) process and a 6 monthly review cycle. Performance requiring improvement is managed in conjunction with HR and in line with documented HR guidelines. As at February 2023, 12 month PRD compliance is sitting at 77.06%.

Support is provided to middle and senior managers on performance management and coaching.

Regular Dashboard reports on PRD, police clearances, excess leave, mandatory training compliance and staffing activity are provided to managers, and monitored by the Clinical Governance and Leadership Council, and Regional Leadership Committee. Current issues are raised and discussed at the weekly Regional MOS meeting, with longer term issues discussed under the People and Culture Key Focus Area.

The LCLHN Clinician and Staff Engagement Strategy is in process of implementation.

The LCLHN Clinical Advisory Council has re-convened with a strengthened multi-disciplinary membership in early 2023. Early discussion focus has been on the LCLHN Strategic Plan, and implementation of the Clinician and Staff Engagement Strategy.

An improvement project is underway focusing on business support requirements and building capacity at sites. This improvement aims to assist in relieving the administrative burden on clinical managers to enable focussed clinical monitoring and clinical staff support.

Key improvement initiatives:

- Continuous improvement of monthly People & Culture Dashboard reporting
- Development of the Clinical Governance and Leadership Council

- Implementation process for LCLHN Clinician and Staff Engagement Strategy
- Re-commencement and diverse clinical membership of the LCLHN Clinical Advisory Council
- Business support project underway

3.4 Credentialing and scope of practice

The SA Health Office for Professional Leadership administers the Credentialing and Scope of Clinical Practice (CSCPS) database and is responsible for the associated policies and standards. Each professional group has a designated Committee that oversees the credentialing and scope of practice processes for the Regional Local Health Networks, with approvals recorded in the CSCPS database. All staff from registered, self-regulated and unregulated professions must be credentialed before providing clinical duties.

The LCLHN has credentialing and scope of practice processes in place to ensure all Allied Health, Nursing & Midwifery and Medical Practitioners are appropriately authorised to deliver services in country health facilities. Credentialing for Allied Health and Medical officers is conducted through central (RSS) credentialing Committees. Credentialing has an explicit expectation re: skills, qualifications and supervision. Scope of clinical practice for allied health is managed by the specific credentialing committee within the Rural Support Service (RSS), scope of clinical practice for Medical Officers is managed through the Executive Director of Medical Services.

The LCLHN Executive Director of Medical Services (EDMS) is a member of the Regional LHN's Credentialing and Scope of Clinical Practice Advisory Committee. The EDMS is able to authorise short term 3 month credentials and scope of practice for short term engagement of medical practitioners.

The LCLHN currently has ten Nurse Practitioners credentialled to provide services within LCLHN, in the areas of Emergency (+ prescribing), Oncology (+ prescribing), Palliative (+ prescribing), Diabetes (+ prescribing), and Amputee Rehabilitation (+ prescribing). One RN has an Advanced Scope of Practice as Lymphoedema Garment Prescriber, and three staff are credentialed as Lymphoedema Garment Prescribers. The RSS facilitates the credentialing and scope of practice process, with information available to all staff through the registers on SharePoint.

Within LCLHN we have a number of credentialled Allied Health professionals, in the areas of Occupational Therapy, Physiotherapy, Speech Pathology, Dietetics, Social Work, Podiatry, Pharmacy and Radiography. The RSS facilitates the credentialing and scope of practice process, with information available to all staff through the registers on SharePoint. The LCLHN Executive Director of Community and Allied Health (EDC&AH) sits on the credentialing committee with all other regional LHN EDC&AHs, plus advanced clinical leads. Regular credentialing compliance reports are provided to the EDC&AH, and tabled through the Clinical Governance and Leadership Council.

Credentialing is a key standing agenda item on the LCLHN Clinical Governance and Leadership Council. Any issues or risks identified are escalated through to the Clinical Governance Committee. Credentialing and Scope of Practice is a standing Agenda item on the Board Clinical Governance Committee.

Key improvement initiatives:

- Authorisation for the EDMS to grant short term 3 month credentials and scope of practice for short term engagement of medical practitioners
- Scoping work for improvement project to bring credentialing functions to LHN process and delegation

3.5 Evidence based care

The Regional LHN Policy and Procedure Framework provides a consistent process for the formulation of policies and procedures applying to all Regional LHN health units and directorates. This process supports the implementation and monitoring of compliance with SA Health Policy, as well as ensuring procedures meet legislative requirements and relevant standards, are evidence-based, and can be applied across Regional LHNs.

The LCLHN procedures, protocols, guidelines and work instructions have a formal approval process through the Clinical Governance structure. New or revised documents are reviewed and recommended by the 'content expert' committees to the governance committees who hold endorsement authority. The full document management process has been formalised, with the implementation of the LCLHN Document Control Procedure, and the implementation of a Document Control Officer position for the LCLHN.

Policy and Procedure and LCLHN Document Control is a standing agenda item discussed at the LCLHN Clinical Governance and Leadership Council, with escalation as required through to the Clinical Governance Committee. LCLHN Document Control activity is reported on a monthly basis to the Administration & Records Management Committee, with escalation of items as required through to Corporate Governance Committee.

The LCLHN Quality, Risk and Safety Framework aims to provide an integrated QRS management system for all Health Units, and works toward achieving the overarching objectives set out in the LCLHN Operational Plan demonstrating compliance with QRS related legislation, standards, quality management, and risk management for LCLHN.

The Aims of the framework are to support:

- A consumer centred health service
- Reliable evidenced-based best practice care
- A positive culture that values effective, high-quality care
- Consumer participation in the delivery and governance of care
- Clinical Risks and causes of harm are systemically addressed
- Staff, Managers and consumers understand and act to improve quality

Current resources to support evidence-based care include:

- Resources via SharePoint (intranet) and SA Health internet
- Info Finder (link to resources)
- Statewide Clinical Networks

Key improvement initiatives:

- Implementation of the LCLHN Document Control Procedure and LCLHN QRS Officer – Document Control position
- Continued improvement to the LCLHN Document Control SharePoint HUB – providing easy searchable access to LCLHN endorsed P&P (LC/DC), regional documents, SA Health P&P and Lippincott
- Strengthened Clinical Governance system for LCLHN. Procedures reviewed through formal channels and endorsed as appropriate to the LHN
- Improvement of the LCLHN Clinical Governance and Leadership Council which review the Policy and Procedure function as a standing agenda item monthly, and functionally Document Control activities are reported monthly to the Administration & Records Management Committee.
- Current project developing LCLHN Acute and Community Continuity of Care Pathways for Chronic Disease
- Approval for implementation of a Level 4 nursing project officer to focus on models of care across the LHN

3.6 Variation in clinical practice health outcomes

Variations in health outcomes are monitored through the incident monitoring, tracking and trending, KPI, Morbidity and Mortality methodology plus external reporting through Health RoundTable and Women's Healthcare Australia. Key data sources include SLS (ISR 1's and 2's), OASIS, CCCME, Business objects, AROC (rehab), PCOC, CHIRON. Joint replacement registry, cardiac outcomes registry, prostate cancer register and the ANZ dialysis/transplant data base.

Monthly Dashboard reports highlighting key performance data are collated and analysed for targeted business areas: Acute, Aged Care, Mental Health, Country Health Connect, Aboriginal Health and Infection Prevention & Control. A dashboard for Disability Services is currently being developed. The monthly dashboards highlight a variety of key performance areas, including (but not limited to): Finance & Activity, Patient Safety and Incident Management, Consumer Feedback, Audit results, Benchmarking indicators, Performance and Capacity information (including PPAs, ALOS, Separations, Readmissions, NEAT, HACs, IC Surveillance, Discharge information, Consumer Self Identification, LOCUM usage, Residential bed occupancy, Referrals, Wait list summary information, Hand Hygiene data), and a summary of current Quality Improvements for each business area. The Dashboard reports are analysed

monthly at the LCLHN Safety, Quality and Clinical Effectiveness Council (SQCEC) alongside the monthly reports from the specialised Committees / Working Parties who identify and drive LHN wide quality improvement. Areas for action which cannot be addressed at the local level are escalated through to the LCLHN Clinical Governance Committee. The Dashboard reports are shared and analysed at the quarterly Board Clinical Governance Committee.

Monthly medical departments Scorecards are produced for the following teams: Anaesthetics, Oncology, Emergency Department, General Medicine, Obstetrics & Gynaecology, Paediatrics and the Surgical team. These Scorecards highlight departmental performance including financial and activity indicators, patient incident and consumer feedback data, HR related information and key KPIs such as discharge summary completion. The Scorecards are utilised by the Heads of Unit to review departmental performance and identify key areas for improvement.

All serious adverse events undergo a comprehensive clinical review and open disclosure supported by the LCLHN Clinical Risk Manager and are reviewed by the LCLHN Mortality & Adverse Events Review Committee (MAERC). All medically based case review meetings report to the MAERC. Shared Learnings are provided to the Safety, Quality and Clinical Effectiveness Council (SQCEC), distributed by MAERC and shared with all staff. All items for escalation are escalated to the LCLHN Clinical Governance Committee.

The LCLHN KPIs are monitored through Regional Leadership, Governance Committees, and LCLHN Governing Board meetings. KPIs include a broad variety of measures from clinical performance (including ALOS, PPAs), through to HR areas (including PRD compliance, mandatory training compliance).

Detailed Quality, Risk and Safety data is reviewed monthly to inform improvement opportunities at all Health Units Unit (split reports for Acute, Aged Care, Country Health Connect and combined site reports for the MPS sites including data for their Acute, Aged Care and Community areas). Detailed Health Unit specific data is presented for review and action under the following headings: Patient Incident data, Audits, Consumer Feedback, Quality Actions/Improvements, and Risk.

QRS subject specific data (including Patient Incident data and trending, Clinical Audit results, Benchmarking, Risk and Consumer Feedback) is presented to the Clinical 'reporting-in' Committees and Working Parties under SQCEC in the form of a detailed regular QRS report. This information is presented and discussed at the content specific committees and working parties to inform and drive region wide improvements, including: Drugs & Therapeutics Committee, Communicating for Safety Committee, Clinical Deterioration Committee, Blood Management Committee, Infection Prevention & Control Committee, Comprehensive Care Committee and its sub-groups (Responsive Behaviour Working Party, End of Life Care Working Party, Emerging and New Criteria Working Party, Falls/Pressure Injury Prevention Working Party and Nutrition and Hydration Working Party).

A number of audits are conducted across the LCLHN for a number of target groups, with results collated and reported in a timely manner to Health Units and relevant committees who analyse, develop, action and monitor improvement. This includes specific audits for Acute, Aged Care, Community & Allied Health, and NDIS. The Daily Care Audit is utilised in Acute to gather real-time and retrospective information to confirm the quality of care provided as well as identify improvement activities to ensure a safe environment for consumer care and outcomes. A suite of Acute care audits are scheduled across the year, with results informing improvement activities. The Moving on Audits electronic system is utilised for all Acute, Home Care, Residential Aged Care Facilities, Multi-Purpose Sites, and NDIS services to ensure detailed monitoring and review of performance, consumer outcomes, systems, procedures and protocols, staff practice, and consumer experience.

The LHN participates in benchmarking activities and monitoring performance against a number of clinical and quality indicators. The Mount Gambier and Districts Health Service (MGDHS) is a member of the Health RoundTable, and this information is being utilised to drive improvement. Data is reviewed by the relevant LHN Committees and Working Parties to inform and drive region wide improvements. Areas for improvement are recorded through QI/PCI. We continue monthly reporting to the South Australian Audit on Surgical Mortality (SAASM) audit, and actively respond with any information requested.

Key improvement initiatives:

- Strengthened Clinical Governance structure promoting detailed review of outcome data and ownership of improvement activities
- Strengthened the use of Health RoundTable (HRT) data and National core hospital-based outcome indicators (CHBOI) at monthly Regional Mortality & Adverse Events Review Committee meetings. Comparison of this data is used to inform discussion, identify variances in practice and make recommendations for practice.

- Shared Learnings are distributed by this rLHN Adverse Events Committee. An action plan is created for any recommendation arising from review and this is then included on the Recommendation Register.
- Monthly reporting to South Australian Audit on Surgical Mortality (SAASM) and compliance with case reports and any information requests.

Safe environment for the delivery of care

4.1 Safe environment

Work Health and Safety (WHS) incidents are reported in the Safety Learning System (SLS) and include:

- hazards, such as equipment faults, environmental factors
- incidents with no harm
- incidents with injury, including muscular stress, challenging behaviour and vehicle accidents

Managers, Health and Safety Representatives (HSRs) and WHS Professionals record details of investigation and review for WHS incidents in SLS. Work Health and Safety provides detailed monthly and quarterly reports to monitor hazards and incident trends, and compliance with the WHS&IM program.

The LCLHN WHS&IM SharePoint HUB is the staff information portal. WHS training requirements are directed and monitored through the LCLHN Mandatory Training schedule and procedure and include training at Orientation/Induction.

A WHS Internal Audit Program is in place and includes scheduling of SA Health, RSS and regional external and internal audits to monitor compliance to policy/procedure. Worksite safety inspections are conducted as per the audit schedule and actions are risk rated and actioned/monitored through the WHS Corrective Action Plan.

The monitoring of WHS requirements in the LHN include current risks and issues identified at the weekly Regional MOS meeting and longer term areas of work are captured under the 'People and Culture' Key Focus Area. The Work Health and Safety & Injury Management Review Advisory Committee oversees the LHN WHS&IM program and provides advice through to Regional Leadership. KPI's are monitored monthly from Site, through to Board level. WHS data is captured in a regular Dashboard and is reported to Regional Leadership. Site management committees monitor compliance and improvements, and actively utilise the WHS Corrective Action Plan (CAP). There is a reporting structure in place with committees reporting upwards to the Regional Leadership Committee through to the Board and with linkages and escalation pathways to the central RSS Committees.

The LCLHN WHS Corrective Action Plan is in place at each site and identifies actions arising from external and internal audits and hazard and incident reports. Recommendations from external audits/inspections/reviews are monitored through relevant Governance Committees.

The LCLHN delivers services from a number of facilities and buildings and equipment are maintained with general and preventative maintenance programs. Building design is conducted in accordance with best practice as out lined in the Australasian Health Facilities Guidelines in consultation with consumers and staff. Larger projects are commissioned with the assistance of corporate services who engage appropriately qualified engineers and architects. Consultation on significant projects closely involves the Health Advisory Councils. Triennial Fire Inspections are undertaken at each site. Water quality, rainwater, legionella testing, and food safety audits are conducted and reported according to frequency required in standards.

The LCLHN Strategic Asset Manager assists with the management and maintenance of assets across the LHN. The Panorama program is used for processing work orders on breakdown, routine maintenance, minor works and small construction works and is managed by the Department of Infrastructure and Transport (DIT). Site based maintenance request systems are also in place to ensure all plant and equipment is maintained in a safe condition as per the sites preventative maintenance program. Asbestos, plant and equipment, hazardous chemicals, working at heights and manual tasks registers are in place. Equipment purchase includes WHS review/approval, and Standard Operating Procedures (SOPs) are in place. Detailed risk assessments undertaken as required; including assistance of Workfit Services Consultants

Sites adhere to the SA Health Cleaning Standard, exceeding requirements where required. The LCLHN Environmental Cleaning Program is embedded.

Biomedical equipment is managed by SA Biomedical Engineering (SABME), ensuring it is appropriate, available, safe, used effectively, functioning correctly and compliant with relevant laws, regulations and standards. The SA Health Management of Biomedical Technology policy outlines roles and responsibilities accordingly.

There is an SA Health Emergency Management Unit in place that manages the SA Health Emergency Management System (SAHEMS) to capture record and share incident information including new incidents, allocation of tasks and decisions made. Emergency Exercises (practical and desktop) are included in audit schedules for each site. Building design, individual responses and alert systems are reviewed as part of this process. Risks identified from these reviews are tabled as part of the corrective action plan and discussed at site meetings.

4.2 Unpredictable behaviours

The Responsive Behaviour Working Party are leading the implementation of the SA Health Challenging Behaviour Framework across the LCLHN. In addition, the working party analyse LHN data, identify improvements and report and escalate as required through to the Comprehensive Care Committee.

They are also leading improvement work in implementing the Cognitive Impairment and Care Planning Model of Care Framework, including supporting and managing patients with Delirium. This framework is aimed at improving the clinical care and practice for hospitalised older people within the LCLHN by reducing potentially preventable adverse events related to cognitive impairment and delirium. This framework outlines the process for all LCLHN staff relating to cognitive impairment and care planning model of care for cognitive screening, ensuring that results are used to facilitate clinical assessment, clinical decision making, care planning, preventative intervention and communication.

This framework assists in the ongoing support for LCLHN staff towards:

- The delivery of appropriate care, reduce variation in care, and promotes shared decision making between patients, carers and clinicians.
- People to know what care should be offered by hospitals within our LCLHN and make informed treatment decisions in partnership with their clinician.
- Clinicians to make decisions about standardised appropriate assessment, investigations and treatment for care and referrals of the patient experiencing delirium or cognitive impairment.
- LCLHN to examine the performance of their organisation and make improvements in the care they provide.
- LCLHN to provide support and ongoing education for staff to meet the above criteria and best patient outcomes.

The LCLHN is currently reviewing the Management of Actual or Potential Aggression (MAPA) training across the LHN (known as Safety Intervention Training (SIT).

The Response to Code Black procedure has been strengthened and templates developed to incorporate a structured debriefing/reflection on incidents (staff and consumer), reflection by the attending Nurse coordinator, the attending medical officer and other staff involved. Senior staff in roles which would incorporate a responsibility in a Code Black situation (Nurse Unit Managers, After Hours Coordinators) are prioritised to be trained in the SIT response. SIT training has been specifically targeted initially to Regional Acute RN's, MGDHS Emergency Department Nursing Staff and nominated mental health nurses to include training in the physical restraint holds and the use of mechanical restraints in keeping with the Mental Health Act and the Regional LHN procedures. At MGDHS, a Staff Assist procedure is in place for those situations where assistance is required but not the usual medical response that comes with a Code Black – this is currently being implemented.

LCLHN Aged Care Facilities aim to provide a home like and restraint free environment. Chemical and physical restraint is monitored monthly and through Mandatory Quality Indicator reporting. The Duty of Care and Dignity of Risk procedure has been implemented across the LHN, in addition to the Aged Care Restrictive Practices Procedure in line with current legislation and Aged Care Responsive Behaviours Protocol.

Key improvement initiatives:

- Implementation of Staff Assist procedure for MGDHS
- Review of MAPA training

- External security review of Mount Gambier and Districts Health Service – multiple improvements in progress
- Strengthening of Mandatory Quality Indicator set for Residential Aged Care
- Duty of Care and Dignity of Risk procedure developed and implemented
- Development and implementation of Aged Care Restrictive Practices Procecedure and Aged Care Responsive Behaviours Protocol
- Delirium, Dementia and Depression study day organised for staff in partnership with the ANMF
- State government election commitment for sub-acute Mental Health beds
- Mental Health Consultation Liaison and Triage Service re-establishment across Mon-Fri. Proposed plan to extend services across 7 days with CL and Nurse Practitioner model - available to support regional spoke sites by telehealth – in assessment, triage, admit, or transfer
- Establishment of the Emergency Management and Security Committee as part of the LCLHN Corporate Governance Structure.

4.3 Welcoming environment for Aboriginal and Torres Strait Islander People

All sites are flexible with visiting hours dependant on the consumers' needs and wishes and encourage boarders to stay with paediatrics patients and other patients as required, including palliative care and midwifery patients. In our acute facilities, we in process of implementing the LCLHN 'Family are not Visitors' procedure. Patients are also able to request limitations to visitors as required. Support people / carers are encouraged to become involved with the patients care, and whiteboards at each bedside are used as a communication tool between staff patients and carers.

The LCLHN has an Aboriginal Health Operational Strategy, Aboriginal Workforce Strategy, and an active Reconciliation Committee who promote a culture of respecting cultural knowledge, diversity and cultural sensitivity. The LCLHN Reconciliation Action Plan is monitored through the Reconciliation Working Party.

The LCLHN has a mandatory Aboriginal Health Cultural Learning Program for all staff. An Acknowledgement of Country is conducted at the commencement of each meeting within the LHN. The LHN utilises Aboriginal artwork across all sites – example: inclusion of CORKA Mob design on Volunteer t-shirts and Mount Gambier way-finding guide station, commissioning of Aboriginal art-work for display in sites, printed of CORKA Mob artwork on entrance doors accompanied by 'Welcome to Country' in language, and we are in the process of re-naming meeting rooms across LHN to appropriate local Aboriginal names.

The LCLHN Aboriginal Experts by Experience register is in place, with members consulted for varying projects. Sites in the LCLHN are actively involved in Reconciliation Week, NAIDOC and other ceremonies, whether by holding events or participating in events. Aboriginal flags flying at all sites, and smaller flags, including Aboriginal and Torres Strait Islander flags, are on display. Aboriginal Health Impact Statements are considered and developed for all projects. 'Are you of Aboriginal and/or Torres Strait Islander origin' posters have been developed specifically for our region and utilised in conjunction with programs to promote self-identification.

5.1 Partnering with Consumers in their own care, Partnering with Carers, Health Care Rights, Informed Consent, and clinical governance and quality improvement systems to support partnering with consumers.

Partnering with consumers is a key focus for the LCLHN. We have implemented the LCLHN Consumer, Carer and Community Engagement Strategy which has been developed through significant consultation by a Board Engagement Strategy Development Working Group. Wide consultation occurred throughout the development of the Strategy with the operational LCLHN Partnering with Consumers working party, HAC and Consumer Network members on the development of the strategy. The Partnering with Consumers Committee hold carriage of the implementation of the strategy, and report to the Board Engagement Strategy Oversight Committee.

Implementation actions of the LCLHN Consumer, Carer and Community Engagement Strategy are distributed within the LCLHN governance committees and regional departments to ensure the important work of partnering with

consumers, engagement and person-centred care is paramount for all. Each committee holds its actions, which are monitored and through the Partnering with Consumers Committee and continues strong work toward embedding strategy. SA Health and RSS policies, procedures and guidelines relating to partnering with consumers are available through the SA Health Intranet and SharePoint. The LCLHN QRS SharePoint information HUB has been significantly improved to provide staff with a one stop shop for engagement and person centred care related resource links.

The LCLHN Partnering with Consumers Vision: *'The Limestone Coast Local Health Network (LCLHN) is committed to actively engaging and partnering with consumers and the community in order to provide an appropriate, safe, and quality health service which meets their needs. We actively support a diverse range of consumers to be true partners in our work with a view to continuous improvement of the safety and quality of their health care. Our consumer and community engagement occurs across a spectrum of engagement, is implemented through a variety of methods based on best practice, is accessible to a range of people, and most importantly is driven by our consumers, carers and community.'*.

The Operational LCLHN Partnering with Consumers Committee comprises Health Unit representatives from each site, plus a range of consumer representatives from across the LHN. The Committee monitors implementation actions for the CCCES, initiates LHN-wide projects and initiatives, communicates regularly with Consumer Network members, and collates information on all PWC projects occurring within the LCLHN. Consumer representatives are engaged as active committee members in the majority of LHN Governance committees and targeted working parties/groups (currently 19 consumers/community members engaged across the governance structure). LCLHN have recruited many consumer representatives for a wide range of LHN Committees. The Committee has been established for a number of years and continues to strengthen to ensure consumers are at the center of all decisions made across the region. The LCLHN Partnering with Consumer Committee reports monthly to LCLHN Clinical Governance Committee. Key activities are reported weekly to Regional Leadership through the 'Person Centred' key focus area at MOS.

There are 6x Health Advisory Councils (HACs) aligned across the LHN to each site. These formal groups meet regularly and provide a means for community consultation and health promotion. Regular meetings are held with site and regional representation and ensure issues, ideas and communication are a key focus at these forums. We have a number of active consumer, carer and community representative networks including the LCLHN Community Network (approx. 90 local members), LCLHN Aboriginal Experts by Experience register, and the Mental Health Lived Experience register. In addition, sites use various other methods to engage with the community including open days, engagement in service planning activities, information sessions and community events. There are a range of consumer groups at sites within the LCLHN.

The LCLHN Partnering with Consumers resources and tools are available and actively promoted to staff through the SharePoint HUB and through Partnering with Consumers champions at each site (LCLHN Partnering with Consumers staff working party members).

The LCLHN MOS is the weekly leadership oversight system for management of the LHN. The Business As Usual area identifies any key issues or risks identified across the LHN, and celebrates achievements/positives, and any events occurring across the LHN. 'Person Centred' is a key 'CCC' (Concern, Cause and Countermeasure) area of focus which is allocated to the Partnering with Consumers Lead for the LHN, the Executive Director of Community & Allied Health and current areas of focus are discussed on a weekly basis.

Operational Risks relevant to Partnering with Consumers and consumer feedback are included on the LCLHN Risk Register. Each risk is detailed to identify causes and consequences and identify existing controls and current treatments along with allocated responsibility and timeframes. The current risks identified are -

- Failure to engage with the community to inform service planning and expectation
- Failure to implement process improvements resulting from consumer feedback

Person centred care and partnering with consumer principles form part of the induction process and ongoing training requirements of staff.

The LCLHN KPIs are monitored through Regional Leadership, Governance Committees, and LCLHN Governing Board meetings which capture consumer feedback and satisfaction measures. Consumer feedback is reported through the monthly Dashboards, Scorecards, and detailed QRS reports for Committees and Health Units. Issues are actively addressed both individually and reviewed as trended information.

A fundamental basis within our LCLHN Safety and Quality Action Framework is person-centred care. The LCLHN have initiated many strategies to encourage patients to partner in their own care.

- Fundamentals of Care program encourages patients at the centre of their care.

- Goals of Care at bedside – encouraging patient goal setting and encouraging a strong person centred care approach
- Continued focus on the Donna project – an end-of-life patient and family centred care approach which was identified through consumer experience.
- #endPJparalysis program is in place across all Health Units – encourages patients to 'Get Up, Get Dressed, Get Moving'.
- Disability, Allied Health, Aged and Community based programs and care focus on consumer directed goal setting for clinical and support services.
- 'Family are not Visitors' program is in progress as part of the current Board 'Consumer, Carer and Community Engagement Strategy' key principles.

Staff training programs ensure staff are supported and encouraged to establish and maintain partnerships with patients and their families/carers: Patient Centred Care training, Partnering with Consumers training are a few examples.

Quality, Risk and Safety training is provided in a number of ways across all staff. The fortnightly Quali-TEA education sessions provide a relaxed space for staff to join in on quality, risk and safety conversations – driven by staff, supported by QRS, and reinforced through best practice. Focus topics include: Person-Centred Care, Open Disclosure, 'Bridge of Satisfaction', Incident Management, Patient Experience, Reporting Incidents, Quality Improvement, Reporting Consumer Feedback, Document Control, Safety and Quality Culture, Reporting Incidents – SLS Classifications, Clinical Risk, and Open sessions.

The QRS Manager and Team Leader study days provide education in quality, risk and safety domains in a 'skills station' format, which allows for the attendees to interact and actively ask system or functional questions or seek specific guidance in small group format. The topics of the 'skills stations' are: Consumer Feedback Management, Quality Improvement, Patient Safety, Risk Management, Document Control and SharePoint, and Clinical Governance. The 'skills stations' are manned by one or more members of the QRS team who support sites with that portfolio.

The LCLHN Interpreter and Translation procedure encourages appropriate engagement and provision of culturally appropriate and safe services.

SA Health and RSS policy and guidelines are utilised and drive informed consent processes. Scheduled audits are undertaken across the annual calendar to track and monitor compliance with informed consent.

The LCLHN Consumer experience surveys (Acute, Aged Care, Disability, and Community) have been developed to capture consistent information from consumers for the different areas of health care provided. A variety of surveys are conducted, including (but not limited to): service participant annual plus monthly 'pulse' surveys through Moving on Audits for Residential Care, Community Home Care and NDIS programs, and snapshot surveys within Acute.

South Australian Consumer Experience Surveillance System (SACESS) is an epidemiological surveillance system involving a representative, randomly selected, monthly sample of South Australian adults, aged 16 years or more who have received inpatient care. This is conducted for the Mount Gambier and Districts Health Service. The Measuring Consumer Experience SA Public Hospital Annual Report details the key findings, and further analysis of the consumer's experiences will ensure that we meet the best standards for our consumers.

Information on current activities are shared with our partners regularly through a variety of means including the LCLHN community newsletter, fact sheets, information sharing at meetings, Facebook pages, and Consumer Displays.

The Australia Charter of Healthcare Rights (the Charter) describes the rights that consumers, or someone they care for, can expect when receiving health care. These rights apply to all people in all places where health care is provided in Australia. This includes public and private hospitals, day procedure services, general practice and other community health services. The second edition Charter (revised with assistance of consumers, health service staff and policymakers), reflects an increased focus on person-centred care and empowers consumers to take an active role in their healthcare. Several resources have been developed to support the use of the second edition of the Charter, including translated versions. These are available and on display at all Health Units.

The Health and Community Services Complaints Commissioner (HCSCC) Charter sets out the rights of all people who use most health and community services in South Australia and to the family members, carers and nominees who act on behalf of a person seeking or using a service. The HCSCC Charter substantially incorporates

the Australian Charter of Health Care Rights (2nd edition 2019). A number of resources are available for consumers and the charter is displayed in all facilities throughout the LCLHN.

The NDIS Commission aims to uphold the rights of people with a disability, including the right to dignity and respect, and to live free from abuse, exploitation, and violence.

The Charter of Aged Care Rights provides the same rights to all consumers, regardless of the type of Australian Government funded aged care and services they receive. A number of resources are provided for consumers, including translated and easy read versions, and the charter is displayed in facilities throughout the LCLHN.

Information on consumer rights is actively promoted to all consumers across all services, including information on advocacy services. The LCLHN Safety & Quality Framework includes a number of audits and surveys to measure and monitor processes for ensuring consumers are aware of their rights and responsibilities, are involved in the delivery of their care, provide informed consent where required, and are involved in decisions around end-of-life care.

5.2 Health literacy

A key focus for LCLHN is the fundamental principle of provision of information to consumers in the language that they understand and receiving this when it is most appropriate in their care journey (sometimes information may be provided multiple times). SA Health, RSS and regional policies, procedures and guidelines are in place and utilised, including:

- SA Health A Framework for Active Partnership with Consumers and the Community
- SA Health Guide for engaging with consumers and the community
- SA Health, Health Literacy Toolkit

In the LCLHN, written health information goes through a process of consumer review prior to publication (including document reviews). Various methods are utilised to engage consumers and the community in reviews as appropriate, including review by consumer advisory groups, consumer Network members, and targeted consumer reviews by current clients. Feedback is incorporated into publications prior to being published. Consumer Health Information is badged as ‘consumer reviewed’, and is registered including dates for review through Document Control processes. Consumer Health Information document creation and reviews are reported through the monthly LCLHN Partnering with Consumers Committee.

Consumer representatives sit on key committees to assist in formulating information for patients and their families/carers. Training for our consumer reps is a key focus. The LCLHN Interpreter and Translator Work procedure has been developed and implemented to guide and facilitate culturally appropriate information sharing.
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The LCLHN Safety & Quality Framework includes a number of audits and surveys to measure and monitor appropriate health information processes e.g., Consumer Experience Surveys, Consumer feedback monitoring, and documentation audits. KPI response data to consumer feedback is monitored and acted upon as needed.

5.3 Partnering with consumers in organisational design and governance

Partnering with consumers in organisational design and governance is a key principle of our governing processes, underpins our LCLHN Consumer, Carer and Community Engagement Strategy.

The LCLHN is currently undertaking “Co-designed Service Planning” across the LHN. This approach is being supported by the Planning and Population Health service within the RSS, with an action learning approach which will continue to evolve as we learn more from our successes. This approach is being used in the development of service plans across the region – which has occurred in Millicent, Mount Gambier, and is currently occurring in Naracoorte. Co-designed service planning is a mechanism in SA strategic directions by creating meaningful partnerships with our people to codesign person centred care for the populations we serve to achieve our best possible outcomes. The codesign process is putting our LCLHN values in action: it places our vision to be a trusted partner in the provision of safe, high-quality, progressive, consumer-directed care and services into the hands of our key stakeholders.

Significant community and stakeholder consultation has occurred to implement a new model of care for the Keith & District Hospital, a private acute and aged facility, to ‘Keith & District Healthcare’ under the LCLHN which will provide

primary health and aged care services to the Keith community. A Model of Care has been developed following extensive consultation with the local community and key stakeholders. Consultation included public meetings, focus groups, website information, a survey and meetings with local community groups.

Regional Governance Committees include active and engaged consumer representatives as integral committee members. The governance committees provide input and oversight of all new program development, new service initiatives, and existing program governance and monitoring. The LCLHN have recruited a wider range of consumer representatives who actively participate in Committees within the LHN. Consumer representative training occurs following recruitment, and consumer representatives on committees are supported with a comprehensive induction process, and ongoing support is provided through a 'buddy' system.

For more information

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