

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

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

- **Emergency Procedures**
  - Emergency codes
  - Emergency response assessment / RACE
  - Malignant Hyperthermia – Dantrium process
  - Evacuation
  - Power failure
  
- **Cardio Pulmonary Resuscitation**
  - Emergency trolley
  
- **Aseptic Technique**
  - Hand hygiene
  
- **Open Disclosure**
  - The process
  - Deciding not to go ahead
  - Points to remember
  
- **Complaints**
  - The complaints management process
  
- **Patient Centred Care**
  - Principles of patient centred care
  - Objectives of patient centred care
  - Model of care
  
- **Antimicrobial Utilisation**
  - Antimicrobial stewardship programme
  - Antimicrobial usage
  - Evaluation

## **EMERGENCY PROCEDURES**

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

## EMERGENCY CODES

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

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

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

## MALIGNANT HYPERTHERMIA - DANTRIUM PROCESS

Stored in the Malignant Hyperthermia box in the Anaesthetic area.

- 24 Vials Dantrium
- Sterile Water for Injection

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

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

## EMERGENCY RESPONSE ASSESSMENT / RACE

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

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

## EVACUATION

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

### Stages of Evacuation

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

#### Stage 1

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

#### Stage 2

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

### Evacuating Patients

Evacuate in group form and staged sections on direction of Fire Officer

- Ambulant patients, requiring a staff member to guide or direct them to a place of safety
- Semi-ambulant patients, requiring some physical assistance
- Non-ambulant patients who need to be physically moved or carried
- Non-compliant aggressive, violent or resistive persons

### Methods of Assisting Patients in Evacuation

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

- Fore and Aft carry
- Swing and hand seat carry

# CLINICAL EDUCATION PACK

- Human crutch support
- Sheet
- Recliner chairs or Trolleys through EXIT doors

## Evacuated Patients

- When the facility remains unsafe to be re-entered, the Fire Safety Officer / Delegate to arrange Ambulance support according to patient needs
- Contact the closest public hospital and advise the Emergency Department and Theatre of patients for transfer:
  - CCDH – Contact Gosford Hospital – 02 4320 2111
  - ESC – Contact Ryde Hospital – 02 9858 7888
  - CPH – Contact the Royal North Shore – 02 9926 7483
  - MDS – Contact Hornsby Ku-ring-gai Hospital - 02 9477 9123
  - COFFS – Contact Coffs Harbour Health Campus - 02 6656 7000
- Patient Clinical Records accompany them out of the facility prior to transfer

## ASSEMBLY AREAS

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

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

## POWER FAILURE

In the event of a power failure:

- The facility has a UPS (Uninterrupted Power Supply) Systems
- Emergency lighting will activate in each theatre, SSD and patient care areas.
- Torches are located in all areas of the facility for use in an emergency and to supplement the emergency lighting

# CLINICAL EDUCATION PACK

- It is important to conserve power during the failure by switching off all unnecessary lights and electrical equipment
- The surgeon and anaesthetist will make a decision on how to proceed, by either terminating or completing the episode of care. All staff & CMP's must be aware that the UPS is able to supply power for the following time frames:

|                    | CCDH       | ESC        | CPH                          | MDS | COFFS |
|--------------------|------------|------------|------------------------------|-----|-------|
| Estimated Run Time | 60 minutes | 30 minutes | Unlimited – Diesel Generator | 90  | 90    |

## CARDIO PULMONARY RESUSCITATION

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

### **STEPS OF RESUSCITATION: DRABCD**

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

### **COMPRESSION VENTILATION RATIO**

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

### **DURATION OF CPR**

Continue until:

- The patient responds or begins breathing normally
- It is impossible to continue (eg exhaustion)

# CLINICAL EDUCATION PACK

- CPR is taken over by another health care professional
- CPR is directed to be ceased by a senior health care professional

## EMERGENCY TROLLEY

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

### EQUIPMENT:

- Airways, laryngeal masks and ET tubes
- Bag – valve- mask
- IV cannulas, giving sets and fluids
- Oxygen and suction
- Defibrillator with AED function

### MEDICATIONS:

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

|            |                    |
|------------|--------------------|
| Adrenaline | Magnesium          |
| Amiodrane  | Potassium          |
| Calcium    | Sodium bicarbonate |
| Lignocaine |                    |

## ASEPTIC TECHNIQUE

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

*This is achieved by correct:*

1. Hand hygiene,
2. Non touch technique,
3. Using new sterilised equipment and or
4. Cleaning existing key parts to a standard that renders them aseptic prior to use.

*Core infection control components:*

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

## **HAND HYGIENE**

**The 5 moments of hand hygiene are:**

1. Before touching a patient in any way
  2. Before doing a procedure, once hand hygiene is done, nothing else in the environment should be touched prior to the procedure starting
  3. After a procedure or exposure to body fluids to prevent health care working infection or environmental contamination
  4. After touching a patient to prevent health care working infection or environmental contamination
  5. After touching a patient surrounds or belongings, even though the patient has not been touched
- **HAND WASHING** should be done immediately if body substances contaminate them. Hand rub is not recommended if hands are grossly contaminated
  - **HAND RUB** should be used for most hand hygiene activities as it is more effective, quicker to use and better tolerated by the hands. It is also easily accessed at the point of care.
  - **A SURGICAL HAND WASH** or rub is required for surgical aseptic technique. The first wash of the day should be 5 minutes, with subsequent washes of 3 minutes or surgical hand rub completed.
  - **HAND HYGIENE AUDITS** are conducted throughout the year to ensure compliance of medical and nursing staff to the 5 moments of hand hygiene.

## **Glove use**

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

**Aseptic fields**

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

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

**Standard Aseptic technique**

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

**Surgical Aseptic technique**

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

**OPEN DISCLOSURE**

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

Open disclosure is required when a patient has suffered some unintended harm (physical or psychological) as a



result of treatment. This may be a recognised complication, unanticipated incident or a result of human or system error. It involves the requirement to say sorry without admission or blame and is an ethical practice that prioritises organisational and individual learning from error.

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

### **The elements of open disclosure**

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

## **THE PROCESS**

### **1. Detecting and assessing incidents**

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

### **2. Signal the need for Open Disclosure**

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

### **3. Prepare for Open Disclosure**

- Hold a multidisciplinary team discussion to prepare
- Consider who will participate

- Appoint a leader for the discussion based on previous involvement with patient, family &/or carer
- Gather all necessary information
- Identify contact person if this hasn't been done

#### **4. Engage in Open Disclosure**

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

#### **5. Providing Follow –up**

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

#### **6. Completing the Process**

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

#### **7. Maintaining Documentation**

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

### **DECIDING NOT TO GO AHEAD**

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

**POINTS TO REMEMBER**

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

**COMPLAINTS**

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

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

**THE COMPLAINTS MANAGEMENT PROCESS**

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

**STAGE 1: RECEIVE THE COMPLAINT**

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

- Actively listen to the complainant;
- Empathise, understand and acknowledge their viewpoint;
- Express regret that they have had a poor experience, and
- Assure them steps will be taken to investigate and resolve their concerns.
- Look for solutions
- Acknowledge receipt of the complaint
- Record the complaint - create a comprehensive record of conversations, concerns, names, addresses, hospital numbers, providers, etc. Other key aspects are the service provided, dates and times. The written record of the complaint is the basis of any action taken about the complaint.

**STAGE 2: ASSESS THE COMPLAINT**

There are several steps:

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

**STAGE 3: INVESTIGATE THE COMPLAINT**

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

**STAGE 4: RESOLVE THE COMPLAINT**

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

**Conciliation**

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

**Recording and using complaints data**

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

## **PATIENT CENTRED CARE**

Patient Centred Care is used to create a health service that is responsive to patient, carer and consumer input and needs. The application of patient centred care provides a standard of nursing care and clinical performance that reflects best practice. Ensuring that there are effective partnerships between

consumers and the organisation at all levels of healthcare provision, planning, and evaluation have been associated with decreased readmission rates, decreased healthcare acquired infection rates, reduced length of stay, and improved adherence to treatment regimens

## **THE PRINCIPLES OF PATIENT CENTRED CARE**

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

## **OBJECTIVES OF PATIENT CENTRED CARE**

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

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

## **ANTIMICROBIAL UTILISATION**

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

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

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

### **Antimicrobial Stewardship Programme**

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

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

### **Antimicrobial Usage**

- Evidenced-based literature supports the utilization of intra-cameral Cephalosporins injected at the end of cataract surgery cases - (cataract surgery amounts to 80% of the total surgical workload across the PMA Facilities) 0.048% (.48 infections per 1000 cases) with Cephalosporin vs 0.35% (3.5 infections per 1000 cases) without Cephalosporin [ESCRS 2013]
- The MAAC endorsed surgeons having the choice of two Cephalosporins – Cephazolin and Cefuroxime. This is because Sydney Eye Hospital utilises Cephazolin whilst many of the European studies utilize Cefuroxime. Both have the same efficacy for surgical prophylaxis.
- The prescribing of Cephazolin and Cefuroxime for cataract surgery prophylaxis is consistent with the Therapeutic Guidelines (Australian): Antibiotic (2010). These Guidelines and eMIMS are available in every PMA Facility.
- A compounding pharmacy provides sterile, pre-packaged Cephazolin and Cefuroxime. Surgeons may elect to utilize either of these two antibiotics.

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- Alternative pre-packaged antibiotics will not be provided by the Facilities in order to discourage other antibiotic utilization inconsistent with the evidence in the literature.
- The use of intracameral antibiotics continues to be entirely up to the discretion of the treating Surgeon.
- Minimal supplies of alternative antibiotics are available at the Centre for peri-operative utilization. These antibiotics must be prepared by the scrub or surgeon at the time of use. A clinical competency is undertaken every year by scrub staff to ensure their compliance.
- **The MAAC and Clinical Microbiologist have identified Vancomycin as a restricted antibiotic for ophthalmic perioperative utilization. Vancomycin's use is restricted across the PMA Facilities.**
- Ophthalmic Surgeons and peri-operative nursing staff document on MR9 - Surgeons Record the antimicrobial used and administered.
- Povidone-Iodine (5-10%) (PVI) is used for all pre-operative antisepsis, unless allergy/contraindication, then aqueous chlorhexidine 0.05% is utilized.
- PVI is applied for three minutes to the cornea, conjunctival sac and periocular skin.
- Pre and post-operative antibiotic eyedrops/ung are also utilized at the Facilities. The eyedrops/ung utilized is consistent with the Therapeutic Guidelines – Antibiotic.

### Evaluation:

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

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