



Delivering Transforming Health

Best Core. First Time. Every Time.

Proposals Paper: Meeting the Clinical Standards

February 2015



Foreword Minister for Health

Transforming Health is about ensuring South Australians have the best quality healthcare system into the future. It has become clear that we need to change the way we manage our system so that we can meet changing community needs and advances in treatments and technology.

Through the process we undertook last year – to involve doctors and surgeons, nurses and midwives and allied and scientific health professionals in redesigning the system – we realised that we need to improve the consistency of our healthcare so that the many areas of excellence that we have in South Australia can be replicated across our system.

The proposals in this paper were developed with groups of clinicians and focus on achieving the quality principles that they consider essential for an effective health system. The response to the Transforming Health Discussion Paper and the Transforming Health Summit held in November 2014 has also been considered in forming these proposals.

This paper sets out changes to specific service categories – for example, better services for Veterans, comprehensive rehabilitation services, better access to stroke services, and clearer distinctions between hospitals that are best equipped for major life-threatening emergencies and those best suited to minor emergencies.

The overarching aim is this: a more streamlined hospital healthcare system that provides better service for patients. We want to make sure patients experience a seamless journey through all stages of care.

Some of the proposed changes challenge our thinking. For example, we would not assume that going further to a hospital will be safer in some circumstances. Yet that is what the evidence has shown and what our medical professionals have found. We now need to commit to implementing the changes that are necessary to meet the quality standards.

I commend the clinicians who have responded to the challenge so far. I've been overwhelmed by the almost universal support for the view that change is necessary and doing nothing is not an option.

Of course, this is not the end of the process. We want to improve the links between our hospitals and GPs and other community based care. Co-ordinated complex disease management will become even more important in the future. We started with the metropolitan hospital system but must also look at the quality of care provided in regional areas in the future. We are also looking at the health administration and how it can better support our health professionals.

The task ahead of us is huge. We can hope to achieve it because every healthcare professional in our system goes to work each day with the goal of making patients' lives better. It is only by working together with our clinicians that we will be able to build the best quality, patient-centred system possible in this state.

I hope you will be open to changes that will improve our healthcare system. I invite you to read these proposals, consider the views of the clinicians who have been involved in developing the proposals and contribute to reform of health in our state.

Best care. First time. Every time.

Jack Snelling
Minister for Health

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Why do we need to change?

The Transforming Health Discussion Paper (released in October 2014 and available at www.transforminghealth.sa.gov.au) outlined why we need to change South Australia's health system.

- > We have more GPs, hospital nurses and hospital beds than other states, yet we don't have better health outcomes in all health areas.
- > We have significant variations in mortality rates for the same medical conditions, depending on the hospital attended or the time of attendance.
- > We have the highest rates in the nation and in some cases internationally for some procedures, without an obvious explanation.
- > On average, across metropolitan hospitals, one in four planned operations are postponed, leading to delays and inconvenience for patients and their families.
- > We have patients with similar conditions staying in hospitals longer depending on the team they are admitted under, the hospital they attend or the day of the week they are admitted.
- > We don't always provide the services that are needed, overnight or seven days a week, which means that people's conditions get worse unnecessarily.
- > There are delays and duplication of services that affect patients and waste resources.

What became clear is that South Australia has pockets of excellence in the healthcare system but doesn't deliver consistent quality outcomes across all services and sites. We can improve care for patients if we reduce the wide variation in effectiveness of services across our system.

This is how we will deliver a more sustainable health system for all South Australians.

The Minister for Health established three clinical advisory committees; doctors and surgeons, nurses and midwives, and allied and scientific health professionals. These clinicians recommended six principles of quality healthcare to guide the transformation of our health system:

Patient-centred	Safe	Effective
Accessible	Efficient	Equitable

Transforming Health

39 
community information
events held across
metropolitan Adelaide
and regional SA


2243  **56%** metropolitan
 **44%** regional
people attended
a community
information event

129 
formal submissions from
interested parties

 **2290**
total video views across all
Transforming Health videos

The clinical committees also proposed almost 300 clinical standards that should be adopted across South Australia to help our system meet those six principles of quality.

These standards were outlined in the Transforming Health Discussion Paper, which was released in October 2014.

There was extensive public consultation on the discussion paper and related standards. Thirty nine community events were held at locations such as shopping centres and transport hubs. Forums were held in health locations for staff to contribute.

The Discussion Paper and questions were available online and were sent to 500 organisations with interest or expertise in health. More than 2,000 staff, community and industry representatives provided input through feedback forms or written submissions.

More than 90% of community members and staff who responded to the Discussion Paper agreed or strongly agreed on the need to change our healthcare system.

The Transforming Health Summit was held in November 2014. It involved more than 600 people from the community, doctors, nurses, midwives, allied health and scientific professionals, consumers, healthcare organisations and academic and research institutions. They heard from the chairs of the clinical advisory committees, looked at the data that was used by the clinicians to develop the quality principles, considered the feedback from the consultation process and heard about changes to health systems that have happened interstate and internationally.

The Summit endorsed the principles of quality and the proposed clinical standards, with an acknowledgment that the standards would be revised and further developed over time. The Summit also developed a Communiqué (Appendix 1) that outlined the expectations of the Summit participants regarding the future of the Transforming Health initiative.

Many of the standards developed can be achieved without reconfiguring the system but around 50 cannot be achieved with the way our hospital system is currently set up. We have a responsibility to change our system so that these standards can be met because they are about improving quality and consistency of care across our system so that people receive better health care and have better health outcomes.

Health Engagement

2097

staff and community feedback forms were completed



2622

staff were spoken to across nine SA Health hospital sites and attended launch presentations



26,615

unique visitors to the Transforming Health website, staying for an average of 2 min

500

information packs mailed to organisations



Some of the implications of adopting the principles were outlined at the Summit. Achieving consistent high quality means changes across the entire system.

Best care, first time, every time.



What kind of standards cannot be met with our current set up?

There are overarching standards to apply to the whole health system that can't currently be met. Some examples are:

- > Care should be delivered in the right place, by the right person, the first time and every time.
- > Healthcare services should be offered seven days a week, every week. Human and infrastructure resourcing should be aligned to achieve this.
- > Care should be delivered in the most appropriate cost-effective venue as close to home as safely possible.

Some speciality services need a minimum number of patients for safe, quality-care standards to be met, meaning that staff need to treat enough patients to maintain their skills and advanced expertise.

Evidence tells us that some speciality services need a minimum number of patients for safe, quality-care standards to be met, meaning that staff need to treat enough patients to maintain their skills and advanced expertise. For example, this concept is found in standards that relate to maternity, paediatrics, gynaecological surgery and cardiology. A full list of the Standards is in Appendix 2.

This paper explains the changes proposed to deliver on these standards.

You are invited to provide feedback about the proposals by **Friday 27 February 2015** by:

- > Online feedback form:
www.transforminghealth.sa.gov.au
- > Email: transforminghealth@health.sa.gov.au
- > Post: Reply Paid 84208, Rundle Mall SA 5000
- > Freecall 1800 557 004



Delivering Transforming Health: Best Care. First Time. Every Time

Our vision for better healthcare

We want consistent, safe, quality care.
Best care. First time. Every time.

Health systems around the world are looking at ways of improving how they deliver better, more effective services. We want a system where:

- > patients are seen by the right person or group of people in the right place at the right time
- > patients, their families and their carers are supported to understand and be involved in ongoing management of their care
- > services that are required overnight and seven days a week are available when needed
- > tests and treatments can be accessed when needed
- > all care that is provided is appropriate
- > more lives are saved, disability is reduced and we make best use of our resources for the benefit of all South Australians.

Our system will need to work differently if we want to deliver best care, first time, every time.

This will mean:

- > patients, ambulance services and the professionals who refer patients to our health system will be directed to the most appropriate setting of care first time
- > our health professionals will work in more effective inter-specialty and inter-disciplinary teams

- > more effective communication with patients, their families and their carers
- > improved use of our specialist resources, such as x-ray machines, operating theatre departments and outpatient clinics, so that tests and treatments are available when needed
- > consistently building on the evidence to enhance how we care for patients
- > improving co-ordination and communication across sites and services to develop better networks of specialist care
- > eliminating inefficiencies and unnecessary duplications that cause delays and unnecessarily use resources in our system.

What does this mean for services?

As well as making sure we work differently as a system, we will also have to change how the system is set up if we want to deliver against these quality standards. Examples of these changes include establishing super-sites for major emergencies; having dedicated specialist centres for complex care like stroke, establishing specialist streams for elective surgery and providing comprehensive models of care for rehabilitation services. Services on sites primarily dedicated to rehabilitation, including the Repatriation General Hospital, St Margaret's Rehabilitation Hospital and Hampstead Rehabilitation Centre will be integrated to other major hospitals.

Super-sites for major emergencies

- > The new Royal Adelaide Hospital (new RAH) will be the major multi-trauma hospital for the state.
- > The new RAH, Flinders Medical Centre and Lyell McEwin Hospital will be super-sites for Major Emergencies.
- > The Queen Elizabeth Hospital and Modbury Hospital Emergency Departments will continue to support local communities, but life-threatening emergencies will go directly to sites with 24/7 specialist care.
- > The Noarlunga Hospital Walk-in Emergency Clinic will be established, replacing the existing emergency model of care, and will include a physical upgrade.

We need to be clear about the different roles of our hospitals. Not all hospitals can provide the same level of access to specialist treatment and diagnostics – South Australia simply doesn't have the population and number of specialists available to be able to manage major emergencies at seven different hospitals, 24-hours a day, seven days a week. Specialists and their teams need to undertake minimum numbers of complex procedures to maintain their high skills, but if they are at sites that do only small numbers of those procedures, they risk reducing their skills in that area, which can put patients at risk.

The outcome for a patient – whether they recover well or poorly – depends most on receiving the right care once they are at a hospital, which means having the right specialist staff, the right equipment and technology, the right testing capabilities and the right treatments.



Most people currently treated at emergency departments are not experiencing life-threatening conditions. For example, at Noarlunga Hospital, the existing emergency department admits only seven percent of the people who go there. Eighty seven percent are treated and return home. About six percent are transferred to another hospital because their conditions are more serious and Noarlunga Hospital is not equipped to provide them with the care they need.



Clinical Standards of Care to be achieved

Many of the standards developed by the clinicians relate to minimum numbers of procedures to achieve the best results for patients: for example Standards 221, 254, 266 and 268. Standards that relate to the availability of particular types of medical staff for the best care include Standards 172 and 192.

South Australia simply doesn't have the population and number of specialists available to be able to manage major emergencies at seven different hospitals, 24-hours a day, seven days a week.

Patient journey

NOW...

Emily's 8-year-old son Braedon is kicking a ball with friends when he slips and cuts his knee open. Emily takes him home and cleans the wound but it continues to bleed, so she thinks it may need stitches. The local GP is closed on Sundays, so Emily takes Braedon to the local emergency department. Braedon is assessed quickly by the paediatric emergency team but the clinicians become involved in managing major trauma care for three people severely injured in a car accident. As Braedon's condition is not life threatening, he and Emily wait three and a half hours before he receives stitches.

WHEN TRANSFORMED...

Emily and Braedon go to the Noarlunga Hospital Walk-in Emergency Clinic for Braedon's stitches. As the clinic is not trying to treat complex conditions or major trauma, Braedon is seen, treated and home within an hour. The ambulance has taken the three people involved in the car accident directly to a Major Emergency Department.



We want to be clearer about the roles of the different hospitals and also reduce the amount of time people have to wait for the simpler procedures, such as stitches or treating broken limbs.

This will reduce delays to decisions and treatments, resulting in lower mortality rates, better recovery and less time in hospital.



Why will this be better?

People with complex, life-threatening conditions will have the specialist expertise they need from the moment they enter a Major Emergency Department, including access to specialist clinicians, the equipment needed for diagnostic tests, quick test results and the full range of support services such as allied health that is needed for a speedy recovery.

Major Emergency Departments will reduce delays to decisions and treatments, resulting in lower mortality rates, better recovery and less time in hospital.

People with urgent but less-serious conditions will be able to be seen more quickly in most cases and closer to their home because staff will be skilled and experienced with the urgent treatments needed and not called away to the more complex, life-threatening situations that are better treated at the super-sites.



Clinical Standards of Care to be achieved

There are a large number of Standards related to emergency pathways. A small number of examples are included here.

8. Care should be delivered in the right place, by the right person, the first time and every time.
10. Care should be delivered in the most appropriate cost effective venues as close to home as safely possible.
45. The skill mix and number of staff in healthcare facilities should be matched with the needs and flow of patients.

How will this happen?

The Royal Adelaide Hospital is currently a specialist site for major trauma. This expertise will move to the new RAH, which will include capacity for major multi-traumas for the state.

The new RAH, Flinders Medical Centre and Lyell McEwin Hospital will be able to deal with a broader range of major emergencies because they will be able to have senior medical staff on site 24-hours a day, seven days a week, with coverage from the full range of medical specialties including complex injuries and multiple trauma events. This means quicker decisions by experienced staff, faster testing and results, and therefore swifter treatment.



These three hospitals will be the best places for treating major emergencies because they will have:

- > 24-hour access to cardiac interventional cardiology laboratories
- > 24-hour access to trauma surgery
- > full infrastructure support for acute care
- > 24-hour diagnostics and imaging services
- > more staff across key areas.

"So I think the evidence shows us that closer to home is not always safer and better."

Professor Dorothy Keefe P.S.M.

The Noarlunga Hospital Walk-in Emergency Clinic will enable faster treatment of urgent needs such as gastroenteritis, ear infections, bronchitis, cuts or other minor injuries.



Clinical Standards of Care to be achieved

275. Hospitals that receive patients with major trauma should have an emergency operating theatre and a radiology intervention suite situated sufficiently close to the emergency department to allow rapid transfer.

Patient journey

NOW...

University student Hùng lands heavily after a collision during a weekend football game. His leg appears to be broken and he is in great pain. A teammate organises an ambulance which takes Hùng to the local emergency department. After a four-hour wait, x-rays confirm Hùng has complex fractures and needs surgery. He is then transferred to the emergency department of a different hospital because it has the required specialties, technology and entire specialist team needed for the surgery. It is midnight when Hùng is wheeled to a bed to wait for surgery the next morning.

WHEN TRANSFORMED...

Hùng's teammates call an ambulance. Ambulance officers examine Hùng and call ahead to a Major Emergency Department. Soon after Hùng arrives, an x-ray is taken, which confirms he has a complex fracture. The required surgery is arranged. Following surgery late that afternoon, Hùng goes to the ward, where a member of the rehabilitation team talks to him about the first of his physiotherapy sessions.



***Does this mean I have to diagnose myself?
How will I know where to go or take a loved
one if they are sick?***

Any person who thinks they may be seriously ill should call 000 for an ambulance. Ambulances are like Intensive Care Units on wheels, so you know you are in the best place when you are very ill. The ambulance team will make a decision about the best hospital to take you to for the best care, first time.

Ambulances are like Intensive Care Units on wheels. The ambulance team will make a decision about the best hospital to take you to for the best care, first time.

We all currently make decisions about where we go when we are seeking medical treatment. This will still be the case but, as the roles of the different hospitals will be clearer, we will have better information when making that decision.

If you go to the Noarlunga Hospital Walk-in Emergency Clinic yourself but need higher level treatment at a Major Emergency Department, an ambulance will take you there.

In some cases you will then be admitted directly to the area of the hospital with the services you need, instead of having to go through the emergency department.

Why don't you just upgrade all emergency departments so they can deal with all types of emergencies? Wouldn't that improve care for everyone?

Even if all the specialist equipment needed for all major emergencies was installed at every hospital, there would not be enough specialist staff available or enough complex care patients to keep their skills at an optimal level. Our existing emergency departments do not all do the same scope of care and cannot provide full 24/7 care. Differentiating the care that will be available at each hospital means that we can provide full treatment for major traumas at every hour of the day, as well as treating people with urgent but less serious health problems more quickly.

"Many of our cases presenting to ED could be managed in other settings in the hospital."

South Australian clinician

Stroke services

- > 24/7 hyper-acute stroke unit at the Royal Adelaide Hospital.
- > Single service, multiple site model stroke services.
- > Dedicated stroke units at Lyell McEwin Hospital and Flinders Medical Centre.

For stroke patients, fast treatment at a specialised stroke unit can be the difference between life and death or the difference between long term disability and none.

When our clinicians examined the difference in mortality rates for stroke, they found that despite South Australia's internationally recognised stroke treatment pathway, there are unacceptable variations in death rates from stroke depending on the time or day of admission. We are not delivering consistent quality of care. Clearly we cannot continue to provide services in the same way when faced with evidence like this.

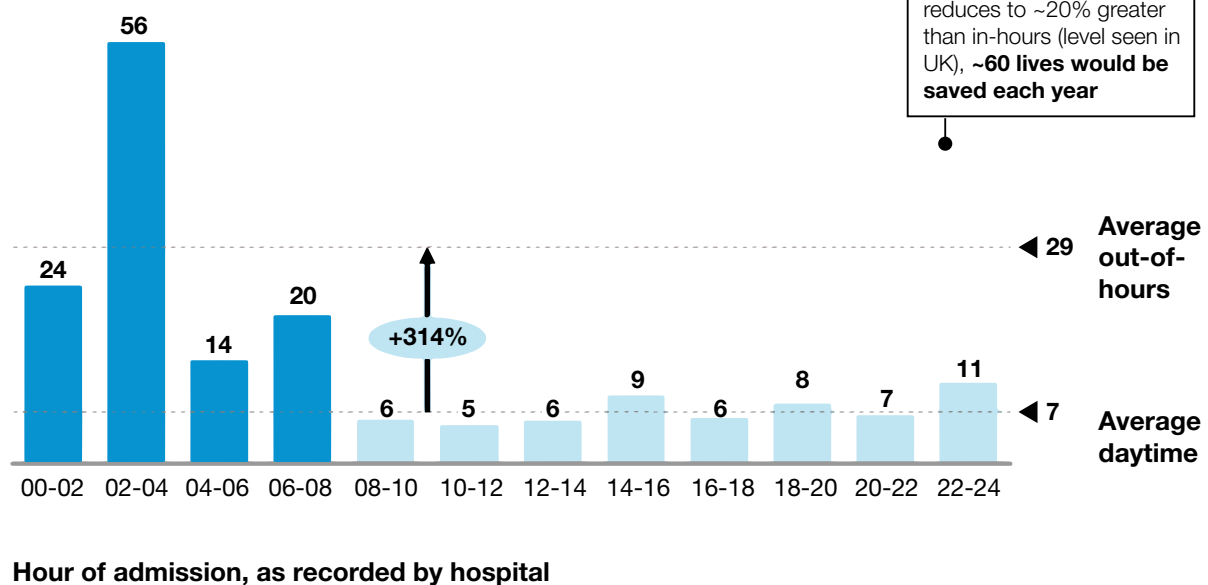
The Royal Adelaide Hospital will have a hyper-acute stroke unit that will have staff on site 24-hours a day, every day. Flinders Medical Centre and the Lyell McEwin Hospital will continue to provide in-hours emergency stroke and management of acute stroke for local residents in dedicated units.

Mortality rates are much higher before 8am

FY13; Stroke DRG volumes

Deaths per 100 ED presentations

Deaths per 100 strokes ED presentations



Source: SA Health (Data extracted 28/07/2014 – "All_Hospital_Inpatient_activity", 19/08/14 – Deaths and Comps – final")



Patient journey

NOW...

Pauline suffers a stroke during her Easter holiday break. At midnight, her partner Chris is shocked to see her mouth drooping, so calls an ambulance, which takes her to the local emergency department. A clinical decision is made that Pauline requires specialist staff and diagnostic equipment at a major hospital. Pauline is transferred to the hospital but the recommended stroke pathway can't begin because the required senior staff are not on site. Pauline's recovery is long and she does not regain full use of one side of her body.

WHEN TRANSFORMED...

Pauline is taken directly by ambulance to the new RAH and admitted to the 24/7 specialist stroke unit. The recommended stroke pathway begins from the moment Pauline arrives at the hospital because it has all the essential equipment and specialist staff on site. Avoiding delays and additional transfers makes a crucial difference to Pauline's treatment and she makes a full recovery.

Why will this be better?

People with stroke symptoms who are taken by ambulance direct to a stroke unit hospital will see experienced staff who have access to essential clinical expertise and equipment from the moment they arrive at the hospital doors. The time lapse in treatment for stroke is a crucial determinant of successful care.

Currently, the stroke pathway is not enacted overnight because the required senior staff are not on site at the hospitals. Patients who have strokes before 8am cannot access a service with full specialist teams, so their treatment is delayed. A 24/7 service will save lives.

One service that operates out of three sites will also create consistent quality of care. There will be more opportunities for hospitals to co-operate for research and education, and to strengthen links between related services such as stroke and neurology services.



How will this happen?

The Royal Adelaide Hospital will provide on-site staff and rural thrombolysis support service 24-hours a day, seven days a week, as well as neuro-interventional and neurosurgical services. This model will continue at the new RAH when it opens.

Flinders Medical Centre and Lyell McEwin Hospital will provide a stroke service in-hours, and after-hours emergency and acute strokes will be treated at the Royal Adelaide Hospital. Lyell McEwin Hospital, Flinders Medical Centre and the Royal Adelaide Hospital will provide acute stroke rehabilitation care. Some patients with acquired brain injury will also be able to access acute rehabilitation services within these dedicated stroke units. The Queen Elizabeth Hospital will provide brain injury and stroke rehabilitation for local patients following their discharge from the Royal Adelaide Hospital and Lyell McEwin Hospital, and an expanded rehabilitation service at Flinders Medical Centre will provide the same sub-acute rehabilitation for patients from their respective catchment areas

Clinical protocols will be adopted across all sites for standardised care quality and benchmarking.

There are existing parameters of acceptable travel times used by the SA Ambulance Service and they will not change.

Will travelling further to a specialist site increase my risk because it takes longer to get care?

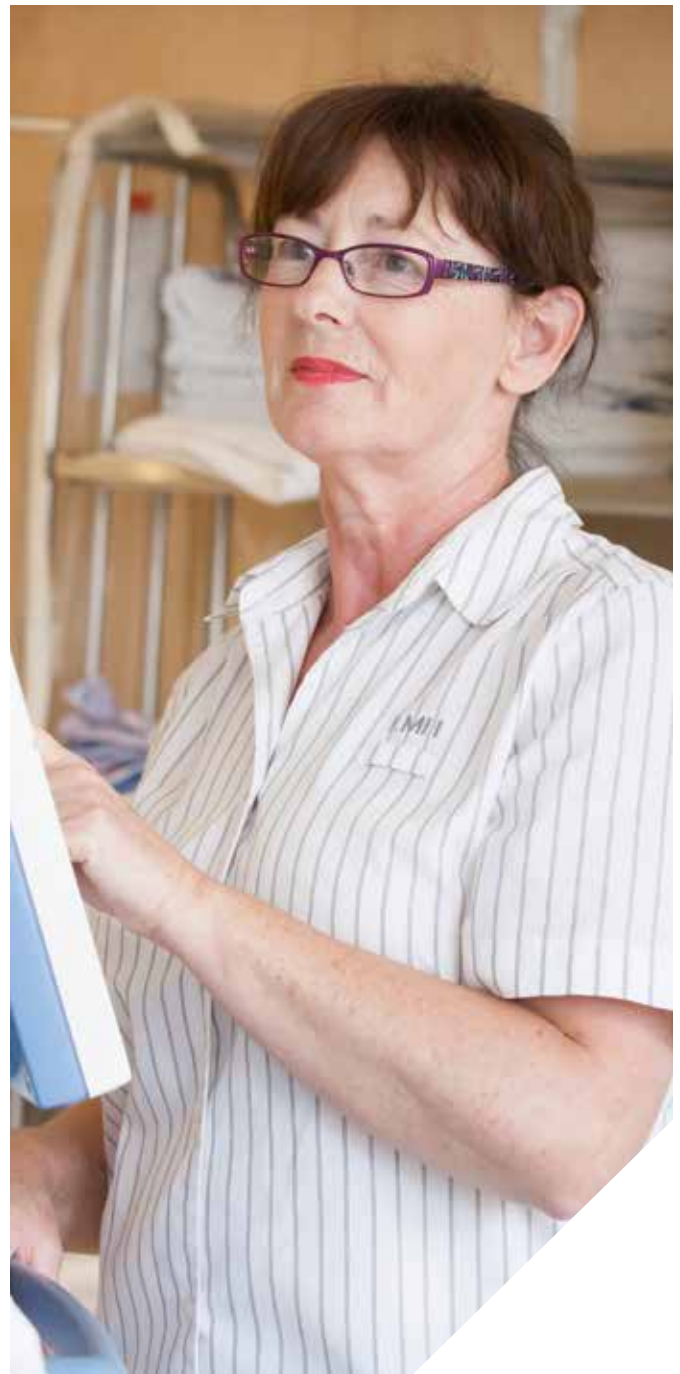
Going to a close site that doesn't have the required expertise, equipment and experience means a greater delay before you get the right treatment, increasing your risk significantly. Accessing the right care, first time may mean some more travelling time but will result in a quicker overall treatment and increase chances of recovery.



Clinical Standards of Care to be achieved

8. Care should be delivered in the right place, by the right person, the first time and every time
11. Quality of care should be determined by patient reported outcomes, patient clinical outcomes and system outcomes.
19. Practice should be evidence-based where sufficient evidence or evidence-based guidelines exist. Where a new practice has been demonstrated to be successful, it should be replicated across the entire system.
20. Effective and efficient models of care should be regularly updated and replicated across the entire system.
23. Principles, protocols, pathways and procedures are statewide, and should include telehealth and patient transfers where necessary. This can be facilitated through co-ordination of services across multiple sites including across Local Health Networks (LHNs) and statewide networks.
280. The evidence based stroke pathway (see SA Health's Stroke Management Procedures and Protocols, September 2014) should be in operation across South Australia. Patients should be managed according to this pathway and outcomes should be monitored for service improvement.
281. There should be a designated 24-hour acute stroke unit and, outside of agreed hours, all stroke patients should be sent to this facility.
282. Door to needle time for a stroke should be less than 45 minutes during normal working hours and 60 minutes after hours. An initial medical assessment should be completed in the first 15 minutes and CT scan within 30 minutes during normal working hours and 45 minutes after hours.

Accessing the right care, first time may mean some more travelling time but will result in a quicker overall treatment and increase chances of recovery.



Orthogeriatric services

- > A single statewide model of care for orthogeriatric services will be developed.

Orthogeriatric services take care of older people with fragility fractures, with hip fractures being the most common. Fragility fractures are highly risky for older people; they may not fully recover their mobility because of permanent injury or deconditioning while in hospital, or in some cases it may mean death.

The longer a person waits for the right treatment, the worse their overall health outcome will be.

Fragility fractures in older people are currently treated at all major hospitals in South Australia. Hospitals operate independently from each other, have no standard pathways, and sometimes limited input from allied health and geriatric care.

An older person arriving at their local emergency department could wait up to 12 hours before being transferred to a ward and they could be many days on the ward before they are prepared, fit and ready for theatre. It is not uncommon for someone to remain in hospital for up to two weeks following surgery, with only limited allied health support to help them out of bed and to get mobile.

Hospitals are particularly hazardous for older people. The longer someone remains in hospital, the higher the risk of condition deterioration, infection, falls and more fractures.

An older person with a fragility fracture could reasonably expect a 17 to 25 day stay in hospital before they are discharged to their place of residence.

Why will this be better?

The improved model of care means when appropriate, a person will be made ready for theatre within 24-hours and then mobilised on the first day after their surgery, with in-reach rehabilitation services on a dedicated orthogeriatric unit.

It is expected that their length of stay in hospital will be reduced by approximately 25 percent, greatly improving their health outcomes. Reducing waiting time in hospital will reduce fractures, functional decline and deterioration.

How will this happen?

A single statewide care pathway will focus our orthogeriatric units with integrated ward gyms for acute rehabilitation at three hospitals; The Queen Elizabeth Hospital, Flinders Medical Centre and Lyell McEwin Hospital.



The service will be senior-led with geriatric, orthopaedic and anaesthetic consultant staff and offer best practice care with access to a falls prevention program, direct access to a dedicated orthogeriatric unit, and early assessment from all relevant allied health professionals. This enhanced service will provide better co-ordination and more timely input from the team members looking after the patient, including emergency personnel, geriatricians, orthopaedic surgeons, specialist nursing, allied health professionals, anaesthesia and rehabilitation services.



Clinical Standards of Care to be achieved

8. Care should be delivered in the right place, by the right person, the first time and every time.
11. Quality of care should be determined by patient reported outcomes, patient clinical outcomes and system outcomes.
19. Practice should be evidence-based where sufficient evidence, or evidence-based guidelines exist. Where a new practice has been demonstrated to be successful, it should be replicated across the entire system, replacing superseded practices
20. Effective and efficient models of care should be regularly updated and replicated across the entire system.
23. Principles, protocols, pathways and procedures are statewide, and should include telehealth and patient transfers where necessary. This can be facilitated through co-ordination of services across multiple sites including across Local Health Networks (LHNs) and statewide networks.

111. There should be geriatrician input into related elderly patient pathways to optimise outcome, for example, orthogeriatrics and geriatric oncology. Surgical pathways for the elderly should include perioperative care to manage comorbidities.
120. To provide effective acute care services to older people, a hospital requires a multidisciplinary consultancy service, led by trained geriatricians working closely with nursing and allied health staff, with a process to facilitate early referral.
123. Acutely unwell elderly patients should see a geriatrician within 24-hours (in person or via telehealth).
125. Screening for and prevention of functional decline within inpatient facilities should occur within the first 24-hours after admission, for any patient expected to stay longer than 72 hours.
135. For the elderly person requiring surgery, correctable comorbidities should be identified and optimised immediately so that surgery is not delayed by anaemia, anticoagulation, volume depletion, electrolyte imbalance, uncontrolled diabetes, uncontrolled heart failure, correctable cardiac arrhythmia or ischemia, acute chest infection or exacerbation of chronic chest conditions.
137. Hip and other fracture surgery should be scheduled on a planned trauma list where an appropriately skilled team is available to undertake the procedure.
138. Unless medically or surgically contraindicated, mobilisation should start the day after surgery, with full weight bearing as an aim.
139. If unable to meet the criteria for early supported discharge, inpatient rehabilitation should be considered for those in whom further improvement with a structured multidisciplinary program is anticipated.

Comprehensive rehabilitation services

- > New or upgraded rehabilitation facilities at five metropolitan hospitals.
- > Expansion of Rehabilitation at Home services.
- > Expanded nurse-led recuperation centre.

Rehabilitation is most successful when it starts as soon as a patient is ready but stand-alone rehabilitation services mean that patients must be transferred from hospital to another site before their rehabilitation can start.



Patient journey

NOW...

Marta has a hip replacement and can't be transferred to the off site rehabilitation facility until she is medically stable. This takes 12 days and, because she is transferred on a Friday afternoon, no rehabilitation is available until Monday so she can't start any intense rehabilitation until two weeks after her operation. She de-conditions – reducing her ability to use her legs – resulting in her total recovery time being much longer.

When Marta is mobile and feeling better, she stays in rehab for another two weeks because she doesn't have anyone at home to help her with the few things she is unable to manage by herself.

WHEN TRANSFORMED...

With the new integrated rehabilitation service, Marta begins rehabilitation at the bedside as soon as she is well enough, instead of waiting for a transfer to a rehabilitation centre. In addition, she can move to a nurse-led recuperation centre until she is ready to go home. She recovers more quickly and returns home much sooner.



Stand-alone rehabilitation facilities can't provide the medical speciality care needed to manage a person's medical condition. They can only provide rehabilitation care to patients who are medically stable. This means delays to treatment starting, longer times before patients can return home and can also result in poorer recovery for patients.

Integrating acute, sub-acute and ambulatory (day) rehabilitation into acute hospitals will improve quality care first time, every time and support our health professionals to deliver best practice care.

The Rehabilitation at Home initiative will provide increased access to rehabilitation for people who are well enough to go home but need support for their ongoing rehabilitation. Rehabilitation specialists and allied health teams working across the hospital and home services will follow up with patients once they have left the hospital, providing continuity of care and ensuring that recovery continues to improve.

Why will this be better?

Effective rehabilitation needs to start early and be available at sites that can meet patients' full medical needs. This will mean better recovery, faster recuperation and better support closer to home.

Reducing the delay in starting rehabilitation reduces the risk of deconditioning and means patients are better able to gain full mobility. Shorter stays in hospital also reduce the risk of hospital-acquired infections, which can mean they recover more quickly.



Clinical Standards of Care to be achieved

16. Healthcare services should be offered seven days a week, every week. Human and infrastructure resourcing should be aligned to achieve this.
17. There should be seven day a week access to allied health and other clinical support.

How will this happen?

Flinders Medical Centre will expand its rehabilitation facility providing acute rehabilitation services in the dedicated stroke and orthogeriatrics units, and sub-acute and ambulatory (day) rehabilitation services including a new therapy pool.

Modbury Hospital will become a major rehabilitation and sub-acute services centre for the north, with a particular focus on ambulatory (day) rehabilitation and geriatric care. The existing rehabilitation ward will be expanded and a rehabilitation gym and pool will be built.

Lyell McEwin Hospital will provide acute rehabilitation for patients in the dedicated stroke and orthogeriatrics units.

The new RAH will provide specialist acute rehabilitation for people with spinal and brain injury.

The Queen Elizabeth Hospital will be the statewide centre for long-term, post-acute rehabilitation for spinal injury and brain injury where there are associated behavioural disorders. A rehabilitation and allied health space will be developed, as well as a therapy pool. The Queen Elizabeth Hospital will also provide acute and sub-acute orthogeriatrics and stroke rehabilitation for local residents.

The Repatriation General Hospital, Hampstead Rehabilitation Centre and St Margaret's Rehabilitation Hospital are primarily dedicated to rehabilitation. These services will be integrated to major hospitals.

The Repatriation General Hospital will have some significant areas retained, with the surrounding space made available for uses that are compatible with the history of the site. St Margaret's Rehabilitation Hospital is a dedicated community health asset and will have a continued health focus into the future. Discussions will take place with other users of the Hampstead Rehabilitation Centre to determine the most appropriate future use of the site.



Clinical Standards of Care to be achieved

8. Care should be delivered in the right place, by the right person, the first time and every time.
11. Quality of care should be determined by patient reported outcomes, patient clinical outcomes and system outcomes.
19. Practice should be evidence-based where sufficient evidence, or evidence-based guidelines exist. Where a new practice has been demonstrated to be successful, it should be replicated across the entire system, replacing superseded practices.



20. Effective and efficient models of care should be regularly updated and replicated across the entire system.

23. Principles, protocols, pathways and procedures are statewide, and should include telehealth and patient transfers where necessary. This can be facilitated through co-ordination of services across multiple sites including across Local Health Networks (LHNs) and statewide networks.

52. No patient should remain in a setting where they are not being actively managed.

58. Acute patients requiring inter-specialty input should be seen by those specialists in a timely manner.

91. Rehabilitation should be started immediately post operation.

145. The rehabilitation multidisciplinary team should have sufficient skills and training to address patient impairments, activity limitations and participation restrictions, to help patients achieve their optimal level of functioning and participation in society.

146. Rehabilitation pathways should be in place and involve treatment goals, periodic assessment and documentation of the functional status of patients, regular case discussion amongst treating practitioners, and attention to the optimal management of concurrent medical problems and psychosocial issues.

147. The rehabilitation pathway should include direct ward admission for allied health monitored chronic conditions.

148. Each patient should be reviewed by a consultant within 24-hours of admission to a rehabilitation ward, using telehealth where appropriate.

149. Each patient should be reviewed by a consultant at least twice a week. Appropriate rehabilitation equipment should be available and easily accessible at appropriate service sites.

150. Lifestyle intervention strategies should be developed and implemented in rehabilitation settings to reduce preventable complications and consequences for high risk patient.

151. Outpatient services will provide timely patient access to appropriate consultations, diagnostic and treatment facilities and interventional and therapy areas.

Specialist centres for elective surgery

- > Noarlunga Hospital will provide a specialty service for single-day elective surgery.
- > The Queen Elizabeth Hospital will be a specialty service for multi-day elective surgery.
- > The new RAH will be a specialty service for high-complex multi-day elective surgery.

Interstate experiences have shown that specialist services for elective surgery can result in shorter waiting times, shorter stays in hospital and better health outcomes for patients.

We will establish three specialist services for elective surgery – one specialising in single-day surgery at Noarlunga Hospital, the second focussing on multi-day surgery, at The Queen Elizabeth Hospital, and the third focussing on multi-day high-complex elective surgery at the new RAH.

Why will this be better?

In 2012-13, more than 11,000 elective surgeries were postponed in our major metropolitan hospitals, many because the surgical theatre was not available. Elective surgery theatres are sometimes made



available for emergencies and surgeons are often called away from elective surgery to emergency departments, but this rarely happens if there are separate, dedicated streams for elective surgery.

Dedicated elective streams will mean fewer postponements, shorter waiting lists and better planned and managed care for patients. It will also reduce emergency surgical team members being distracted by elective surgery, improving their ability to focus on emergency work.

Evidence tells us that the most experienced health teams deliver the best outcomes for patients and that some specialty services need a minimum number of patients for safe, quality care standards to be met. Health teams focussing on particular types of elective surgery will improve their skills and effectiveness, resulting in better quality outcomes for patients. Doctors in training can also attend these sites to become skilled in elective surgery procedures.

The size of South Australia's population and need for services supports three elective surgery streams.



Clinical Standards of Care to be achieved

- 81. In specialties with a high emergency workload, the surgical team should be free of elective commitments when covering emergency and consultants should not cover more than one site.
- 86. Post-operative management should be standardised by procedure as part of a clinical pathway.
- 92. Nurse practitioners should be utilised across the surgical system to improve efficiency.

- 161. Where possible, patients should be triaged based on need for surgery or not. Those definitely not requiring surgery should be diverted to non-surgical services such as allied health led clinics.
- 162. There should be adequate allied health services to support our elective surgery pathways.
- 164. Pre-operative assessment should be carried out to determine and optimise fitness for procedure; effective models should be introduced. For example, SA Health model of telehealth care.
- 166. Day surgery should be performed where possible; rates should rise to meet international norms.
- 167. There should be dedicated elective surgery lists with separate resources that are not impacted by emergency surgery demands.
- 169. Appropriate waiting list metrics should be measured and benchmarked against statewide and national targets. These should align with urgency categories. For example, time from referral to first assessment and from first assessment to treatment.
- 172. There should be a minimum of two anaesthetists for any stand-alone surgical sites.
- 173. Patients presenting with acute conditions requiring urgent surgery that is appropriate for managing as a day case should be treated as such via a semi-elective pathway.

Patient journey

NOW...

Eleni organises a house sitter to care for her pets in readiness for her long-awaited knee replacement surgery. Eleni's son, Dimitris, arrives early at Eleni's rural retirement village to drive her to the city hospital. Eleni has been fasting from midnight. When Eleni and Dimitris arrive at the admission centre, they are met by apologetic administration staff. Her surgery has been cancelled. The winter flu epidemic has meant emergency department patients have been admitted to hospital for treatment, many with severe respiratory distress. No beds will be available until clinicians start rounds to see patients who waited over the weekend for discharge. To manage critical overcrowding in the emergency department, planned elective surgery has been cancelled for the day. Admission staff inform Eleni they will be in contact to reschedule her surgery, working around the specialist surgical team's next availability in their busy diaries.

WHEN TRANSFORMED...

Eleni has her surgery booked with a specialist elective surgery team at the dedicated elective surgery centre. She knows her surgery will go ahead that day because surgeons won't be called away to emergency cases, which are now dealt with by a different stream at that site. Across the metropolitan area, waiting lists for elective surgery are significantly reduced.





Most elective surgery is once-in-a-lifetime for that condition. Closest to home won't always be better for those treatments.

How will this happen?

The Queen Elizabeth Hospital will become the specialty centre for multi-day elective surgery procedures, which are more suitable for patients who have complicating factors such as diabetes or obesity.

The new RAH will provide a dedicated specialty elective stream for highly complex elective surgery.

Noarlunga Hospital will provide a speciality service for single-day elective surgery. Patients will have their surgery and return home safely on the same day.

The most efficient, effective and safe systems and processes will be developed for the different patient needs. Assessment, scheduling, pre-surgery preparation, care and ongoing management at home will be tailored to the different requirements associated with going home on the same day or staying several days.

More complex routine elective surgery, for example, for patients with multiple complicating factors, who may need intensive care support after their operation,

will continue to be provided at the new RAH, Flinders Medical Centre and Lyell McEwin Hospital for their local patients.

Elective non-surgical therapy that is required regularly and frequently, such as chemotherapy and dialysis, will be available at many sites across the state, so it is as close to home as safely possible.

Will I have to travel further for elective procedures?

The type of elective surgery you need and whether or not you have any complicating factors will determine which site you go to. The decision will be based on where you can get the best, most appropriate care for your procedure and health circumstances.

Most elective surgery is once-in-a-lifetime for that condition. Closest to home won't always be better for those treatments. The type of treatments that are frequent or ongoing will be offered across many hospitals.

Cardiothoracic surgical services

- > A single statewide cardiothoracic surgical service will be created.
- > Specialist sites will be available at the Royal Adelaide Hospital and Flinders Medical Centre.

Flinders Medical Centre and the Royal Adelaide Hospital will provide routine cardiac and thoracic surgical services. Flinders Medical Centre will focus on complex cardiac surgical cases and the Royal Adelaide Hospital will focus on complex thoracic surgical cases, optimising the skill set of each hospital.

Why will this be better?

A statewide cardiothoracic service will consolidate the high level of skill among practitioners and their teams, which will improve the quality of cardiothoracic patient care. Cardiothoracic surgery is very complex and requires a high level of skill and supporting infrastructure. These two sites will work together in a single statewide service to ensure patients are treated in the right place to receive the most expert care.

There is no scope in South Australia to have more than two sites for this surgery because we must ensure specialists and their teams can perform a high volume of procedures to continuously improve and maintain their skill levels. Doing so will ensure high-quality outcomes for patients.



How will this happen?

Flinders Medical Centre will focus on complex cardiac surgical cases and the Royal Adelaide Hospital will focus on complex thoracic surgical cases. Both will continue to provide non-complex services in each cardiothoracic sub-specialty. This model will continue at the new RAH when it opens.

Referrals, inter-specialty case assessment, waiting lists, data collection and auditing will improve wait times, case allocation, use of operating theatres and critical care facilities, and clinical outcomes, as they will be co-ordinated and standardised under the single-service, multi-site model. A referral co-ordinator and dedicated perioperative co-ordinator will be appointed.

The sites will be aligned with associated clinically interdependent services such as trauma, interventional cardiology, critical care units, anaesthesia and rehabilitation, to support fast recovery for patients.

The Queen Elizabeth Hospital, which currently undertakes a small number of procedures, will no longer provide thoracic surgical services.

Patient journey

NOW...

Rachel is sitting at home one night watching TV when she experiences chest pains that are travelling through to her back. She agrees with her husband Cyril's suggestion that he drive her to the local emergency department. Her pain worsens as they arrive. The pair explain the situation to the triage nurse and Rachel is called in to begin monitoring. It is not clear what the diagnosis is, so Rachel is then transferred to an emergency department at a neighbouring major hospital where she can be assessed by the cardiology team. They determine that she has a tear in her aorta – the major artery of the heart – and they transfer her to the emergency department of a third hospital so she can be assessed by the cardiothoracic surgical team. The team determines that she needs emergency surgery.

WHEN TRANSFORMED...

Cyril calls 000 and the experienced ambulance crew reviews Rachel's chest pain and provides a fast assessment. The crew notes that she has a history of high blood pressure and they begin immediate heart monitoring – while speaking directly to a cardiology specialist – and also offer pain relief. They stabilise Rachel ready for her direct transfer to the cardiology team. The cardiology team conduct specialised tests and confirm that she has a tear in her aorta. The cardiology team transfer her directly to the Intensive Care Unit at Flinders Medical Centre where she is prepared for emergency surgery by the critical care and cardiothoracic teams. Rachel is treated promptly and so recovers sooner.

Women's and Children's care

- > The co-location of the Women's and Children's Hospital and the new RAH will be accelerated.
- > Statewide services will be under the care of the Women's and Children's Hospital.

The relocation of the Women's and Children's Hospital to the new RAH site will be brought forward as much as possible so that Women's and Children's services are alongside an adult intensive care unit and a wide range of adult specialty services are available for mothers.

The Women's and Children's Hospital will be a centre of excellence in complex maternity, neonatal and paediatric services.

The Women's and Children's Hospital will provide:

- > a statewide service for high complex maternity and neonatal care
- > statewide service for complex gynaecology
- > statewide service for paediatric surgery
- > specialist 24/7 emergency service for children.

Some of these statewide services will be delivered at other sites but under the care and direction of the Women's and Children's Hospital.





Why will this be better?

Consistency and quality will be improved because each site will provide the care for which it is best equipped. This will be the safest option for women, babies and children. Where this safety focus means greater distances to travel, for example for best maternity care, the disadvantages will be explained to women so they can make educated decisions about their care.

In South Australia, the Women's and Children's Hospital provides the highest acuity care for mothers and babies. However, if the mother becomes very sick after she gives birth, she has to be separated from her newborn and taken to a major hospital because there is no adult Intensive Care Unit at the Women's and Children's Hospital.

The relocation of the Women's and Children's Hospital to the new RAH site will mean mothers and babies will stay together, even if there is a medical emergency, reducing stress, enhancing bonding and assisting early childhood development.



Clinical Standards of Care to be achieved

There are a large number of Standards related to maternity, neonatal, paediatric and gynaecological care. A small number of examples are included here.

- 184. There should be a statewide co ordinated and networked paediatric trauma service.
- 187. Service hubs (metropolitan and regional) should support sufficient volumes of services to ensure clinical expertise, quality and safety of services.
- 214. Level 6 Neonatal Intensive Care Units (ICUs) should be co-located with a tertiary obstetric hospital with access to an adult ICU and a tertiary paediatric hospital.
- 226. A facility that delivers babies should have ready access to adult services. Facilities doing high-risk births should have access to an adult ICU.
- 254. All sites doing highly complex gynaecological surgery should meet minimum volume standards to maintain a high quality service.

How will this happen?

The new Women's and Children's Hospital will co-locate and become integrated with the new RAH.

Flinders Medical Centre will continue to provide care for all but the most extremely sick babies. The most acutely ill newborns (known as Level 6 neonates) will be cared for at the Women's and Children's Hospital, ensuring medical staff can specialise and share expertise for this small number of highly vulnerable babies.

Low risk, non-complex maternity will continue to be available at sites as close to home as possible.

New specialty eye centre for South Australia

> A new dedicated elective eye centre will operate at Modbury Hospital.

Ophthalmology day procedures will be specialised at the new dedicated eye centre at Modbury Hospital, enabling our top eye specialists to share knowledge and constantly improve their service. Ophthalmology includes procedures like cataract removal, laser corrections, treatment of glaucoma and other diseases and infections of the eye.

Why will this be better?

Eye care is currently provided through separate stand-alone services in each hospital, meaning there is limited coverage at weekends or after midnight and expert knowledge is not always easily accessible. The new specialty centre will provide a statewide elective service that will develop and ensure consistent quality standards of care in the treatment of eyes across all hospitals. This will mean better co-ordination so that new evidence can be quickly translated into practice through one statewide team rather than dispersed multiple teams.

A specialty centre will also create more capacity for study and research.



How will this happen?

Modbury Hospital will provide a statewide centre for elective eye care and will also provide in-reach eye services to other facilities. For example, it will support the new RAH to manage multi-trauma patients with eye damage.

Mental health

- > Where appropriate, acute mental health consumers will be directly admitted to a mental health bed, avoiding the emergency department.
- > Mental health clinicians will be aligned with Local Health Network boundaries.

Transforming Health is about delivering consistent, safe and quality care to meet current needs and prepare for future challenges. This is important for all patients, including mental health consumers.

Transforming Health aims to strengthen and ensure a whole-of-health approach to mental health services.

There are mental health beds at all metropolitan hospitals and where appropriate, mental health patients requiring acute care will be admitted directly to a mental health bed, avoiding the emergency department altogether.



Mental health boundaries and bed management processes will be primarily aligned with local health network boundaries and systems.

Why will this be better?

Increased demand for mental health services places pressure on emergency departments and acute units, mental health consumers, families and staff.

Currently, mental health consumers needing acute care must attend the emergency department before they can be admitted. This process can cause delays in accessing timely and appropriate care, additional distress for mental health consumers and backlogs in emergency departments.

The new approach will improve access, lessen distress for consumers, reduce the likelihood of their condition deteriorating and ease backlogs.

Alignment of mental health with the Local Health Network boundaries will improve co-ordination of care between mental health and general health, which will improve overall services for mental health consumers and their families.

How will this happen?

The model of care facilitated by Transforming Health will mean some mental health consumers will be admitted directly to a mental health unit where appropriate.

Some patients who are intoxicated or drug affected and experiencing mental health issues will need a short stay in an emergency department if medical care and stabilisation is required.



Clinical Standards of Care to be achieved

97. Equity of access, quality and speed of service should be ensured for people seeking acute mental health care. Safety of mental health and non-mental health patients and care-givers is a priority.
103. Mental Health care in the emergency department is provided by a combination of general emergency department clinicians and mental health clinicians including nurses, mental health and allied health.

Patient journey

NOW...

Andre is experiencing another acute anxiety attack one weekend but is unsure where to go for help. He arrives at his local emergency department and waits four hours to be diagnosed and treated. The emergency department is very busy and noisy as hospital staff help higher priority patients injured in a car accident and a person suffering from a drug overdose. Andre's symptoms worsen in this highly stressful environment.

WHEN TRANSFORMED...

Andre contacts his regular mental health service about how he's feeling. A mental health nurse discusses Andre's symptoms with him, reassures him he is safe and advises him on some coping mechanisms to help with the anxiety attack. Andre is calmed and the mental health nurse provides a referral for further evaluation and treatment without the need to visit Emergency.

If Andre had required a hospital admission the nurse would have arranged a direct admission, avoiding Emergency and enabling Andre to arrive at the hospital more relaxed and prepared for his evaluation and treatment.

What the Government has done so far

The Government continues to work hard to ensure that our health system gives mental health consumers the right care in the right location.

This is central to Transforming Health.

The Government has:

- > Set new targets for the mental health sector:
By January 2016, no mental health consumer should wait more than 24-hours for admission to an acute hospital bed. By July 2018, 75 per cent of mental health patients should be admitted within four hours, and 90 per cent within eight hours.
- > Opened new mental health beds at Lyell McEwin Hospital, Flinders Medical Centre and Glenside Health Service, easing the pressure on our emergency departments.
- > Planned to open six new mental health beds in Mount Gambier and a further 10 forensic mental health beds at James Nash House.
- > Opened 12 new mental health beds in Whyalla and Berri to provide acute mental health care services to country patients closer to where they live.
- > Introduced new governance structures for mental health services so they are clinician led, in line with other medical specialties.
- > Established a new Mental Health Advisory Group with mental health clinicians to focus on reducing patient waiting times in hospital emergency departments, improve access to acute mental health beds and resolve system blockages.
- > Appointed a new Director of Mental Health Strategy and began recruiting a new Chief Psychiatrist.

Better services for Veterans

- > Major funding will be provided for a Centre for Excellence for the treatment of Post-Traumatic Stress Disorder (PTSD).
- > Veterans will be involved in deciding a suitable new site for the Centre.

The current facilities for Veterans were built in 1942 for soldiers returning from war. The Repatriation General Hospital provided support and rehabilitation for physical injuries but modern technology now means that recovery is much faster. The buildings belong to the last century and can't provide the spaces, equipment and layout that is needed for modern medical treatments.

Current Veterans, such as those returning from conflicts in Afghanistan and Iraq, need ongoing, long term support for mental health recovery. South Australia has a national reputation for advances in the treatment of PTSD, with strong support for the services provided at Ward 17 at the Repatriation General Hospital. Adelaide will be the home of a new Centre for Excellence in the treatment of PTSD, which will be a national leader that incorporates research and innovation, as well as providing the high-quality facilities that we expect for the women and men who have served our country.



Rehabilitation will be available for Veterans and others at five different hospitals across the metropolitan area, as well as through the Rehabilitation at Home program detailed in the Comprehensive Rehabilitation Services section.

A Veterans' consultative process will be established so that the best options can be discussed with the different Veterans' groups.



Why will this be better?

The new Centre will provide dedicated, high-level expertise to all returned service personnel, using leading evidence-based practices and building on the renowned work of the existing PTSD team.

The main location for rehabilitation for Veterans is currently at the Repatriation General Hospital in Daw Park. It is a difficult location for some Veterans to access, including those who live and work near the Edinburgh defence precinct in the northern suburbs of Adelaide. The excellent service currently provided at the Repatriation General Hospital's Ward 17 is housed in old buildings that are unsuitable for a leading PTSD service.

How will it happen?

The Veterans' communities include those who served in World War II, Korea and Vietnam, and Veterans who have served in recent conflicts in countries such as Afghanistan and Iraq. The location of the PTSD Centre for Excellence must cater for their vastly different needs and preferences.

A Veterans' consultative process will be established so that the best options can be discussed with the different Veterans' groups. The sites considered by the Veterans' consultation group will be those with suitable outdoor spaces needed for people recovering from PTSD.

As the buildings at the current Repatriation General Hospital are no longer suitable for the high-level services our Veterans deserve, the services provided there will be integrated into our metropolitan hospitals. The Chapel and the Remembrance Garden will be retained for their considerable significance, particularly to WWII Veterans and their families. The existing prosthetics service will also remain on the site. The surrounding area will be made available for uses that are compatible with the history of the site.

Pathways for Veterans' care will be improved across all metropolitan hospitals to provide better care, closer to home, where appropriate.

Ambulance services

- > Ambulances will take patients to the right hospital, first time.
- > The ambulance fleet will be expanded and existing vehicles will be upgraded, where necessary.
- > Ambulance crews will be expanded.
- > Opportunities will be explored for constructing new ambulance super stations to house new vehicles and their crews.
- > How the skills and expertise of Extended Care Paramedics are used will be maximised.

South Australians deserve to get the right major emergency treatment, first time.

The ambulance will travel directly to the best hospital for a patient's condition. This does not mean treatment is delayed – getting to the right place, first time saves lives.

That means taking the patient straight to the best major hospital for their condition, where the right specialists have essential equipment and support staff.

The ambulance will travel directly to the best hospital for a patient's condition. This does not mean treatment is delayed – an ambulance is like an intensive care unit on wheels, and getting to the right place, first time saves lives.



For example, an ambulance crew will take a person with stroke symptoms directly to the major hospital stroke unit, where specialist staff are on standby.

If you go to the wrong hospital the first time and have to be transferred again by ambulance to a major hospital, time is wasted. SA Ambulance Service, emergency department and radiology staff all work together to achieve better outcomes by getting patients specialist treatment within the recommended time.

More ambulances and crews will be needed so the ambulance service can match the reconfiguration of the health system under Transforming Health, so extra funding will be needed to increase our ambulance fleet and ambulance crews. We will explore opportunities for the construction of new 'Super Stations' to house new ambulance vehicles and crews.



Patient journey

NOW...

Joan is a very frail but active 90-year-old who lives at a residential aged care facility. Reaching down to grab her walking stick, Joan slips and hurts her wrist. Staff at the nursing home fear her wrist is fractured and call an ambulance, which takes Joan to the closest emergency department. Due to a rise in emergency presentations of flu patients, Joan waits for two hours in the ambulance outside the emergency department before being taken inside, where she finds the noise and numbers of strangers confronting. After four hours, an x-ray shows Joan doesn't have a fracture but she does have a bad sprain. Her wrist is bandaged and she returns to the nursing home exhausted. Overnight, the nursing home staff notice Joan has developed a fever.

WHEN TRANSFORMED...

Joan's situation is assessed by ambulance officer Mei, who works as part of the Extended Care Paramedic team. Mei attends the nursing home, examines Joan and offers pain relief. Mei bandages Joan's wrist and organises an x-ray. Joan gets the all clear and is back in time for afternoon tea. Mei asks the nursing home to undertake a falls risk assessment for Joan and a medication review by her GP. Joan avoids a visit to the emergency department, where she may have been exposed to other patients with serious illnesses.

Investment in other care

- > An expanded nurse-led recuperation centre will support people who don't need to be in hospital.
- > A new Psychogeriatric ward will be created at Flinders Medical Centre.

Many patients, including the elderly and disabled, don't need to be in hospital but are not yet able to return home.

A nurse-led recuperation centre will care for older people who need some support and those who are waiting for a place in a nursing home, as well as others such as younger disabled patients who need extra assistance before returning home.

Why will this be better?

Appropriate care will be provided in a nurse led environment that is less clinical than a hospital, with more individualised support. Patients will receive help with activities of daily living to assist them in preparing for their return home. In addition, caring for patients in the nurse led recuperation centre will mean more acute hospital beds will be available for those who need high levels of medical care.

Psychogeriatric services look after older people with specific mental health needs, but acute medical geriatric services deal with other medical conditions. This can result in psychogeriatric patients having to be transferred to other areas for treatment.

Services at The Queen Elizabeth Hospital and Lyell McEwin Hospital will be enhanced and a new purpose-built ward will be built at Flinders Medical Centre to provide proximate care for elderly patients with mental health needs.

Why will this be better?

Better integration of psychogeriatric services with acute medical geriatric services will ensure that patients with any medical conditions or patients who start to become unwell can be effectively managed by specialists. An integrated service provided to the patient on the ward will mean fewer transfers.



Clinical Standards of Care to be achieved

9. Healthcare is provided by the most cost effective health worker while ensuring quality and safety standards are met.
10. Care should be delivered in the most appropriate cost effective venue as close to home as safely possible.
20. Effective and efficient models of care should be regularly updated and replicated across the entire system.



Community and other services

- > Better co-ordination of care to use existing out of hospital services.

One of the ways of achieving Transforming Health's overarching goal of best care, first time, every time, is better co-ordination of care for patients. Although GP care is not under the jurisdiction of the state health system it is a key component of people's healthcare. We will continue to develop ways to work better with GPs for better patient outcomes.

"We have great community-based programs that could prevent unnecessary hospital care, but they're largely underutilised."

South Australian clinicians

There are also better ways to use services that we already have in the state system, such as Healthcare@Home, Hospital@Home, Extended Care Paramedics and Nurse Practitioners. These experts can liaise directly with hospital-based services, helping people avoid unnecessary hospital visits.





Why will this be better?

Providing care in settings other than hospitals is better for patients because hospital stays can increase infection rates and the likelihood of falls and other risks.

Out of hospital services are usually more convenient for patients who need frequent services, such as those with chronic illnesses like diabetes. These kinds of services can be provided closer to home by improving ambulatory (day) care services and community-based services.

"Governments, at national and state level must invest more in disease prevention, health promotion and assisting people living with chronic health conditions such as asthma, high blood pressure or mental health conditions to control their health to the best extent possible."

*Adj Assoc Prof Elizabeth Dabars, ANMF,
'A Prescription for Change'.*

How will this happen?

Dedicated specialist teams will be used to co-ordinate and provide intermediate care in the community, meaning fewer people will need to be admitted to hospital.

Ambulatory (day) services will be increased and Healthcare@Home, Hospital@Home, Extended Care Paramedics and Nurse Practitioners will be fully utilised across the system.

Patient journey

NOW...

Nina lives with her husband Alexei and manages her Type 2 Diabetes with regular visits to the GP. While sitting down to read the weekend newspaper, Nina drops a cup of tea in her lap. She doesn't want to go to hospital to wait in an emergency department because she thinks it is 'just a superficial burn' and she will become very tired during the wait.

WHEN TRANSFORMED...

Alexei calls an ambulance and an Extended Care Paramedic, Graeme, visits Nina at home. Graeme assesses the wound and sends a photograph to the hospital's burns unit. He speaks to a specialist, who organises direct admission for Nina. Nina receives early treatment and can avoid a visit to the emergency department.

A few questions answered

What do these changes mean for staff?

All health professionals strive to provide patients with the best care. Transforming Health will transform our system so that all aspects of it can support and enable the delivery of a patient-centred system.

By creating enhanced opportunities for staff to lead and manage change that benefits their patients, Transforming Health will be professionally rewarding for those who work in our health system.

Transforming Health will also mean new opportunities through the development of new and expanded roles, including expanded practice roles, increased allied health capability and the creation of statewide speciality teams. Enhanced ambulatory and out of hospital care will also support staff to give their patients the full scope of treatment in the best place.

New ways of working will bring greater collaboration in hospitals, across sites and for the full range of health professionals. A greater focus on the entire health system in South Australia – not merely a solo service, isolated at a single site – will increase opportunities to improve services to patients. Expertise can be better shared across all sites, supporting the common goal and focus on the patient.

There will be changes for some staff in terms of where and how they work. Employee representatives will be involved to engage staff in the best ways to help deal with changes and accommodate their work preferences where possible.

How can we afford these changes?

The Capital Reconfiguration Fund, which was announced as part of the 2014 State Budget will

support Transforming Health initiatives including upgrades and construction of new facilities. The fund consists of money that was allocated for hospital developments and quarantined when Transforming Health began.

Other funding requirements will be met by running our metropolitan hospital services better. Services that have been spread too thinly to offer maximum effectiveness will now be co-located, providing better services for patients at reduced cost. Better quality healthcare is always less expensive because it means fewer complications and fewer repeat admissions.

Will we continue to need all the sites we currently have?

The Repatriation General Hospital, St Margaret's Rehabilitation Hospital and Hampstead Rehabilitation Centre currently provide services that will integrate to other major hospitals. Rehabilitation will be better integrated and a new facility will be developed for PTSD services currently provided at the Repatriation General Hospital's Ward 17. Palliative care services, elective surgery and outpatient services currently provided at the Repatriation General Hospital will also integrate to other locations.

The Repatriation General Hospital will have some significant areas retained, with the surrounding space made available for uses that are compatible with the history of the site. St Margaret's Rehabilitation Hospital is a dedicated community health asset and will have a continued health focus into the future. Discussions will take place with other users of the Hampstead Rehabilitation Centre to determine the most appropriate future use of the site.

Will we have fewer beds?

South Australia currently has more beds per head of population than the rest of the country yet patients still spend far too long in emergency departments, waiting for beds to become available in other parts of the hospital.

By reducing unnecessarily long stays in hospital and improving the flow through the system with better processes, like admission and discharge, we will not need as many beds.

"The test of a quality system is not how many beds it has, but how many people receive quality treatment."

Professor Dorothy Keefe P.S.M.

Greater access to services
= more people treated.

Better utilisation of beds = ability to
reduce beds + improved service.

Is administration of the health system being addressed?

Every part of South Australia's health system needs to support the delivery of the proposed changes and, as a result, consistent, safe and high quality care. Our entire system needs flexible and adaptable supporting systems and structures, a transparent, accountable and collaborative culture, and connected leadership.

The primary focus will be on how management can facilitate excellent clinical care and innovation. The Department for Health and Ageing is currently being reviewed to see how red tape can be reduced and to identify administrative structures that will best support the roll out of Transforming Health.

Are these final decisions?

The government is committed to improving quality and consistency of care across South Australia's health system. The proposals in this document have been developed by listening to the clinicians – doctors and surgeons, nurses and midwives, scientific and allied health professionals – and by looking at the quality standards they developed.

These proposals enable us to meet those quality standards; that means reducing significant variations in mortality rates for the same procedures, reducing the unnecessary time patients spend in hospitals, and expanding our existing pockets of excellence to the whole system.

It means improving services and outcomes for patients.

Feedback from the community, consumers and clinicians will be considered before final decisions are made.

Have your say

You are invited to provide feedback about the proposals by Friday 27 February 2015.

A template for feedback is available and can be returned by:

- > Using the form online:
www.transforminghealth.sa.gov.au
- > Email: transforminghealth@health.sa.gov.au
- > Post: Reply Paid 84208, Rundle Mall SA 5000
- > Freecall 1800 557 004

Appendix 1

Transforming Health Communiqué

Adelaide, Friday 28 November 2014

At an unprecedented gathering today, more than 600 South Australians have agreed that a transformation is required to ensure the State's health system delivers the best quality health care first time, every time, beginning with our metropolitan hospital system.

South Australia's health experts including doctors, surgeons, nurses, midwives, allied health and scientific and other professionals – joined consumers, representatives from the community, local government, unions, the public service and the non-government sector at the Transforming Health Summit.

The Summit follows five months of in depth evaluation of the South Australian hospital system which uncovered areas of excellence and areas where quality was lacking and inconsistent.

The Summit noted that during the first phase of consultation 2,225 submissions were received, 4,865 staff and community were directly engaged in the consultation process, and that over 90 percent endorsed the need for change and supported the Quality Principles.

Transforming Health is all about putting quality outcomes first for all South Australians so we can create the best healthcare system for our state.

The Summit noted that this process began with the formation of three Clinical Advisory Committees by the Minister for Health, the Hon. Jack Snelling M.P. who wanted doctors, surgeons, nurses, midwives and allied and scientific health professionals at the heart of the process so they could look closely at our system and understand what we do well and where we can improve.

The Summit also noted that the Clinical Advisory Committees developed the quality principles and standards needed to deliver a sustainable quality healthcare system to meet future healthcare needs of South Australians.

The Summit endorsed the approach of operating in partnership with clinicians and consumers at the core of our health system to increase the likely success of Transforming Health in building one of the world's best performing and most effective healthcare systems.

The Summit affirmed that evidence-based high quality patient-centred services are required across primary and secondary care, that consider the needs of all health consumers, regardless of background and individual circumstances.

In particular, the Summit notes the gap in outcomes for vulnerable South Australians, mental health consumers, Aboriginal consumers and country communities.

The Summit recognised that transformation will be complex, difficult and will require significant resources and must involve proper change management and genuine engagement and consultation.

This Summit:

1. Supports the need to improve the South Australian healthcare system.
2. Supports the six Quality Principles put forward by the Transforming Health Clinical Advisory Committees for the South Australian Healthcare system. These Principles state that a quality, world-class health system is:
 - > Patient Centred
 - > Accessible
 - > Safe
 - > Efficient
 - > Effective
 - > Equitable
3. Agrees that delivering these Quality Principles drives the case for change to enable South Australia's healthcare system to deliver consistent, quality services into the future.
4. Endorses in principle the Clinical Standards of Care, noting that consultation is ongoing and that standards will evolve and change as healthcare advances.
5. Supports the vision that South Australians deserve consistent, quality healthcare: Best Care. First Time. Every time.
6. Recognises that to achieve consistent, quality care, ongoing innovative and integrated teaching and training for healthcare professionals is essential.
7. Agrees that proposals for change to the structures and services of the health system necessary to implement the principles and standards should be identified and be the subject of further specific consultation before adoption or implementation and notes the Minister's commitment to consult further before the final decisions are made.
8. Accepts that Transforming Health is a journey that will continue and adapt to take into account new practises and medical and technological innovation and advances.
9. Expects that any planned changes to South Australia's hospital system are based on the Quality Principles and not founded on cutting costs.

Appendix 2

Clinical Standards of Care

The proposed Clinical Standards of Care were originally developed by members of the three Ministerial Clinical Advisory Committees as the result of over two months of discussion, debate and review of local, national and international data and evidence.

Following the release of the Transforming Health Discussion Paper on 17 October 2014 and subsequent consultation with the community, staff and industry, the Standards have been updated to reflect the feedback received.

The Standards do not cover every aspect of public health care, but rather these focus on four aspects of care: General Unscheduled Care, Routine Elective Care, Women's and Children's Care and Selected Specialties.

The Standards will be regularly reviewed, monitored and assessed to ensure they are effective in driving quality.

Understanding the Standards

- > **Standard wording changed**
- > **Checked against other Standards**
- > **Standard moved to a different section**
- > **New Standard**



This Standard cannot be met under the current configuration of the healthcare system but can be met if the changes proposed in this document are implemented.

Overarching Standards to apply to the whole health system

1. Every South Australian has an equal right to access quality healthcare. This means specific groups may need to be targeted for affirmative action to ensure their needs are met, this includes: veterans, frail and elderly, those with mental health needs, the disabled, children, those with eating disorders, **LGBTIQ people (lesbian, gay, bisexual, transgender, intersex and queer)** and Aboriginal and Torres Strait Islanders. All aspects of care should be patient-centred and focus on quality outcomes. This includes service design, delivery and evaluation, supported by research and teaching.
2. Health literacy should be promoted in the general population.
3. A holistic approach should **include individual patient preferences** and involve partnerships between patients, their families, service providers including multidisciplinary professional practices and primary and community healthcare organisations.
4. Patients, their families and care-givers should be actively involved in decision making.
5. Consumers have a right to information, data and reporting that is relevant to them. All information and test results should be shared with patients and they should be advised of all options for treatment and treatment setting.
6. Patients have a right to dignity and respect at all times. Patients should be able to express their wants and needs, or complain, without fear of retribution. Their privacy must be respected. There is zero tolerance of all forms of abuse.
7. Efforts to continually improve the health system should have clinical leadership and promote multidisciplinary clinical engagement and teamwork.
8. Care should be delivered in the right place, by the right person, the first time and every time.
9. Health care is provided by the most cost effective health worker whilst ensuring quality and safety standards are met.
10.  Care should be delivered in the most appropriate cost effective venue as close to home as safely possible.
11. Quality of care should be determined by patient reported outcomes, patient clinical outcomes and system outcomes.
12. Agreed and uniform reporting related to patient outcomes should be made accessible to health agencies and clinical care delivery staff. There should be consistent data recording, coding, measurement and accounting, developed by clinicians in partnership with SA Health.
13. Hospitals should all participate in morbidity and mortality reviews and use them as a learning exercise to improve quality of care.
14. Electronic systems should be used to track care pathways and collect information about key milestones to support audit, research and quality activities.

15. Information should follow the patient through the care continuum. For example, through the Personally Controlled Electronic Health Record.
16.  Healthcare services should be offered seven days a week, every week. Human and infrastructure resourcing should be aligned to achieve this.
17.  There should be seven day a week access to allied health and other clinical support.
18. All services should be culturally and linguistically appropriate.
19. Practice should be evidence-based where sufficient evidence, or evidence-based guidelines exist. Where a new practice has been demonstrated to be successful, it should be replicated across the entire system, replacing superseded practices.
20. Effective and efficient models of care should be regularly updated and replicated across the entire system.
21. Each presentation should follow a defined end-to-end patient pathway consistent across the state. Patients may require more than one pathway for multiple diagnoses, or if they belong to a group with identified special needs. Care should be delivered against this pathway, with protocols in place to ensure continuity.
22. Clinical pathways should be developed by a multidisciplinary team and should be diagnosis or procedure specific rather than doctor specific. They should specify outcomes to be achieved, relevant timelines and should incorporate discharge-planning principles.
23. Principles, protocols, pathways and procedures are statewide, and should include telehealth and patient transfers where necessary. This can be facilitated through co-ordination of services across multiple sites including across Local Health Networks (LHNs) and statewide networks.
24. There should be consistent documentation of policies and procedures to ensure safe, appropriate, accountable, effective and measurable improvement in patients and their quality of life.
25. All policies and procedures are living documents and should be updated regularly and as required by advances in evidence.
26. Technology should be used to its maximum extent to provide more effective care when appropriate. For example, shared electronic health records, telehealth, phone or SMS follow-up, and SMS-based appointment reminders. Telehealth should be made use of to support patient assessment if distance is a potential issue.
27. Agreed pathways and protocols should be followed by all clinicians and unnecessary duplication should be avoided. All practitioners should engage in continuous professional development, including the best implementation of patient pathways.
28. Appropriately credentialed practitioners should be able to make referrals in accordance with patient pathways, including nurse and allied health referral to specialists.
29. Models of care should include escalation policies if deviation from accepted pathways is required.
30. Governance and accountability structures for adhering to principles and meeting targets should be in place, with ongoing change management.
31. Clinicians should adhere to and report on the National Safety and Quality Health Service Standards.
32. Practitioners must be adequately trained and credentialed for their scope of practice. There should be appropriate response mechanisms when practice is outside accepted norms.
33. Ongoing training and development opportunities should be available to all staff to ensure development and maintenance of a skilled workforce, including advancing teamwork and leadership skills.
34. Sufficient teaching, continuing education and research should be built in to all pathways; research and development activities should facilitate continuous improvement of services. Research and training programs should evolve to fit with new models of care.
35. Admission pathways need to be clearly defined and communicated to the public.
36. Admitted patients should be seen within a specified time period, pre-defined by presentation, risk-profile and age.
37. Delayed discharges should be routinely reviewed with action taken to address any identified problems.
38. **Multidisciplinary criteria-led discharge should be established. Diagnostic and therapeutic support should be readily available for all disciplines to use when appropriate.**

39. Referrals should be pathway-based not directed to individual specialists, for example a patient with congestive cardiac failure should be referred to the congestive cardiac failure service.
40. There should be a consistent step by step process for developing a resuscitation and care plan for clinical decision making for patients near the end of their lives.
41. All patients (and relevant support persons) should be actively engaged in developing care plans and end-of-life plans. Advance Care Directives should be in place.
42. Administrative and managerial support should be available 24-hours every day.
89. **Discharge planning for potentially long-stay patients should be proactively managed from admission.**
91. **Rehabilitation should be started immediately post-operation.**

General unscheduled care

Acute Medicine

43. Hospital should be the last resort for patients; admissions and presentations to emergency departments should be minimised with alternate models of care, chronic disease pathways and palliative care.
44. Systems should be in place to ensure continuity of care along the patient pathway without gaps.
45. The skill mix and number of staff in healthcare facilities should be matched with the needs and flow of patients.
46. Clinical handovers should be structured, documented and resourced appropriately.
47. There should be structured arrangements in place for handover of patients at each change of responsible health professional/team.
48. There should be a clear decision tree and chain of authority to avoid disagreement around which admission clinic is appropriate.
49. Risk profiling for patients should be routine and standardised to give due consideration to frailty, co-morbidities and malnutrition.
50.  Results from diagnostic tests should be available in a timely manner, and should be viewed and acted on during the emergency visit where possible.
51. The use of diagnostic tests should be determined by the patient's pathway and used to inform management decisions.
52. No patient should remain in a setting where they are not being actively managed.
53. Newly admitted patients should be reviewed a minimum of three times in the first 24-hours by a clinician, for example a doctor or nurse practitioner, involved in their decision making, and at least once by a consultant.
54.  Acute medical care needs the presence of a senior consultant 12-16 hours every day, who is readily **accessible** to ensure early decision making. There should be clear protocols for their involvement, and the ability for 24-hour input in-person, over the phone or via telehealth.
55.  All acute admissions should be seen by a consultant within 12 hours of initial assessment. High risk patients should not be discharged without having been seen by a consultant.
56.  There should be a consistent standard of resourcing and infrastructure support based on need across the entire acute care pathway, for example diagnostics, across Acute Medical Unit (AMU), Critical Care Unit (CCU) and Intensive Care Unit (ICU).
57. AMUs should have defined medical and nursing leads, written operational policies and regular audits including 24-hour mortality, seven day readmission and direct discharge rates.
58. Acute patients requiring inter-specialty input should be seen by those specialists in a timely manner.
59. Surgical units should have ready access to acute medical services for medical co-morbidities or for those who develop medical complications.
60. Where a patient in AMU requires surgical input, a senior surgical review should occur within 4 hours.
61. Emergency Departments (EDs) should monitor 'did not wait' patients and implement systems to detect patients who may be at significant risk following departure from the ED.
62. Where critical care units send a team to the Emergency Department (ED) to transfer the patient to the intensive care facility, the medical and nursing handover should occur in the ED and the transfer of responsibility occurs at that point.

63. Prior to patient's discharge from ED, staff should identify and communicate with the appropriate healthcare professional who will be responsible for follow-up.
64. ED staff should prepare an interim plan and orders for ward care of the patient until the planned review by the receiving unit, and should take reasonable and appropriate steps to ensure the clinical safety of the patient until reviewed.
65. The hospital and its medical staff must provide the ED with a list of appropriate on-call and admitting specialists.
66. All patients discharged or transferred from a healthcare facility should have specific, printed (or legibly written) aftercare instructions given at the time of discharge.
67. Systems should be in place to enable staff to quickly identify the treating ED doctor.
68.  Interdisciplinary pathway-based care should be available for all patients, and allied health input should be sought as early as possible.
77. As an absolute minimum, for patients not considered at high risk, all emergency surgical admissions must be discussed with the responsible consultant within 12 hours of admission. Active and continued monitoring of the patient must be carried out and the consultant should be notified immediately if the patient's condition deteriorates.
78.  Interventional radiology should be available within one hour of request.
79. Clinical staff should adhere to safe working hours.
80. High-risk patients may need access to multispecialty teams for resuscitation and optimal care. Early input from senior anaesthetists and critical care specialists should be considered.
81.  In specialties with a high emergency workload the surgical team should be free of elective commitments when covering emergency and consultants should not cover more than one site.
82. Surgeons with private practice commitments should make arrangements for their private patients to be cared for by another surgeon/team when they are on call for **public** admissions.

Emergency Surgery

69. Access to theatre should be based on need, regardless of whether emergency or elective surgery.
70.  Theatre allocations should be planned to allow adequate time for emergency surgery.
71. No surgery should be performed out-of-hours except in pre-defined emergency cases.
72. The time between the decision to operate and the time of operation is recorded and audited locally along with other appropriate metrics.
73.  Appropriate diagnostic imaging, interventional radiology and pathology support should be available as required by the patient pathways.
74. Theatre must be appropriately resourced with respect to storage, equipment, access, workforce and seniority of presence.
75. Where out-of-hours surgery occurs, there should be a dedicated, adequately resourced 24-hour emergency theatre with 24-hour consultant cover every day.
76. High risk patients must be discussed with the consultant surgeon within four hours if the management plan remains undefined and/or the patient is not responding as expected. These patients must have their operation carried out in a timely manner under the direct supervision of a consultant surgeon and consultant anaesthetist.
83. Day surgery should be performed whenever possible.
84. Inter-disciplinary clinicians, whose input will be required, such as anaesthetists, critical care specialists and allied health professionals, should be involved in a planned way from the start. Telehealth should be utilised if required.
85. Discharge planning should begin at time of admission; a discharge plan should be in place within 24-hours of admission.
86. Post-operative management should be standardised by procedure as part of a clinical pathway.
87. There should be clearly defined parameters for monitoring and detecting deterioration in surgical ward patients with guidelines and defined responsibilities for escalation of care and involvement of senior staff from critical care, anaesthesia and surgery.
88. The WHO Surgical Safety checklist should be used for all procedures.
90. Outcomes of emergency surgery should be regularly reviewed by risk and clinical governance groups.
92. Nurse practitioners should be utilised across the surgical system to improve efficiency.

283. **Allied health practitioners should be utilised across the surgical system to improve efficiency.**

Acute Mental Health

93. In mental health, community care is central to care.
94. Consumers and carers are centrally and actively involved in care planning at every stage.
95. Pathways should include structured phone follow up after acute care, where appropriate.
96. There should be early referral to appropriate community or specialist teams for those patients requiring ongoing care, including early clinic appointments.
97. Equity of access, quality and speed of service should be ensured for people seeking acute mental health care. Safety of mental health and non-mental health patients and care-givers is a priority.
98. Allied health staff in the ED Mental Health team should facilitate psychosocial assessments and interventions that underpin some mental health presentations.
99. There should be specific pathways integrating mental health care where non-mental health comorbidities exist. For example, when patients are admitted under acute medicine or surgery.
100. Mental health services and emergency departments should collaborate closely to develop appropriate pathways for treatment and admission, including hospital avoidance strategies.
101. Escalation policies should be in place for when there are insufficient dedicated mental health resources.
102. Access to mental health services should occur via mental health clinicians located in the ED, off-site community mental health teams, on-call clinicians, and psychiatric triage phone services. While not all components of a mental health service are readily available to every ED, crisis intervention should facilitate prompt referral to other programs and providers.
103. Mental health care in the ED **should be** provided by a combination of general ED clinicians and mental health clinicians including nurses, mental health and allied health.
104. ED staff should check the mental health care plan of each mental health patient, and consolidate or create as appropriate.
105. Appropriate handover should occur on transfer between units; supervision protocols should be utilised when a mental health patient is transferred out of the ED.
106.  A comprehensive multidisciplinary psychiatry liaison service should be provided throughout the acute hospital.
107. All acute mental patients admissions should be seen by a consultant psychiatrist within 24-hours of admission.
108. There should be provision of some 'same day' or 'next day' services, such as an alcohol support worker, who may then initiate brief interventions.

Acute Elderly Care

All Acute Elderly Care Standards checked against other standards

109. Care pathways should be adapted in an age-appropriate fashion and should include community aspects of care.
110. The pathways for the elderly should be fully integrated with functioning connections between Geriatric Consultation Liaison Teams, General Practitioners, and specialists.
111. There should be geriatrician input into diagnosis related elderly patient pathways to optimise outcome, for example, ortho-geriatrics and geriatric-oncology. Surgical pathways for the elderly should include peri-operative to manage co-morbidities.
112. Acute support in nursing home should be promoted as a hospital avoidance mechanism (and can include Extended Paramedic Care).
113. Where appropriate, actions that can avoid transfer to a public hospital should be considered, particularly in the case of predictable medical requirements, and when there are known alternatives to hospitalisation (for example where there are pathways to 'in reach' services inclusive of GP visitation, or rapid response services).
114. Technological advances should be incorporated into pathways to reduce the need for elderly patients to visit hospital.
115. All healthcare professionals interacting with the elderly should be capable of looking after older people.
116. EDs should be configured in such a way that they can screen for common frailty syndromes in all older people, and then initiate (but not necessarily deliver entirely) more detailed assessments in selected individuals.

117. The use of validated ED assessment tools such as Identification of Seniors At Risk (ISAR) tool should be considered to identify older persons at risk for mortality, functional decline, readmission and institutionalisation on discharge.
118. There should be consideration of the cultural context of the individual and if any additional services (for example interpreter services) are required.
119. Patients should have carers or next-of-kin notified by telephone on admission unless contraindicated.
120. To provide effective acute care services to older people, a hospital requires a multidisciplinary consultancy service, led by trained geriatricians working closely with nursing and allied health staff, with a process to facilitate early referral.
121. Consultant review for acute elderly inpatient care should occur at least three times per week, or more if clinically indicated.
122.  There should be a daily consultant visit (in-person or via telehealth) to all medical wards on weekends and holidays – to address new problems and to progress patient care.
123. Acutely unwell elderly patients should see a geriatrician within 24-hours (in-person or via telehealth).
124. There should be a review of medication by pharmacy within 24-hours (may need electronic review for settings with no on-site cover).
125. Screening for and prevention of functional decline within in-patient facilities should occur within the first 24-hours after admission, for any patient expected to stay for longer than 72 hours.
126. Active case management should be in place for high risk, high complexity patients.
127. Carer involvement should be facilitated during inpatient management.
128. Specialist geriatric inpatient units should not need to accommodate all older people admitted to hospital. However, older people not admitted to specialist units should have access to specialist geriatric services through the Geriatric Consultation Liaison Teams.
129. Geriatric Consultation Liaison Teams should target patients older than 65 years (50 years for Aboriginal people). Priorities include those aged over 80 years and those at risk of functional decline, geriatric syndromes (delirium, frailty, falls, fracture) or prolonged hospitalisation.
130. Patients admitted from residential aged care facilities should not be excluded from rehabilitation programmes in the community or hospital, or as part of an early supported discharge programme.
131. Every rehabilitation patient should be seen by a consultant ward round and discussed at a multidisciplinary team meeting once a week or more frequently if required.
132. Older people should be screened for delirium risk with appropriate tools for assessing delirium and enacting the relevant pathway. There should be suitable hospital facilities to address delirium.
133. If a procedure is required for a person who is confused, two health care professionals should perform the procedure, one to monitor, comfort and distract, and the other to undertake the procedure.
134. Analgesia should be sufficient to allow movements necessary for investigations (as indicated by the ability to tolerate passive external rotation of the leg), and for nursing care and rehabilitation.
135. **For the elderly person requiring surgery, correctable** co-morbidities should be identified and optimised immediately so that surgery is not delayed by anaemia, anticoagulation, volume depletion, electrolyte imbalance, uncontrolled diabetes, uncontrolled heart failure, correctable cardiac arrhythmia or ischemia, acute chest infection or exacerbation of chronic chest conditions.
136. Patients should be offered a choice of regional or general anaesthesia after being informed of the risks and benefits. Intraoperative nerve blocks should be considered for all patients.
137.  Hip and other fracture surgery should be scheduled on a planned trauma list where an appropriately skilled team is available to undertake the procedure.
138. Unless medically or surgically contraindicated, mobilisation should start the day after surgery **for hip fracture**, with full weight bearing as an aim.
139. If unable to meet the criteria for early supported discharge, in-patient rehabilitation should be considered for those in whom further improvement with a structured multidisciplinary program is anticipated.
140. Carers for elderly patients should be advised of expected date of discharge, and called on the morning of discharge.

141. There should be safe and timely transfer of individuals across the public health service-residential aged care interface every day of the week with adequate continuity of care and support.
142. Where possible, the GP should be involved in discharge planning. The aim is to maximise the support of the GP in the transfer and follow up care.
143. Elderly patients living alone should not be discharged from the ED back to their homes unless appropriate support has been confirmed, particularly after-hours.
144. Patients at risk of re-admission should be identified and proactively managed to prevent re-admission.

Rehabilitation

145. The rehabilitation multidisciplinary team should have sufficient skills and training to address patient impairments, activity limitations and participation restrictions, to help patients achieve their optimal level of functioning and participation in society.
146. Rehabilitation pathways should be in place, and involve treatment goals, periodic assessment and documentation of the functional status of patients, regular case discussion amongst treating practitioners, and attention to the optimal management of concurrent medical problems and psychosocial issues.
147. The rehabilitation pathway should include direct ward admission for allied health monitored chronic conditions.
148. Each patient should be reviewed by a consultant within 24-hours of admission to a rehabilitation ward, using telehealth where appropriate.
149. Each patient should be reviewed by a consultant at least twice a week. Appropriate rehabilitation equipment should be available and easily accessible at appropriate service sites.
150. Lifestyle intervention strategies should be developed and implemented in rehabilitation settings to reduce preventable complications and consequences for high risk patients.
151. Outpatient services will provide timely patient access to appropriate consultations, diagnostic and treatment facilities and interventional and therapy areas.

Routine Elective care

Elective Medicine

152. The GP and the specialist clinic (outpatient service) work in partnership to share the care of patients with complex and chronic conditions.
153. Patients with chronic disease should be risk stratified with interventions targeted appropriately. Chronic disease follow-up should be by the most cost efficient, fully qualified person, such as a nurse practitioner where appropriate.
154. All patients with a chronic disease should have a self-care plan, supported by appropriately qualified staff.
155. There are effective processes in place to support the transition of care between specialist clinics and community based care.
156. There should be mechanisms for streamlined re-entry to the clinic for the same problem once a patient has been discharged.
157. During the telehealth consultation, the main focus needs to be on direct communication with the patient rather than communicating with the clinician. However, it is recommended that a staff member must always be present at the patient end of a telehealth consultation.
158. Targeted interventions should be utilised to avoid hospital admissions for repeat presenters.
159. Pathways in elective medical care should include event-led discharge.
160. Patients should be discharged from hospital care back to the community as soon as possible based on their healthcare needs. Only people who require specialist care should continue to see a specialist.

Elective Surgery

161. Where possible, patients should be triaged based on need for surgery or not. Those definitely not requiring surgery should be diverted to non-surgical services such as allied health led clinics.
162. There should be adequate allied health services to support our elective surgery pathways.
163. Referral criteria **for elective surgery** should be established and consistently applied for commonly presenting conditions.

164. Pre-operative assessment should be carried out to determine and optimise fitness for procedure; effective models should be introduced. For example, SA Health model of telehealth care.

165. Pre-admission assessment must be performed by professionals with the right skills, and should be standardised, comprehensive, and benchmarked for quality.

166.  Day surgery should be performed where possible; rates should rise to meet international norms.

167. There should be dedicated elective surgery lists with separate resources that are not impacted by emergency surgery demands.

168. There should be dedicated lists for high-throughput cases with separate resources.

169. Appropriate waiting list metrics should be measured and benchmarked against statewide and national targets. These should align with urgency categories. For example, time from referral to first assessment and from first assessment to treatment.

170. ***The decision to operate on high risk patients (including the frail and elderly) should be taken at the consultant level, using a risk categorisation tool and sub-specialist input when possible.***

171. Systems should be in place to reduce the conflicting commitments of on-call staff.

172.  There should be a minimum of two anaesthetists for any stand-alone surgical sites.

173.  ***Patients presenting with acute conditions requiring urgent surgery that is appropriate for managing as a day case should be treated as such via a semi-elective pathway.***

174. Day surgery anaesthesia should be a consultant-led service. Enhanced recovery **protocols** should be used for all patients. Domains include: pre-operative preparation, intra-operative issues and post-operative factors. For example comorbidities, type of anaesthetic, drains, and mobilisation.

175. Where same day discharge is clinically appropriate but not practically feasible, patients should be pro-actively managed to be discharged within 23 hours.

176. For stand-alone surgical sites there must be clear operational policies for: management of patients who cannot be discharged home, management of problems after discharge, appropriate cover until patients are discharged, management of medical emergencies, transfer agreements to other facilities, teaching, training and supervision for research.

177. Effective audit **should be used as** an essential component of good care in all aspects of day and short stay surgery.

Women's and Children's Care

General Paediatrics

178. There should be statewide agreement on the definition of "paediatric", "adolescent" and "adult", based on physiology.

179. The transition from paediatric, through adolescence and into adult care should be adequately planned and implemented to ensure continuity.

180. Paediatric health services should be delivered by a skilled, innovative and flexible workforce. The paediatric health workforce should be valued and supported to acquire and maintain the necessary skills and competencies to deliver high-quality care.

181. Hospital admission should be the choice of last resort for children. Services should be community-based and provided as close as possible to the child's home, when it is clinically safe to do so.

182.  Paediatric patients should have access to allied health services seven days a week.

183. Like all other services, paediatrics should follow the principles of multidisciplinary care.

184.  There should be a statewide co-ordinated and networked paediatric trauma service.

185. Adolescent mental health services should address comorbidity issues, particularly drugs and alcohol, with a co-ordinated and integrated approach.

186.  Statewide high complexity/low volume services should be planned and delivered to provide optimal health outcomes and maximise efficiencies while avoiding unnecessary duplication.

187.  Service hubs (metropolitan and regional) should support sufficient volumes of services to ensure clinical expertise, quality and safety of services.

188. ✓ The specialist care of children at tertiary level should be concentrated in designated units where there are the appropriate staff and facilities and a critical mass of patients sufficient to ensure an adequate level of experience.

189. ✓ **Children and adolescents should be kept separate from adult patients, ideally in dedicated facilities. Where they are co-located with adult services there should be clear separation from adult access.**

193. **Family and carers should be actively involved in decision making and care when services are provided to their children.**

Unscheduled Paediatrics care

190. Outreach services should be considered to avoid hospitalisation and facilitate management of chronic conditions in the community.

191. ✓ Adequately qualified, designated, senior paediatric staff should be available 24-hours a day in the hospital or via telehealth for immediate consultation when necessary. This includes paediatricians, paediatric surgeons and anaesthetists. Consultants should be aware of all admissions.

192. There should be a minimum of two registered paediatric nurses at all times in all inpatient and day care areas.

194. Non-specialised and specialist centres caring for children should participate in multidisciplinary networks for surgery and anaesthesia.

195. There should be at least one medical handover in every 24-hours led by a paediatric consultant (or suitably qualified person) and consultant-led ward rounds should occur daily.

196. Every child or young person with an acute medical problem who is referred for a paediatric opinion should be seen by, or have their case discussed with, a paediatric staff member.

197. Every child or young person who is admitted to a paediatric department with an acute medical problem should be seen by a consultant paediatrician, within the first 12 hours.

198. ✓ All EDs which treat children but do not have in house paediatric and neonatal intensive care facilities must have immediate access for consultation with and utilisation of appropriate retrieval services.

199. Paediatric guidelines regarding assessment and treatment of specific conditions must be available in the ED at all times.

200. Paediatric resuscitation equipment must be available wherever and whenever children are treated, and anaesthetists must maintain their skills in advanced paediatric life support.

201. ✓ Paediatric anaesthetic services for children require specially trained clinical staff together with equipment, facilities and an environment appropriate to the needs of children. They should be led at all times by consultants who regularly anaesthetise children.

202. ✓ There should be 24-hour a day access to a paediatrician and social worker or **psychologist** with child protection experience and skills, available to give immediate advice and subsequent assessment, if necessary, where there are child protection concerns. This must be culturally appropriate.

203. A medical and/or nursing staff member must be appointed to act as the local paediatric clinical leader in facilities that have attached inpatient paediatric services.

204. ✓ A Level 6 emergency service should provide 24-hour ED and triage by qualified paediatric emergency staff, access to a 24-hour child and adolescent psychiatric emergency service, and access to paediatric medical and surgical subspecialties on-site.

205. In a life-threatening **surgical** emergency where transfer is not feasible, the most senior appropriately experienced anaesthetist available should lead the resuscitation/ anaesthesia in consultation with paediatric services.

206. There should be a properly staffed and funded acute pain service that covers the needs of children, and access to a chronic pain service.

207. Neonatal and paediatric high dependency and intensive care services should be available as appropriate for the type of surgery performed.

Routine Elective Paediatric care

208. ✓ Paediatric surgery should occur in hospitals equipped and supported to provide such surgical services. Consideration should be given to the specific paediatric skills of the surgeon required to provide a safe surgical service. Appropriately trained and skilled anaesthetic and nursing staff must be available during surgical procedures and to provide necessary after care. Arrangements for appropriate in and out of hours cover must be in place for services provided.

209. When children receive hospital care other than in the paediatric unit (for example emergency department or x-ray), there is a process of liaison with a designated paediatric care team (medical and nursing) in the paediatric unit to ensure appropriate advice is available (for example on consent issues and pain management).
210. Day surgery is the preferred option whenever possible.
211. Elective surgery for children is scheduled on dedicated paediatric theatre lists.
212. As part of the service delineation, standards for pre-anaesthetic consultation should be developed. Pre-anaesthetic consultation can be done in-person or via telehealth.

Neonatal Care

All Neonatal Care Standards checked against other standards

213. **Neonatal surgery should be done in a specialist unit closely linked to a neonatal ICU.**
214.  Level 6 Neonatal ICUs should be co-located with a tertiary obstetric hospital with access to an adult ICU and a tertiary paediatric hospital.
215. All newborn infants should have a complete clinical examination as soon as possible and certainly within 24-hours of birth and before discharge.
216. Minimum standards with respect to the immediate care of the newborn require that basic life support skills should be available wherever a baby is born, and this will be provided in the first instance by midwives.
217. When an obstetric unit provides neonatal special care but is not intending to provide neonatal intensive or high-dependency neonatal care, there should be a designated link paediatrician for the labour ward and neonatal service and 24-hour availability of a consultant paediatrician, who can attend within 30 minutes.

Maternity

218. The South Australian Perinatal guidelines should be used for determining when caesarean sections are appropriate, and parents should be informed of risks.
219. All women should have access to the most appropriate care giver who is qualified to manage their level of risk in accordance with the statewide guidelines.
220. All women should have access to midwifery care.

221.  There should be a minimum number of planned births at all delivery sites to maintain quality of care.
222. Workforce from lower volume sites should have exposure to higher volume sites to guarantee adequate training, via telehealth and staff rotations.
223. Birthing options should consider risk factors in pregnancy and maternal preference where it does not compromise safety.
224. As with all common presentations, there should be standardised pathways for all uncomplicated vaginal birth for all women regardless of the lead carer (obstetrician or midwife).
225.  Units should have in place arrangements to ensure safe care when there are increases in demand or reduced levels of staffing. There should be an early warning system so that, if the unit is becoming busy, proactive intervention can reduce the need for it to 'close'. There should be an arrangement within and between LHNs to ensure that problems in one unit are not transferred to a neighbouring unit with just as many difficulties.
226.  A facility that delivers babies should have ready access to adult services. Facilities doing high-risk births should have access to an adult ICU.
227. Obstetric units should have support from different services, including onsite access to emergency surgery, interventional radiology, and critical care, in addition to appropriate neonatal support. Each maternity and gynaecology unit should have ready access to the full range of medical specialties.
228. A paediatrician (GP or specialist) trained and assessed as competent in neonatal advanced life support should be available 24-hours a day and accessible within 30 minutes.
229.  Maternity services that do not have adult intensive care facilities, advanced imaging and cardiology on site must have protocols in place to ensure that women in need have access to these resources.
230. **Maternity services that do not have high level neonatal services should have defined arrangements for both in utero transfer and the transfer of a recently delivered mother and her newborn baby to a linked secondary or tertiary unit.**
231. **All at-risk women should be identified as soon as possible after pregnancy is confirmed (including some women with complex comorbidities). Mothers with risk of birth <32 weeks should go to the appropriate hospital.**

232. During pregnancy, all women who are at identified risk of serious perinatal mental illness should be assessed by a psychiatrist or psychiatric team. They should have a written management plan of possible agreed multidisciplinary interventions to be undertaken, which includes a system of close supervision following birth.
233. Women with complex **medical needs** and those receiving care from a number of specialists or agencies should receive the support of a lead medical practitioner throughout the pregnancy. This could be the woman's family doctor or an obstetrician.
234. Women with complex needs should be referred to an obstetrician as soon as possible after pregnancy is confirmed and, where necessary, be seen at a combined consultation with the team that will be caring for her.
235. Women with complex medical conditions or high risk factors must be managed (including collaborative management) by a consultant obstetrician. Such conditions include for example, epilepsy, neurological disorders, diabetes, asthma, renal disease, congenital or known acquired cardiac disease, autoimmune disorders, haematological disorders, obesity (body mass index 30 or more), severe pre-existing or past mental health disorder and any condition for which they are under continuing specialist medical review. (Refer to the Australian College of Midwives National Guidelines for Consultation and Referral, 2013.)
236. When women and babies are transferred into hospital with complications, the risk assessment should be discussed and form an integral part of the initial medical review undertaken by the most senior obstetrician present on the labour ward, either immediately if a life-threatening emergency exists or, in any case, within 30 minutes of admission.
237. Complicated births in maternity units should be managed by a consultant obstetrician.
238.  Maternity services that provide intrapartum care should have access to a 24-hour anaesthesia and analgesia service, haematology and blood transfusion services, and a neonatal care service. Where, by virtue of location, these services are not available, the woman and her family should be made aware of the limitations and be given an opportunity to birth elsewhere.
239.  Complex intrapartum cases should have integrated, multi-professional specialist management and direct consultant involvement.
240. Every pregnant woman attending an emergency department for problems other than obvious minor injuries should be seen by a midwife or **obstetric doctor**. Where this is not possible, a midwife or **obstetric doctor** should be consulted by telephone. A consultant obstetrician should be available within 30 minutes outside the hours of consultant presence.
241. Categorisation of emergency caesarean sections should be used to facilitate communication and reduce misunderstanding between health care professionals.
242. The risk level of the woman and the timing of decision making by medical practitioners (general practitioners or specialists) should be taken into account when determining the place for delivery.
243. In the case of emergencies, anticipated difficult births, including caesarean sections or whenever the clinical situation gives cause for concern, the consultant obstetrician must be contacted and must attend the obstetric unit as required.
244. The consultant obstetrician must be contacted prior to emergency caesarean section and must be involved when a patient's condition gives rise for concern and attend as required.
245. The anaesthetic team's response time is such that a caesarean section may be started within a time appropriate to the clinical condition.
246.  There must be separate provision of staffing and resources to enable elective work to run independently of emergency work, in particular to prevent delays to both emergency and elective procedures and provision of analgesia in labour.
247. To ensure 24-hour managerial cover, each labour ward must have a roster of experienced senior midwives as labour ward shift co-ordinators, supernumerary to the staffing numbers required for one-to-one care. Their role is pivotal in facilitating communication between professionals and in overseeing appropriate use of resources.
248. High-dependency care should be available on or near the labour ward, with appropriately trained staff. If this is unavailable women should be transferred to a general high-dependency unit in the same hospital.
249. All women should be assessed immediately after giving birth by a suitably qualified member of the birth team (doctor or a midwife) and again prior to transfer to community care and/or within 24-hours of giving birth, by a midwife.

250. There should be a 'Hospital in the Home' program to support out of hospital care.

Gynaecology

251. All obstetric or gynaecology services should have access to general surgery and other relevant surgical specialties.
252. Gynaecological oncology services should be provided through a multidisciplinary team, and follow the agreed statewide pathway.
253. Gynaecological oncology inpatients should have designated ward beds and facilities and should be reviewed daily by a gynaecological oncologist.
254.  All sites doing highly complex gynaecological surgery should meet minimum volume standards to maintain a high quality service.
255. Any centres performing emergency abdominal surgery on women should have access to a gynaecologist.

Selected Specialities

256.  In all specialist areas, a centre designated as a statewide comprehensive centre, must be able to provide all relevant, appropriate treatment options. Services only able to provide a limited range cannot be designated a statewide centre, and must be integrated with centres able to provide appropriate alternatives.

Cardiology

257.  As a minimum, a designated consultant interventional cardiologist must be available on a formal on-call rota to provide overnight medical cover after all elective Percutaneous Coronary Intervention (PCI) procedures, including day-case procedures.
258. Cardiac catheterisation laboratories performing only diagnostic coronary angiography do not require on-site surgical facilities.
259. Laboratories performing diagnostic angiography should have access to coronary care or intensive care facilities and their staff should be capable of inserting intra-aortic balloon pumps, and transvenous pacemakers.
260. Patients with a stable clinical profile can have angiography as a day case procedure.
261. High-risk patients should have diagnostic cardiac catheterisation in facilities with onsite surgical backup.

262.  Coronary interventional procedures, other than simple angiograms, should be performed at a facility with on-site **cardiac-surgical backup, or arrangements in place for immediate transfer.**

263.  Facilities providing only elective PCI should have an on-call team available to deal with post-procedural complications for at least 24-hours after the last procedure is performed.
264. Rural and regional centres without cardiac surgery should establish a formal liaison with a high volume PCI centre which has on site cardiac surgery.
265. For centres undertaking complex ablation procedures, there should be on site access to emergency cardiothoracic surgery or arrangements in place for immediate transfer.
266. Paediatric cardiac catheterisation should only be undertaken in centres with access to paediatric intensive care and paediatric anaesthesia. The paediatric cardiac catheterisation laboratory should perform a minimum of 60 cases a year to maintain proficiency.

Vascular

267. When needed, transfer to a specialist vascular centre should occur within 30 minutes of diagnosis.
268.  Elective abdominal aortic aneurysm (AAA) repair should only be undertaken in hospitals where: there is a 24-hour on-site vascular on call roster every day covered by consultant vascular surgeons, there is a 24-hour critical care facility every day, and there are a minimum of 33 AAA procedures per year.
269. There should be protocols and pathways in-place to deliver adequate multidisciplinary care for patients requiring vascular procedures, including: pre-operative, acute care, resuscitation, and rehabilitation.
284. **Patients requiring carotid endarterectomy should be allocated to the next available operating list (ideally within three days of referral).**

Bariatric

270. In circumstances where the benefits of bariatric surgery have been proven, bariatric operations should be performed by surgeons who have substantial experience with the required procedures and who are working in a clinical setting with adequate support for all aspects of patient assessment, treatment and management, including psychological support.
271.  A bariatric service (surgeon with all support facilities) should perform at least 40 bariatric cases per year.

Major Trauma

272. High level trauma patients should be sent directly to a major trauma centre (MTC) if the travel time is under 45 minutes, unless there is an imperative to go to a closer trauma unit (TU) for the immediate management of a life-threatening condition. The majority of patients presenting to TUs with major trauma should be transferred to an MTC after immediate management.
273. Where the estimated travel time is more than 45 minutes and the preferred destination is an MTC, consultation should occur between the paramedic, ambulance clinician and retrieval trauma advice and referral line.
274. Hospitals admitting patients with major trauma should have a HDU and ICU on site.
275.  Hospitals that receive patients with major trauma should have an emergency operating theatre and a radiology intervention suite situated sufficiently close to the emergency department to allow rapid transfer.
276. All major trauma centres and trauma units that receive acutely injured patients should have a defined response to major trauma that includes the prompt assembly of a multidisciplinary trauma team in the emergency department.
277. High volume major trauma centres should provide dedicated consultants in trauma resuscitation and anaesthesia to respond to major trauma calls in the emergency department, and provide a seamless transition to intra-operative care. There should be a defined agreement for immediate or emergency access to an operating theatre or intervention suite with appropriately trained and experienced staff to provide rapid intervention in life-threatening or limb-threatening conditions.
278. All patients requiring acute intervention for haemorrhage control must be in a definitive management area within 60 minutes.
279. Definitive skeletal stabilisation of open fractures and wound cover should be achieved within 72 hours.

Stroke

280. The evidence based stroke pathway (see SA Health's Stroke Management Procedures and Protocols, Sept 2014) should be in operation across South Australia. Patients should be managed according to this pathway, and outcomes should be monitored for service improvement.
281.  There should be a designated 24-hour acute stroke unit and, outside of agreed hours, all stroke patients should be sent to this facility.
282.  Door to needle time for a stroke should be less than 45 minutes during normal working hours and 60 minutes after-hours. An initial medical assessment should be completed in the first 15 minutes and CT scan within 30 minutes during normal working hours and 45 minutes after-hours.

For more information

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