ACT Government | Canberra Health Services

Virtual Care Program Model of Care

Division of Medicine

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Contents

Approvals

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Document version history

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Model of Care Development Participants

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Covid Care @ Home nursing team	

1. Introduction

This Model of Care (MoC) outlines the principles, aims and objectives of the elements of care and service delivery for the operation of the Virtual Care Program. The MoC provides the basis for how we will deliver evidence-based care to every person accessing the program, through integrated clinical practice, education, and research. The MoC contains information about risk assessment and service co-ordination (the linkages required for seamless access and care).

Models of care are dynamic and can be refined over time to reflect new evidence and better ways of working. This first version of the Virtual Care Program MoC has been developed to inform the design process and as a starting point for broader communication. The MoC will be further evaluated over time and with ongoing feedback.

Canberra Health Services (CHS) is being challenged by an escalating demand for health care provision, whilst being constrained by financial, workforce and other infrastructure capacity. The COVID-19 pandemic precipitated a sudden but necessary transition to virtual health care services. Given this experience, we now have a proof of concept that virtual health care provision in selected populations for selected conditions is safe, efficient, timely, cost-effective and accepted by providers and consumers alike.

Embedding sustainable virtual care services into the ACT offers opportunities for patients, their family and carers, healthcare workers and the system as a whole. All services and models of care are encouraged to consider the use of virtual care as a part of normal practice. This will increase the choices available to clinicians and patients, so that there are a variety of options to provide and access care.

Health economic assessments continue to demonstrate substantial savings in utilisation of virtual care. Similar programs nationally (NSW, Victoria, and South Australia) have realised considerable costs savings and value from their financial investment. This MOC builds on the current Covid Care @ Home service at Canberra Hospital. The Virtual Care Program will continue to manage COVID-19 positive patients.

We will also have the advantage of incorporating elements of other successful virtual care services already available in Australia; and as the CHS and North Canberra Hospital merger comes online, we will work with those partners in that

part of the business to further mature the model, population groups and how the MoC is expressed across ACT.

2. Principles

Our vision and role reflect what we want our health service to stand for, to be known for and to deliver every day. The vision and role are more than just words, they are our promise to each other, to our patients and their families and to the community. We all have a role to play in delivering on this promise:

- Vision: Creating exceptional health care together
- Role: To be a health service that is trusted by our community

Our values together with our vision and role, tell the world what we stand for as an organisation. They reflect who we are now, and what we want to be known for. They capture our commitment to delivering exceptional health care to our community. Our values:

- We are reliable - we always do what we say.
- We are progressive - we embrace innovation.
- We are respectful - we value everyone.
- We are kind - we make everyone feel welcome and safe.

Our Strategic Plan sets out our path forward as an organisation for the next three years. It is values driven—it outlines how we will deliver against our vision of 'creating exceptional health care together' for our consumers, their families, and carers.

Our Partnering with Consumers Framework provides clear principles for a shared understanding of our approach and what is required from all team members for effective partnerships with consumers and carers in line with our organisational values. The principles have been developed in collaboration with our consumer and carer organisations and underpin this Framework.

These service principles will guide our work and how we deliver services to patients:

Person-centered

- Patients (and where possible their family members and carers) will be equal partners within the multidisciplinary care team (MDT), enabling them to be actively involved in their own care as well as that of their family (particularly when there are multiple family groups).

- The Virtual Care Program will support the patient and family/carer involvement in the planning of their care.
- The Virtual Care Program will recognize the rights of a patient in line with all relevant legislative requirements.
- The Virtual Care Program will actively involve primary care to ensure seamless care.
- Participation in the Virtual Care Program is voluntary and verbal consent to participate is obtained on the first contact. Informed consent will be required prior to any intervention.
- Any person who requires an interpreter or other accessibility support will be provided same.

Embracing diversity and accessibility

- The service and staff will acknowledge the diversity and complexity of patients accessing services through the adoption of informed, flexible, and adaptive practices.
- The Virtual Care Program will provide services that are timely and responsive to patient's needs.

Multidisciplinary

- The Virtual Care Program will connect with a range of providers to ensure best practice care to Adult Patients including:
    - Canberra North Hospital
    - Mental Health
    - Alcohol and Other Drug Services
    - Hospital In the Home (HITH) services
    - General Practice
    - Emergency Departments
    - Staff Specialists
    - Inpatient wards
    - Walk in Centre's
    - Community nursing
    - GRACE / RADAR
    - Specialist nursing staff e.g. diabetic educator, heart failure nurse

Safe and effective

- The Virtual Care Program will be in line with jurisdictional documents addressing the clinical and virtual care of patients including:
    - Vital Signs and Early Warning Scores
    - Adult Hospital in the Home (HITH) Guideline - Canberra Health Services Procedure - and Calvary Public Hospital Bruce (CPHB)
    - Clinical Guideline for Telehealth

3. Purpose

Virtual Care is any interaction between patients and clinicians, occurring remotely with the use of technology, that aims to optimise the quality and effectiveness of patient care. Virtual care connects clinicians or any other person(s) responsible for providing care to a patient and carer(s). It can be used for the purposes of assessment, intervention, consultation, education and/ or supervision. Where clinically appropriate, virtual care is a safe, effective, and valuable tool to support many models of care. Virtual care offers benefits for patients, their family and carers, healthcare workers and the health system through improved access, availability, efficiency, and quality of healthcare. Patient-centred, clinician-led virtual care provides an efficient and effective model of care that complements and supplements face-to- face consultation.

The Virtual Care Program model provides a timely, accessible, comprehensive, evidenced based approach to the management of patients suitable for Virtual Care. Having an integrated approach to the model of care will ensure that the capacity of the system is optimised to deliver the best outcomes for those patients. The benefits to be realised by this Model include:

- Virtual Care Program operating hours will be 08.00hr to 17.00hr, 7 days a week.
- Early risk stratification ensures appropriate escalation.
- All patients who require appropriate monitoring at home, receive equipment.
- Emergency Department presentations are avoided and admissions where appropriate are through a direct admission pathway.

- Positive outcomes for patients and their families.
- Patients are linked in with the appropriate services for any ongoing needs.

4. Background

The demand for both emergency and inpatient care is placing a strain on the publicly funded hospitals in the ACT, in terms of bed capacity, patient flow and staffing.

The reasons for this are multi-fold, and include:

- An aging population with multiple co-morbidities and disability
- COVID-19 pandemic – direct and indirect impacts on service provision
- Nursing, medical, and allied health shortages – increased demand during pandemic exacerbated by staff contracting or being close contacts of COVID-19 patients, and with the new Building 5 services coming online this may increase workforce pressures due to those activities.

Opening more beds is not perceived as a sustainable, financially viable, timely or even the most appropriate solution given that at any point in time, many of the acute beds are taken up by non-acute patients.

There is a need, and an opportunity, to better manage demand and service provision and thereby reduce the pressure on staff and beds and other resources, whilst enabling more streamlined, efficient and safe care for those who do require ED, outpatient and inpatient care. The overall aim is to improve community access for acute services whilst ensuring those non-acute or sub-acute receive that care in a different way or different location.

In the ACT, the excess demand is felt across the health sector:

- Ambulances services
- Emergency departments with crowding, long waits
- Outpatient clinics
- Inpatient wards
- General practice

There are various virtual care models that have been implemented suitable for each of these settings, including:

- Ambulances services being called to attend people in the community, who they assess as not requiring an ambulance/hospital-based assessment/care are assessed and managed by a virtual ED Nurse/MO, freeing up the ambulance whilst also maintaining physical capacity in the ED.
- A virtual ED where the patient is triaged and assessed (and as needed, followed up) by telehealth/video-health, avoiding patient travel, a hospital presentation, maintaining physical capacity in ED, and transferring care to primary care/ GP where appropriate.
- Outpatient consultations being performed by video-conferencing – saving time, outpatient clinic crowding, and reducing the 'DNA's (applicable across a number of specialties, especially for follow up consultations) including orthopedics, Endocrinology.
- Identifying those patients who can be appropriately and safely managed in the home rather than the ward (e.g., selected post-operative patients during convalescent phase, peripheral vascular disease, heart failure, patients with mental health issues)
- General practice has already shifted to telehealth as routine practice.

Quantitative benefits

Evidence of quantitative benefits are determined by key performance indicators, review of data and planned audits.

This includes:

- A reduction in related presentations to Emergency Departments which could have otherwise been managed within the community.
- A review of access to the service ensuring safe and effective management using Standard Operating Procedures (SOPs), Clinical Treatment Protocols (CTPs) and Medication Standing Orders (MSOs), as well as the ongoing development of CTPs and MSOs to meet new and emerging health needs within the ACT Community.

- Appropriate redirection of patients for timely advanced management to reduce risk to the patient and ensure the correct level of care in a timely manner.
- Appropriate risk management based on identified incidences.
- Staff auditing tools.
- Participation in the Canberra Health Services (CHS) accreditation processes and adherence to the National Safety and Quality Health Service Standards.
- CHS Work Health and Safety audits.

Description of Service

The CHS Virtual Care Program will aim to safely transition adult patients/consumers from hospital inpatient settings back into a community setting. This service will operate 7 days a week, 8.00 am to 5pm, staffed by registered nurses who monitor patients remotely with regular phone and telehealth follow up. The regular telehealth sessions provide a clinical assessment, and are designed to trigger early escalation, further treatment and or admission.

The Virtual Care Program is under the governance of the Division of Medicine at CHS.
The service will incorporate the COVID Care @ Home service, including the infusion service for antivirals in collaboration with HITH, primarily for immunosuppressed patients. This service manages referrals from GPs for infusions in consultation with the Infectious Disease Unit. The IV Remdesivir pathway provides clear management for these patients.

The existing Covid Care@ Home service has resources and capabilities in place, with staff skilled in managing respiratory diseases such as COVID. The Virtual Care Program will utilize existing CC@H resources: nursing and administration staffing, IT software and hardware as well as technical support, accommodation, and networks. The focus of the program is supporting patient flow and early discharge of patients.

The Virtual Care Program Nursing team will:

- **Triage** patients and determine who can safely be cared for in the community at the time of referral.
- **Identify** patients who are eligible for COVID treatment and other patients who are suitable for early discharge and virtual care.
- **Provide advice** for patients regarding monitoring of symptoms and appropriate home-based care.
- **Predict** patients who may be at risk of requiring hospitalization.
- **Detect** clinical deterioration.
- **Escalate** appropriately.

5. Referral pathway – Eligibility

A consumer will be eligible for the Virtual Care program if they meet the below criteria:

INCLUSION CRITERIA	EXCLUSION CRITERIA
Patients over 16 years of age.	Paediatric patients
Be a resident or currently residing in the ACT for the duration of their virtual care	Non-ACT residents
Patients discharged by their medical team and allied health (if involved) with a completed discharge summary and medical plan for follow-up.	Patients who are discharging against medical advice. Patients without a complete discharge summary. Please note, AVS is not an acceptable substitute.
Medically stable patients with acceptable adjustments to typical parameters documented. Medically stable patients who have acceptable parameters for altered MEWS, needs to be pre-established by treating team prior to acceptance into VCP	Medically unstable patients

INCLUSION CRITERIA	EXCLUSION CRITERIA
Patients who have been compliant with their treatment and consent to being part of the program.	Non-compliant or non-consenting patients.
Access and ability to use a telephone or have a family, friend or carer that can assist them.	
The ability to self-monitor observations, using monitoring equipment supplied by VCP. Or have a family member who can provide assistance or support.	
Patients with the cognitive abilities to participate in their virtual care	Patients without the cognitive ability to participate in a Virtual health consult.
	Patients who usually live in or have been discharged to aged care facilities.

Referral

Patients can be flagged and referred by a specialty service, usually from:

- IP Wards
- Emergency Department
- Acute Medical Unit
- HITH

The Virtual Care Program referral form is to be completed in DHR. The nursing team will assess if the patient is suitable for the program and provide feedback and acceptance to the referring team.

Patient conditions suitable for the program can include the following:

- COPD
- Heart Failure
- Patients with unstable Diabetes
- Patients recovering from an infection such as cellulitis requiring monitoring.
- Frailty requiring daily support in early days post discharge.

6. Clinical Assessment

Once the patient is deemed appropriate for the program a clinical assessment will be completed. The assessment contains details of:

- Referral
- Patient core identifiers
- Specialty team discharge plan
- GP
- Social situation
- Risk assessment
- Recent observations
- Medications
- Consent
- Discharge requirements
- Program detail and information to consumer
- Patient checklist
- Clinical assessment
- Management plan

The patient will be orientated to the program and verbal consent obtained. The nursing staff will liaise with the patient to ensure that they have a landline, reliable access to mobile reception and internet service to support videoconferencing.

The nursing team uses the Patient assessment tools embedded in DHR to conduct a clinical assessment. All patients will have twice daily telehealth consultation by the nursing staff and documented in DHR.

Telehealth

How to do the telehealth link for the patient - Patient - MyDHR Video Visit Telehealth (act.gov.au)

How to telehealth for the Staff - Patient Connect Via Direct Link Telehealth / Video Visit act.gov.au)

Observations

Observations recorded at each telehealth consult can include:

- Oxygen saturation
- Blood pressure
- Temperature
- Weight
- Blood Glucose Level

Equipment available:

- Saturation monitor
- Thermometer
- Scales
- Blood pressure machine
- Blood Glucose monitor

7. Program details

- Admission to the Virtual Care Program is for a period of up to 2 weeks (14 days)
- Parameters are individualized according to the patient's condition - individual goal setting is set on admission.
- Nurse Telehealth sessions will occur up to twice a day.
- Verbal Consent will be obtained.
- The patient will be provided education on program content, a consumer handout will be provided and education on the use of monitoring equipment before leaving hospital.
- Virtual care nurses will do an assessment on the ward.
- The program is responsible for the care of patients referred for short term virtual care in the community. If concerned clinically, the nursing staff will escalate to the home team medical staff who will determine whether a patient can remain in the community, require assessment and intervention, or be admitted to HITH or to a physical inpatient bed.

- The patients GP will be notified of the admission to program and an appointment made with the GP at the earliest convenience.
- A nursing discharge summary will be sent to the patients regular GP on discharge.
- A staff information flyer / poster will be available on the Hub with program details.
- The program has an education PowerPoint available to be used to conduct in services to wards.

8. Clinical Escalation Pathway

A clinical escalation pathway is used to guide the nursing staff using red flags and causes for concern as triggers for escalation. Nursing will escalate to the patients GP, medical home team or call 000 to seek emergency assistance for the patient.

Clinical Escalation Pathway

CAUSES OF CONCERN

Temperature >38°C (Not responding to paracetamol or ibuprofen)
Feeling cold and sweaty
Oxygen saturation < 94% on room air (or baseline saturation if underlying lung disease)
Heart rate >100 in adults at rest
Blood pressure <110 or >140
Ongoing nausea, vomiting, dehydration or unable to tolerate oral fluids.
Decreased urine output.
Increasing pain, swelling, redness, tenderness, or bleeding from a drain site or surgical wound

RED FLAGS

Severe breathlessness or sudden onset shortness of breath
Blue lips, or face/cyanosis, blotchy peripheries
Respiratory rate >20 per minute at rest
Chest pain or pressure (including pain on inspiration)
Haemoptysis or Haematemesis
Appearing agitated, confused or very drowsy.

Unstable BGl not within patients' normal parameters and/or positive ketones
Hypertension >160 with headache or vision/gait changes
Severe or sudden onset headache (thunderclap) +/- visual disturbance, nausea, or changes to speech/gait
Syncope +/- head strike
Paralysis or numbness particularly one side of the body
New onset confusion +/- trouble with walking, speaking, or swallowing.
PR bleeding or severe Haematuria
No urinary output.
Constipation with severe abdominal pain, nausea and vomiting.
Uncontrolled pain

Urgent Telehealth assessment (within 5 minutes)
Inform TL/RN2

Encourage to consult regular GP and or medical home team.

Immediately instruct consumer/carer to call 000 or present to ED

An ISBAR handover report is utilised to provide a daily handover to oncoming staff and the weekend shift.

Out of hours contact.

Patients will be provided with details on who to call out of hours.

Canberra Afterhours Locum Medical Service (CALMS) after 6pm weekdays and all-day weekends and public holidays. 1300 422 567.

Health Direct provides advice by phone only on phone 1800 022 222.

Equipment

All patients will be provided with appropriate equipment for their condition.

A log is kept for equipment distribution and for cleaning, returning to department.

An Equipment brochure is sent to patients to provide education on the use of the equipment. A log is kept on all equipment sent out, as equipment is retrieved and cleaned to re-use for the next patient. The patient is supplied with a remote monitoring diary to record their observations.

Mental Health screening

Mental health screening can be completed by nurses using the Patient Health Questionnaire 9 (PHQ9). The Virtual Care program nurses will initiate a referral to the appropriate program if any concerns with mental health, such as Access Mental Health and the patients GP, following the initial risk assessment, and during the time on the program, as appropriate. The nursing staff have mental health service providers resources to refer to, if required.

The PHQ9 is a tool used to monitor the severity of the depression and the response to treatment.

Resources for consumers and carers

- Virtual Care Program consumer handout
- Condition specific information
- Equipment brochure

Use of Monitoring App

The My DHR application enables virtual patient monitoring with an escalation ability that is used as an electronic record for the program. All patients will be given access to the APP and support for loading and continued use. In progress to be developed by DHR for Virtual Care. A nurse will be allocated to always cover the escalations list. The list will be reviewed regularly, provide follow up phone calls to the patients and recommend further action.

Primary Care - GP

The patient's GP will be notified when the patient is enrolled in the Virtual Care Program and when there is an escalation in care, including admission to HITH or Hospital. The programs nursing team will complete a discharge summary post discharge from the program, which is then sent to the GP.

Documentation

It is a clinical requirement that all clinical activity, including telehealth consultations, is documented in the patient's digital health record. Activity data will be gained from EPIC and regular auditing will occur.

EPIC dashboard – virtual care is in design mode.

Reporting

A daily report can be provided by close of business each day which will include a status update for all patients in the program.

Reporting Indicators for the program include:

- Readmission to hospital
- Number of patients in the service daily
- Daily escalations on APP
- Number of referrals to GP and other clinicians
- Patient satisfaction

9. Length of stay

Contact with the ACT Ambulance Service

A patient in the program will still contact 000 for any medical emergencies.

10. Virtual Care @ Home Program

Hours of Operation	0800 to 1700hr every day including weekends and public holidays.		
Referral only	Referral form in DHR		
Eligibility	Patients aged over 16 years. Resident in ACT. Patients discharged with a clear medical plan.		
Volume of total patients	50		
Workforce Nursing	ADON CNC 2 RN 2 1 RN 1		
Workforce – Administration	ASO3 x1		
Governance	CHS Division of Medicine.		
Equipment / Supplies	Imprest will be determined and stocked as per existing arrangements.		
Billing	Activity will be captured as an outpatient appointment. Funding will be via Activity Based Funding.		
Clinical Records	Digital Health record is the primary clinical record for all patients.		
Discharge / Transfer	Direct admissions will be arranged should a patient require further inpatient care or deteriorates. Where possible Emergency Department presentations will be avoided. Rapid deterioration of patients and transfer to hospital will require contact to 000 and ambulance transfer.		

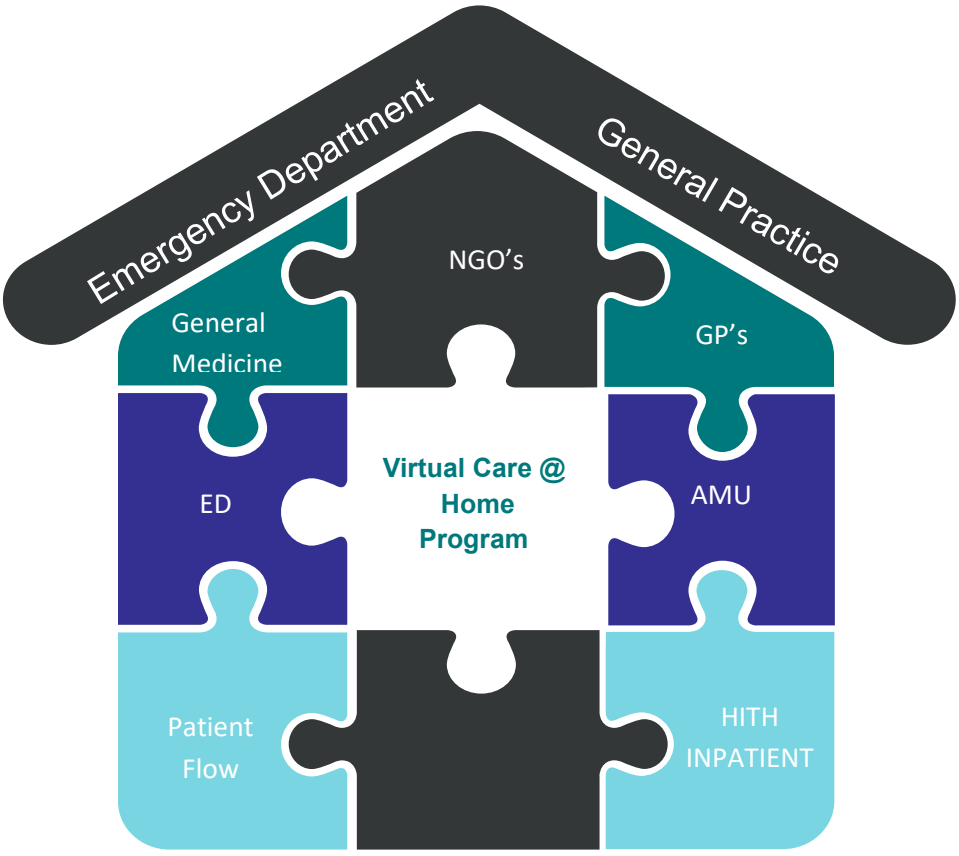
Interdisciplinary Team

Integral to the success of the Virtual Care Program is the interdependency with ACT Health.

Key stakeholders in the Program include but are not limited to:

- Primary Health practitioners with links provided through the CHS GP Liaison Unit (GPLU), Capital Health Network (CHN), event summaries and notifications.
- Consumers with links directly and formally through the Health Care Consumers Association (HCCA).
- Non-Government Organization (NGO) providers with links provided through direct relationships.
- **The current trial of the Liaison Navigation service and the ACT Primary Care pilot will work very well in unison with the Virtual Care program.**

The diagram below indicates these as well as some of the other main interdependencies that are crucial for the success of the program.



Facilities & Equipment Requirements

Location

The Virtual Care Program team is located at Canberra Hospital, Building 1 Level Ten. The location includes the ability to support 10 (or more) work desks and holds clinical stores.

Transport

Transporting of equipment is required by the Virtual Care Program and will be included as part of the program.

Equipment

The equipment is obtained through Facilities Management. Basic equipment and infrastructure required for Program are identified below:

- IT equipment
    - 7 laptops
    - Phones
    - Mobiles
    - Webex TV screen
    - Headsets
- Supply Storage
    - Supplies in a locked storage area.
    - Supplies will need to be advised of stock and regular delivery from the Purchasing and Inventory Control System (PICS)
- Furniture/Equipment
    - Desks
    - Chairs
    - Cupboards
- Telemonitoring equipment
    - Saturation monitor
    - Thermometer
    - Scales
    - Blood pressure machine
    - Blood Glucose monitor
    - iPad

Service support

This section describes the services which support the operations of the team.

Data Entry and the Electronic Medical Record

Clinicians have access to computers to enter relevant patient information into DHR. This system can send referrals, provide discharge emails (to patient and GPs). This includes a combination of fixed computers located within the staff base as well as several laptops.

Biomedical Equipment Management

Biomedical Equipment Management services is provided by Healthcare Technology. To progress having a regular supply of oxygen monitors and thermometers through PICS.

Communication within the Team

Staff have access to telephone communications through VoIP telephones and mobile phone networks. Staff VoIP telephones and wireless internet access points (allows internal and public internet access) are available for 30 minutes through uninterrupted power supply battery backup in the event of a power failure to provide continued communications during systems failure or a disaster response.

Infection Control

The Virtual Care Program will comply with the National Safety and Quality Health Service (NSQHS) Standard on Prevention and Control of Healthcare Infections; CHS policy and procedure; and work with the infection Prevention and Control Unit (ICPU) to minimise the risk of health care related infection. Processes in the community and within the office will include hand hygiene practices, standard and additional precautions, and environmental cleaning.

Interpreter services

Interpreters are available to the staff for patients and families who are unable to communicate effectively in English through the Translating and Interpreting Services (TIS) – for ease of contact.

Printer

A multifunction printer and a pharmacy scanner are located within staff workstations.

Staff profile

The staff profile in the Virtual Care Program requires a skilled workforce adept at assessing and treating patients with chronic disease and multiple comorbidities. The Virtual Care Program requires a workforce that may be required to work flexibly across the Division as required.

The Program is comprised of a specialist nursing and administration team.

Nursing staff including:

- Assistant Director of Nursing (ADON) overseeing the Program
- CNC with responsibilities across all aspects of the program, including taking case load.
- Registered nurses
- Administration staff

Accreditation and Training

CHS is committed to the strategic priority of improving the experience of people accessing healthcare at CHS. This is achieved through accreditation and training pathways that support sustainable MoC which deliver the highest standards of safety and quality in an efficient and effective way. CHS is accredited with the Australian Council on Healthcare Standards (ACHS) as compliant against the 10 National Safety and Quality Health Service (NSQHS) Standards. Accreditation occurs at four yearly intervals.

Clinicians need to have sufficient skills, training, and competence to provide treatment for the presenting problems of patients accessing the service. While it is not expected that clinicians will be able to manage every problem they encounter, they will only work within their scope of practice as defined by their training, competence, and any relevant professional affiliation.

The Virtual Care Program is a learning environment that contributes to the professional development and evidence-based practice of future clinicians and supports clinicians to receive training which meets the key principles of care for service. Clinicians are expected to engage in professional development. The staff in the Program have access to the CHS training calendar, accessible via HRIMS.

CHS has other training commitments and responsibilities for a range of Medical (undergraduate and graduate), Specialist, Nursing, Allied Health, and other professional staff, and is part of the:

- Australian National University (ANU) Medical School teaching for general medical undergraduate placements, and post-graduate specialist training.
- University of Canberra (UC), particularly for Nursing and Allied Health.
- Australian Catholic University.
- Charles Sturt University.
- Canberra Institute of Technology for Nursing and Allied Health.

11. Implementation

The implementation of this MoC will commence and continue to be updated by the Division of Medicine.

The MoC will be implemented through the development and implementation of:

- an ongoing training program for staff working within the team.
- an orientation for new staff employed to work within the team.
- processes and documentation used within the team that support the principles of the MoC.

12. Monitoring and Evaluation

Evaluation of the program will occur in the first 6 months and include parameters around:

- Access to care
- Timeliness of care measurements
- Patient numbers

- Length of stay
- Cost-effectiveness (use of budget including effective use of staff)
- Patient experience (patient journey, technology access and ease of use etc.)
- Effectiveness of the program (patient outcomes and quality and safety measures)

The Virtual Care Program will ensure the provision of a high-quality service through ongoing feedback from those who use the service, measurement of staff satisfaction and well-being and through the collection of data relating to the characteristics of service utilization.

The Assistant Director of Nursing is responsible for monitoring and evaluation in consultation with the Clinical Director of Division of Medicine. Meetings will occur monthly including Quality / Safety Clinical Governance and a report provided to the Clinical Director, DOM.

The Program will evaluate its performance against the goals outlined in this MoC and through national standards and accreditation. The Program MoC will be reviewed within 6 months following implementation. Monitoring and evaluation will occur through a range of mechanisms including:

- CHS Clinical Governance Structure and Committees
- CHS Risk Management Processes
- Australian Council of Health Care Standards (ACHS) against the National Quality and Safety Health Service Standards.
- Staff well-being measures such as leave rates and culture surveys.
- Patient satisfaction surveys.
- Staff satisfaction survey

Records Management

Following the relevant consultation, this finalised document and any further updates will be electronically stored on the Canberra Health Services intranet site, 'Models of Care', to ensure accessibility for all staff.

13. Abbreviations

ACTAS	ACT Ambulance Service
CHN	Capital Health Network
CHS	Canberra Health Services
CNC	Clinical Nurse Consultant
COWS	Computers on Wheels
CPF	Clinical Patient Folder
CPHB	Calvary Public Hospital Bruce
CTP	Clinical Treatment Protocols
ED	Emergency Department
EPIC	Vendor of the Digital Health Record
GPLU	GP Liaison Unit
HCCA	Health Care Consumers Association
HITH	Hospital in the Home
ICU	Intensive Care Unit
ID Consultant	Infectious Diseases Specialist On-Call
IPCU	Infection Prevention and Control Unit
JMO	Junior Medical Officer
MSO	Medication Standing Order
NGO	Non-Government Organisation
PHECC	Public Health Emergency Coordination Centre
PICS	Purchasing and Inventory Control System
SNSWLHD	Southern New South Wales Local Health District
TIS	Translating and Interpreting Services

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ACKNOWLEDGMENT OF COUNTRY

Canberra Health Services acknowledges the Traditional Custodians of the land, the Ngunnawal people. Canberra Health Services respects their continuing culture and connections to the land and the unique contributions they make to the life of this area. Canberra Health Services also acknowledges and welcomes Aboriginal and Torres Strait Islander peoples who are part of the community we serve.

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