National Safety and Quality
Health Service Standards

Guide for Day Procedure Services

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Quick guide

Contents

Introduction

The National Safety and Quality Health Service (NSQHS) Standards were developed by the Australian Commission on Safety and Quality in Health Care (the Commission) in collaboration with the Australian Government, states and territories, the private sector, clinical experts, patients and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health care. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure that expected standards of safety and quality are met.

There are eight NSQHS Standards, which cover high-prevalence adverse events, healthcare-associated infections, medication safety, comprehensive care, clinical communication, the prevention and management of pressure injuries, the prevention of falls, and responding to clinical deterioration. Importantly, these NSQHS Standards have provided a nationally consistent statement about the standard of care consumers can expect from their health service organisations.

The NSQHS Standards require the implementation of organisation-wide systems for clinical governance, partnering with consumers, healthcare-associated infections, medication safety, comprehensive care, effective communication, blood management, and recognising and responding to acute deterioration.

The Commission has developed the *National Safety and Quality Health Service Standards Guide for Day Procedure Services* to assist day procedure services to align their patient safety and quality improvement programs using the framework of the NSQHS Standards (second edition). This guide will also assist individuals involved in the accreditation process.

The Clinical Governance Standard and the Partnering with Consumers Standard set the overarching system requirements for the effective implementation of the remaining six standards, which consider specific high-risk clinical areas of patient care. The NSQHS Standards describe the patient care journey and are designed to be implemented in an integrated way. Similar implementation strategies apply to multiple actions across the NSQHS Standards. It is important to identify the links between actions across each of the eight NSQHS Standards. This will help health service organisations to ensure that their safety and quality systems are integrated, and reduce the duplication of effort in implementing the eight standards separately.

Important improvements in the safety and quality of patient care have been documented following implementation of the first edition of the NSQHS Standards from 2011, including:

- A decline in the *Staphylococcus aureus* bacteraemia rate per 10,000 patient days under surveillance between 2010 and 2014, from 1.1 to 0.87 cases
- A drop in the yearly number of methicillin-resistant *S. aureus* bacteraemia cases between 2010 and 2014, from 505 to 389
- A decline of almost one-half in the national rate of central line-associated bloodstream infections between 2012–13 and 2013–14, from 1.02 to 0.6 per 1,000 line days
- Greater prioritisation of antimicrobial stewardship activities in health service organisations
- Better documentation of adverse drug reactions and medication history
- Reduction in the yearly red blood cell issues by the National Blood Authority between mid-2010 and mid-2015, from approximately 800,000 units to 667,000 units
- Declining rates of intensive care unit admissions following cardiac arrests and in-hospital cardiac arrest rates.

The Commission has worked closely with partners to review the NSQHS Standards and develop the second edition, embedding person-centred care and addressing the needs of people who may be at greater risk of harm. The NSQHS Standards (2nd ed.) set requirements for providing comprehensive care for all patients, and include actions related to health literacy, end-of-life care, care for Aboriginal and Torres Strait Islander people, and care for people with lived experience of mental illness or cognitive impairment.

The eight NSQHS Standards are:

Clinical Governance, which describes the clinical governance, and safety and quality systems that are required to maintain and improve the reliability, safety and quality of health care, and improve health outcomes for patients.

Partnering with Consumers, which describes the systems and strategies to create a person-centred health system by including patients in shared decision making, to ensure that patients are partners in their own care, and that consumers are involved in the development and design of quality health care.

Preventing and Controlling Healthcare-Associated Infection, which describes the systems and strategies to prevent infection, to manage infections effectively when they occur, and to limit the development of antimicrobial resistance through prudent use of antimicrobials, as part of effective antimicrobial stewardship.

Medication Safety, which describes the systems and strategies to ensure that clinicians safely prescribe, dispense and administer appropriate medicines to informed patients, and monitor use of the medicines.

Comprehensive Care, which describes the integrated screening, assessment and risk identification processes for developing an individualised care plan, to prevent and minimise the risks of harm in identified areas.

Communicating for Safety, which describes the systems and strategies for effective communication between patients, carers and families, multidisciplinary teams and clinicians, and across the health service organisation.

Blood Management, which describes the systems and strategies for the safe, appropriate, efficient and effective care of patients' own blood, as well as other supplies of blood and blood products.

Recognising and Responding to Acute Deterioration, which describes the systems and processes to respond effectively to patients when their physical, mental or cognitive condition deteriorates.

For each standard, this guide contains:

- A description of the standard
- A statement of intent
- A list of criteria that describe the key areas covered by the standard
- Explanatory notes on the content of the standard
- Item headings for groups of actions in each criterion
- Actions that describe what is required to meet the standard
- Key tasks, strategies, and use of examples of evidence to support each action.

Icons for specific actions

This guide uses icons to indicate actions that are relevant for particular groups or issues.

The following icons identify actions relating to safety and quality issues that were addressed in separate standards in the first edition of the NSQHS Standards. These issues have been incorporated into the requirements of the second edition.

The Comprehensive Care Standard includes actions relating to:

Preventing falls and harm from falls

Preventing and managing pressure injuries

The Communicating for Safety Standard includes actions relating to:

Patient identification and procedure matching

This guide relates to the second edition of the NSQHS Standards, released in November 2017.

The key tasks, strategies, and use of examples of evidence and resources provided in this guide are not mandatory.

Day procedure services can choose improvement strategies that are specific to their local context. These strategies should be meaningful, useful and relevant to the organisation's governance, structure, workforce and consumers.

Day procedure services that are part of a corporate group may need to refer to the implementation strategies recommended by the group's governing body or management.

This guide includes examples of the kind of evidence a day procedure service may use to show that it meets each of the actions required for the NSQHS Standards.

It is not expected that day procedure services will have all the listed examples of evidence in place. Day procedure services vary in size and structure, and will have different ways of developing and presenting evidence.

More information

A range of other supporting resources to assist health service organisations to implement the NSQHS Standards are available on the Commission's website.

The Advice Centre provides support for health service organisations, surveyors and accrediting agencies on NSQHS Standards implementation.

Email: accreditation@safetyandquality.gov.au

Phone: 1800 304 056

Types of evidence included in this guide

This guide includes specific and generic examples of evidence. Most of the examples of evidence are listed as generic evidence by category. Examples of these categories of evidence are shown below.

Policy documents can include:

- By-laws
- Policies
- Procedures
- Protocols
- Guidelines
- Pathways.

A policy document may exist for a single action, a number of actions, parts of one or more standards, or a whole standard. The number of policies and detail in each policy will depend on the organisation's size, complexity and type of services.

Training documents can include:

- Orientation manuals
- Education calendars
- Training presentations
- Attendance records
- Online education modules
- Contracts with external education providers.

Organisations need to use a risk management approach to decide what training is required, which members of the workforce need training and how often training needs to occur. Training can also include competency-based assessments and professional development.

Committee and meeting records can include:

- Committee membership
- Committee terms of reference
- Agenda papers, minutes or actions arising from a meeting
- Dashboard reports
- Committee correspondence
- Reports submitted to a committee.

The number, structure and function of committees will vary across organisations. Smaller organisations may have one committee that covers one or several

standards, whereas larger organisations may have committees for specific actions in the standards, such as antimicrobial stewardship.

Audit results can include:

- Survey instruments, forms and tools used to conduct audits
- Analysis of data collected
- Reports on audits conducted
- Documents showing that audit results were benchmarked.

A risk management approach should be taken when determining what areas of a health service organisation are to be audited, how big the sample size will be, how often the audit will be conducted, and how the audit results will be used to improve safety and quality of health care for patients.

Communication with the workforce, health service organisation or highest level of governance can include:

- Reports tabled at meetings
- Intranet content or online message boards
- Correspondence, such as broadcast emails
- Newsletters
- Posters.

Employment documents can include:

- Position descriptions
- Duty statements
- Employment contracts
- Performance review documentation
- Notification of scope of clinical practice.

Observations can be undertaken for:

- The presence of a resource, such as signage, personal protective equipment or guidelines
- Clinical practice
- The inclusion of a specific tool or form in healthcare records.

Observations will be used by assessors from accrediting agencies, but can also be used by organisations as part of an ongoing monitoring process.

1

Clinical Governance Standard
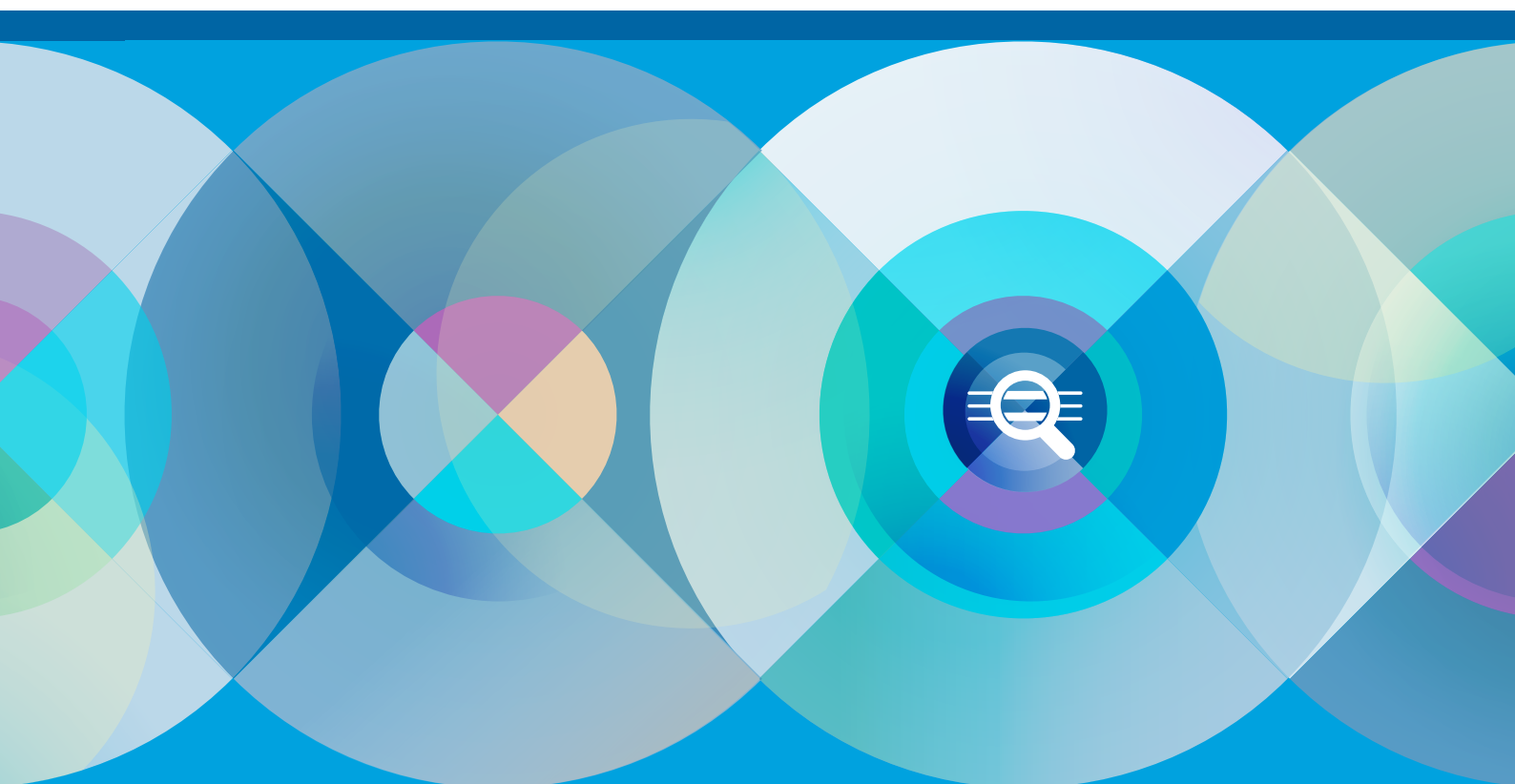
Clinical Governance Standard

Leaders of a health service organisation have a responsibility to the community for continuous improvement of the safety and quality of their services, and ensuring that they are patient centred, safe and effective.

Intention of this standard

To implement a clinical governance framework that ensures that patients and consumers receive safe and high-quality health care.

Criteria

Governance, leadership and culture

Patient safety and quality systems

Clinical performance and effectiveness

Safe environment for the delivery of care

Introduction

Patients and the community trust clinicians and health service organisations to provide safe, high-quality health care.

Clinical governance is the set of relationships and responsibilities established by a health service organisation between its department of health (for the public sector), governing body, executive, workforce, patients and consumers, and other stakeholders to deliver safe and high-quality health care. It ensures that the community and health service organisations can be confident that systems are in place to deliver safe and high-quality health care, and continuously improve services.

Clinical governance is an integrated component of corporate governance of health service organisations. It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of health services that are safe, effective, high quality and continuously improving.

Each health service organisation needs to put in place strategies for clinical governance that consider the organisation's local circumstances.

To support the delivery of safe and high-quality care for patients and consumers, the Australian Commission on Safety and Quality in Health Care (the Commission) has developed the National Model Clinical Governance Framework. The framework has five components based on the criteria in the Clinical Governance Standard and the Partnering with Consumers Standard. Health service organisations should refer to the framework for more details on clinical governance, and the associated roles and responsibilities.

See the National Model Clinical Governance Framework[1] and *National Safety and Quality Health Service Standards Guide for Governing Bodies*.[2]

CRITERION: Governance, leadership and culture

Leaders at all levels in the organisation set up and use clinical governance systems to improve the safety and quality of health care for patients.

Corporate governance encompasses the establishment of systems and processes that shape, enable and oversee the management of an organisation. It is the activity performed by governing bodies (often boards) of formulating strategy, setting policy, delegating responsibility, supervising management, and ensuring that appropriate risk management and accountability arrangements are in place throughout the organisation.

Management has an operational focus, whereas governance has a strategic focus. Managers run organisations, whereas the governing body ensures that the organisation is run well and in the right direction. It is the board's responsibility to ensure good governance.[3]

The governing body derives its authority to conduct the business of the organisation from enabling legislation, licences and the organisation's constitutional documents. The organisation is governed using corporate and clinical governance processes, elements of which are implemented by the governing body and the workforce.

Governance, leadership and culture

Action 1.1

The governing body:

a. Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation

b. Provides leadership to ensure partnering with patients, carers and consumers

c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community

d. Endorses the organisation's clinical governance framework

e. Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce

f. Monitors the action taken as a result of analyses of clinical incidents

g. Reviews reports and monitors the organisation's progress on safety and quality performance

Reflective questions

How does the governing body understand and promote safety and quality within the health service organisation?

How does the governing body set strategic direction, and define safety and quality roles and responsibilities within the health service organisation?

What information does the governing body use to monitor progress and report on strategies for safe and high-quality clinical care?

Key tasks

- Identify the governing body – this is the group of people or individuals with ultimate responsibility and accountability for decision-making about safety and quality

- Ensure that the roles, responsibilities and accountabilities for safety, quality and clinical governance within the organisation are clearly articulated
- Review the organisational structure, and the position descriptions and contracts for managers, and ensure that roles, responsibilities and accountabilities for safety (including clinical safety) and quality are clearly defined and articulated at all levels in the organisation
- Endorse the organisation's clinical governance framework, strategic direction, safety and quality improvement objectives, and objectives for partnering with consumers, which may be articulated in one or more plans
- Review the template or calendar for reporting to the governing body on safety and quality indicators and data, and ensure that it covers all services, major risks, dimensions of quality and key elements of the quality improvement system
- Regularly review quality indicators to ensure that they are relevant and comprehensive
- Review relevant data from clinical incidents, and reports of complaints and other incidents
- Review the processes for providing feedback to the workforce, patients, consumers and the community about the organisation's safety and quality performance
- Review the organisation's audit program to ensure that it has enough safety and quality content
- Ensure that mitigation strategies are in place to manage all major risks
- Ensure that systems are in place to regularly survey and report on organisational culture.

Strategies for improvement

Leaders, managers and clinicians have an important role in influencing the safety and quality of care by shaping culture within the organisation, setting direction, providing support to the workforce, and monitoring progress and improvement in safety and quality performance.[4,5]

Define safety culture

There are many definitions of a safety culture. It involves the interaction of attitudes, beliefs and behaviours of members of the workforce that influence their commitment to the organisation's safety management.

A common interpretation of safety culture – which is perhaps more meaningful – is 'the way things are done around here'.[6]

Positive safety cultures in health care have strong leadership to drive and prioritise the safety of all. Commitment from leadership and management in this context is important because their actions and attitudes influence the perceptions, attitudes and behaviours of members of the workforce throughout the organisation.

Organisations with positive safety cultures have:
- Strong leadership to drive the safety culture
- Strong management commitment, with safety culture a key organisational priority
- A workforce that is engaged and always aware that things can go wrong
- Acknowledgement at all levels that mistakes can occur
- The ability to recognise, respond to, give feedback about, and learn from, adverse events.

Define governance processes

The governing body has ultimate responsibility for the clinical governance of the organisation. It has obligations to ensure that effective safety and quality systems, and robust governance practices are in place and performing well. The governing body must ensure that safety and quality are consistently and effectively monitored, and that responses to safety and quality matters are prompt and appropriate.

The governing body should define its expectations about the safety and quality performance of the organisation, and the behaviours expected from its workforce. It should also be clear about how and when the safety and quality culture of the organisation will be measured and monitored.

The organisational structure for day procedure services varies from small, owner–operator models of service delivery to large corporations. The governance arrangements for smaller organisations may be less formal than those of large ones, but owners still have a responsibility to ensure that appropriate systems are in place so that they can provide safe and high-quality care.

The governing body and management need to regularly assess the systems in place to help them perform their clinical governance roles, such as:

- Identifying the appropriate structures and processes to manage and monitor clinical performance
- Describing the expected outcomes in safety and quality through the organisation's vision, mission and goals
- Setting the requirements for time frames, targets, and reporting on safety and quality performance
- Monitoring implementation and compliance with strategic, business, or safety and quality improvement plans.

Involve consumers and define patient experience

The governing body should ensure that effective partnerships are developed, and promote the organisation's engagement with patients and consumers. Strategies may involve:

- Allocating time in meeting agendas to hear and discuss patient stories or consumer feedback
- Ensuring that resources are available to support activities such as collecting patient experience data, engaging with consumers, supporting workforce training in person-centred care, and developing or adapting shared decision support tools.

The governing body should define the expected quality of the patient experience. Setting priorities and targets for safety and quality enables the organisation to define the roles and responsibilities of the workforce to achieve these goals, and to set up systems that support quality patient experiences.

Information about the expected quality of the patient's experience can be communicated to the workforce through strategic plans, policy documents or newsletters.

Endorse the clinical governance framework

The responsibility of a governing body (such as a board) for clinical governance is an integrated element of its overall responsibility and accountability to govern the organisation. As a component of broader systems for corporate governance, clinical governance involves a complex set of leadership behaviours, policies, procedures, and monitoring and improvement mechanisms

that are directed towards ensuring good clinical outcomes.

The clinical governance system of a health service organisation therefore needs to be conceptualised as a system within a system – a clinical governance system within a corporate governance system.

Under this model, it is important to recognise the following points:

- Clinical governance is of equivalent importance to financial, risk and other business governance
- Decisions regarding other aspects of corporate governance can have a direct impact on the safety and quality of care, and decisions about clinical care can have a direct impact on other aspects of corporate governance, such as financial performance and risk management
- Governing bodies are ultimately responsible for good corporate (including clinical) governance
- Governing bodies cannot govern clinical services well without the deep engagement of skilled clinicians working at all levels of the organisation
- Clinicians, managers and members of governing bodies have individual and collective responsibilities for ensuring the safety and quality of clinical care. As well as being reflected in the NSQHS Standards, many of these are also specified in relevant professional codes of conduct.

Clinical governance relies on well-designed systems that deliver, monitor and account for the safety and quality of patient care. Although it is ultimately the responsibility of a governing body to set up a sound clinical governance system and be accountable for outcomes and performance within this system, implementation involves contributions by individuals and teams at all levels of the organisation.

The Commission has developed the National Model Clinical Governance Framework.[1] Health service organisations can adapt and implement the framework to best meet the needs of their patients and local circumstances, and to ensure that systems are regularly evaluated to improve safety and quality. See Action 1.3 for establishing and maintaining a clinical governance framework.

The National Model Clinical Governance Framework is based on the NSQHS Standards – in particular, the Clinical Governance Standard and the Partnering with Consumers Standard.

The Clinical Governance Standard and the Partnering with Consumers Standard together ensure the creation of clinical governance systems within health service organisations that:

- Are fully integrated within overall corporate governance systems
- Are underpinned by robust safety and quality improvement systems
- Maintain and improve the reliability, safety and quality of health care
- Improve health outcomes for patients, and ensure the safety and quality of care.

Together, these two standards constitute a complete and robust clinical governance framework.

Support the governance system

The governing body should describe the roles and accountabilities for the safety and quality of care within the health service organisation.

The governance system should provide:

- A clear definition of safety and quality that articulates reporting lines, responsibilities and accountabilities
- Position descriptions for all members of the workforce that clearly document responsibilities and accountabilities for the safety and quality of clinical care
- Safety and quality policies, procedures or protocols that describe how patient safety is embedded in the operation of the organisation
- A structured performance development system for clinicians and managers that incorporates a regular review of their engagement in safety and quality activities.

Monitor and review performance

The governing body is responsible for reviewing reports, and monitoring the organisation's safety and quality performance. The governing body should regularly review a selection of the organisation's most important quality metrics, which may include:

- Key national priority indicators and regulatory requirements
- A selection of measures covering safety, clinical effectiveness, patient experience, access, and efficiency and appropriateness of care

- Trends in complaints from patients and the workforce, and action taken to resolve complaints
- Trends in reported adverse events, incidents and near misses, and actions taken
- Workforce surveys to monitor the organisational culture
- Risk ratings
- Compliance with best-practice pathways
- Comparisons with peer organisations, and state and territory or national performance data.

In addition to monitoring indicators and trends, governing bodies should review relevant clinical and organisational systems to ensure that they are fit for purpose and being used in the organisation.

Examples of evidence

Select only examples currently in use:

- Policy documents that describe the
  - roles and responsibilities of the governing body
  - health service organisation's clinical governance framework
  - processes for partnering with consumers
- Strategic, business or risk management plans that describe the priorities and strategic directions for safe and high-quality clinical care that are endorsed by the governing body
- Committee and meeting records in which clinical governance, leadership, safety and quality culture, or partnering with consumers are discussed
- Documented clinical governance framework that is endorsed by the governing body
- Audit framework or schedule that is endorsed by the governing body
- Safety and quality performance data, compliance reports and reports of clinical incidents that are monitored by the governing body, managers or the clinical governance committee
- Annual report that includes information on the health service organisation's safety and quality performance
- Terms of reference or letter of appointment to the governing body that describes members' safety and quality roles and responsibilities
- Communication with the workforce or consumers on the health service organisation's clinical governance framework for safety and quality performance.

Action 1.2

The governing body ensures that the organisation's safety and quality priorities address the specific health needs of Aboriginal and Torres Strait Islander people

This action applies to day procedure services that commonly provide care for Aboriginal and Torres Strait Islander people. These services should refer to *NSQHS Standards Guide for Hospitals*, *NSQHS Standards Accreditation Workbook* and *NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health* for detailed implementation strategies and examples of evidence for this action.

Day procedure services that rarely provide care for Aboriginal and Torres Strait Islander people, or when the risk of harm for these patients is the same as for the general patient population, should manage the specific risk of harm, and provide safe and high-quality care for these patients through the safety and quality improvement systems that relate to their whole patient population.

Day procedure services need to implement strategies to improve the cultural awareness and cultural competency of the workforce under Action 1.21, and identify Aboriginal and Torres Strait Islander patients under Action 5.8.

Organisational leadership

Action 1.3

The health service organisation establishes and maintains a clinical governance framework, and uses the processes within the framework to drive improvements in safety and quality

Reflective questions

Does the health service organisation have a documented clinical governance framework?

How is the effectiveness of the clinical governance framework reviewed?

Key tasks

- Develop a clinical governance framework
- Educate the workforce about the key aspects of the clinical governance framework, and their responsibilities for improving safety and quality
- Review policies, procedures and protocols to ensure that they align with the clinical governance framework

- Review results of clinical audits and system evaluation reports for compliance with the clinical governance framework.

Strategies for improvement

Day procedure services are responsible for designing and implementing the systems for an effective clinical governance system, as directed by the governing body. These systems and processes include:

- Identifying and managing risk
- Testing and influencing organisational culture
- Ensuring quality improvement
- Managing clinical practice
- Managing workforce performance and skills
- Managing incidents and complaints
- Ensuring patients' rights and engagement.

To ensure the effectiveness of these systems and processes, managers should use the clinical governance framework to:

- Monitor, analyse and report on performance
- Collect, analyse and report on feedback
- Recommend actions to improve the safety and quality of care, and provide advice to the governing body about the issues identified and actions taken.

Strategies may include:

- Establishing a group or committee that is responsible for overseeing the clinical governance framework
- Implementing policies, procedures and protocols that describe the clinical governance framework
- Clearly defining and articulating the roles and responsibilities of clinical leaders and members of the workforce at all levels in improving safety and quality
- Reviewing the implementation of the clinical governance framework

- Reviewing audit findings of compliance with policies, procedures and protocols.

See the National Model Clinical Governance Framework[1] for more information.

Examples of evidence

Select only examples currently in use:

- Documented clinical governance framework
- Documented safety and quality goals and performance indicators for the health service organisation
- Documented organisational and committee structure that is aligned to the clinical governance framework
- Audit results of compliance with the health service organisation's clinical governance framework, and management of safety and quality risks
- Reviews or evaluation reports on the effectiveness of the health service organisation's safety and quality systems.

Action 1.4

The health service organisation implements and monitors strategies to meet the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander people

This action applies to day procedure services that commonly provide care for Aboriginal and Torres Strait Islander people. These services should refer to *NSQHS Standards Guide for Hospitals*, *NSQHS Standards Accreditation Workbook* and *NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health* for detailed implementation strategies and examples of evidence for this action.

Day procedure services that rarely provide care for Aboriginal and Torres Strait Islander people, or when the risk of harm for these patients is the same as for the general patient population, should manage the specific risk of harm, and provide safe and high-quality care for these patients through the safety and quality improvement systems that relate to their whole patient population.

Day procedure services need to implement strategies to improve the cultural awareness and cultural competency of the workforce under Action 1.21, and identify Aboriginal and Torres Strait Islander patients under Action 5.8.

Action 1.5

The health service organisation considers the safety and quality of health care for patients in its business decision-making

Reflective questions

How are patient safety and quality issues considered when making business decisions?

How are decisions about patient safety and quality of care documented?

Key tasks

- Review the organisation's strategic planning and business planning processes to ensure that they explicitly capture safety and quality improvement strategies and initiatives, including those articulated in the organisation's clinical safety and quality plan
- Review templates for submitting business proposals to the governing body and management, and ensure that they take account of impacts on safety and quality.

Strategies for improvement

Include safety and quality goals, objectives and strategies prominently in business and strategic plans. This will ensure that all strategic and decision-making processes consider the safety and quality of all services being provided.

If a proposal for service development or a change in scope of clinical practice explicitly identifies implications for patient safety and quality of health care, adopt policies, procedures or protocols to explain how clinical risks will be managed.

Other strategies may include ensuring that:

- The terms of reference for committees (for example, finance and audit committees, strategic planning committees) consider safety and quality implications when making business decisions

- Decisions about the procurement of building, plant, consumables and equipment are informed, and that products and services are fit for purpose, comply with relevant standards, and take into consideration safety and quality issues such as multiple chemical sensitivity.

Examples of evidence

Select only examples currently in use:

- Committee and meeting records, such as for finance and audit committees, and strategic planning committees, that show that safety and quality of health care are considered in business decision-making
- Strategic plans, operational plans or business plans that outline the potential impact of decisions on patient safety and quality of care
- Business proposal templates that include consideration of safety and quality risks
- Register of safety and quality risks that includes actions to manage the identified risks.

Clinical leadership

Action 1.6

Clinical leaders support clinicians to:

a. Understand and perform their delegated safety and quality roles and responsibilities

b. Operate within the clinical governance framework to improve the safety and quality of health care for patients

Reflective questions

How do clinical leaders engage with other clinicians on safety and quality matters?

How does the health service organisation ensure that the clinical workforce operates within the clinical governance framework?

Key tasks

- Define and allocate the delegated safety and quality roles and responsibilities of the clinical workforce
- Conduct clinical audits to ensure that clinicians operate within the clinical governance framework
- Report audit findings to the governing body.

Strategies for improvement

Strong leadership can drive safety and quality improvements, and make them a priority. Commitment from leaders is important, because their actions and attitudes influence the perceptions, attitudes and behaviours of the workforce.[7]

Define the delegated safety and quality roles and responsibilities of clinical leaders. These may include implementing strategic direction, managing the operation of the clinical governance system, reporting on safety and quality, and implementing the organisation's safety culture.

Clinical leaders may support the clinical workforce by:

- Supervising relevant members of the clinical workforce
- Conducting performance appraisals or peer reviews
- Reviewing safety and quality performance data within the organisation
- Ensuring that the workforce understands the clinical governance system.

Strategies to achieve this may include:

- Providing safety and quality training for clinicians
- Ensuring that the workforce has access to information about their expected roles and responsibilities for safety and quality, and the operation of the clinical governance framework
- Clearly documenting the reporting lines and relationships for safety and quality performance
- Conducting performance appraisals and auditing clinical practice to ensure that clinicians operate within the clinical governance framework
- Reviewing clinical audit results and taking action to deal with any issues identified.

Day procedure services should ensure that all members of the clinical workforce understand and perform their safety and quality roles and responsibilities, including credentialed medical and other practitioners and nurses.

Examples of evidence

Select only examples currently in use:

- Policy documents that outline the delegated safety and quality roles and responsibilities of clinical leaders
- Employment documents that describe the safety and quality roles and responsibilities of clinical leaders
- Documented workforce performance appraisals that include feedback to clinical leaders on the performance of safety and quality roles and responsibilities
- Training documents relating to workforce safety and quality roles and responsibilities.

CRITERION: Patient safety and quality systems

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

Effective clinical governance creates a learning environment and a comprehensive program of continuous quality improvement. The organisation's safety and quality systems should ensure that patient safety and quality incidents are recognised, reported and analysed, and used to improve the care provided. It is important that these systems are integrated with governance processes to enable health service organisations to actively manage risk, and to improve the safety and quality of care.

The organisation's approach to delivering and supporting clinical care should be described in policies, procedures and protocols, which may need to be endorsed by the governing body. Include the following topics:

- Developing policies, procedures and protocols
- Monitoring and reporting clinical performance
- Managing clinical risk
- Managing and reporting adverse events, including reporting on sentinel events
- Managing complaints and compliments
- Managing open disclosure
- Engaging clinicians in planned, systematic audits of clinical services following agreed protocols and schedules.

Policies and procedures

Action 1.7

The health service organisation uses a risk management approach to:

a. Set out, review, and maintain the currency and effectiveness of, policies, procedures and protocols

b. Monitor and take action to improve adherence to policies, procedures and protocols

c. Review compliance with legislation, regulation and jurisdictional requirements

Reflective questions

How does the health service organisation ensure that its policy documents are current, comprehensive and effective?

How does the health service organisation ensure that its policy documents comply with legislation, regulation, and state or territory requirements?

Key tasks

- Set up a comprehensive suite of policies, procedures and protocols that emphasise safety and quality

- Set up mechanisms to maintain currency of policies, procedures and protocols, and to communicate changes in them to the workforce
- Review the use and effectiveness of organisational policies, procedures and protocols through clinical audits or performance reviews
- Periodically review policies, procedures and protocols to align them to state or territory requirements, and ensure that they reflect best practice and current evidence
- Develop or adapt a legislative compliance system that incorporates a compliance register to ensure that policies, procedures and protocols are regularly and reliably updated, and respond to relevant regulatory changes, compliance issues and case law.

Strategies for improvement

The governing body should ensure the development, review and maintenance of a comprehensive set of organisational policies, procedures and protocols. These documents should cover clinical safety and quality risks, and be consistent with the organisation's regulatory obligations.

Develop policies, procedures and protocols

The governing body must clearly delegate responsibility for developing and maintaining policies, procedures and protocols. This includes identifying a custodian to ensure that the processes for developing, reviewing and monitoring compliance with policies, procedures and protocols are documented. Roles and responsibilities of individuals and committees with the authority to amend or endorse each policy, procedure or protocol should be documented.

All policy, procedure and protocol documents should be incorporated into a single, coherent system to maximise the effectiveness of the policy development process.

Support effective implementation of a policy system by ensuring that the workforce has:

- Ready access to relevant policies, procedures and protocols
- Position descriptions, contracts, by-laws or other mechanisms that require the workforce to comply with their roles, responsibilities and accountabilities, and with organisational policies, procedures and protocols.

Monitor compliance with legislation, regulation and state or territory requirements

Keep information about instances of noncompliance with the organisation's policies, procedures and protocols. Where appropriate, incorporate the information into the organisation's risk register and quality improvement planning processes.

Maintain well-designed legislative compliance processes. Incorporate a compliance register to ensure that the organisation's policies are regularly updated, enabling the organisation to respond to regulatory changes, compliance issues and case law.

Identify relevant industry standards, and develop processes to implement and monitor compliance with these standards, which may include:

- Service-specific standards such as for mental health, pathology or medical imaging, where these services are applied
- Standards Australia standards
- The Building Code of Australia
- Guidance developed by peak bodies, such as the *Australian Medicines Handbook*.

Examples of evidence

Select only examples currently in use:

- Documented processes for developing, authorising, and monitoring the implementation of, the health service organisation's policy documents
- Register of policy document reviews, including the date of effect, dates that policy documents were amended and a prioritised schedule for review
- Examples of policy documents that have been reviewed in response to identified risks, or changes in legislation, regulation or best practice
- Committee and meeting records that describe the governance structure, delegations, roles and responsibilities for overseeing the development of policy documents
- Audit results of healthcare records and clinical practice for compliance with policy documents
- Results from workforce surveys and feedback on policy documents
- Data and feedback from the risk management, incident management and complaints management systems that are used to update policy documents
- Communication with the workforce on new or updated policy documents
- Training documents on new or amended policy documents, or use of policy documents
- Schedule and time lines for statutory reporting.

Measurement and quality improvement

Action 1.8

The health service organisation uses organisation-wide quality improvement systems that:

a. Identify safety and quality measures, and monitor and report performance and outcomes

b. Identify areas for improvement in safety and quality

c. Implement and monitor safety and quality improvement strategies

d. Involve consumers and the workforce in the review of safety and quality performance and systems

Reflective questions

How does the quality improvement system reflect the health service organisation's safety and quality priorities and strategic direction?

How does the health service organisation identify and document safety and quality risks?

What processes are used to ensure that the actions taken to manage identified risks are effective?

Key tasks

- Define quality for clinical services (for example, effectiveness, safety, consumer experience) and share this information with the workforce
- Review the quality improvement system, including the vision, mission, values and objectives, to ensure that they reflect the organisation's clinical safety and quality priorities, and strategic direction
- Decide how feedback will be collected from the workforce, patients and consumers
- Consider whether there is a coherent, planned and systematic schedule of audits of clinical and organisational systems, and reliable processes to capture findings and implement necessary improvements
- Develop a schedule for reporting to the governing body and managing the design and performance of key clinical systems
- Monitor and review progress on actions taken to improve safety and quality, and provide feedback to the workforce, patients and consumers

- Provide information and training, where necessary, to the workforce, patients and consumers to encourage their involvement in the analysis of performance data.

Strategies for improvement

Develop a quality improvement system

The elements of a successful quality improvement system include:

- A description of 'high quality' that is reflected through the organisation's vision, mission and values
- A definition of the organisation's stakeholders
- Clearly defined and aligned organisational objectives and clinical quality objectives
- Clearly defined processes and responsibilities that are required to meet quality objectives
- Training for the organisation's workforce in safety and quality
- Processes to verify that the quality improvement system is operating effectively
- Mechanisms for monitoring consumer satisfaction, measuring quality and implementing improvements.

Define quality and how it will be measured

Define the elements of quality to be used by the organisation (for example, safety, effectiveness, consumer experience). Provide a common language and understanding for the design, implementation and monitoring of safety and quality performance throughout the organisation.

Define the key indicators for safety and quality measures that will be routinely collected and reported to management and the clinical workforce, as well as the level of detail required to enable the governing body and workforce to fulfil their responsibilities. These may include data from incidents and complaints management systems, safety and quality audit reports, infection control reports, reviews of clinical practice, and clinical indicators relating to specific actions in the NSQHS Standards.

Routinely measure and monitor patient experience by using national core common questions on patient experience developed by the Commission.

Conduct regular reviews and audits

Record outcomes of clinical system audits on a register, together with proposed actions and responsibilities, and evidence of implementation and follow-up. These records can be used to show how risks and opportunities identified through the quality improvement system are addressed, to improve safety and continuously improve performance.

Actively engage clinicians and consumers in the audit processes and analysis of results. Ensure that audits test the design and performance of the organisation's clinical governance system.

Examples of evidence

Select only examples currently in use:

- Policy documents that describe the processes and accountability for monitoring the safety and quality of health care
- Documented safety and quality performance measures
- Schedule for internal or external audits
- Audit reports, presentations and analysis of safety and quality performance data
- Feedback from the workforce about the use of safety and quality systems
- Feedback from consumers about their involvement in the review of safety and quality performance data
- Quality improvement plan that includes actions to deal with issues identified
- Examples of specific quality improvement activities that have been implemented and evaluated
- Committee and meeting records in which reports, presentations, and safety and quality performance data are regularly reviewed and reported to the governing body or relevant committees
- Training documents on the health service organisation's quality improvement system
- Communication with the workforce, patients and carers that provides feedback regarding safety and quality of patient care.

Action 1.9

The health service organisation ensures that timely reports on safety and quality systems and performance are provided to:

a. The governing body

b. The workforce

c. Consumers and the local community

d. Other relevant health service organisations

Reflective question

What processes are used to ensure that key stakeholders are provided with accurate and timely information about safety and quality performance?

Key tasks

- Endorse a schedule of reporting that outlines the topic areas, format and frequency of reporting on safety and quality performance, and the effectiveness of the safety and quality systems
- Collaborate with the workforce, consumers, local communities and other health service organisations to identify the topic areas, format and frequency of reporting to these groups on safety and quality performance, and the effectiveness of the safety and quality systems.

Strategies for improvement

Routinely collecting process and outcome data, monitoring data for trends and reporting clinical alerts enables organisations to understand outcomes from service delivery, and to respond to deviations from the expected outcomes promptly.

Clearly documented processes to ensure the accuracy, validity and comprehensiveness of information will increase the organisation's confidence in data quality. Providing the governing body and the workforce with access to the organisation's most important safety and quality metrics (indicators) will enable regular review of progress and will allow the organisation to respond to issues as they arise. Suitable metrics may include:

- Key relevant national priority indicators and regulatory requirements

- Indicators covering safety, clinical effectiveness, patient experience, access and efficiency across the organisation's services
- Trends in reported adverse events, incidents and near misses
- Compliance with best-practice pathways.

Provide the governing body and management with regular, comprehensive safety and quality presentations and reports from managers and clinicians. Schedule data presentations following agreed criteria (for example, significance of risk, patient volume, organisational priority or focus).

Effective data presentations should cover:

- The design of the systems and processes being used
- Evaluation and management of risks
- Compliance with evidence-based practice
- Safety and quality outcomes, including consumer experience and patient-reported outcome measures
- Plans to improve safety and quality, and reduce risk.

Some organisations may choose to participate in benchmarking groups, in which they submit clinical indicator data and are provided with benchmarking reports. This enables them to assess their performance against data collated from similar peer groups.

Examples of evidence

Select only examples currently in use:

- Reports on safety and quality performance data that are provided to the governing body, managers, committees, the workforce or consumers
- Committee and meeting records in which information on safety and quality indicators, data or recommendations by the governing body are discussed
- Committee and meeting records in which the appropriateness and accessibility of the health service organisation's safety and quality performance information are discussed
- Communication strategy that describes processes for disseminating information on safety and quality performance to the community
- Communication with the workforce and consumers on the health service organisation's safety and quality performance
- Records of safety and quality performance information published in annual reports, newsletters or other local media
- Reporting templates and calendars
- Reports provided to external organisations.

Risk management

Action 1.10

The health service organisation:

a. Identifies and documents organisational risks

b. Uses clinical and other data collections to support risk assessments

c. Acts to reduce risks

d. Regularly reviews and acts to improve the effectiveness of the risk management system

e. Reports on risks to the workforce and consumers

f. Plans for, and manages, internal and external emergencies and disasters

Reflective questions

How does the health service organisation identify and document risk?

What processes does the health service organisation use to set priorities for, and manage, risks?

How does the health service organisation use the risk management system to improve safety and quality?

Key tasks

- Review the organisation's risk management system, and ensure that it is appropriately designed, resourced, maintained and monitored
- Consider existing sources of information about patient safety, and whether more information is needed to reliably assess risk
- Consider whether risk management orientation, education and training are adequately covered in the organisation's education and training program
- Ensure clear allocation of roles, responsibilities and accountabilities for maintaining the risk management systems and for performing the actions required
- Regularly review risks and report on risk to the governing body, the workforce and consumers
- Periodically review the effectiveness of the risk management system

- Use a risk management approach to planning for emergencies and disasters that may affect the organisation's operation or patient safety
- Implement and monitor a risk register, and review it regularly to ensure that:
  – it is kept up to date
  – it includes all relevant information
  – members of the workforce with roles and responsibilities in risk management use and maintain the register, and are accountable for actions required
  – risks are regularly reviewed, and reports are provided to the governing body, the workforce and consumers
  – plans exist to manage emergencies and disasters that may affect the operation of the organisation or patient safety.

Strategies for improvement

Define the governing body's responsibility

The governing body is responsible for ensuring the integrity of the organisational risk management system. The governing body should:

- Determine the organisation's risk appetite and tolerance – that is, the amount and type of risk that an organisation is willing to take to meet its strategic objectives
- Ensure that the organisation's risk management system is clearly documented in policies, procedures and protocols that define a vision, principles, objectives, practices, responsibilities, resources, outcomes and how outcomes will be measured
- Ensure that enough resources are allocated to the organisation's risk management system
- Foster an organisational culture that focuses on clinical safety and continuous improvement in identifying and managing risk
- Ensure appropriate integration of clinical and non-clinical risk in all risk systems.

Take a systems approach to risk management

Embed a systems approach to risk management by:

- Maintaining risk management policies, procedures and protocols that follow best practice, and ensuring that all clinical leaders, managers and other members of the workforce are familiar with them

- Establishing a reliable and systematic process of hazard identification across all areas
- Actively encouraging and supporting the workforce, patients and other stakeholders to report potential or actual risks
- Describing and establishing a mechanism for capturing non-clinical risks in the risk management system
- Maintaining a comprehensive, accurate and current risk register, which can be used as a practical tool for risk management
- Assigning all risks to a 'risk owner', who is responsible for managing and monitoring risks, and ensuring that appropriate accountability arrangements are in place
- Ensuring that the organisation has a reliable system to scan for, identify and respond to hazards and risks reported by other sources (for example, from the scientific literature, government agencies, insurers, coroners, or safety and quality commissions)
- Conducting a planned, systematic program of in-house and external audits or reviews on the design and performance of clinical and organisational systems, in collaboration with clinicians and consumers, and incorporating this risk audit program into the organisation's formal audit program
- Ensuring that the risk management system includes strategies, resources and clear accountability for remedying risks
- Making use of clinical registers, if possible
- Systematically providing appropriate information, orientation, education and training to employees on using the risk management system, at induction and at regular intervals
- Regularly auditing the risk management system
- Systematically monitoring and assessing performance regarding risk, within a defined performance monitoring framework, at all levels of the organisation, including the governing body and management.

Engage the clinical workforce

The clinical workforce has the best knowledge of, and ability to identify, clinical risks. Foster engagement and participation of the workforce by:

- Regularly providing information about the organisation's risk management system at orientation, and through ongoing education and training
- Reinforcing information about roles, responsibilities and accountabilities for reporting and managing risk to managers, clinicians and other members of the workforce (for example, by using screensavers, the intranet, newsletters and standing items on meeting agendas)
- Establishing within the committee structure responsibility for systematic risk identification, assessment, review and management
- Using routine meetings as an opportunity to identify and discuss clinical and other safety concerns
- Including patient safety as a standing item on meeting agendas of the governing body and management
- Including questions about patient safety risks in employee culture surveys
- Providing feedback to the workforce and consumers on actions taken to mitigate risks
- Regularly assessing the organisational climate in areas of risk, safety and quality using validated survey tools.

Plan for, and manage, emergencies and disasters

Use the risk management system to prepare for potential emergencies and disaster management. Perform a series of audits to identify potential risks and management opportunities to enable the organisation to respond efficiently and effectively in an emergency. This may involve considering:

- Appropriate infrastructure, such as emergency signage, lighting systems and backup generators
- Workforce training in evacuation systems and emergency drills
- Planning for the coordination of workforce rosters and reporting lines during an emergency
- Planning to support patient transfer internally or externally (to other health service organisations) during an emergency

- Business continuity planning for recovery and returning services to normal following an emergency.

Examples of evidence

Select only examples currently in use:

- Policy documents that describe the processes for implementing and monitoring the risk management system
- Policy documents for emergencies and disasters that describe the reporting lines, and roles and responsibilities of the workforce
- Risk register that includes actions to manage identified risks
- Reports on safety and quality data that are analysed to identify and monitor safety and quality risks
- Data analysis and reports on safety and quality performance trends
- Feedback from the workforce on safety and quality risks, and the effectiveness of the risk management system
- Committee and meeting records regarding oversight of the risk management system, or the review of clinical and other data collections
- Committee and meeting records in which risk, and the appropriateness and accessibility of safety and quality performance information have been discussed
- Audit schedule and reports on compliance with policies, procedures or protocols regarding the health service organisation's risk management system
- Communication with the workforce and consumers on risks and risk management
- Records of safety and quality performance information published in annual reports, newsletters, newspaper articles, radio items, websites or other local media
- Business continuity plan, or emergency and disaster management plan
- Training documents relating to risk management, and the management of emergencies and disasters, including evacuation and emergency drills.

Incident management systems and open disclosure

Action 1.11

The health service organisation has organisation-wide incident management and investigation systems, and:

a. Supports the workforce to recognise and report incidents

b. Supports patients, carers and families to communicate concerns or incidents

c. Involves the workforce and consumers in the review of incidents

d. Provides timely feedback on the analysis of incidents to the governing body, the workforce and consumers

e. Uses the information from the analysis of incidents to improve safety and quality

f. Incorporates risks identified in the analysis of incidents into the risk management system

g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems

Reflective questions

How does the health service organisation identify and manage incidents?

How are the workforce and consumers involved in reviewing incidents?

How is the incident management and investigation system used to improve safety and quality?

Key tasks

- Implement a comprehensive incident management and investigation system for the organisation that:
  - complies with state or territory requirements
  - is appropriately designed, resourced, maintained and monitored
  - clearly designates responsibility for maintaining the system
- Train the workforce about the risk management system
- Inform patients about how they can report risks or concerns
- Implement a reporting and management framework to ensure that incident data are used to inform the governing body, the workforce and consumers, to drive improvements in safety and quality

- Periodically audit the incident management and investigation system to improve its design and performance, and to see whether it is adequately resourced.

Strategies for improvement

Incident reporting can improve safety (especially when it is based on a cycle of quality improvement), improve care processes, change the way clinicians think about risk and raise awareness of good practice. The nature of the risks faced by organisations varies according to the type of organisation and the context of service delivery. This highlights the importance of evaluating the effectiveness of incident management and investigation systems at the local level.[8]

Review the incident management and investigation system

A well-designed incident management and investigation system should support the workforce to identify, report, manage and learn from incidents. The system should comply with legislative requirements and with state or territory clinical incident management policies.

A well-structured system would generally incorporate the following elements:

- A clear policy framework that defines the key elements of the system; the roles and responsibilities of individuals and committees; the type of events to be reported; the process for reporting, investigating, analysing and monitoring clinical incidents; and the responsibility of clinicians to report incidents they observe or that arise from the use of healthcare records, including digital healthcare records
- A focus on managing each incident appropriately from a clinical perspective and ensuring the provision of safe, high-quality care to the patient following the incident, including open disclosure, if appropriate
- A designated individual with responsibility for maintaining the integrity of the system and coordinating incident management
- Adequate and appropriate systems (including relevant equipment and technology) to support incident reporting and analysis
- Workforce responsibilities for managing reported incidents, including grading their severity and leading further investigations
- Policies, procedures and protocols regarding confidentiality of information and the ability of members of the workforce to report anonymously
- Responsibilities for analysing incident data, and identifying trends and opportunities for improvement
- Responsibilities for disseminating information about incidents and their quality improvement implications
- Responsibilities for following up incidents to ensure that improvements have been made, if appropriate; this may include ensuring that information about relevant incidents is incorporated into the organisation's risk management processes
- Responsibilities for reporting incidents to other parties (for example, health departments) according to relevant organisational obligations
- Links to the organisation's open disclosure, risk management, and credentialing and scope of clinical practice systems; the state or territory incident management and investigation system, if applicable; and the procedure for communicating with the organisation's professional indemnity insurers.

Support the workforce

Leaders, including clinical leaders, should encourage the workforce to use the incident management and investigation system to report clinical incidents, near misses and adverse events.

Engaging the workforce to find solutions to issues is important for improving safety[8], especially when the improvement actions require coordination across teams or departments.

Support patients, carers and families

Support patients, carers and families to communicate their concerns by:

- Distributing information to patients and carers about what incidents and concerns are, and how to report them
- Training the workforce on how to respond to patients or carers who raise concerns or report incidents
- Providing, when possible, appropriately skilled members of the workforce to liaise with patients or carers who report concerns or incidents
- Conducting patient experience surveys or seeking feedback on safety incidents on discharge
- Providing information about improvement activities that have been implemented based on patient feedback.

Report on, and review, incidents

Provide comprehensive information to the governing body and management on all serious incidents, and summary information about all other incidents. Include information such as the actions taken as a result of a specific incident or category of incidents, and indicators such as time to complete actions stemming from incident reports. This will enable governing bodies and management to fulfil their governance responsibilities.

Ensure that each incident is reviewed by the clinicians involved and the manager responsible for the operational area in which the incident occurred. This enables lessons to be learned and local improvements to be implemented. A system to verify that managers follow up incidents appropriately will ensure integrity of the risk management system.

Set up classification and escalation processes to ensure that serious incidents, and incidents

associated with major risks are managed appropriately, including external reviews, if required.

Periodically review the design and performance of the incident management and investigation system. The governing body should consider whether it complies with best-practice design principles, and whether enough resources have been allocated to support effective clinical governance and risk management.

Examples of evidence

Select only examples currently in use:

- Incident management and investigation system in which clinical incidents are documented, analysed and reviewed
- Policy documents for reporting, investigating and managing clinical incidents
- Information on clinical incidents, adverse events and near misses, and the actions taken to manage identified risks that are incorporated into the health service organisation's risk management system or quality improvement plan
- Training documents on recognising, reporting, investigating and analysing incidents, adverse events and near misses

- Committee and meeting records that describe the incident management and investigation system, and the strategies and actions to reduce risk
- Committee and meeting records that show workforce and consumer involvement in the analysis of organisational safety and quality performance data
- Clinical incident reporting forms and tools that are accessible to the workforce and consumers
- Information and resources that support the workforce and consumers to report clinical incidents
- Feedback from the workforce and consumers regarding their involvement in the review and analysis of organisational safety and quality performance data
- Examples of specific improvement activities that have been implemented and evaluated to reduce the risk of incidents identified through the incident management and investigation system
- Results of completed clinical incident investigations
- Audit results of compliance with the incident management and investigation system.

Action 1.12

The health service organisation:

a. Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework[9]

b. Monitors and acts to improve the effectiveness of open disclosure processes

Reflective questions

How are clinicians trained and supported to discuss with patients incidents that caused harm?

How is information from the open disclosure program used to improve safety and quality?

Key tasks

- Adopt and implement the Australian Open Disclosure Framework in a way that reflects the context of service provision
- Ensure that members of the workforce who will be involved in open disclosure are trained
- Periodically conduct audits that focus on the management of clinical incidents and consistency with the Australian Open Disclosure Framework.

Strategies for improvement

Open disclosure is a discussion with a patient or carer about an incident that resulted in harm to the patient. Open disclosure is:

- A patient and consumer right
- An essential professional requirement and institutional obligation
- A normal part of an episode of care should the unexpected occur
- An attribute of a high-quality service organisation and an important part of healthcare quality improvement.

An open disclosure discussion should include:

- The elements of an apology or expression of regret (including the word 'sorry')
- A factual explanation of what happened
- An opportunity for the patient to relate their experience
- An explanation of the steps being taken to manage the event and prevent a recurrence.

Health service organisations implementing an open disclosure program should:

- Develop or adapt policies, procedures or protocols that are consistent with the Australian Open Disclosure Framework
- Ensure that responsibility for implementing the framework is allocated to an individual or committee
- Ensure that a system is in place for monitoring compliance with the framework; all variations from the framework should be investigated and addressed
- Review regular reports on open disclosure to ensure that the principles and processes of the framework are met
- Provide training and support for the relevant members of the workforce who will be involved in open disclosure in the organisation, including those responsible for managing open disclosure issues.[9]

In a day procedure service, open disclosure incidents are most likely to occur in the theatre setting, and involve the surgeon or anaesthetist. The organisation should ensure that credentialed medical and other practitioners are aware of policies, procedures, protocols and by-laws regarding open disclosure, and cover this requirement through their contractual arrangements.

The performance of credentialed medical and other practitioners who participate in open disclosure incidents should be monitored by a medical advisory committee or through the incident management and investigation system.

See the Australian Open Disclosure Framework web page for more information.

Examples of evidence

Select only examples currently in use:

- Policy documents that are consistent with the principles and processes outlined in the Australian Open Disclosure Framework[9]
- Reports on open disclosure that are produced by the health service organisation
- Information and data on open disclosure presented to the governing body and relevant committees
- Committee and meeting records about issues and outcomes relating to open disclosure.

Feedback and complaints management

Action 1.13

The health service organisation:

a. Has processes to seek regular feedback from patients, carers and families about their experiences and outcomes of care

b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality systems

c. Uses this information to improve safety and quality systems

Reflective questions

How does the health service organisation collect patient experience feedback?

How does the health service organisation collect feedback from the workforce?

How are patient experience data and workforce feedback used to improve safety and quality?

Key tasks

- Implement a comprehensive feedback system that is appropriately designed, resourced and maintained
- Describe the framework for reviewing feedback from patients and the workforce, and incorporate issues identified into the organisation's quality improvement system
- Review reports on the analysis of patient experience data and the actions to deal with issues identified
- Periodically review the effectiveness of the organisation's patient feedback system.

Strategies for improvement

Reported patient experiences are an important element in determining the quality of care provided. Patient and carer feedback should be gathered systematically, using well-designed (and, ideally, validated) data collection tools. The data should be used to improve the quality of care.

The health service organisation should promote the organisation's ability to respond to patient experience information by:

- Ensuring that the organisation adopts a validated and reliable method to systematically seek feedback from patients and carers; systematic analysis and testing of feedback will enable system improvement
- Ensuring that a designated individual is responsible for maintaining the integrity of feedback systems
- Allocating enough resources to support the feedback system
- Seeking patient feedback regularly and from the types of patients who represent the patient population, to ensure that data are reliable and cover the services provided
- Providing a mechanism to regularly seek feedback from the workforce to test the culture of the organisation
- Ensuring that information gained from the feedback system is analysed for safety and quality risks and improvement opportunities, and used to inform the organisation's quality improvement system
- Reviewing information about the performance of the patient feedback system
- Ensuring that the workforce, patients and carers receive information about what has been learned from the feedback system, and how it has been used to generate improvements in the organisation
- Comparing performance with similar services and any nationally available benchmarks.

Strategies for obtaining patient experience feedback may include:

- Using a validated survey instrument that incorporates the national core common patient experience questions
- Regularly collecting feedback from patients, and providing feedback to the workforce, governing body and consumers.

Other informal mechanisms include:

- Contacting patients after their episode of care
- Having morning tea with patients to obtain feedback
- Talking to patients while they are waiting for services.

Examples of evidence

Select only examples currently in use:

- Data collection tools for collecting workforce, patient and carer feedback
- Committee or meeting records about the selection of patient experience questions, and review of workforce, patient and carer feedback
- Data analysis and reports of consumer feedback or surveys used to evaluate the health service organisation's performance
- Strategic, business and quality improvement plans that incorporate workforce, patient and carer feedback.

Action 1.14

The health service organisation has an organisation-wide complaints management system, and:

a. Encourages and supports patients, carers and families, and the workforce to report complaints

b. Involves the workforce and consumers in the review of complaints

c. Resolves complaints in a timely way

d. Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken

e. Uses information from the analysis of complaints to inform improvements in safety and quality systems

f. Records the risks identified from the analysis of complaints in the risk management system

g. Regularly reviews and acts to improve the effectiveness of the complaints management system

Reflective questions

What processes are used to ensure that complaints are received, reviewed and resolved in a timely manner?

How are complaints data used to improve safety and quality?

What processes are used to review the effectiveness of the complaints management system?

Key tasks

- Implement and maintain a framework for reporting complaints and incorporating issues into the organisation's quality improvement system

- Implement a comprehensive complaints management and investigation system
- Review reports on the analysis of complaints data and the actions to deal with issues identified
- Implement processes to involve the workforce, patients and carers in the review of organisational safety and quality performance information
- Periodically review the effectiveness of the organisation's complaints management system.

Strategies for improvement

Implement a complaints management system

A well-designed complaints management system should incorporate the following elements:

- A clear policy framework defining the key elements of the system, and the roles, responsibilities and accountabilities of the workforce
- Delegation of an individual with responsibility for maintaining the integrity of the system, and receiving and coordinating the management of complaints
- A documented philosophy that acknowledges that complaints represent opportunities for improvement
- Compliance with state or territory requirements.

Support patients, carers and the workforce

Organisations may use different strategies to encourage the workforce, patients and carers to report complaints. These mechanisms should be documented in the organisation's policies, procedures or protocols. The policy documents for complaints management should consider confidentiality of information, and responsibilities for:

- Receiving, investigating and managing complaints, and taking immediate action if required
- Grading the severity of complaints
- Communicating effectively with complainants about the management of the complaint
- Analysing complaints data, and identifying trends and opportunities for improvement.

Provide information about the complaints process to the workforce, patients and carers. The information should include a statement about the organisation's philosophical approach to complaints management, and outline the formal and informal pathways to make a complaint. It may include details about how complaints are managed, the expected time frames for investigation and how the complainant will be notified of the outcome of the investigation.

Provide support for the workforce, patients and carers, and other individuals who are involved in incidents that lead to complaints. This may include:

- Nominating a support person to assist members of the workforce, patients or carers who wish to make a complaint
- Providing training to the workforce on complaints handling
- Ensuring that systems are in place to encourage the workforce, patients and carers to report complaints, and that support the analysis of the complaints process.

Involve the workforce, patients and carers in the review of complaints by:

- Inviting members of the workforce to join groups or committees responsible for reviewing complaints information or safety and quality performance data
- Providing information and training for consumers and the workforce to support them to understand data and measurements used by the organisation.

Refer to Action 2.11 for further information and strategies for involving consumers in committees.

Information on involving consumers in complaints handling committees is available from the Health Issues Centre.

Report on, and review, complaints

Roles and responsibilities of those overseeing the complaints management system (including data analysis) should be clearly defined. Responsibilities may include:

- Initiating an open disclosure process
- Following up complaints to ensure that improvements have been made, if appropriate
- Disseminating information about complaints and their quality improvement implications
- Reporting complaints to other parties (for example, complaints commissioners, regulatory authorities) under the relevant organisational obligations
- Linking complaints to the organisation's policies on open disclosure, risk management, credentialing and scope of clinical practice, and quality improvement systems
- Linking complaints to the procedure for communicating with the organisation's insurer.

Use information from complaints to improve the safety and quality of care. Ensure that each complaint is reviewed by the member(s) of the workforce involved and the manager responsible for the operational area in which the complaint was generated. This enables lessons to be learned and local improvements to be implemented. Implement a system to verify that managers follow up complaints appropriately to ensure system integrity.

Define a reporting framework that clearly identifies the data that will be available and reported on at each level in the organisation. This will enable the workforce and members of the governing body to monitor and respond to system performance.

Provide comprehensive information to the governing body and management about complaints associated with major risks, and summary information, including trend reports, about all other complaints.

Incorporate relevant information from the complaints management system into the risk management system and the quality improvement system, and report it to the governing body or management, if appropriate.

Periodically review the design and performance of the complaints management system. The governing body should consider whether it complies with best-practice design principles, and whether enough resources have been allocated to support effective clinical governance and risk management.

Examples of evidence

Select only examples currently in use:
- Policy documents that describe the processes for recording, managing and reporting complaints
- Complaints register that includes responses and actions to deal with identified issues, and its schedule for review
- Training documents about the complaints management system
- Consumer and carer information and resources about the health service organisation's complaints mechanisms
- Feedback from the workforce on the effectiveness of the complaints management system
- Feedback from consumers and carers on the analysis of complaints data

- Audit results of compliance with complaints management policies
- Evaluation reports that note the effectiveness of responses and improvements in service delivery
- Committee and meeting records in which trends in complaints and complaints management are discussed
- Reports or briefings on complaints provided to the governing body, workforce or consumers
- Quality improvement plan that includes actions to deal with issues identified
- Examples of improvement activities that have been implemented and evaluated.

Diversity and high-risk groups

Action 1.15

The health service organisation:

a. Identifies the diversity of the consumers using its services

b. Identifies groups of patients using its services who are at higher risk of harm

c. Incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care

Reflective questions

What are the sociodemographic characteristics of the patient population?

How do these characteristics affect patient risk of harm?

How is this information used to plan service delivery and manage inherent risks for patients?

Key tasks

- Periodically audit the clinical and administrative data systems to identify the diversity of the patients using the organisation's health services
- Develop strategies to identify high-risk patients, and mechanisms to provide further safety and quality protections for these patients.

Strategies for improvement

Identify the groups of patients using the health service who have an increased risk of harm, and implement strategies to proactively manage these risks. This may involve:

- Reviewing demographic data (such as age, gender, postcode or ethnicity) to understand the diversity of the patient population
- Analysing relevant data to identify the key risks faced by different demographic groups
- Conducting a risk assessment for groups of patients, procedures or locations of treatments that are known to be high risk

- Discussing the strategies to overcome these risks with the clinical governance committee, the clinical workforce or representatives of the different risk groups.

In day procedure services, pre-admission screening processes for patients should include collecting demographic information and information on relevant risk factors. See **Action 5.10** for more information about screening processes.

Strategies for each group may vary widely, and may need to be tailored to individual patients.

Incorporate patient risk assessment processes in the organisation's quality improvement system if there are specific risks associated with particular types of patients or locations of treatment.

Ensure that clinical guidelines and pathways for particular conditions or interventions incorporate risk management strategies (for example, preoperative anaesthetic assessment) relevant to known patient risk groups (for example, bariatric patients).

Monitor the health outcomes for at-risk patient groups and the actions taken to manage the risks.

Monitor the risk management system and relevant external sources of information (for example, coroners' reports, published literature) to identify emerging risks affecting particular groups of patients.

Examples of evidence

Select only examples currently in use:

- Demographic data for the health service organisation and community that are used for strategic planning purposes
- Organisational risk profile that details patient safety and quality risks, and their potential impact
- Results of an assessment or survey of local health needs
- Strategic or business plans that reflect the diversity of the patient population
- Training documents on diversity and cultural awareness

- Consumer information that is available in different formats and languages that reflect the diversity of the patient population
- List of local interpreters or consumer advocacy services, and reports on interpreter use and access
- Examples of actions taken to meet the needs of high-risk patients (for example, cultural awareness events)
- Health service organisation representation at local network meetings that reflect the local diversity of the patient population
- Membership of committees with consumer representation that reflect the diversity of the patient population.

Healthcare records

Action 1.16

The health service organisation has healthcare records systems that:

a. Make the healthcare record available to clinicians at the point of care

b. Support the workforce to maintain accurate and complete healthcare records

c. Comply with security and privacy regulations

d. Support systematic audit of clinical information

e. Integrate multiple information systems, where they are used

Reflective questions

How does the health service organisation ensure that clinicians have access to accurate and integrated healthcare records?

How does the health service organisation ensure the privacy and security of healthcare records?

Key tasks

- Review the availability of healthcare records at the point of care

- Review the processes for maintaining confidentiality and privacy of patient information, including infrastructure, policies and workforce training for paper-based and digital healthcare records, and ensure that they are consistent with the law and good practice
- Review the design of the healthcare record to ensure that it facilitates documentation of the relevant clinical elements and clinical audit
- Ensure that systems are in place for data entry to clinical registries, if required
- Periodically audit the performance of the healthcare records systems, and improve them as necessary

- If multiple information systems are used to capture patient clinical information, periodically review the data systems to ensure that the processes for information capture are well designed, well resourced and working effectively
- Identify individuals or committees responsible for the development, review and document control of forms, documents and files that make up the paper or digital healthcare record.

Strategies for improvement

The governing body and managers should ensure that an effective system is in place for recording, communicating, using and securely storing patient clinical information. This is to provide safe, high-quality care to individual patients, and to enable relevant information to be extracted for quality assurance purposes.

Access to the healthcare record at the point of care facilitates recording of the patient's status and changes to treatment. There may be two sets of records for patients receiving care in a day procedure service – one held by the clinician in their consulting rooms and one that is held by the day procedure service.

Review the healthcare records system

A number of standards, guidelines and policies apply to healthcare record documentation – for example, medical record–keeping requirements for good medical practice[10] of the Medical Board of Australia, and state or territory health department standards for healthcare record documentation and data capture.[11,12]

An effective healthcare records system should incorporate:

- A workforce that is appropriately qualified and experienced in the management of healthcare records systems, with appropriate leadership skills and authority
- Orientation and training of the clinical workforce in the organisation's requirements for healthcare record documentation, including the safety and quality rationale for those requirements

- Clearly documented accountabilities and terms of reference for the individual or committee responsible for governance of the healthcare records system
- Accountability for healthcare records documentation in performance development processes for the clinical workforce
- Policies, procedures and protocols addressing
  – standards and processes for managing healthcare records (including retention, digital healthcare and manual storage and transport systems, access at the point of care, emergency access to electronic records when a patient is unable to consent, and record disposal requirements)
  – standards for documentation, with a focus on the information that should be recorded to enable monitoring of quality of care, contemporaneous recording of clinical information, and the availability of formal reports on investigations, including imaging and pathology tests
  – how changes to the healthcare record are authorised
  – standards and processes for establishing standalone clinical registries for quality or research purposes
  – the conduct of compliance audits
  – compliance with the relevant standards, and professional and legislative requirements in the relevant state or territory
- Structures (for example, healthcare record committees) and processes to enable healthcare record risks and opportunities to be evaluated, and changes made to improve the standard of documentation
- Physical or digital facilities for the reliable and secure management of patient healthcare records
- Periodic audit and continuous improvement of the healthcare records system.

Review privacy and confidentiality

Information about an individual's physical or mental health and wellbeing is both personal and sensitive, and there are many ethical, professional and legal restrictions on the way this information can be used.

People assume that all communications with their clinicians are private, and the law reflects this expectation. The confidentiality or privacy of most health information is protected by statutory or common law requirements of confidentiality and privacy. However, the precise legislative requirements vary between states and territories.

Providing the appropriate physical infrastructure (for example, private interview rooms, patient status boards that are screened from public view) is not enough to ensure privacy and confidentiality. The culture and practices of the workforce are key to the appropriate protection of patient clinical information.

Consider the need to:

- Explicitly recognise the sensitivity of patient clinical information, and the need to protect confidentiality and privacy
- Recognise the role of patient consent in the use or disclosure of information for purposes other than direct provision of care
- Explain to patients and carers how patient information is collected, used and disclosed, and the safeguards that apply
- Develop and implement specific policies and procedures addressing the use of clinical information for clinical, educational, quality assurance and research purposes, including robust authorisation procedures for any uses or disclosures outside the usual provision of care (including the development of clinical registries).

Audit the system

Periodically audit the design and performance of the healthcare records system to ensure system effectiveness. Structure the healthcare record to guide the clinical workforce to record important information relevant to the safety and quality of care. This will also assist organisations to audit compliance with relevant standards.

If more than one information system is used to capture patient clinical information, periodically review these systems to ensure that the processes for information capture are well designed, well resourced and working effectively (that is, the transfer of information is accurate, prompt, compatible and secure).

Examples of evidence

Select only examples currently in use:

- Policy documents about healthcare record management, including access, storage, security, consent and sharing of patient information
- Audit results of healthcare records for compliance with policies, procedures or protocols on healthcare records management, including access to healthcare records and sharing of information
- Audit results of the accuracy, integration and currency of healthcare records
- Observation that healthcare records are accessible at the point of patient care
- Observation that computer access to electronic records is available to the clinical workforce in clinical areas
- Committee and meeting records in which the governance of the health service organisation's data and information technology (IT) systems is monitored or discussed
- Code of conduct that includes privacy and confidentiality of consumer information
- Signed workforce confidentiality agreements
- Secure archival storage and disposal systems
- Observation of secure storage systems in clinical areas
- Observation that computers are password protected
- Records of ethics approval for research activities that involve sharing patient information
- Templates for issuing login and password details for electronic healthcare records systems
- Audit results of the use of a unique identifier in the healthcare records management system
- Training documents about the healthcare records management system
- Systems in place that enable combining of multiple information systems.

Action 1.17

The health service organisation works towards implementing systems that can provide clinical information into the My Health Record system that:

a. Are designed to optimise the safety and quality of health care for patients

b. Use national patient and provider identifiers

c. Use standard national terminologies

Reflective questions

What processes are used to ensure that the health service organisation's IT systems comply with the requirements of the My Health Record system?

How does the health service organisation ensure that the workforce is appropriately trained in the use of the My Health Record system, including the use of identifiers and terminology?

Key tasks

• Use unique national identifiers for patients, clinicians and health service organisations in local systems and in clinical documents loaded into the My Health Record system

• Implement standard national terms such as the Australian Medicines Terminology (AMT) in healthcare records and clinical documents loaded into the My Health Record system.

Strategies for improvement

The My Health Record system allows secure collection, storage and exchange of health information between consumers and providers. It uses information from general practitioners, pharmacies, pathology laboratories, imaging services and hospitals to improve the safety and quality of care by supporting clinical handover and making clinical information accessible in different settings.

Health service organisations will have different levels of preparedness to provide clinical information to the My Health Record system. Implementation of this action may depend on the resources available and the organisation's current healthcare records system.

Use unique national healthcare identifiers

Unique healthcare identifiers help ensure that individuals and providers are confident that the correct information is associated with the correct individual at the point of care.

The My Health Record system uses unique national identifiers for patients, clinicians and health service organisations to ensure secure access to healthcare records. Use of national patient identifiers in local systems can prevent duplication of records and minimise the chance of information being assigned to the wrong patient. It also allows correct identification of treating clinicians and health service organisations, enabling follow-up by other healthcare providers involved in the patient's care.

Every Australian resident is allocated a unique 16-digit identifier called the Individual Healthcare Identifier (IHI).

The Australian Health Practitioner Regulation Agency issues unique national identifiers to the clinicians it registers.

Health service organisations that employ one or more clinicians can apply for an organisational identifier from the Healthcare Identifiers Service.

For more information, see Healthcare Identifiers Service – frequently asked questions.[13]

Use standard national terminologies

Adopting standard terms such as AMT and SNOMED CT-AU ensures that clinical information captured in local systems can be readily understood and used by other clinicians accessing this information. See the Australian Digital Health Agency website for more details.

For more information on My Health Record, visit the Commission's Safety in e-health web page.

Examples of evidence

Select only examples currently in use:

- Healthcare records management system that uses IHIs and standard national terminologies
- Policy documents about the healthcare records management system
- Audit results of compliance with policies, protocols or procedures for accessing healthcare records and sharing information
- Audit results of the use of unique identifiers to link the paper healthcare record to the electronic healthcare record
- Committee and meeting records in which the governance of the health service organisation's data and IT systems is monitored or discussed, including validation and protection of data
- Training documents on the use of the My Health Record system
- Observation that data and records are kept secure and safe in both soft and hard copies
- Observation that systems are in place to provide IT infrastructure and support to the workforce using national standard secure messaging to generate national standard e-referral discharge summaries or event summaries
- Examples of electronic correspondence or referrals that use secure messaging.

Action 1.18

The health service organisation providing clinical information into the My Health Record system has processes that:

a. Describe access to the system by the workforce, to comply with legislative requirements

b. Maintain the accuracy and completeness of the clinical information the organisation uploads into the system

Reflective questions

How does the health service organisation manage the policy implications and risks associated with introducing the My Health Record system?

How does the health service organisation check the accuracy and completeness of clinical information in the My Health Record system?

Key tasks

- Develop, maintain and regularly review organisational policies for using the My Health Record system, to ensure that access follows the requirements of the *My Health Records Act 2012*
- Take reasonable steps to ensure that clinical documents provided to the My Health Record system are accurate at the time of loading, and that any amendments made to these clinical documents are also loaded into the system.

Strategies for improvement

Health service organisations that use, or load documents into, the My Health Record system are required to develop and maintain a My Health Record system policy that outlines the:

- Process for authorising clinicians to use the system, and for deactivating accounts of those who no longer require access
- Training to be provided to the workforce on their professional and legal obligations in using the system
- Physical and technical security measures to control access to the system
- Identification and management of system-related security risks to be escalated to the executive.

Regularly review this policy to ensure that it is up to date and in line with any changes to the My Health Records Act.

The My Health Records Act requires that health service organisations take reasonable steps to ensure that clinical documents provided to the My Health Record system are accurate at the time of loading. If a clinical document on the My Health Record system contains incorrect information, the organisation should remove the incorrect version as soon as practically possible.

A clinical document may be subsequently amended or updated. This can occur, for example, when diagnostic test results are provided and the discharge summary is reissued with these results added. In such cases, the corrected version should be loaded into the My Health Record system.

Conduct periodic audits to ensure that:

- Clinicians loading documents into, or amending information in, the My Health Record system do so following the organisation's policies, procedures and protocols
- Access to data and records complies with legislative requirements.

Implementing the strategies above would be considered a reasonable step towards ensuring the accuracy of the records uploaded.

See the Australian Digital Health Agency website for information on how to register with the My Health Record system.

Examples of evidence

Select only examples currently in use:

- Audit results of compliance with policies, procedures or protocols about healthcare records management
- Audit results of completeness and integration of healthcare records systems.

CRITERION: Clinical performance and effectiveness

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

Safety and quality of care will be at risk if the workforce does not have the appropriate level of skill or experience, even if systems of care are well designed. Organisations have a responsibility to ensure that the care they provide meets minimum standards, to support continuous improvement, and to identify and manage clinicians whose performance does not meet appropriate standards. Credentialing, clinical audit, performance review, education and training, compliance with acceptable clinical guidelines, and evaluating variation in practice can all assist in the provision of safe, high-quality services.[14]

Several methods are used to confirm and assess a clinician's qualifications, experience, professional standing and other relevant professional attributes. These include recruitment processes, registration checks, peer review, oversight and supervision, and competency assessment. For some clinicians, a credentialing process is used.

Credentialing is a formal process used to confirm a clinician's competence, experience and professional suitability to provide safe, high-quality care. Scope of clinical practice is defined following credentialing. This involves delineating the extent of an individual clinician's practice within the organisation based on their credentials, competence, performance and professional suitability, and the needs and capability of the organisation.

Performance development programs enable an organisation to ensure that members of its clinical workforce meet their professional registration and continuing professional development requirements. Issues affecting an individual's performance are identified and addressed as part of the performance development process. Goals for quality improvement, and further education and training are also agreed to.

The values of fairness, accountability and support underpin effective systems of performance development. If underperformance is identified, the first response that is triggered should include increased support, and access to relevant tools, education and expertise. However, patient safety is paramount, and remedial strategies need to protect patient safety at all times.

Health service organisations are accountable for ensuring adequate supervision of the clinical workforce. In particular, junior clinicians who have limited clinical experience require oversight and regular review of their clinical practice. The purpose of supervision is to ensure that the practice of less experienced clinicians is of an acceptable standard, and to identify opportunities for learning and development.

Orientation is an important activity that provides the workforce with the basic knowledge and skills to work safely within the health service organisation. Comprehensive orientation includes an introduction to the organisation's:

- Model of care
- Policies, procedures and protocols
- Risk reporting and risk management processes
- Quality assurance, improvement and monitoring systems
- Incidents management and investigation systems
- Feedback and complaints management systems
- Healthcare records systems
- Performance development and human resources systems
- Information systems.

Health service organisations need to support clinicians to use the best available evidence to provide safe, high-quality care. Good clinical governance promotes clinical practice that is effective and based on evidence.[15] The introduction, use, monitoring and evaluation of evidence-based clinical pathways support the provision of effective care.

Clinicians are accountable for their practice. This includes compliance with accepted clinical guidelines or pathways. Oversight of clinical practice should enable the early identification and management of practices that place patients at risk of harm.[16]

Effective quality improvement systems should identify the extent of variation from agreed clinical guidelines or pathways, and how such variation is managed. The Commission's clinical care standards[17] support the delivery of appropriate care, reduce unwarranted variation in care, and promote shared decision making between patients, carers and clinicians.

Safety and quality training

Action 1.19

The health service organisation provides orientation to the organisation that describes roles and responsibilities for safety and quality for:

a. Members of the governing body

b. Clinicians, and any other employed, contracted, locum, agency, student or volunteer members of the organisation

Reflective question

What information is provided to new members of the governing body and workforce about their roles and responsibilities for safety and quality?

Key task

- Review the organisation's orientation policies and programs, and consider whether they provide appropriate and effective orientation in safety, quality and clinical governance.

Strategies for improvement

Orientation introduces a member of the governing body or workforce to the organisation. A well-designed orientation program will detail the key safety and quality systems.

Provide orientation that, among other things, covers the main elements of clinical governance and quality improvement systems to set expectations for members of the governing body and managers, and help develop or maintain their competence and expertise in clinical governance.

Consider whether induction is reliably provided to all members of the workforce, including contracted, locum, agency, student and volunteer members.

Periodically evaluate the content of the orientation and induction training program for its effectiveness and currency of content.

Examples of evidence

Select only examples currently in use:

- Orientation and induction documents that detail the safety and quality roles and responsibilities of the workforce and the governing body
- Attendance records for orientation and induction training
- Reports on evaluation of orientation and induction training content.

Action 1.20

The health service organisation uses its training systems to:

a. Assess the competency and training needs of its workforce

b. Implement a mandatory training program to meet its requirements arising from these standards

c. Provide access to training to meet its safety and quality training needs

d. Monitor the workforce's participation in training

Reflective questions

How does the health service organisation test the skills level of the workforce?

What training does the health service organisation provide on safety and quality?

How does the health service organisation identify workforce training needs to ensure that workforce skills are current and meet the health service organisation's service delivery requirements?

Key task

- Review the organisation's education and training policies and programs, and consider whether they provide appropriate and effective education and training in safety, quality and clinical governance.

Strategies for improvement

Maintaining a competent and capable workforce requires education and training. All health service organisations have a responsibility to provide access to ongoing education and training. Day procedure services that do not have the capability to provide in-house training should consider using external training providers.

The governing body and management should consider whether regular training in safety, quality, leadership and risk (including orientation to relevant organisational policies, procedures and protocols) is reliably provided to the whole workforce.

The governing body and management should ensure that the organisation's education and training policies:

- Define mandatory education and training requirements in relevant aspects of safety, quality, leadership and clinical risk for all members of the workforce

- Support the provision of education and training to the workforce based on comprehensive and regularly updated assessment of need

- Require evaluation of the outcomes of education and training in safety, quality, leadership and risk

- Ensure that appropriate records are maintained of education and training undertaken by each member of the workforce

- Provide each member of the workforce with the opportunity (through performance review and development programs) to define their education and training goals, and agree with their manager on opportunities to achieve these goals.

Training for the governing body and the workforce can be provided internally or externally using a variety of formats, including:

- Face-to-face programs
- Short sessions
- Peer review, mentoring and supervised practice
- Self-directed programs
- Online learning modules
- Audio or video content
- Competency-based assessments
- Conferences and seminars
- Secondments and placements.

Regularly assess the training needs of workforce members, and implement a training program that both meets the needs of the workforce to effectively perform their roles and incorporates elements to meet the requirements of the NSQHS Standards. Training needs may be identified through several pathways, including professional development activities, analysis of incident management and investigation systems, or a workforce survey.

Use a risk management approach to schedule training for the workforce based on a needs assessment. Use external training providers if training cannot be efficiently provided internally. Record and monitor attendance at training sessions to ensure that the workforce maintains skills and competencies.

The organisation is responsible for ensuring that members of the workforce who are employed indirectly (for example, using contract or locum arrangements) have the required qualifications, training and skills to effectively perform their roles. Organisations may:

- Have a contractual arrangement with agencies that provide temporary or locum members of the workforce
- Implement a formal process to verify that credentialed medical practitioners or locum members of the workforce have the required qualifications, training and skills
- Provide training to locum or agency members of the workforce at orientation and induction.

Examples of evidence

Select only examples currently in use:

- Policy documents about orientation and training of the clinical workforce
- Employment records that detail the skills and competencies required of the position, as well as the safety and quality roles and responsibilities
- Evidence of the assessment of clinicians' needs for education and competency-based training
- Schedule of clinical workforce education and competency-based training that includes the requirements of the NSQHS Standards
- Orientation manuals, education resources or records of attendance at workforce training
- Audit results of the proportion of the workforce with completed performance reviews
- Skills appraisals and records of competencies for the workforce, including the locum and agency workforce
- Feedback from the workforce about their training needs
- Reviews and evaluation reports of education and training programs
- Communication to the workforce about annual mandatory training requirements.

Action 1.21

The health service organisation has strategies to improve the cultural awareness and cultural competency of the workforce to meet the needs of its Aboriginal and Torres Strait Islander patients

Reflective question

How does the health service organisation work to meet the needs of Aboriginal and Torres Strait Islander patients?

Key tasks

- Ensure that actions to improve cultural competency are implemented and monitored for effectiveness
- Review the organisation's education and training policies and programs to ensure that they adequately cover cultural competency and monitor workforce participation in training

- Review and maintain the organisation's targets regarding the participation of Aboriginal and Torres Strait Islander people in the health workforce across clinical, managerial, support and advocacy roles.

Strategies for improvement

Having an effective culture in place means that an organisation has a defined set of values and principles, and demonstrates behaviours, attitudes, policies and structures that enable it to work effectively.[18]

Health service organisations should acknowledge and be respectful of the cultural factors and complex kinship relationships that exist in the local Aboriginal and Torres Strait Islander community.[19]

Day procedure services may have a small Aboriginal and Torres Strait Islander patient population. For many Aboriginal and Torres Strait Islander people receiving care in a day procedure service, their risk of harm will be similar to that of the general patient population using the service. However, Aboriginal and Torres Strait Islander people do not always see mainstream health services as offering them a safe and secure place to get well. In many instances, they experience[20]:

- Isolation from community and kin
- Language barriers in understanding health messages and difficulty in informing clinicians of their needs
- Financial difficulties in gaining access to treatments (for example, travel costs) and funding the costs of the treatment
- Perceived inferior treatment.

To improve the cultural competency of both the workforce and the organisation, consider[21]:

- Incorporating culturally specific requirements into recruitment processes, or including Aboriginal and Torres Strait Islander people on the interview panel
- Addressing cultural competency as part of performance review processes
- Ensuring that the workforce participates in cultural competency activities and training in a variety of learning formats, such as training exercises, reflective practice and face-to-face training whenever possible

- Providing access to ongoing learning for individuals through training, professional development, critical reflection and practice improvement
- Providing cultural competency training that is developed in collaboration with the local Aboriginal and Torres Strait Islander communities and includes content relevant to those communities
- Monitoring and reporting on the implementation and effectiveness of the cultural competency program to the governing body or management
- Implementing follow-up strategies (including counselling, performance improvement or more stringent approaches when necessary) if a culturally appropriate approach is not adopted
- Expanding the Aboriginal and Torres Strait Islander workforce and supporting them to fulfil their role as cultural mentors
- Incorporating cultural competency into policies and program development
- Collaborating with partner communities about service and facility design, delivery and evaluation, and to seek feedback on, and improve, cultural competency.

Further strategies are available in *NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health*.

Examples of evidence

Select only examples currently in use:

- Evidence of assessment of the workforce's needs for cultural competency and cultural awareness training
- Training documents on Aboriginal and Torres Strait Islander cultural awareness and cultural competency
- Policy documents in which the needs of Aboriginal and Torres Strait Islander patients are recognised
- Review and evaluation reports of cultural awareness education and training programs
- Committee and meeting records in which the cultural needs of Aboriginal and Torres Strait Islander patients are discussed, and strategies to meet their needs are monitored or evaluated

- Employment documents that detail the roles and responsibilities of Aboriginal support officers
- Strategies for increasing employment opportunities for Aboriginal and Torres Strait Islander people in the organisation

- Data analysis and evaluation of feedback from the workforce and consumers about the workforce's cultural competency and cultural awareness.

Performance management

Action 1.22

The health service organisation has valid and reliable performance review processes that:

a. Require members of the workforce to regularly take part in a review of their performance

b. Identify needs for training and development in safety and quality

c. Incorporate information on training requirements into the organisation's training system

Reflective questions

What are the health service organisation's performance review processes?

What process is used to identify the training needs for each member of the workforce?

How is this information incorporated into the health service organisation's training system?

Key tasks

- Implement processes to review participation in the performance development program for all clinicians and other members of the workforce
- Consider whether the performance development system is appropriately designed, resourced, maintained and monitored
- Periodically review the performance development system to ensure that it follows the agreed processes, engages clinicians and achieves the desired outcomes.

Strategies for improvement

'Performance review' and 'performance development' describe the systematic processes of goal-setting and periodic one-on-one review of workforce performance.

The organisation is responsible for:

- Establishing a culture in which safe, high-quality care can be delivered
- Assisting members of the workforce to develop their competence and performance by supporting them to achieve agreed goals.

Members of the workforce are responsible for:

- Understanding organisational objectives
- Setting professional goals that are consistent with the organisation's objectives
- Working collaboratively with the organisation to achieve professional and organisational goals.

Performance review processes present an opportunity for managers and clinicians to clarify reciprocal obligations between organisations and the workforce. Through performance review processes, organisations can state how they will meet their responsibility to clinicians, and clinicians can clarify their obligations to the organisation.

For organisations, this may mean describing how they will provide clinicians with support, resources, training, and access to evidence-based tools and data on their performance, and how time will be allocated to support a clinician's practice. Performance review also provides an opportunity

to describe a clinician's roles and responsibilities for safety and quality in the organisation.

For clinicians, performance review processes support reflective practice and provide opportunities to identify practice improvements. Reflective practice is effective when accurate and timely data are available that describe and benchmark a clinician's practice outcomes. Organisations should seek to collect and present clinician-specific data that can be used to support practice improvement and encourage clinicians to participate regularly in performance appraisals.

Develop an effective system

The governing body should ensure that effective performance development systems are in place.

The performance development system should include systematic monitoring of each clinician's participation in formal audit, peer review and continuing professional development, following the requirements of their professional organisation and registration body, and identify individual training needs.

Formal performance development systems may not be in place for members of the workforce who are employed indirectly (for example, through contract or locum arrangements). In these cases, performance management may be addressed by:

- Using the processes for credentialing and scope of clinical practice outlined in Actions 1.23 and 1.24
- Reviewing clinical performance data when contracts are due for renewal
- Addressing feedback or issues identified by the medical advisory committee
- Liaising with the locum agency.

Monitor and review the system

Clearly document the requirements of the organisation's performance development system. This includes identifying a designated person(s) responsible for ensuring compliance with the organisation's performance development policy. Monitor and report on performance to support effective implementation of the performance development system.

Review the performance of the performance development system, including workforce participation, and actions to address training and development needs. Consider how to assess the skills of the clinical workforce if competency-based assessment and training are required.

Examples of evidence

Select only examples currently in use:

- Policy documents about the performance review process for the workforce
- Documented performance development system that meets professional development guidelines and credentialing requirements
- Audit results of the proportion of the clinical workforce with completed performance reviews, including actions taken to address identified training and development needs
- Mentoring or peer-review reports
- Feedback from the workforce about their training needs
- Review and evaluation reports of education and training
- Committee and meeting records in which performance review and credentialing of clinicians are discussed.

Credentialing and scope of clinical practice

Action 1.23

The health service organisation has processes to:

a. Define the scope of clinical practice for clinicians, considering the clinical service capacity of the organisation and clinical services plan

b. Monitor clinicians' practices to ensure that they are operating within their designated scope of clinical practice

c. Review the scope of clinical practice of clinicians periodically and whenever a new clinical service, procedure or technology is introduced or substantially altered

Reflective questions

What processes are used to ensure that clinicians are working within the agreed scope of clinical practice when providing patient care?

How does the health service organisation match the services provided with the skills and capability of the workforce?

How does the health service organisation assess the effect on safety and quality of a new clinical service, procedure or technology?

Key tasks

- Verify that the organisation has adopted and implemented an evidence-based process for defining scope of clinical practice for all clinicians, including those with independent decision-making authority or working under supervision
- Consider whether the process for defining scope of clinical practice is appropriately designed, resourced, maintained and monitored
- Incorporate periodic review of the organisation's process for defining scope of clinical practice into audit programs, with a focus on consistency with adopted standards, performance measures and outcomes.

Strategies for improvement

Scope of clinical practice processes are key elements in ensuring patient safety. The aim is to ensure that only clinicians who are suitably experienced, trained and qualified to practise in a competent and ethical manner can practise in health service organisations.[22]

All clinicians providing care in a health service organisation must have their scope of clinical practice clearly defined. The processes for defining scope of clinical practice may include developing a position description, conducting a credentialing process or describing the clinician's role in a contract for services. Regardless of its form, the process describes the mutual commitment between the organisation and each member of the clinical workforce to provide safe, high-quality care.

The governing body should ensure that processes are in place for monitoring and maintaining effective systems for defining scope of clinical practice. The governing body is responsible for ensuring that compliance is monitored and reported, and that variations are investigated.

Define scope of clinical practice

The *Standard for Credentialing and Defining the Scope of Clinical Practice*[23] describes structures and processes that ensure:

- Clear definition of clinicians' scope of clinical practice in the context of the organisation's needs and capability
- Regular review of clinicians' scope of clinical practice
- Safe and appropriate introduction of new clinical services, procedures and other technologies
- Appropriate supervision of clinicians, when necessary
- Effective processes for reviewing clinicians' competence and performance
- Procedures to be followed if a concern arises about the capability of a clinician.[22]

Examples of evidence

Select only examples currently in use:

- Policy documents about the scope of clinical practice for clinicians in the context of the organisation's needs and capability
- Committee and meeting documents that include information on the roles, responsibilities, accountabilities and monitoring of scope of clinical practice for the clinical workforce
- Audit results of position descriptions, duty statements and employment contracts against the requirements and recommendations of clinical practice and professional guidelines
- Audit results of diagnosis-related groups cared for by clinicians compared with their granted scope of clinical practice and the organisation's clinical services capability framework
- Reports of key performance indicators for clinicians
- Audit results of signatures and role designation in patient healthcare records
- Workforce performance appraisal and feedback records that show a review of the scope of clinical practice for the clinical workforce
- Peer-review reports
- Evaluation of the health service organisation's clinical services targets

- Procedure manuals or guidelines for new services, procedures and technologies
- Defined competency standards for new services, procedures and technologies
- Planning documents to introduce new services (including workforce, equipment, procedures, scope of clinical practice applications and approval for licensing)
- Training documents about new clinical services, procedures and technologies
- Communication to the workforce that defines the scope of clinical practice for new clinical services, procedures or technologies.

Action 1.24

The health service organisation:

a. Conducts processes to ensure that clinicians are credentialed, where relevant

b. Monitors and improves the effectiveness of the credentialing process

Reflective question

What processes are used to ensure that clinicians have the appropriate qualifications, experience, professional standing, competencies and other relevant professional attributes?

Key tasks

- Ensure that the processes for credentialing clinicians are documented in the organisation's policies, procedures or protocols
- Ensure that the organisation's by-laws cover requirements for credentialing clinicians
- Review results of audits and system evaluation reports for compliance with the credentialing policies, procedures or protocols.

Strategies for improvement

Health service organisations are required to appoint clinicians who are suitably experienced, skilled and qualified to practise in a competent and ethical manner, taking into account service needs and organisational capability. Organisations have several processes to ensure that clinicians are suitably credentialed before they start work.

These are detailed in *Credentialing Health Practitioners and Defining their Scope of Clinical Practice: A guide for managers and practitioners*.[22]

Collect evidence of credentials

Collect evidence of minimum credentials as part of any recruitment process, and reconsider the evidence when there is a change in circumstances or a change in role for clinicians. Verify the information submitted by, or on behalf of, a clinician for determining scope of clinical practice, even when a recruitment agency is used to source applicants and they conduct some verification processes.

Collect evidence for each of the following areas[22]:

- Education, qualifications and formal training
- Previous experience, including relevant clinical activity and experience in similar settings to the relevant scope of clinical practice
- Clinician references and referee checks
- Continuing education that relates to a role in which the clinician is engaged and that is relevant to the scope of clinical practice
- Current registration with the relevant national board
- Professional indemnity insurance
- Other documentation and pre-employment checks, such as
  - a current curriculum vitae
  - an applicant's declaration
  - proof of identity (100-point identity check)
  - passport and copies of relevant visas (for overseas-trained practitioners)
  - a police or working with children check
- The applicant having no registration board restrictions or conditions on their registration, no criminal history, no report of professional misconduct against them, no report of unsatisfactory professional conduct and no outstanding complaints
- Permission to contact previous facilities or organisations where the clinician has been employed.

The credentialing process requires submission and review of a number of supporting documents. If the originals are not supplied or previously verified through other processes, organisations may require certification by a Justice of the Peace or similar recognised certifying agent.

Given the diversity of skills and experience of internationally qualified clinicians, it is important that the references and checks on education, training, competencies and experience are thorough and diligent. Consider any extra support, supervision or training that may be required by international clinicians to ensure that their practices are safe.[22]

Improve the credentialing process

Monitoring and improving the effectiveness of the credentialing process may involve:

- Setting up credentialing committees with clear terms of reference, and ensuring that committee members understand their responsibilities, and have the required knowledge and skills to fulfil their responsibilities
- Reviewing and validating the processes for credentialing, defining and managing scope of clinical practice, and ensuring that these are diligent and effective
- Verifying (and periodically re-verifying) each clinician's credentials following defined organisational policy.

Examples of evidence

Select only examples currently in use:

- Policy documents that describe the formal credentialing processes for health practitioners
- Committee and meeting records for the credentialing committee
- Register of workforce qualifications and areas of credentialed practice
- Documented recruitment processes that ensure that clinicians are matched to positions, and have the required skills, experience and qualifications to perform their roles and responsibilities
- Employment documents that define the roles of clinical supervisors and trainees undertaking regular clinical supervision
- Evidence that the health service organisation has verified clinicians' qualifications before employment
- Documented use of a checklist for scope of clinical practice
- Documented performance reviews or peer reviews for the clinical workforce
- Audit results of clinical documentation for compliance with guidelines, policies, procedures or protocols
- Documented process for identifying clinicians to be credentialed.

Safety and quality roles and responsibilities

Action 1.25

The health service organisation has processes to:

a. Support the workforce to understand and perform their roles and responsibilities for safety and quality

b. Assign safety and quality roles and responsibilities to the workforce, including locums and agency staff

Reflective question

How are members of the workforce informed about, and supported to fulfil, their roles and responsibilities for safety and quality of care?

Key tasks

- Ensure that the governing body appropriately delegates responsibility for governance

- Review the organisation's performance development policy, and ensure that it incorporates leadership in safety and quality improvement and governance for all managers and clinicians
- Review the organisational structure, position descriptions and contract templates of management, clinicians and other members of the workforce to ensure that responsibility for safety and quality is clearly defined at all levels.

Strategies for improvement

Ensure that members of the workforce understand their roles, responsibilities and accountability for ensuring the safety and quality of care.

The clinical governance system should be supported by:

- Clear definition and delegation of reporting lines, and responsibilities for safety and quality
- Clearly documented accountabilities for safety and quality of clinical care within the position descriptions and contractual responsibilities of the chief executive, management and clinicians
- Safety and quality policies, procedures or protocols; responsibilities should be allocated through the organisational management system
- A structured performance development system for all clinicians and managers, incorporating regular review of their engagement in safety and quality, and in specific activities such as peer review and audit.

Consider the following strategies when implementing delegated roles and responsibilities in the workforce:

- Ensure that safety and quality roles and responsibilities are clearly defined by
  - reviewing workforce position descriptions
  - discussing safety and quality responsibilities in routine performance management processes
  - providing information to the workforce about their safety and quality roles and responsibilities
- Educate and train members of the workforce in their governance roles, responsibilities and accountabilities

- For managers and senior clinicians, identify professional development opportunities in clinical safety and quality, leadership and risk, and schedule training in clinical governance
- Ensure that contractual arrangements are in place for the agency and locum workforce, and verify that credentialing and scope of clinical practice are undertaken before or after they start work
- Provide agency and locum members of the workforce with an orientation to safety, quality and clinical governance that includes access to policies and procedures that outline roles and responsibilities
- Provide support material to help the workforce orientate agency and locum members of the workforce.

Examples of evidence

Select only examples currently in use:

- Policy documents that outline the delegated safety and quality roles and responsibilities of the workforce
- Employment documents that describe the safety and quality roles, responsibilities and accountabilities of the workforce
- Contracts for locum and agency workforce that specify designated roles and responsibilities, including for safety and quality
- Organisational chart and delegations policy that demonstrates clinical governance reporting lines and relationships
- Training documents about safety and quality roles and responsibilities of the workforce
- Communication to the workforce about their safety and quality roles and responsibilities
- Performance appraisals that include feedback to the workforce about delegated safety and quality roles and responsibilities
- Results of workforce surveys or feedback regarding their safety and quality roles and responsibilities.

Action 1.26

The health service organisation provides supervision for clinicians to ensure that they can safely fulfil their designated roles, including access to after-hours advice, where appropriate

Reflective question

How does the health service organisation monitor and support clinicians to safely fulfil their designated roles?

Key task

- Identify clinicians who require supervision, including junior clinicians, clinicians in training, clinicians who are expanding their scope of clinical practice and clinicians who require oversight of their performance.

Strategies for improvement

Supervision is a key safeguard for safe and high-quality care. Supervision of junior clinicians should be appropriate to their assessed capabilities, and be consistent with organisational policies, procedures and protocols. A key goal of supervision is to safely develop a clinician's capabilities.

Formally document the roles and responsibilities of clinicians who are in training in their position description and training program. Monitor compliance with training requirements as part of the clinician's training program and performance reviews.[22]

Clearly define clinical supervision responsibilities in the contracts of employment or engagement of all senior clinicians, and in relevant organisational policies, including those that apply to the performance development system. This will help to ensure that junior clinicians develop their skills, while protecting the safety and quality of patient care.

Ensure that clinicians who supervise other clinicians[22]:

- Have the qualifications and skills necessary to supervise in the nominated area of clinical practice
- Have experience at the appropriate level of practice
- Have the training and experience necessary to provide supervision
- Are located appropriately to provide adequate supervision
- Participate in the process of reviewing the supervised clinicians' scope of clinical practice.

Examples of evidence

Select only examples currently in use:

- Individual performance reviews for the clinical workforce, including requirements for supervision
- Audit of the extent and effectiveness of supervision
- Observation of clinical practice
- Mentoring or peer-review reports
- Audit results of members of the clinical workforce who have completed performance reviews, including supervision that is required, and actions taken to deal with identified training and development needs.

Evidence-based care

Action 1.27

The health service organisation has processes that:

a. Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice

b. Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care

Reflective questions

How does the health service organisation decide which best-practice guidelines, integrated care pathways, clinical pathways, decision support tools and clinical care standards are to be used?

How does the health service organisation support and monitor clinicians' use of these tools?

Key tasks

- Evaluate the extent to which documented clinical guidelines or pathways have been formally adopted by the clinical workforce, and whether opportunities exist to adopt clinical guidelines or pathways as a quality improvement activity
- Review how compliance with, and variations of practice from, evidence-based clinical guidelines or pathways are monitored, especially for high-volume or high-risk conditions.

Strategies for improvement

Use clinical guidelines and pathways

Good clinical governance promotes clinical practice that is effective and evidence based.[15] Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways, decision support tools, and the clinical care standards developed by the Commission relevant to their clinical practice.

The introduction, use, monitoring and evaluation of evidence-based clinical pathways support effective care, and promote an organisational culture in which evaluation of organisational and clinical

performance, including clinical audit, is expected in every clinical service.[24]

Promote clinical effectiveness by developing or adopting guidelines and protocols for particular diseases and clinical interventions. The National Health and Medical Research Council's clinical practice guidelines portal provides links to clinical practice guidelines developed for use in Australian healthcare settings.

Promote accountability of clinicians for their practice, including compliance with accepted clinical guidelines or pathways. Overseeing clinical practice should enable the early identification and management of practices that place patients at risk of harm.[16]

Effective quality improvement systems identify the extent of variation from agreed clinical guidelines or pathways, and how such variation is managed. Use audits to monitor the proportion of care that is provided following clinical guidelines or pathways, and communicate this to the workforce, managers and the governing body.

The governing body and management should periodically review compliance with, and variations from, evidence-based practice, to provide assurance of appropriate care and identify quality improvement opportunities.

Use clinical care standards

Clinical care standards support the delivery of appropriate care, reduce unwarranted variation in care, and promote shared decision making between patients, carers and clinicians. Clinical care standards target key areas and provide opportunities to better align clinical practice with the best evidence.

Clinical care standards are designed to:

- Inform patients about the care they can expect to receive
- Provide guidance to clinicians on delivering appropriate, high-quality care
- Identify the systems that organisations need to have in place to support and monitor appropriate care.

Clinical guidelines form the evidence base for the clinical care standards. It is recommended that clinical care standards are used by health service organisations when they apply to services being provided.

If appropriate, build the requirements of the clinical care standard into the organisation's policies, processes or protocols, and give clinicians access to relevant clinical care standards.

Each clinical care standard includes nationally agreed quality statements outlining key areas of care.

In complex organisations, or the private health sector, the care described in the quality statements may not be offered or delivered by one care provider. Identify which of the quality statements are the responsibility of the health service organisation and which other service providers may be responsible for care set out in the quality statements. Establish formal agreements on responsibility for implementing the quality statements with any other organisations or service providers delivering care.

Action 3.15 and Action 5.29 include strategies related to the Antimicrobial Stewardship Clinical Care Standard and the Delirium Clinical Care Standard.

Clinical care standards are available to download from the Commission's website.

Support evidence-based practice

Ensure that systems are in place that periodically review compliance with, and variations from, evidence-based practice, and report to the governing body, to provide assurance of appropriate care and identify quality improvement opportunities.

Strategies to support clinicians to use the best available evidence and limit unwarranted variations in care may include:

- Adopting clinical guidelines, pathways or clinical care standards where they are appropriate

- Identifying or establishing committees or individuals with responsibility for approving and reviewing the use of best-practice guidelines, integrated care pathways, clinical pathways, clinical care standards and decision support tools, and for communicating this information to the workforce
- Making resources available to implement clinical guidelines, pathways or clinical care standards
- Establishing processes that enable peer-based feedback to the clinical workforce about compliance with evidence and management of variation
- Monitoring compliance with clinical care standards being used, and informing clinicians if unwarranted variation is detected.

Examples of evidence

Select only examples currently in use:

- Policy documents about access to, and use of, best-practice guidelines, pathways, decision support tools and clinical care standards that reflect best available evidence and are appropriately referenced
- Committee and meeting records in which decisions about the implementation and use of best-practice guidelines, pathways, decision support tools and clinical care standards were discussed
- Training documents about best-practice guidelines, pathways, decision support tools and clinical care standards
- List of procedures with agreed clinical pathways available to the workforce
- List of web addresses for the workforce to use, and electronic copies of best-practice guidelines, pathways, decision support tools and clinical care standards
- Audit results of healthcare records for adherence to available best-practice guidelines, pathways, decision support tools and clinical care standards
- Observation of best-practice guidelines, pathways, decision support tools and clinical care standards in clinical areas.

Variation in clinical practice and health outcomes

Action 1.28

The health service organisation has systems to:

a. Monitor variation in practice against expected health outcomes

b. Provide feedback to clinicians on variation in practice and health outcomes

c. Review performance against external measures

d. Support clinicians to take part in clinical review of their practice

e. Use information on unwarranted clinical variation to inform improvements in safety and quality systems

f. Record the risks identified from unwarranted clinical variation in the risk management system

Reflective questions

How does the health service organisation use both external and internal systems for monitoring and improving clinical and patient outcomes?

How does the health service organisation interact with clinicians regarding their clinical practice and the health outcomes of their patients?

Key tasks

- Identify key external data collections, registries, audits or reports that cover the specific areas of clinical practice relevant to patients, or procedures or services offered by the organisation

- Support and encourage clinicians to participate in national and state or territory clinical quality registries

- In collaboration with clinicians, review clinical practice data from the organisation, and compare them with data from similar geographic areas or health service organisations

- Identify any areas of practice that vary from best practice, that show widely differing practice within the organisation or that vary from practice in similar services

- Investigate the reasons for any variation, and identify whether it is unwarranted variation in the safety and quality of care

- Identify actions to ensure that practice changes align with best practice

- Consider issues of inappropriate resource allocation (including workforce) to ensure that practice changes align with best practice

- Identify any areas of risk and act to mitigate them

- Review the schedule of data and reports provided to the governing body and clinicians to ensure that it is comprehensive and relevant, and covers actions taken to align practice with desired care.

Strategies for improvement

People expect to receive care that is appropriate for their needs and informed by evidence. However, use of healthcare interventions and outcomes of care vary for different populations, across geographic areas, and among services and clinicians. Understanding this variation is critical to improving the quality, value and appropriateness of health care. Some variation is desirable and warranted – it reflects differences in people's healthcare needs. If variation is unwarranted, it signals that people are not getting appropriate care.

Review the data

Examining variation in care from that provided by similar services is an important first step in identifying and addressing any unwarranted variation. Identify internal and external data sources, and select quality metrics that are relevant to the population served and the services provided.

Review the data to see whether the organisation's performance varies from known best practice or from the performance of similar organisations. Investigate any outlying data to identify whether any of the variation is warranted, and implement possible approaches to deal with unwarranted variation. Compare the service's data with data from peer services; data from other organisations; or state, territory or national performance data.

Data derived from the clinical care standard indicators can be used to show variation and improvement in clinical practice.

The clinical and management teams should be responsible for analysing these data, and for:

- Identifying issues, and solutions to deal with them
- Disseminating information about any unwarranted variation, and how it will be addressed
- Acting to make changes to care, if required
- Reporting actions taken to reduce unwarranted variation and ongoing performance to the governing body, through the clinical governance framework, and to other relevant organisations.

Analyse information on unwarranted clinical variation for opportunities to improve safety and quality. Support clinicians to take part in the data analysis, and encourage them to review and, if necessary, change their practice in light of the findings.

Use clinical quality registries

Australia currently has limited capacity to measure and monitor the degree to which health care benefits the patient (effectiveness), and how closely that care aligns with evidence-based practice and patient preferences (appropriateness). Clinical quality registries monitor and report on the appropriateness and effectiveness of health care, but only a small number of data collections currently capture and report process and outcomes data for specific clinical conditions or interventions.

Clinical quality registries are organisations that systematically monitor the quality (appropriateness and effectiveness) of health care, within specific clinical domains, by routinely collecting, analysing and reporting health-related information. The information is used to identify benchmarks and marked outcome variance, and inform improvements in healthcare quality.[25]

A number of well-established clinical quality registries operate in Australia, to which hospitals contribute information. Examples are:

- Australian and New Zealand Intensive Care Society Adult Patient Database
- Australia and New Zealand Dialysis and Transplant Database
- Australian Orthopaedic Association National Joint Replacement Registry
- Australasian Cardiac Outcomes Registry
- Australian and New Zealand Neonatal Network
- Victorian Prostate Cancer Registry
- Victorian State Trauma Registry.

Day procedure services should ensure that they contribute data to established clinical registries and, if possible, use the information generated from clinical quality registers as part of their data analysis.

Clinical registries are usually established and maintained by specialist groups. The clinical governance group should investigate the clinical registries that are relevant to the organisation.

The Commission has developed a framework for Australian clinical quality registries[25] in collaboration with states, territories and expert registry groups, to reduce the gap in the measurement of healthcare quality and inform improvements in patient care.

More information on variation in healthcare provision across Australia is available in the *Australian Atlas of Healthcare Variation*.[26]

Examples of evidence

Select only examples currently in use:

- Policy documents that identify the external clinical quality systems that the health service organisation contributes to and encourages its clinicians to take part in
- Reports on data analyses that are used to identify variation in clinical practice and areas of risk associated with variation in clinical practice
- Reports that compare clinical practice and outcomes with those of similar services or peer organisations
- Reports on comparative data analysis from meetings involving clinicians that identify potential reasons for any variation, further investigations that may be needed and potential areas of risk associated with variation in clinical practice
- Comparative data analysis on clinical variation and the outcomes associated with care using external sources such as the *Australian Atlas of Healthcare Variation*, or data provided by, or shared with, external organisations such as clinical quality registries, the Health Roundtable, peer organisations, and states and territories
- Committee and meeting records in which reports on clinical variation or appropriateness of practice were discussed, and clinicians assessed interventions and managed changes in practice
- Audit results of clinical practice against the recommended best-practice guidelines, pathways or clinical care standards, and reports on findings that are provided to all relevant clinicians, managers and committees
- Records of clinical participation in morbidity and mortality reviews, external audits of clinical care, and external clinical registries
- Risk management system that includes actions to manage identified risks associated with unwarranted variation
- Quality improvement system that includes actions to deal with identified issues
- Examples of improvement activities that have been implemented and evaluated to reduce unwarranted variation.

CRITERION: Safe environment for the delivery of care

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

A variety of legislation covers building codes, and workplace health and safety issues. The actions in this criterion focus on how the health service environment can support the delivery of safe and high-quality care for patients.

The health service environment, which includes all facilities, plant and equipment, needs to be fit for purpose and maintained in good working order to reduce hazards and ensure patient safety. Good design can also reduce the potential for adverse events – for example, by providing good lighting in areas where medicines are dispensed, or selecting surfaces that are easy to clean and disinfect.

Having clear directions and signage can help patients find the services they need, and the use of furnishings, artwork, light, colour and sound can improve patients' comfort and experience of care.

Spaces that are designed for flexible use can help clinicians provide the right level of engagement or stimulation for patients with mental health issues, and can assist patients with cognitive impairment by simplifying the environment to reduce unnecessary stimulation.

Safe environment

Action 1.29

The health service organisation maximises safety and quality of care:

a. Through the design of the environment

b. By maintaining buildings, plant, equipment, utilities, devices and other infrastructure that are fit for purpose

Reflective questions

How does the health service organisation ensure that the design of the environment supports the quality of patient care?

How does the health service organisation ensure that buildings and equipment are safe and maintained in good working order?

Key tasks

- Regularly conduct environmental audits to see whether the environment is safe and promotes best practice
- Implement a schedule of review to ensure that all buildings, plant and equipment are fit for purpose, safe and in good working order at all times.

Strategies for improvement

Develop maintenance strategies

Develop a comprehensive maintenance plan that includes:

- clear and easy-to-use documentation of maintenance and repairs
- records of all plant and equipment, including (as a minimum) the date of purchase, preventive maintenance schedule, location and serial number
- details of routine and preventive maintenance performed for each item of equipment and plant, including electromedical equipment
- records of dates when equipment is regularly tested to ensure its readiness, including information relating to generators and battery backup.

When equipment is regularly tested to ensure its readiness, record these dates, including information relating to generators and battery backup.

Australian standards are available for devices and equipment, and these should be reflected in the organisation's policies and procedures so that purchases, repairs and replacements are carried out following a specified standard. Similarly, the Building Code of Australia articulates the technical provisions for the design and construction of buildings and other structures throughout Australia, and should also be reflected in the organisation's policies and procedures. Manufacturers also set guidelines for the use and tolerance of equipment and devices. Faulty devices may need to be reported (for example, to the Therapeutic Goods Administration) or may be subject to a recall.

Use evidence-based design principles to promote safe practice

The physical environment can have a major impact on safety and quality performance. Good design can contribute to safe and high-quality care by promoting safe practices and removing potential hazards. It can reduce healthcare-associated infections and medical errors[27], improve patient and workforce satisfaction, and increase organisational performance.[28]

Consider the following design principles when redesigning or upgrading amenities:

- Automating processes, if appropriate (for example, dispensing medicines, handwashing facilities)
- Designing spaces to prevent adverse events (for example, removing tight corners, selecting appropriate furnishings and surfaces that can be easily decontaminated, providing enough lighting)[27]
- Providing information that is visible and easily accessible to patients and the workforce
- Using soft furnishings to reduce the impact of background noise on patients
- Providing clearly marked signs, maps and instructions to help patients and visitors navigate the health service.

Examples of evidence

Select only examples currently in use:

- Policy documents that describe the health service organisation's
  - requirements for maintaining buildings, plant, equipment, utilities and devices
  - reporting lines and accountability for actions, including during emergency situations
- Strategic plan for facilities and capital works
- Maintenance schedule for buildings, equipment, utilities and devices
- Audit results of compliance with maintenance schedules and inspections of equipment
- Register of equipment that is assigned to meet individual patients' needs
- Audit results of the use of a pre-purchase checklist and risk assessment to identify suitability of all new equipment
- Observation of design and use of the environment to reduce risks relating to self-harm (for example, removal of ligature points, collapsible curtain rails)
- Observation that the different types of accommodation (for example, private and shared rooms, designated palliative care rooms, patient/consumer/carer lounge) are allocated based on clinical need
- Observation that the physical environment includes consideration of safety and quality (for example, interview rooms in high-risk areas that have double doors, use of CCTV surveillance, duress alarms, access to security services, a secure environment after hours)
- Business continuity plan
- Analysis of incident reports and action taken to deal with issues identified
- Risk register and quality improvement plan that includes information from analysis of incidents.

Action 1.30

The health service organisation:

a. Identifies service areas that have a high risk of unpredictable behaviours and develops strategies to minimise the risks of harm for patients, carers, families, consumers and the workforce

b. Provides access to a calm and quiet environment when it is clinically required

Reflective questions

How does the health service organisation identify and manage aspects of the environment and other factors that can increase risks of harm?

What processes are in place to assess the appropriateness of the physical environment of the health service organisation for people at high risk of harm, such as people with cognitive impairment?

Key tasks

- Review the design of the clinical environment to identify safety risks for patients, carers, families and the workforce
- Conduct a risk assessment to identify service areas where there is a high risk of unpredictable behaviours, and develop strategies to manage identified risks

Strategies for improvement

Day procedure services should use pre-admission screening processes to identify patients with a high risk of unpredictable behaviour. The screening processes listed under Actions 5.10 and 5.11 could also be used to demonstrate the management of risk for Action 1.30a.

Action 1.30b may not be applicable for many day procedure services because of the size of the service and the nature of the clinical environment.

Services should refer to *NSQHS Standards Guide for Hospitals* and *NSQHS Standards Accreditation Workbook* for detailed implementation strategies and examples of evidence for this action, as required.

Examples of evidence

Select only examples currently in use:

- Policy documents for safe work practices and emergency situations
- Audit results of healthcare records for compliance with policies, procedures or protocols regarding unpredictable behaviours
- Training documents about safe work practices and emergency situations
- Observation that the physical design of the environment includes consideration of safety and quality (for example, interview rooms in high-risk areas that have double doors, use of CCTV surveillance, duress alarms, access to security services, a secure environment after hours)
- Security contracts and surveillance systems.

Action 1.31

The health service organisation facilitates access to services and facilities by using signage and directions that are clear and fit for purpose

Reflective question

How do patients and visitors find the facilities to gain access to care?

Key task

- Review the signage and directions provided throughout the facility.

Strategies for improvement

Consider how to direct patients to the health service, including with information about parking, public transport and other essential services. Also consider the types of signs used, graphics and terminology.[29]

Instructions should[29]:

- Be simple, intuitive, user friendly and accessible
- Integrate with the requirements of a safe and secure facility
- Meet the legal requirements for accessibility
- Be easy to maintain
- Align with the principles of universal design.

Wayfinding strategies may include hard copies of signs, maps and written directions, or more interactive approaches such as employees or volunteers who help people with directions, interactive information kiosks and smartphone apps.

Examples of evidence

Select only examples currently in use:

- Policy documents for signage, disability access and inclusion
- Observation of the use of universal signage to enable wayfinding for people from culturally and linguistically diverse backgrounds
- Audit results that show whether signs are clearly visible to people with disability
- Location maps that are displayed at entrances and in areas of high visual impact
- Facility map that is available in multiple languages
- Observation of the use of volunteers in reception areas to assist consumers with directions.

Action 1.32

The health service organisation admitting patients overnight has processes that allow flexible visiting arrangements to meet patients' needs, when it is safe to do so

This action is not applicable for day procedure services that do not admit patients overnight.

Day procedure services that admit patients overnight (for example, those with 23-hour licences) should refer to *NSQHS Standards Guide for Hospitals* and *NSQHS Standards Accreditation Workbook* for detailed implementation strategies and examples of evidence for this action.

Action 1.33

The health service organisation demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander people

This action applies to day procedure services that commonly provide care for Aboriginal and Torres Strait Islander people. These services should refer to *NSQHS Standards Guide for Hospitals*, *NSQHS Standards Accreditation Workbook* and *NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health* for detailed implementation strategies and examples of evidence for this action.

Day procedure services that rarely provide care for Aboriginal and Torres Strait Islander people, or when the risk of harm for these patients is the same as for the general patient population, should manage the specific risk of harm, and provide safe and high-quality care for these patients through the safety and quality improvement systems that relate to their whole patient population.

Day procedure services need to implement strategies to improve the cultural awareness and cultural competency of the workforce under Action 1.21, and identify Aboriginal and Torres Strait Islander patients under Action 5.8.

Partnering with Consumers Standard

Partnering with Consumers Standard

Leaders of a health service organisation develop, implement and maintain systems to partner with consumers. These partnerships relate to the planning, design, delivery, measurement and evaluation of care. The workforce uses these systems to partner with consumers.

Intention of this standard

To create an organisation in which there are mutually valuable outcomes by having:

- Consumers as partners in planning, design, delivery, measurement and evaluation of systems and services
- Patients as partners in their own care, to the extent that they choose.

Criteria

Clinical governance and quality improvement systems to support partnering with consumers

Partnering with patients in their own care

Health literacy

Partnering with consumers in organisational design and governance

Introduction

After more than 40 years of growing recognition and acceptance, consumer partnerships in health care are now viewed as integral to the development, implementation and evaluation of health policies, programs and services.[30-32] Patient and consumer partnerships are also a pillar of person-centred care – that is, care that focuses on the relationship between a patient and a clinician, and recognises that trust, mutual respect and sharing of knowledge are needed for the best health outcomes.[33]

Patient and consumer partnerships should take many forms, at many levels

Different types of partnerships with patients and consumers exist within the healthcare system. These partnerships are not mutually exclusive, and are needed at all levels to ensure that a health service organisation achieves the best possible outcome for all parties.[34] Partnerships with patients and consumers comprise many different, interwoven practices that reflect the three key levels at which partnerships are needed:

- **Individual**
  At the level of the individual, partnerships relate to the interaction between patients and clinicians when care is provided. This involves providing care that is respectful; sharing information in an ongoing way; working with patients, carers and families to make decisions and plan care; and supporting and encouraging patients in their own care and self-management.[35]

- **Service, department or program of care**
  At the level of a service, department or program of care, partnerships relate to the organisation and delivery of care within specific areas. Patients, carers, families and consumers participate in the overall design of the service, department or program. They could be full members of quality improvement and redesign teams, including participating in planning, implementing and evaluating change.

- **Health service organisation**
  At the level of the health service organisation, partnerships relate to the involvement of consumers in overall governance, policy and planning. This level overlaps with the previous level in that a health service organisation is made up of various services, departments and programs. Consumers and consumer representatives are full members of key organisational governance committees in areas such as patient safety, facility design, quality improvement, patient or family education, ethics and research. This level can also involve partnerships with local community organisations and members of local communities.

Supporting effective consumer partnerships means supporting multiple mechanisms of engagement. Meaningful methods of engagement range from representation on committees and boards, to contributions at focus groups, to feedback received through surveys or social media. When selecting methods of consumer participation, consider the diversity of the consumer population that uses, or may use, the services.[30]

Consumer partnerships should not be viewed in isolation, but as a continuum of activity. From partnering with consumers in their own care to representation of consumers on boards or governance committees, consumer partnership is needed at multiple levels of healthcare delivery. Consumers need to be represented at the highest levels of governance for their input to have the greatest impact.[30,31]

Consumer partnerships add value

Consumer partnerships add value to healthcare decision-making. Consumer involvement in the development, implementation and evaluation of health care contributes to[31,32]:

- Appropriately targeted initiatives
- Efficient use of resources
- Improvement in the quality of care provided by a health service.

There is growing acceptance that practices that support partnerships at the level of the individual – from communication and structured listening, through to shared decision making, self-management support and care planning – can improve the safety and quality of health care, improve patient outcomes and experience, and improve the performance of health service organisations.[35]

As consumer partnership becomes more embedded in the healthcare system, there is an increasing need to monitor and evaluate its impact. Monitoring, measuring and evaluating consumer partnerships – through mechanisms such as recording patient experience and patient-reported outcome measures – are vital to ensure that the partnerships are meeting the needs of the community and consumers.[32]

Organisational leadership and support are essential to nurture consumer partnerships

Regardless of the mechanisms used, all forms of consumer partnership require organisational commitment, organisational support and appropriate resourcing. Organisational commitment and support can be demonstrated through the support of executive leadership and governing bodies. Strong leadership in support of consumer partnerships can lay a solid foundation for adopting partnerships at the service level. Appropriate resourcing may include consumer training, workforce roles that focus on nurturing consumer partnerships, and remuneration and reimbursement to support consumers to actively participate.[30,31]

Consumer partnerships should be meaningful and not tokenistic. To maximise the contribution of partnerships, consumers need to be seen and treated as people with expert skills and knowledge. In the same way that clinicians and other organisational partners are respected for their areas of expertise, consumer partnerships need to be recognised and valued for their unique perspective on the patient experience.[31]

Many resources are available to help organisations of any size set up and support consumer partnerships

There are multiple successful approaches to partnering with consumers. Different health service organisations have different contexts and resources available to embed consumer partnerships in their systems, and partnering approaches can be adapted to the nature and context of the health service organisation. Although capacity and resource limitations may appear to pose a barrier to forming consumer partnerships, a simple approach to partnering can often be the most effective.

CRITERION: Clinical governance and quality improvement systems to support partnering with consumers

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

Good governance systems promote the effective delivery of health care, empower patients and contribute to improvements in health outcomes.[36,37]

Consumer engagement at multiple levels of governance is a key element for effective and sustainable governance systems.[38]

This criterion requires organisation-wide governance, leadership and commitment to partnering with consumers.

To meet this criterion, health service organisations are required to:

- Apply safety and quality systems to processes for partnering with consumers
- Use quality improvement systems to monitor, review and improve processes for partnering with consumers.

This criterion aligns closely with the Clinical Governance Standard.

Integrating clinical governance

Action 2.1

Clinicians use the safety and quality systems from the Clinical Governance Standard when:

a. Implementing policies and procedures for partnering with consumers

b. Managing risks associated with partnering with consumers

c. Identifying training requirements for partnering with consumers

Reflective questions

How are the health service organisation's safety and quality systems used to:

- Support implementation of policies and procedures for partnering with consumers
- Identify and manage risks associated with partnering with consumers
- Identify training requirements for partnering with consumers?

Key tasks

- Set up and implement governance structures for partnering with consumers
- Develop and implement policies and procedures for partnering with consumers
- Use organisation-wide risk management systems to identify, monitor, manage and review risks associated with partnering with consumers
- Deliver or provide access to training on partnering with consumers based on the specific needs of the clinical workforce.

Strategies for improvement

The Clinical Governance Standard has specific actions relating to health service organisations' safety and quality systems.

Action 1.7 – policies and procedures

Action 1.10 – risk management systems

Actions 1.19, 1.20 and **1.21** – education and training

Health service organisations should:

- Use these and other established safety and quality systems to support policies and procedures, risk management and training for partnering with consumers

- Ensure that current versions of all relevant policies and procedures are readily available and accessible to clinicians.

Clinical policies may be developed or adapted at different levels within the organisation. However, all policy documents should be incorporated into a single, coherent set to maximise the effectiveness of the policy development process.

Establish governance for partnering with consumers

For Action 2.1, the health service organisation should ensure that all actions in the Partnering with Consumers Standard have appropriate governance structures and support from the governing body and management.

Actions 2.11, 2.12, 2.13 and 2.14 outline strategies for partnering with consumers in discussions and decisions regarding the design, implementation and evaluation of health policies, programs and services.

Implement policies and procedures

Ensure that organisational policies and procedures are in place that cover:

- Healthcare rights
- Informed consent, including financial consent
- Shared decision making and planning care
- Health literacy and effective communication with patients, carers, families and consumers
- Partnering with consumers in governance.

Manage risks

Use the organisation's established risk management systems (Action 1.10) to identify, monitor, manage and review risks associated with partnering with consumers. Develop processes to manage clinical risks for different populations served within the organisation, clinical and workplace risks for the workforce, and organisational risks.

Use information from measurement and quality improvement systems, adverse events, clinical outcomes and patient experiences to inform and update risk assessments and the risk management system.

Identify training requirements

Assess the competency and training needs of the workforce in line with the requirements of Actions 1.19, 1.20 and 1.21. Perform a risk assessment to inform the training schedule and to set priorities for the members of the workforce who require training. Develop, or provide access to, training and education resources to meet the needs of the workforce with regard to partnering with consumers.

Education and training to support understanding and awareness of the value of partnerships with consumers can include training on person-centred care, shared decision making, communication techniques and health literacy. It may also involve consumer input through stories, presentations or advice on the development of training materials.

Consider the training the workforce may need to effectively use the incident management and investigation system to inform risk management, and to plan and implement quality improvement processes to mitigate risks.

Examples of evidence

Select only examples currently in use:

- Policy documents that describe the health service organisation's processes for partnering with consumers, including the
  - mechanisms available to engage with consumers
  - financial and physical resources that are available to support consumer participation and input at the governance level
- Observation of clinicians' practice that demonstrates use of the health service organisation's processes for partnering with consumers
- Records of interviews with clinicians that show that they understand the health service organisation's processes for partnering with consumers
- Organisational structure that identifies where and how consumers are engaged

- Committee and meeting records that show clinician and consumer involvement in the discussion of consumer engagement strategies, including implementing policy, managing risk, and building skills and capacity for partnering with consumers
- Data from the health service organisation's risk management and reporting systems on risks associated with partnering with consumers and risk mitigation strategies
- Training documents that include information on the value of consumer engagement, and the potential roles for consumer partners in clinical governance and strategic leadership
- Documented examples of consumer engagement in workforce recruitment or review of recruitment processes
- Feedback from consumers, consumer representatives, consumer organisations and carers on their experience of engagement with the health service organisation in clinical governance.

Applying quality improvement systems

Action 2.2

The health service organisation applies the quality improvement system from the Clinical Governance Standard when:

a. Monitoring processes for partnering with consumers

b. Implementing strategies to improve processes for partnering with consumers

c. Reporting on partnering with consumers

Reflective questions

How are the processes for partnering with consumers continuously evaluated and improved?

How are these improvements reported to the governing body, the workforce and consumers?

Key tasks

- Review, measure, and assess the effectiveness and performance of, organisational and clinical strategies for partnering with consumers

- Implement quality improvement strategies for partnering with consumers based on the outcomes of monitoring activities
- Provide information on the outcomes of quality improvement activities to the governing body, the workforce, consumers and other organisations.

Strategies for improvement

The Clinical Governance Standard has specific actions relating to health service organisations' quality improvement systems:.

Action 1.8 – quality improvement systems

Action 1.9 – reporting

Action 1.11 – incident management and investigation systems

Health service organisations should use these and other established safety and quality systems to support monitoring, reporting and implementation of quality improvement strategies for partnering with consumers.

Monitor effectiveness and performance

Use the organisation's quality improvement systems to identify and set priorities for the organisational and clinical strategies for partnering with consumers.

Strategies to monitor the effectiveness of systems for partnering with consumers include:

- Developing or adopting meaningful performance indicators that are relevant to the day procedure setting and can be used to measure improvements in consumer partnerships
- Regularly collecting feedback from consumers through surveys, suggestion boxes, follow-up phone calls, and formal or informal consultation[32]
- Seeking feedback from consumer representatives about their experience of consumer partnerships
- Using the outcomes of evaluations or feedback processes to identify areas for improvement and implement solutions
- Using internal newsletters or memos to report on the effectiveness of consumer partnerships and any quality improvements the organisation has made
- Using local community media to disseminate stories about consumer partnerships to the wider community
- Publishing profiles or stories of consumers involved in consumer partnerships with the organisation, and the contributions they have made.

Examples of evidence

Select only examples currently in use:

- Organisation-wide quality improvement system that includes performance measures for partnering with consumers
- Audit of health service organisation performance against identified measures for partnering with consumers
- Results of consumer and carer experience surveys reviewed by the governing body or relevant committees
- Committee and meeting records in which feedback from consumers and the workforce on the health service organisation's safety and quality systems is reported
- Review of the incident monitoring system to identify areas of concern in consumer partnerships
- Quality improvement plan that includes actions to deal with issues identified
- Consumer and carer information packages or resources about the health service organisation's processes for partnering with consumers
- Examples of improvement activities that have been implemented and evaluated to maximise the engagement of patients and consumers
- Reports on safety and quality performance that are published in annual reports, newsletters, newspaper articles, radio items, websites or other local media
- Records of focus groups or meetings involving consumers in which the appropriateness and accessibility of safety and quality performance information were discussed
- Communication with the workforce and consumers on the effectiveness and outcomes of the health service organisation's consumer partnerships
- Formal progress reports or evaluation reports provided to members of the health service organisation's governance committees, leadership team and workforce; consumers; and the wider community
- Feedback from consumers, carers and the workforce on involvement of consumers in quality improvement systems.

CRITERION: Partnering with patients in their own care

Systems that are based on partnering with patients in their own care are used to support the delivery of care. Patients are partners in their own care to the extent that they choose.

Person-centred care is globally recognised as the gold standard approach to healthcare delivery. It is a diverse and evolving practice, encompassing concepts such as patient engagement and patient empowerment. Partnering with patients in their own care is an important pillar of person-centred care. It focuses on the relationship between a consumer and a clinician, and recognises that trust, mutual respect and sharing of knowledge are needed for the best health outcomes.[33]

Partnerships with patients comprise many different, interwoven practices – from communication and structured listening, through to shared decision making, self-management support and care planning. There is growing acceptance that these practices can improve the safety and quality of health care, improve patient outcomes and experience, and improve the performance of health service organisations.[35]

Effective partnerships between clinicians and patients require:

- Organisational development and promotion of person-centred care
- Education and training to equip clinicians with a rounded mix of skills
- Tools and resources to support communication and shared decision making
- Integrated care models
- Meaningful methods of measuring success, such as recording patient experience and patient-reported outcome measures.

Today, health service organisations and clinicians are adopting strategies to encourage patients to become partners in their own care.[34] Key strategies have included:

- Providing health information in engaging and accessible formats, such as print, mobile apps and online channels
- Eliciting and documenting individual needs, preferences and goals
- Using patient decision aids
- Encouraging and prompting patient questioning during clinical encounters
- Providing education to support self-management
- Establishing self-help and support groups
- Developing programs to encourage treatment adherence
- Providing consumers with open access to their own healthcare record.

Health service organisations can also look at strategies for engaging with patients' carers and families.[34] Carers and families can often provide unique insight into a patient's health history, and provide valuable reassurance to the patient during their treatment.

Healthcare rights and informed consent

Action 2.3

The health service organisation uses a charter of rights that is:

a. Consistent with the Australian Charter of Healthcare Rights[39]

b. Easily accessible for patients, carers, families and consumers

Reflective questions

Does the health service organisation have a charter of rights that is consistent with the Australian Charter of Healthcare Rights?

How do patients, carers, families and consumers use the charter at different points throughout their healthcare journey?

Key tasks

- Adopt the Australian Charter of Healthcare Rights (with or without amendments)
- Provide ready access to copies of the charter, in appropriate languages or formats, to all patients, and their carers and families.

Strategies for improvement

The Australian Charter of Healthcare Rights[39] was developed by the Australian Commission on Safety and Quality in Health Care (the Commission) and adopted by all health ministers in 2008. It describes the rights of patients and other people using the Australian healthcare system. These rights are essential to ensure that safe and high-quality care is provided to all people, in all health settings in Australia (including day procedure services).

Review or develop a charter of rights

If the day procedure service is part of a larger or networked group that has developed a charter of healthcare rights, ensure that the requirements of the charter are being met by the service.

If the day procedure service needs to implement its own charter of rights, use the Australian Charter of Healthcare Rights as a foundation for developing a charter for people seeking and receiving health care in the service.[39]

Review the Australian Charter of Healthcare Rights and, if necessary, adapt it to meet the specific needs of the organisation; however, the seven original rights must remain in place.

If the organisation already has a charter of rights in place, review how it aligns with the Australian Charter of Healthcare Rights.

Health service organisations may need to:

- Replace their existing charter with the Australian Charter of Healthcare Rights
- Edit the existing charter so that it better aligns with the Australian Charter of Healthcare Rights
- Keep the existing charter, noting that it is consistent with the Australian Charter of Healthcare Rights but may include modifications to suit the organisation's services.

Adopt the charter of rights

Support the effective adoption of the charter in the organisation. Strategies may include:

- Allocating responsibility for implementing and reviewing the charter to a manager with decision-making authority
- Including information about the charter during orientation for new members of the workforce and consumer representatives
- Running regular education and training sessions for the workforce on their responsibilities for implementing the charter; this includes clinical and non-clinical members of the workforce, and, if relevant, volunteers.

Inform patients, families and carers about the charter, and make sure that they can easily gain access to it.

Strategies may include:

- Discussing the charter with patients
- Displaying brochures or posters advertising the charter
- Including information about the charter in communication with patients, such as on the organisation's website or in information brochures
- Including the charter in information packs sent to elective patients before their procedure
- Making information about the charter available to patients at their bedside
- Ensuring that copies of the charter are available in community languages, and providing copies of the charter to any nominated interpreters
- Providing information in a format that is suitable for patients who are visually impaired
- Seeking support from external agencies, such as telephone interpreting services.

Review the effectiveness of the charter

Measure the impact of the charter to see whether promotion efforts are successful and whether this affects patient experience. Strategies may include:

- Conducting surveys of patients to see whether they have received the charter, and whether the rights in the charter have been respected
- Conducting surveys of the workforce about their awareness of, and attitudes towards, the charter
- Monitoring patient requests for the charter
- Monitoring printing of the charter.

The brochure *Using the Australian Charter of Healthcare Rights*[40] is a guide that outlines ways in which health service organisations can provide information about health rights and incorporate a charter in their systems. This brochure is available on the Commission's website, along with other resources to assist with the adoption of the Australian Charter of Healthcare Rights.

Examples of evidence

Select only examples currently in use:

- Policy documents that describe the use of a charter of rights
- Charter of rights that is consistent with the Australian Charter of Healthcare Rights in different languages and formats, consistent with the patient profile
- Observation that a charter of rights is displayed in areas that are accessible to the public
- Consumer and carer information packages or resources that explain consumer healthcare rights
- Evidence that patients and carers received information about their healthcare rights and responsibilities, such as audits of patients, interviews or surveys
- Admission checklist that includes provision and explanation of a charter of rights
- Feedback from patients and consumers about awareness of the charter of rights.

Action 2.4

The health service organisation ensures that its informed consent processes comply with legislation and best practice

Reflective questions

How does the health service organisation ensure that its informed consent policy complies with legislation and best practice?

How does the health service organisation monitor compliance with consent processes?

Key tasks

- Adopt a comprehensive policy and associated procedures on informed consent by patients in clinical decision-making
- Schedule periodic reviews of the effectiveness and outcomes of the policy.

Strategies for improvement

Informed consent is a person's voluntary decision about their health care that is made with knowledge and understanding of the benefits and risks involved.[41]

If the day procedure service is part of a larger or networked group that has informed consent policies and procedures, ensure that the service has adopted these.

If no such policies or procedures exist, the day procedure service should develop and implement effective processes to:

- Inform patients (and, if applicable, their carers and substitute decision-makers) about the risks, benefits and alternatives of a treatment, including any fees and charges
- Determine patient preferences for treatment
- Document patient consent to treatment.

This includes processes for consent relating to transfusions of blood or blood products (Action 7.3), and specific situations that require informed consent for treatment with a medicine (Action 4.11).

Have a process in place to ensure that informed consent has been obtained, including by maintaining a copy of the signed consent form. In some instances, the patient may have given informed consent to the referring clinician before being admitted to the day procedure service. However, the day procedure service should not assume that consent has been obtained before admission.

Effective processes may include policies and procedures to guide and support the clinical workforce towards good standards of practice that meet legal and ethical requirements.

Review current informed consent processes

Informed consent processes should comply with legislation and best practice. The following are best-practice principles for informed consent systems[41,42]:

- Provide information to patients in a way that they can understand before asking for their consent – for example, provide an accredited interpreter to help with communication, or adapt information into accessible formats (such as translation into community languages, or providing audio or visual information); other strategies for tailoring communications to the diverse needs of the patient population are provided in Action 2.8
- Obtain informed consent or other valid authority before undertaking any examination or investigation, or providing treatment (except in an emergency)
- Document consent appropriately, and provide guidance on what to do if there are concerns about a patient's capacity to provide consent
- Meet the common law and legal requirements of the relevant state or territory relating to
  - providing information about treatment
  - obtaining consent to treatment, including the requirement to disclose all risks

- Nominate a manager who is responsible for maintaining the integrity of the consent system and its continuous improvement
- Support informed consent through safety and quality systems across all areas of the organisation that ensure that
  - no treatment is provided without the patient's informed consent (or, if applicable, that of their substitute decision-maker)
  - specific consent requirements established by state or territory legislation – such as mental health Acts, guardianship and administration Acts, and human tissue Acts – are complied with
- Support informed consent through education and training for all members of the clinical workforce
- Incorporate protocols for receiving, investigating and managing complaints about consent processes
- Link informed consent to the organisation's open disclosure policy and the state or territory consent policy (if applicable).

If an organisation's informed consent processes do not meet the best-practice principles outlined above, adapt the policies and procedures accordingly.

Some states and territories have developed informed consent templates or identified appropriate consent strategies for use in that state or territory. Adopt or adapt these if available; otherwise, develop a local system.

The National Health and Medical Research Council's *General Guidelines for Medical Practitioners on Providing Information to Patients*[42] provides guidance on the information that clinicians need to give to patients.

The Queensland Health *Guide to Informed Decision-Making in Health Care*[43] provides guidance on how to implement the principles of informed decision-making in clinical practice.

Monitor design and performance of informed consent processes

Periodically review the design and performance of informed consent processes to evaluate whether they comply with best-practice principles and whether enough resources have been allocated. This will support effective clinical governance, including risk management.

For private sector organisations where informed consent may be obtained in a process separate from the health service organisation, it is not intended that visiting medical officer practices are monitored. Rather, the health service organisation takes a risk management approach and confirms with patients on admission, or the commencement of an episode of care, that they understand why they are there and what treatment they will receive.

Examples of evidence

Select only examples currently in use:
- Policy documents for informed consent that reference relevant legislation or best practice and consider issues such as
  - when consent should be obtained
  - when consent is not required
  - when written consent is required
  - requirements for valid consent
  - refusal of treatment or consent
  - obtaining consent from patients from culturally and linguistically diverse backgrounds
  - consent ages and consent for minors
  - guardianship or advocacy
- Training documents on informed consent processes
- Standardised consent form that is in use
- Audit results of healthcare records for compliance with informed consent policies, procedures or protocols
- Audit results of healthcare records to see whether patients are informed of the risks and benefits of treatment, and whether there is a record of consent
- Results of consumer and carer experience surveys, and actions taken to deal with issues identified about informed consent
- Patient information packages or resources about treatment and consent processes that are available for consumers in different formats and languages, consistent with the patient profile
- Feedback about the consent process from patients and carers after treatment.

Action 2.5

The health service organisation has processes to identify:

a. The capacity of a patient to make decisions about their own care

b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves

Reflective questions

What processes are in place to support clinicians to identify a patient's capacity to make decisions about their own care?

How are clinicians supported to identify a substitute decision-maker?

Key tasks

- Adopt a comprehensive policy and associated procedures to identify patients who do not have the capacity to make decisions about their own care
- Schedule periodic reviews of the effectiveness and outcomes of the policy.

Strategies for improvement

Under Australian legislation, all adults are presumed to have the capacity to decide whether they wish to receive health care, except when it can be shown that they lack the capacity to do so.

A person has the capacity to make a decision about their care if they can[43]:

- Understand and retain the information needed to make a decision
- Use the information to make a judgement about the decision
- Communicate the decision in some way, including by speech, gestures or other means.

Decision-making capacity can be decision- and situation-specific. This means that a person's capacity can vary at different times, in different circumstances and between different types of decisions.

Review processes for determining patients' capacity to make decisions

If the day procedure service is part of a larger or networked group of day procedure service providers, see whether the wider group has any policies or procedures for identifying patients who do not have the capacity to make decisions about their own care. Ensure that the organisation has adopted any such existing policies or procedures.

If no such policies or procedures exist, the day procedure service should implement a system to identify:

- Patients who do not have the capacity to make decisions about their own health care
- Appropriate substitute decision-makers who can make decisions on behalf of the patient.

If these systems are not in place, use the strategies below to develop them:

- Review the local legislation regarding the criteria for a patient to be considered capable of making decisions about their own care, and incorporate these criteria into any policies and procedures that the organisation develops; state and territory legislation may differ in its definition of patients who have the capacity to make healthcare decisions[43,44]
- Develop an organisational policy that outlines the requirements of clinicians to assess patients for their capacity to make healthcare decisions
- Work with clinicians and consumers to develop procedures to support the organisational policy, including guidance on
  - assessing decision-making capacity during pre-admission screening
  - assessing fluctuations in decision-making capacity
  - considerations for special populations, such as children
  - requirements for recording and documenting decisions

- Educate the workforce about assessing a person's capacity to make decisions about their care; consider training from a third party with expertise in this area, such as Capacity Australia
- Develop or provide resources and tools to reinforce training and assist the workforce to assess a person's capacity to make decisions; SA Health's *Impaired Decision Making Factsheet*[45] is an example.

Review processes for identifying substitute decision-makers

If a patient does not have the capacity to make decisions about their own care, a substitute decision-maker may be appointed.[43] Consult local legislation and best-practice guidelines to identify who is authorised to provide substitute decision-making in the state or territory. Examples of substitute decision-makers are a nominated carer, a health attorney, or a person nominated under an enduring power of attorney or guardianship arrangement.

Incorporate a list of appropriate substitute decision-makers into the organisation's informed consent policy. Educate the workforce about these appropriate substitute decision-makers during orientation and ongoing training sessions.

Include information about substitute decision-makers in any consumer communications about informed consent.

Develop an associated procedure for identifying and appointing a substitute decision-maker, such as a determination flowchart.

Periodically review the design and performance of these processes

Periodically review processes to evaluate whether they meet the needs of patients and reflect best practice. Strategies may include:

- Collecting informal feedback from patients during discussions in waiting rooms and on discharge to see whether they felt involved in their healthcare decision-making
- Collecting formal feedback from consumers through submissions and events (such as focus groups or community meetings) to see whether they felt involved in their healthcare decision-making

- Surveying patients to self-report on their experience and satisfaction with the level of engagement they had in their healthcare decision-making.

For guidance on undertaking consultations and surveys, see the Victorian Government's Engagement Toolkit[46] or the Scottish Health Council's Participation Toolkit.[47]

Examples of evidence

Select only examples currently in use:

- Policy documents or processes for
  - identifying a patient's capacity for making decisions about their care
  - identifying a substitute decision-maker, if a patient does not have the capacity to make decisions about their care
  - documenting substitute decision-makers such as next of kin, advocates, people with power of attorney and legal guardians
- Admission screening and assessment tools that identify the patient's capacity for choice and decision-making
- Audit results of healthcare records that identify patients' capacity to make decisions, and confirm the identity of the substitute decision-maker, if required
- Audit results of healthcare records for compliance with policies, procedures or protocols, and completeness of documentation relating to advocacy or guardianship
- Patient information packages or resources about advocacy, power of attorney and legal guardianship that are available for consumers in different formats and languages, consistent with the patient profile
- Examples of applications regarding guardianship or use of the Office of the Public Advocate.

Sharing decisions and planning care

> ## Action 2.6
>
> The health service organisation has processes for clinicians to partner with patients and/or their substitute decision-maker to plan, communicate, set goals and make decisions about their current and future care

Reflective questions

What systems and processes are available for clinicians to partner with patients or their substitute decision-maker to plan, communicate, set goals, and make decisions about current and future care?

How does the health service organisation review the use and outcomes of systems and processes for partnering with patients or their substitute decision-maker?

Key tasks

- Develop policies and processes (or review existing policies and processes) to involve patients or their substitute decision-maker in planning, communication, goal-setting and decision-making for their current and future care, and review workforce compliance with these policies and processes
- Set up mechanisms to support communication between clinicians and patients or their substitute decision-maker
- Periodically review the systems for partnering with patients or their substitute decision-maker in their own care.

Strategies for improvement

Partnering with patients in their own care is integral to the delivery of safe and high-quality person-centred health care. Day procedure services will generally engage with patients for a short time, and patients may have discussed their procedure with the referring clinician before admission. The service should still have systems in place to support clinicians to partner with patients in any planning, communication, goal-setting and decision-making related to the care they receive.

Review current systems for supporting clinicians and patients to be partners in care

If systems are already in place to support partnerships between clinicians and patients, review the strategies outlined below, and consider any additions or updates.

If the organisation does not have systems in place to support partnerships between clinicians and patients, use the strategies outlined below to develop or adapt policies and processes for partnering with patients while they receive care at the day procedure service.

Create a supportive organisational culture

Supportive organisational climates are vital for achieving person-centred care, in which partnerships between clinicians and patients become the established norm. Strategies may include:

- Engaging leadership and the governing body to act as champions for partnerships between clinicians and patients
- Providing enough resources to support clinicians to partner with patients in their care
- Providing education and training to equip clinicians to partner with patients in their care; further information on education and training for clinicians is provided in Action 2.7.[33]

Encourage communication and knowledge exchange between clinicians and patients

Patients can be partners in their own care in many ways, including shared decision making and self-management of their condition. For these partnerships to be meaningful, both the clinician and the patient must feel trusted and respected. Good communication is vital to foster this trust

and respect, and drive clinician and patient partnerships.[33]

Use the following strategies to encourage communication and knowledge exchange between clinicians and patients[48-51]:

- Review the current admissions process to see what information is provided to patients and how that information is given; identify any communication barriers and areas for improvement, and implement solutions to overcome these; consider engaging consumers in this review process by holding informal discussions with patients in waiting rooms.
- Provide consumers with access to information and resources in a format that meets their needs; this may include
  - general information about their health, condition and procedure
  - information and tools about how they can be involved in their own care
  - information that has been developed specifically for them.
- Encourage clinicians to create an environment in which patients feel confident asking questions, and in which clinicians respond positively to patient needs; this may involve speaking with patients in a neutral environment, away from the clinical setting.
- Use technology such as telehealth, and mobile and tablet apps to interact and share information with patients before, during and after their care, especially as a strategy for facilitating clinician and patient partnerships across long distances; ensure that any healthcare records transmitted electronically are encrypted or aligned with privacy regulations.
- Support patients to take part in shared decision making with decision support tools, such as information sheets, pamphlets and videos that provide structured information about their health options.

The Agency for Healthcare Research and Quality[52] provides practical advice for improving clinician and patient communication, including tools to educate consumers on how to be involved in their care.

The SA Health *Guide for Engaging with Consumers and the Community*[53] provides a tool to help clinicians encourage questions from their patients.

The Commission and Healthdirect Australia developed Question Builder[54], a free web-based tool to help consumers prepare for a visit to the doctor. In addition, the Commission's *Top Tips for Safe Health Care*[55] can help consumers, carers, families and other support people get the most out of their health care.

Develop meaningful measures to monitor success

Monitoring and measuring the success of clinician and patient care partnerships is important for ensuring that systems are relevant and useful to consumers and the organisation.[33,51]

Strategies for monitoring and measuring the success of the systems may include:

- Collecting feedback from patients in waiting rooms and during rounds
- Surveying patients to self-report on their experience and satisfaction with the level of engagement they had in their care.

Use the outcomes of these evaluations to set realistic goals for improving partnerships between clinicians and patients.

For guidance on undertaking consultations and surveys, see the Victorian Government's Engagement Toolkit[46] or the Scottish Health Council's Participation Toolkit.[47]

The Point of Care Foundation's Patient and Family-Centred Care toolkit[56] also provides guidance and tools to measure consumer partnerships.

Examples of evidence

Select only examples currently in use:

- Policy documents for partnering with consumers in their care, including communication and interpersonal skills, shared decision making, and planning current and future care
- Training documents about communication and interpersonal skills, partnering with consumers and shared decision making
- Tools to support shared decision making, care planning and development of goals of care
- Audit results of healthcare records to see whether
  - information was provided to patients and carers about care options
  - patients and carers were involved in preoperative assessment, including information about the impact that surgery or the intervention will have on them post-discharge (for example, when they can fly, drive, return to work or sport)
  - a plan for care was developed with patients and clinicians, and provided to patients to review, sign and receive as a copy relating to their treatment
    - patients and carers were involved in decision-making (for example, case conference records)
    - patients and carers could choose the dates for surgery, if possible
    - patients could choose their own music, reading material, comforters and so on
    - carers were able to stay with patients throughout their treatment, if they chose to
    - patients and carers were involved in discharge planning
    - patients were engaged in developing goals of care (for example, in an advance care plan)
- Patient information packages or resources about care options that are available for patients in different languages and formats, consistent with the patient profile
- Results of patient and carer experience surveys, and actions taken to deal with issues identified regarding participation in making decisions about their care
- Observation of patients and carers taking part in making decisions about their care
- Feedback from patients and carers about their experiences in shared decision making and care planning.

Action 2.7

The health service organisation supports the workforce to form partnerships with patients and carers so that patients can be actively involved in their own care

Reflective questions

How is the workforce supported to form partnerships with patients so that they can be actively involved in their own care?

How is workforce participation in education and training to support patient partnerships monitored and evaluated?

Key task

- Implement an education and training program to develop the skills of the health workforce to partner with patients in their care.

Strategies for improvement

Do not assume that clinicians have all the interpersonal or communication skills required to effectively partner with patients in their care. It is important to develop clinicians' skills so that they feel confident about approaching consumer partnerships.

Education and training may include:

- Communication and interpersonal skills
- Techniques for shared decision making
- Awareness of individual health literacy and the health literacy environment.

Day procedure services may not have the capacity to develop an education and training program for clinicians. If the service is part of a larger, networked group, see whether the wider group provides any training opportunities.

Alternatively, day procedure services can source training through established clinician education and training programs that support engagement with consumers, such as:

- The Health Issues Centre and other state-based health consumer organisations that provide consumer engagement training for clinicians[57]
- The NSW Clinical Excellence Commission Partnering with Patients program Patient Based Care Challenge, which can be adopted as a training tool[58]
- The Point of Care Foundation's Patient and Family-Centred Care toolkit, which provides a step-by-step method to help clinicians understand the importance of partnering with consumers[56]
- The Agency for Healthcare Research and Quality Communicating to Improve Quality Strategy, which provides a PowerPoint presentation and handout on communication competencies for clinicians[59]
- The Australian Institute for Patient & Family Centred Care clinical education play *Hear Me*.

Clinicians working in day procedure services, such as credentialed medical and other practitioners, may also work for other health service organisations, and may have access to education and training through these organisations. In these circumstances, it may be enough to request evidence of the completion of such training. These clinicians may also feel well equipped to provide peer-to-peer training to other members of the workforce.

Examples of evidence

Select only examples currently in use:

- Policy documents for partnering with consumers in their care, including policies on communication and interpersonal skills, shared decision making and health literacy
- Training documents about partnering with consumers in their care and shared decision making
- Audit results of healthcare records to identify the involvement of clinicians and patients in developing a plan of care, including coordinated care meetings
- Analysis of feedback data from the workforce about partnering with consumers in their care.

CRITERION: Health literacy

Health service organisations communicate with consumers in a way that supports effective partnerships.

Health literacy refers to how people understand information about health and health care, and how they apply that information to their lives, use it to make decisions and act on it.

The Commission separates health literacy into two components[60]:

- **Individual health literacy** is the skills, knowledge, motivation and capacity of a person to gain access to, understand, appraise and apply information to make effective decisions about health and health care, and take appropriate action
- **Health literacy environment** is the infrastructure, policies, processes, materials, people and relationships that make up the healthcare system and affect the way that people gain access to, understand, appraise and apply health-related information and services.

Health literacy plays an important role in facilitating communication and enabling effective partnerships with consumers. For partnerships to work, everyone involved needs to be able to give, receive, interpret and act on information such as treatment options and plans.

Health literacy is important for:

- Consumers, because it affects their capacity to make informed decisions and take action to manage their health
- Clinicians, because it affects the way they manage their communication and partnerships with consumers and deliver care
- Managers and policymakers, because the complexity of their systems can affect consumers' ability to navigate health services and systems, collaborate with organisations and engage with their own care.

Health literacy is a complex and challenging area for health service organisations. Only about 40% of adults have the level of individual health literacy required to meet the demands of everyday life. This means, for example, that only 40% of adults can understand and follow health messages in the way in which they are usually presented.[61]

Consumers' individual health literacy may be affected by:

- **Age** – people aged 15–19 years and those over 45 years have been shown to have lower rates of health literacy
- **Education** – higher levels of education are associated with high rates of adequate or better individual health literacy
- **Disability** – people living with disability may be at risk of low individual health literacy for functional reasons, such as poor vision or cognitive impairment
- **Culture and language** – these factors can affect the way people make meaning out of their experiences, which can have a direct impact on their expectations and understanding of health issues; in addition, difficulty with the English language has been associated with lower rates of individual health literacy
- **Aboriginal and Torres Strait Islander status** – national data on the individual health literacy of Aboriginal and Torres Strait Islander people are limited; however, factors such as lower school-based literacy and socioeconomic disadvantage across education, employment and income may place Aboriginal and Torres Strait Islander people at risk of lower individual health literacy.

Health service organisations can play an important role in addressing health literacy. Organisations have a responsibility to build a health literacy environment that supports effective partnerships with consumers. This may involve[60,62]:

- Developing and implementing health literacy policies and processes that aim to reduce the health literacy demands associated with information materials, the physical environment and local care pathways
- Providing and supporting access to training for clinicians in health literacy and interpersonal communication, including training in communicating risk
- Providing education programs for consumers to develop health knowledge and skills
- Reducing unnecessary complexity for consumers in using and navigating the health service.

Communication that supports effective partnerships

Action 2.8

The health service organisation uses communication mechanisms that are tailored to the diversity of the consumers who use its services and, where relevant, the diversity of the local community

Reflective questions

How are the communication needs of consumers and the community identified?

What strategies are used to tailor communication to meet the needs of a diverse consumer and community population?

Key tasks

- Develop a framework for meeting the communication needs of a diverse consumer and community population
- Ensure that accredited interpreter services are available to consumers who need them
- Use a variety of mechanisms to meet the communication needs of a diverse consumer and community population.

Strategies for improvement

Language and cultural factors can create barriers to accessing health care, leading to poorer health outcomes and a lower quality of care for some sections of diverse populations. Diversity comes in many forms; for example:

- Language factors may affect consumers for whom English is not their first language, consumers with a cognitive impairment and consumers with a physical condition such as deafness or blindness
- Cultural factors may affect consumers from culturally and linguistically diverse communities, whose view of health and wellbeing may differ from the Australian experience; the diversity of cultures accessing health care in a multicultural country such as Australia can pose challenges for a health service organisation and its workforce to engage in a culturally responsive way.

There is no 'one size fits all' solution to meeting the communication requirements of a diverse consumer population. However, health service organisations can work to develop a framework that integrates cultural competency into its communication mechanisms.[63]

Different consumers will engage with different communication mechanisms. Some consumers may prefer casual, verbal conversations, whereas others may prefer written information resources or audiovisual presentations. Communication mechanisms should not be viewed in isolation; instead, the mechanisms chosen should complement each other and aim to appeal to different consumer communication preferences.

Day procedure services may provide care to people from different communities, not just from the local area. Services should identify the diversity of consumers who use their service to develop or improve current communication mechanisms.[63] A first step in this process is to routinely collect patient data through pre-admission screening or by administering surveys to identify diversity among current consumers.

For guidance on undertaking consultations and surveys, see the Victorian Government's Engagement Toolkit[46] and the Scottish Health Council's Participation Toolkit.[47]

Review current communication mechanisms

Determine whether the organisation's current communication mechanisms meet the needs of diverse patient populations by reviewing:

- Consumer information developed by the organisation, such as patient brochures, posters and consent forms, to see whether they are
  - culturally appropriate or available in culturally appropriate formats
  - available in a variety of community languages
  - available in a variety of accessible formats, such as audio or braille
- The availability of interpreting services, and methods of access to these services for patients and members of the workforce
- The cultural competency and confidence of the workforce in communicating with diverse patient populations.

One Size Does Not Fit All: Meeting the healthcare needs of diverse populations[63] can be used to help evaluate the current services provided for diverse patient populations.

If the organisation does not use communication mechanisms that are tailored to the needs of its consumers, use the strategies outlined below to develop or adapt a framework to help meet these needs.

Set up a supportive foundation for tailoring communication mechanisms

This may involve:

- Engaging the support of the organisation's management and governing body to help drive change and build workforce support
- Implementing a policy that requires cultural and language issues to be incorporated into all communication strategies
- Implementing a plain-language policy that makes written information easier to understand[64]
- Educating the workforce about the diversity of the consumers who use the organisation's services; consider accessing cultural competency training if people from culturally and linguistically diverse communities, or Aboriginal and Torres Strait Islander communities regularly use the service

- Facilitating easy access to interpreting services by
  - identifying and promoting appropriate interpreting services that are competent at working in a health setting (for example, discussing health and medical issues); the Australian Government's Translating and Interpreting Service can supply phone and on-site services
  - developing policies and procedures, and educating the workforce on when and how to engage an interpreting service
  - educating the workforce on the appropriate use of interpreters – family or friends may not be appropriate interpreters because of health privacy issues.

Resources and tools include:

- The Agency for Healthcare Research and Quality Health Literacy Universal Precautions Toolkit[65]
- Centers for Disease Control and Prevention *Simply Put: A guide for creating easy-to-understand materials*[66]
- The Plain Language Action and Information Network's PlainLanguage.gov website.[67]

Implement communication mechanisms that consider the needs of specific populations

This may involve:

- Adapting existing consumer information into culturally appropriate formats by changing the design and messaging used in a resource, or adapting the information for an alternative delivery channel, such as video or audio
- Sourcing culturally appropriate and accessible consumer information from other organisations that have developed relevant materials
- Translating existing consumer information into community languages
- Providing multiple opportunities for consumers to gain access to information in a variety of formats
- Employing or engaging interpreters as part of the patient care team
- Using techniques to check a consumer's understanding of information, such as a 'teach back' method.[53]

A number of tools and resources can help guide effective and tailored communication with diverse patient populations, including:

- SA Health *Guide for Engaging with Consumers and the Community*, Tool 3: Tips for communicating clearly[53]
- Health Translations directory, which provides links to reliable translated health resources produced in Australia
- Eastern Health Cue cards in community languages[68]
- Centers for Disease Control and Prevention Health literacy website.[69]

Examples of evidence

Select only examples currently in use:

- Policy documents about communication, including the use of plain language, and addressing the cultural and linguistic diversity of the community that the health service organisation serves
- Demographic profile or demographic survey for the health service organisation that identifies the diversity of the community it serves
- Results of a needs assessment project that identifies local health needs
- Demographic data from external sources that are used for strategic and communication planning to identify the cultural diversity and needs of patients and carers
- Training documents about cultural awareness and diversity
- Consumer and carer information packages or resources that are culturally appropriate, and are available in different languages and accessible formats
- Feedback from consumers from culturally or linguistically diverse backgrounds during the development or review of information packages or resources
- Committee and meeting records that show that the health service organisation is represented at local network meetings that reflect the local diversity of the patient population
- Reports on interpreter use and access
- Feedback from patients and carers about whether communication processes meet their needs
- Observation that clinicians have access to communication resources that provide contact details for support services such as local consumer health advocates, interpreters, or cultural support and liaison services.

Action 2.9

Where information for patients, carers, families and consumers about health and health services is developed internally, the organisation involves consumers in its development and review

Reflective question

How are consumers involved in the development and review of patient information that is developed internally?

Key tasks

- Develop and implement a process for engaging consumers during the development of consumer information about health and health care

- Develop and implement a process for sourcing consumer feedback on internally developed consumer information and using this feedback to inform future improvements.

Strategies for improvement

Consumers can play an important role in supporting health service organisations to develop information that is clear, easy to understand, and relevant to the needs of consumers and the local community.[32,70]

Day procedure services may not have the resources to develop their own consumer information. If this is the case, source and use publications that have been developed in partnership with consumers, such as those developed by state and territory health departments, professional associations or external providers. Publications from other organisations may need to be tested to ensure that they suit the patients who use the day procedure service, and adapted if necessary.

Review existing processes for involving consumers in the development of consumer information

This could include identifying the publications that the organisation has produced, looking at how they were developed and determining whether consumers were involved in their development.

If consumers were not involved in developing the publications, develop and implement a process to involve consumers for all new consumer information. Strategies may include:

- Holding waiting-room discussions, focus groups or workshops to plan and develop consumer information
- Engaging consumers to co-author information in conjunction with the organisation
- Collaborating with local health consumer organisations to develop information
- Conducting interviews or one-on-one consultations with consumers to inform the development of information.

Engage consumers to review and provide feedback on existing patient information

Strategies may include:

- Conducting electronic, mail or phone surveys of consumers who have used the organisation's publications
- Making follow-up phone calls to consumers who have been provided with patient information publications, to identify any problems they had with understanding the information
- Holding waiting-room discussions, focus groups or workshops for consumers to review and provide feedback on consumer information.[32,70]

Further information on involving patients in testing information publications can be found in:

- The Agency for Healthcare Research and Quality Health Literacy Universal Precautions Toolkit[65]
- *Can They Understand? Testing patient education materials with intended readers*[71]
- Health Consumers Queensland Consumer Representatives Program *Agency Handbook*.[72]

Incorporate feedback and report on how this was done

Show the revised document to consumers to check that the interpretation and changes are appropriate. This could be done on a one-on-one basis, or through discussions in waiting rooms or workshops.

Provide feedback to the community about the kinds of changes made to the publications in response to consumer feedback. This could be through information and updates in newsletters, meetings or reports for the people who were involved in identifying, developing and implementing the changes.

Examples of evidence

Select only examples currently in use:

- Committee and meeting records that show consumer involvement in the development and review of patient information resources
- Feedback from consumers who have used the health service organisation's information publications
- Evaluation reports on existing patient information publications that identify how consumers were involved in development and review
- Examples of publications that have changed in response to consumer feedback
- Communication with consumers who provided input into the development or review of resources about the types of changes made in response to their feedback.

Action 2.10

The health service organisation supports clinicians to communicate with patients, carers, families and consumers about health and health care so that:

a. Information is provided in a way that meets the needs of patients, carers, families and consumers

b. Information provided is easy to understand and use

c. The clinical needs of patients are addressed while they are in the health service organisation

d. Information needs for ongoing care are provided on discharge

Reflective questions

What processes are used to ensure that the information available for clinicians to give to patients meets the patients' needs?

How are clinicians supported to meet the information needs of patients for ongoing care on discharge?

Key task

- Set up processes to support clinicians to communicate effectively with consumers about their health and healthcare needs.

Strategies for improvement

Clear and open communication between consumers and clinicians is vital for the delivery of effective, efficient and ethical health care. It also facilitates good clinical decision-making, protects the legal rights of consumers to be informed and involved in decision-making, and assists when supported decision-making is required.

Processes to support clinicians to communicate effectively with patients and their carers about all aspects of their care involve obtaining informed consent, and determining a patient's treatment preferences and goals of care. Use the strategies below to adapt current systems or adopt new systems for supporting communication between clinicians and consumers.

Set up an environment that supports open, clear and effective communication between clinicians and consumers

This may involve[62,73]:

- Auditing the health literacy environment (either in the annual audit program of the organisation or as a standalone audit)
- Providing clinicians with training that highlights the importance of health literacy
- Implementing a plain-language policy that makes written information easier to understand.

Provide access to appropriate consumer information resources and tools to support communications

Consumer information should be at a level that can be understood and used by diverse consumers. It may be appropriate to identify or develop both simpler and more complex information resources, so that clinicians have access to the most appropriate information for an individual patient.

Information resources and tools that clinicians can use to support their communications may include:

- Written information (for example, brochures, fact sheets, posters, online material); if developed locally, consumers should be involved in developing these resources (Action 2.9)
- Visual diagrams and decision aids (for example, the Commission's patient decision aids)
- Cue cards or symbols to support communication with people who do not understand English (for example, Eastern Health's Cue cards in community languages[68]).

Health service organisations are responsible for ensuring that the information provided to patients is current.

Monitor and assess communication

Strategies may include:

- Providing a mechanism for patients to give feedback about the communication and information they receive during an episode of care
- Seeking feedback on communication and information resources from consumers who use the services (for example, including questions about medicines information in patient experience surveys).

Examples of evidence

Select only examples currently in use:

- Observation that the workforce, patients and carers have access to information about the health service organisation and the services it provides
- Audit results of healthcare records that reflect an assessment of need, and the information and support provided before, during and after an episode of care
- A register of interpreter and other advocacy and support services available to the workforce, patients and carers
- Examples of information materials provided to patients and carers that are in plain language, and available in different languages and formats
- Results of patient and carer experience surveys regarding the information provided
- Audit of the proportion of patients receiving a discharge summary
- Feedback from patients and carers about the information communicated to them in the health service organisation and on discharge.

CRITERION: Partnering with consumers in organisational design and governance

> *Consumers are partners in the design and governance of the organisation.*

The role of consumer representatives within the Australian healthcare system has evolved significantly during the past two decades.[30] Partnering with consumers and the community is viewed as a basic element in discussions and decisions about the design, implementation and evaluation of health policies, programs and services.[31,74]

Since 2010, an increase in the volume and diversity of research conducted on consumer input into decision-making has strengthened the evidence base for the benefits of partnering with consumers in health service design and governance.[30]

A 2015 literature review conducted by the Consumers Health Forum of Australia concluded that there is a substantial body of research supporting the involvement of consumers in health decision-making, and consumer engagement can add value to the healthcare system by improving quality of care, efficiency of resource use, and community support for programs or services.[30]

Specific methods of partnership range from informal, one-off events or feedback through social media, through to formal and ongoing participation on boards and committees. Consumers can be engaged as individuals, or in small or large groups.[31]

Evidence on the benefits and sustainability of specific partnership approaches is lacking. When selecting methods to use locally, consider the diversity of the local community, and the organisation's design and governance needs. The use of mixed methods is common and supports the concept that not all consumers will engage with health services in the same way.[31]

In Australia, the concept of consumer partnership and the principles of person-centred care have gained broad support.[35] However, capacity, skill and resource limitations can challenge consumer

partnerships in practice. Several well-established methodologies and resources can support health services to partner with consumers for design, governance and overall improvement activities.

Partnerships in healthcare governance planning, design, measurement and evaluation

Action 2.11

The health service organisation:

a. Involves consumers in partnerships in the governance of, and to design, measure and evaluate, health care

b. Has processes so that the consumers involved in these partnerships reflect the diversity of consumers who use the service or, where relevant, the diversity of the local community

Reflective questions

How does the health service organisation involve consumers in governance planning, and the design, measurement and evaluation of health care?

How does the health service organisation ensure that the diversity of consumers and local communities who use the service is reflected in these partnerships?

Key tasks

- Identify the diversity of consumers who use the services and who are part of the local community
- Implement a framework and systematic processes for partnering with consumers in the design, measurement and evaluation of healthcare services delivered by the organisation
- Implement a policy to ensure that the consumers involved in these partnerships represent the diversity of consumers who use the organisation's services.

Strategies for improvement

Consumers can make effective and meaningful contributions to health service planning and development through their involvement in organisational governance and decision-making.[32] To support these contributions, integrate partnering with consumers into the governance systems of the organisation.

Interactions of day procedure services with consumers are generally short term. However, many effective strategies are available for engaging consumers in the design, measurement and evaluation of services. If the day procedure service is part of a larger, networked group, see whether the network partners with consumers in its design or evaluation activities. If so, the service may be able to draw on these partnerships for input into local design or evaluation activities.

If the service is not part of a larger network or does not already partner with consumers, use the strategies below to adopt or adapt a framework that encourages consumer input into design and evaluation activities.

Strategies to promote consumer input include:

- Engaging organisational leaders to act as champions for consumer partnerships
- Incorporating consumer stories into the organisation's governance and leadership meetings to keep consumers' needs and perspectives in mind; this may involve starting each meeting by reading a story of a consumer's recent experience with the service or by inviting a consumer to speak at meetings
- Inviting consumers to participate in the governance group or strategic planning team; services can identify interested consumers through pre- or post-procedure surveys, or through informal conversations during their care
- Building relationships with local health consumer organisations; services may be able to draw on these relationships to provide input into strategic planning, safety and quality, and performance management activities

- Providing opportunities for consumers to provide feedback on the governance and leadership of the service, and the safety and performance of the services provided – for example, surveys, suggestion boxes, and opportunities for formal or informal consultation at multiple times throughout a patient's care, such as during follow-up phone calls[32]
- Shaping the attitudes of the workforce so that there is greater acknowledgement, acceptance and understanding of the value of consumer feedback; consumers can provide a unique insight into safety and quality risks, which issues should have priority, and which solutions are acceptable.[32]

It is also important to ensure that consumer partnership and engagement activities truly reflect the diversity of consumers who use, or may use, the service.

Day procedure services may provide care to people from different communities, not just those from the local area. Services should gather information about the diversity of consumers who use their service to identify specific consumer groups who should be involved in partnerships, and develop or improve current communication mechanisms.[63]

A first step in this process is to routinely collect patient data through pre-admission screening or by administering surveys to help identify diversity among current patients.

For guidance on undertaking surveys, see the Participation Toolkit, including the 'Surveys and questionnaires' section.

In addition, the following resources can be used to guide partnerships with consumers:

- Health Issues Centre Getting Started toolkit[75]
- *Health Care Providers' Guide to Engaging Multicultural Communities and Consumers*[76]
- Cancer Australia Consumer Involvement Toolkit.[77]

Examples of evidence

Select only examples currently in use:

- Policy documents that describe the process for involving consumers in partnerships to design, measure and evaluate health care
- Description of the roles and responsibilities of consumers in strategic, operational and service planning partnerships
- Membership of groups tasked with steering design and redesign projects, including consumers who are representative of the patient population
- Committee and meeting records that show consumer involvement in activities relating to healthcare planning, design, measurement and evaluation
- Project plans and reports that include information on consumer involvement in the development of design or redesign projects
- Reports from designers and architects outlining how they have responded to consumer suggestions for improvements
- Feedback from consumers, survey results or evaluation reports on the processes of engagement and support provided to consumers
- Reports that detail consumer participation in activities to design, measure and evaluate health care, such as notes from interviews or focus groups, planning workshops or forums, or meetings with community and consumer organisations
- Committee and meeting records that show that the health service organisation is represented at local network meetings that reflect the diversity of the local consumer population
- Feedback from consumers and consumer representatives on the involvement of consumers in governance, planning, design, measurement and evaluation of health care.

Action 2.12

The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation

Reflective questions

What training and support are offered to consumers who are partnering in the governance, design, measurement and evaluation of the health service organisation?

How is feedback from consumers used to evaluate and improve the effectiveness of the support provided?

Key task

- Develop (or adapt), and provide access to, orientation training and resources for consumers who take part in governance processes, or contribute to design, measurement or evaluation activities.

Strategies for improvement

Provide training and support for consumers involved in the organisation's governance process, and those who take part in design, measurement or evaluation activities. This gives these consumers the best opportunity to contribute meaningfully and effectively to the organisation. Training can be provided face to face, through take-home resources or through online portals.

Day procedure services may not have the capacity to develop comprehensive training and resources. Instead, look to adapt resources from similar organisations or arrange access to external training programs for consumers partnering with the organisation. Many consumer organisations provide consumer representative training. See the Resources section at the end of this standard for a list of consumer organisations. In addition, the Health Issues Centre has developed Australia's only accredited consumer representative training course.[78]

Other strategies for orientating and training consumers may include:

- Providing a tour of the facility, introducing the consumer to key members of the workforce, and explaining the consumer's role and expectations of their involvement
- Having a key member of the workforce meet with the consumer regularly to touch base and identify any information required or skills that the consumer would like to develop as part of their role.

Examples of evidence

Select only examples currently in use:

- Policy documents that describe the orientation and ongoing training provided to consumers who have formed partnerships with the health service organisation
- Calendar of internal and external training that is available to support consumers who take part in the governance, design, measurement and evaluation of the health service organisation
- Feedback from consumers and consumer representatives on their experience of orientation, support and education for involvement in governance, design, measurement and evaluation.

Action 2.13

The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs

This action applies to day procedure services that commonly provide care for Aboriginal and Torres Strait Islander people. These services should refer to *NSQHS Standards Guide for Hospitals*, *NSQHS Standards Accreditation Workbook* and *NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health* for detailed implementation strategies and examples of evidence for this action.

Day procedure services that rarely provide care for Aboriginal and Torres Strait Islander people, or when the risk of harm for these patients is the same as for the general patient population, should manage the specific risk of harm, and provide safe and high-quality care for these patients through the safety and quality improvement systems that relate to their whole patient population.

Day procedure services need to implement strategies to improve the cultural awareness and cultural competency of the workforce under Action 1.21, and identify Aboriginal and Torres Strait Islander patients under Action 5.8.

Action 2.14

The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce

Reflective question

How are consumers involved in the design and delivery of workforce training and education?

Key tasks

- Implement a policy that involves consumers in the design and delivery of workforce training
- Consult regularly with consumers to seek their views and input for the development and delivery of workforce training.

Strategies for improvement

Develop or adapt policy or processes on workforce training to include consumer involvement

Day procedure services may use an external provider to provide training about partnerships with consumers. If this is the case, try to use a provider that involves consumers.

If training to the workforce is delivered locally, services can:

- Invite consumers or local consumer organisations to speak to members of the workforce
- Talk to patients and carers in waiting areas about what they think is important to include in training about partnerships for the clinical workforce

- Hold workshops or focus groups with consumers to seek their advice on key information, resources and strategies for training the clinical workforce in partnerships
- Invite consumers to attend and review training sessions to ensure that the training reflects their needs and perspectives.

Information on collecting patient stories can be found in the Resources section.

Examples of evidence

Select only examples currently in use:
- Project plans, communication strategies or consultation plans that describe the involvement of consumers in the development of training curriculums and materials

- Committee and meeting records in which training curriculums for the workforce were discussed and feedback was provided by consumers
- Training documents that incorporate consumers' views and experiences
- Records of training or presentations provided to the workforce by consumers
- Feedback from consumers involved in developing training and education resources for the workforce.

Resources

Partnerships at the individual and health service level

Agency for Healthcare Research and Quality – Guide for Developing a Community-Based Patient Safety Advisory Council

Cancer Australia – Consumer Involvement Toolkit

Health Consumers Queensland – *Consumer Representatives Program: Agency handbook*

Health Issues Centre – Getting Started toolkit

NSW Clinical Excellence Commission – Partnering with patients

Point of Care Foundation – Experience-Based Co-Design toolkit

SA Health – *Guide for Engaging with Consumers and the Community*

Scottish Health Council – *The Participation Toolkit*

Waitemata District Health Board – Health Service Co-Design toolkit

Collecting patient stories

Cancer Australia – *Storytelling for Health Services*

Healthwatch Cambridgeshire – *Guidance for Collecting & Using People's Stories*

National Health Service Education for Scotland – *Making the Most of Patient Safety Stories*

NSW Agency for Clinical Innovation – Collect patient and carer stories

WA Health – *Patient Stories: A toolkit for collecting and using patient stories for service improvement in WA Health*

Health literacy

Agency for Healthcare Research and Quality – Health Literacy Universal Precautions Toolkit

Australian Commission on Safety and Quality in Health Care – Health literacy

Centers for Disease Control and Prevention – Health literacy

Centre for Culture, Ethnicity and Health – Supportive systems for health literacy

National Health Service – DISCERN instrument

NSW Clinical Excellence Commission – *Health Literacy Guide*

PlainLanguage.gov

Shared decision making

Agency for Healthcare Research and Quality – The SHARE approach

National Health Service – Shared decision making

The Health Foundation – MAGIC: Shared decision making

Partnerships with Aboriginal and Torres Strait Islander communities

Australian Human Rights Commission – *Aboriginal and Torres Strait Islander Peoples Engagement Toolkit*

Australian Indigenous Governance Institute – Indigenous Governance Toolkit

Oxfam Australia – *Aboriginal and Torres Strait Islander Cultural Protocols*

Queensland Government – *Protocols for Consultation and Negotiation with Torres Strait Islander People*

Reconciliation Australia – Respectful relationships

Australian health consumer organisations and networks

Consumers Health Forum of Australia

Health Care Consumers' Association (ACT)

Health Consumers Alliance of SA Inc

Health Consumers' Council (WA) Inc.

Health Consumers NSW

Health Consumers Queensland

Health Issues Centre (Vic)

Preventing and Controlling Healthcare–Associated Infection Standard

Preventing and Controlling Healthcare-Associated Infection Standard

Leaders of a health service organisation describe, implement and monitor systems to prevent, manage or control healthcare-associated infections and antimicrobial resistance, to reduce harm and achieve good health outcomes for patients. The workforce uses these systems.

Intention of this standard

To reduce the risk of patients acquiring preventable healthcare-associated infections, effectively manage infections if they occur, and limit the development of antimicrobial resistance through prudent use of antimicrobials as part of antimicrobial stewardship.

Criteria

Clinical governance and quality improvement to prevent and control healthcare-associated infections, and support antimicrobial stewardship

Infection prevention and control systems

Reprocessing of reusable medical devices

Antimicrobial stewardship

Introduction

Many healthcare-associated infections are thought to be preventable. Australian and overseas studies have demonstrated mechanisms to reduce the rate of infections associated with health care. Infection prevention and control practice aims to minimise the risk of transmission by identifying and isolating patients harbouring infectious agents and resistant organisms. However, just as there is no single cause of infection, there is no single solution to preventing infections. Successful infection prevention and control practice requires several strategies across the healthcare system.

The Preventing and Controlling Healthcare-Associated Infection Standard has been developed in line with the recommendations and evidence in the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*.[79] This standard aims to prevent patients from acquiring preventable healthcare-associated infections, and to effectively manage these infections when they occur by using evidence-based strategies. It should be applied in conjunction with the other NSQHS Standards, particularly the Clinical Governance Standard, the Partnering with Consumers Standard and the Medication Safety Standard.

Although infection prevention and control programs have essential elements that must be considered, it is expected that programs will be tailored to reflect the local context and risk. Key tasks will be tailored to reflect the complexity of services offered and the risks associated with delivery of services in the organisation. Regardless of the size or type of the health service organisation, successful implementation of this standard depends on clinicians and executive leaders working together within a strong governance framework.

CRITERION: Clinical governance and quality improvement to prevent and control healthcare–associated infections, and support antimicrobial stewardship

Systems are in place to support and promote prevention and control of healthcare-associated infections, and improve antimicrobial stewardship.

Antimicrobial stewardship is the ongoing effort by a health service organisation to optimise antimicrobial use to improve patient outcomes, ensure cost-effective therapy and reduce the adverse effects of antimicrobial use, including antimicrobial resistance.[80]

This criterion requires organisation-wide governance, leadership and commitment to prevent and control healthcare-associated infections, and support antimicrobial stewardship.

To meet this criterion, health service organisations are required to:

- Apply safety and quality systems to prevent and control healthcare-associated infections, and support antimicrobial stewardship

- Use quality improvement systems to monitor, review and improve the systems to prevent and control healthcare-associated infections, and to support antimicrobial stewardship

- Apply principles of partnering with consumers when designing and implementing systems to prevent and control healthcare-associated infections, and support antimicrobial stewardship.

This criterion aligns closely with the Clinical Governance Standard and the Partnering with Consumers Standard.

Infection risk varies in each health service organisation, so there is no single risk management approach. However, the basic principles of risk management apply across all settings.

The principles of clinical governance apply regardless of the setting, but the management structure associated with infection control will differ with the size of the organisation, its context and the complexity of services delivered.

The governance framework and risk management principles for preventing and controlling healthcare-associated infections are outlined in the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*.[79]

Integrating clinical governance

Action 3.1

The workforce uses the safety and quality systems from the Clinical Governance Standard when:

a. Implementing policies and procedures for healthcare-associated infections and antimicrobial stewardship

b. Managing risks associated with healthcare-associated infections and antimicrobial stewardship

c. Identifying training requirements for preventing and controlling healthcare-associated infections, and antimicrobial stewardship

Reflective questions

How are the health service organisation's safety and quality systems used to:

- Support implementation of policies and procedures to minimise healthcare-associated infections
- Identify and manage risks associated with healthcare-associated infections
- Identify training requirements to prevent and control healthcare-associated infections, and improve antimicrobial stewardship?

Key tasks

- Set up and implement governance structures for healthcare-associated infections and antimicrobial stewardship
- Develop and implement policies and procedures for healthcare-associated infections and antimicrobial stewardship
- Use organisation-wide risk management systems to identify, monitor, manage and review risks associated with healthcare-associated infections and antimicrobial stewardship
- Deliver or provide access to training on healthcare-associated infections and antimicrobial stewardship based on the specific needs of the workforce.

Strategies for improvement

The Clinical Governance Standard has specific actions relating to health service organisations' safety and quality systems.

Action 1.7 – policies and procedures

Action 1.10 – risk management systems

Actions 1.19, 1.20 and **1.21** – education and training

Health service organisations should:

- Use these and other established safety and quality systems to support policies and procedures, risk management and training for healthcare-associated infections and antimicrobial stewardship
- Ensure that current versions of all relevant policies and procedures are readily available and accessible to clinicians.

Policies may be developed or adapted at different levels within the organisation. However, all policy documents should be incorporated into a single, coherent set to maximise the effectiveness of the policy development process.

Implement policies and procedures

Ensure that current, readily available and accessible organisational policies and procedures are in place that cover priority areas for infection prevention and control, and antimicrobial stewardship, in the organisation, including:

- Standard and transmission-based precautions
- Environmental cleaning and disinfection
- Reprocessing of reusable medical devices
- Single-use items
- Insertion and maintenance of invasive devices
- Outbreaks or unusual clusters of infection or communicable disease
- Reporting requirements for communicable and notifiable diseases
- Antimicrobial prescribing and use
- Safe work practices for
  - use, handling and disposal of sharps
  - waste and linen management
  - workforce immunisation
  - exposure-prone procedures
  - prevention and management of occupational exposures to blood and body substances
- Product management and evaluation of new and existing products, equipment and devices
- Preventive maintenance, including repairs, refurbishment and upgrade of infrastructure, including buildings, equipment, fixtures and fittings.

These policies, procedures and protocols may be developed by the individual service or the corporate group.

Manage risks

Use established risk management systems (see Action 1.10) to identify, monitor, manage and review risks associated with preventing and controlling healthcare-associated infections. Develop processes to manage clinical risks for different populations served within the organisation, clinical and workplace risks for the workforce, and organisational risks.

Use information from measurement and quality improvement systems, adverse events, clinical outcomes and patient experiences to inform and update risk assessments and the risk management system. Consider the training the workforce may need to effectively use incident management and investigation systems to inform risk management, and to plan and implement quality improvement processes to mitigate these risks.

Day procedure services should manage the risk of infection and have local risk management strategies in place, regardless of where the governance for the service is located.

Identify training requirements

Assess the competency and training needs of the workforce in line with the requirements of Actions 1.19–1.21. Perform a risk assessment to inform the training schedule and set priorities for the members of the workforce who require training. Develop, or provide access to, training and education resources to meet the needs of the workforce regarding infection prevention and control activities, reprocessing of reusable medical devices, and antimicrobial prescribing and use.

Identify the processes used in the health service organisation to manage training requirements for infection prevention and control activities, reprocessing of reusable medical devices, and antimicrobial prescribing and use.

If appropriate, use a competency-based assessment process that is aligned with the organisation's policies, procedures and protocols for hand hygiene, aseptic technique, invasive device insertion and maintenance, putting on and removal of personal protective equipment, reprocessing of reusable medical devices, and environmental cleaning.

Competency-based assessment is the assessment of actual skills and knowledge that a person can show in the workplace. A workplace assessor reviews the evidence and verifies the person's competence in performing the assessed task.

Review the organisation's induction, and ongoing education and training programs to ensure that they include relevant information, tools and instructions on infection prevention and control policies and procedures for new and existing employees and contractors.

Develop, review or introduce an appraisal process for the workforce that incorporates:

- Awareness and understanding of relevant policies, procedures and protocols relating to infection risks in the workplace
- Use of infection prevention and control policies, procedures and protocols
- Education, training or competency assessment for relevant risk management processes, and incident management and investigation systems for infection prevention.

Related actions

In addition to these strategies, Actions 3.15 and 3.16 include specific strategies for the implementation, monitoring and evaluation of the organisation's antimicrobial stewardship program.

Examples of evidence

Select only examples currently in use:

- Policy documents about infection prevention and control that include risk assessment and risk management strategies, and instructions for clinicians
- Audit results of workforce compliance with policies and procedures for infection prevention and control, and antimicrobial stewardship
- Surveillance data that are used to improve infection prevention and control
- Action plan based on the risk assessment of the health service organisation's infection prevention and control systems
- Training documents about the health service organisation's infection prevention and control systems.

Applying quality improvement systems

Action 3.2

The health service organisation applies the quality improvement system from the Clinical Governance Standard when:

a. Monitoring the performance of systems for prevention and control of healthcare-associated infections, and the effectiveness of the antimicrobial stewardship program

b. Implementing strategies to improve outcomes and associated processes of systems for prevention and control of healthcare-associated infections, and antimicrobial stewardship

c. Reporting on the outcomes of prevention and control of healthcare-associated infections, and the antimicrobial stewardship program

Reflective questions

How are the systems for prevention and control of healthcare-associated infections, and the effectiveness of the antimicrobial stewardship program continuously evaluated and improved?

How are the outcomes of improvement activities communicated to the governing body, the workforce, consumers and other organisations?

Key tasks

- Review, measure, and assess the effectiveness and performance of, organisational and clinical strategies for the prevention and control of healthcare-associated infections, and antimicrobial stewardship
- Implement quality improvement strategies for healthcare-associated infections and antimicrobial stewardship based on the outcomes of monitoring activities

- Provide information on the outcomes of quality improvement activities to the governing body, the workforce, consumers and other organisations.

Strategies for improvement

> The Clinical Governance Standard has specific actions relating to health service organisations' quality improvement systems.
>
> **Action 1.8** – quality improvement systems
>
> **Action 1.9** – reporting
>
> **Action 1.11** – incident management and investigation systems
>
> Health service organisations should use these and other established safety and quality systems to support monitoring, reporting and implementation of quality improvement strategies for healthcare-associated infections and antimicrobial stewardship.

Monitor effectiveness and performance

Use the organisation's quality improvement systems to identify, and set priorities for, organisational and clinical strategies to prevent healthcare-associated infections and manage the risks.

Review these systems to ensure that they include requirements for:

- Using the organisation's incident management and investigation system to identify and improve safety and quality activities
- Measuring performance and identifying opportunities for improvement
- Reporting outcomes to the organisation's leadership, workforce, consumers and (if appropriate) other health service organisations
- Engaging with consumers to review the performance of safety and quality activities
- Communicating the outcomes of quality improvement activities in newsletters and publications

- Maintaining and improving the effectiveness of the antimicrobial stewardship program.

Identify the key elements of an antimicrobial stewardship program that will both show performance and inform prescribing practice and use of antimicrobials in the organisation.

Identify how the organisation will evaluate compliance with policies, procedures and protocols relating to infection prevention and control, and antimicrobial stewardship (including hand hygiene, aseptic technique, invasive device insertion and maintenance, infection surveillance, environmental cleaning, workforce immunisation, standard and transmission-based precautions, reprocessing of reusable medical devices, and antimicrobial prescribing and use).

Review the results of annual evaluation of the organisation's quality improvement program for infection prevention and control, to acknowledge successes and identify opportunities for improvement.

Implement quality improvement strategies

Use the results of monitoring activities to show improvements or areas where improvement is required. Where appropriate, use quality improvement activities that are consistent and measurable across the corporate group, network or health service.

Use the results of the organisational risk assessment to identify gaps, plan, and set priorities for areas for investigation or action.

Identify where the organisation is performing well, including where infection risks have been minimised or eliminated.

Report outcomes

Report evaluation findings to the governing body and the workforce. Use the data to work with consumers, the workforce, clinical leaders and managers to identify and implement improvements.

Related actions

In addition to these strategies:

- Action 3.4 outlines surveillance strategies to support infection prevention and control activities, and the antimicrobial stewardship program; these strategies can be used to identify gaps and set priorities for action to minimise risk in the prevention and control of healthcare-associated infections, and antimicrobial stewardship

- Action 3.16 includes specific strategies for ongoing monitoring, evaluation and improvement activities for the organisation's antimicrobial stewardship program.

Examples of evidence

Select only examples currently in use:

- Improvements made to the health service organisation's infection prevention and control system

- Reports to the highest level of governance, the workforce and consumers on infection prevention and control outcomes of the health service organisation's quality improvement program

- Performance evaluation of the infection prevention and control program by leadership, the workforce and consumers as part of the health service organisation's quality improvement program

- Audit results of infection prevention and control activities included in the quality improvement system.

Partnering with consumers

Action 3.3

Clinicians use organisational processes from the Partnering with Consumers Standard when preventing and managing healthcare-associated infections, and implementing the antimicrobial stewardship program to:

a. Actively involve patients in their own care

b. Meet the patient's information needs

c. Share decision-making

Reflective questions

How do clinicians use the processes for partnering with consumers to involve patients in planning and making decisions about infection prevention and control?

How does the health service organisation collect feedback from patients about information provided on infection prevention and control?

Key tasks

- Review strategies in the Partnering with Consumers Standard to inform the implementation of actions in the Preventing and Controlling Healthcare-Associated Infection Standard

- Provide information to patients about healthcare-associated infections and antimicrobial stewardship tailored to their specific needs and level of health literacy.

Strategies for improvement

> The Partnering with Consumers Standard has specific actions (**Actions 2.3–2.10**) related to health service organisations' processes for involving patients in their own care, shared decision making, informed consent and effective communication.

Day procedure services should use established processes to partner with patients to prevent healthcare-associated infections. If the service is part of a larger corporate group that has a governance structure that includes resources for partnering with patients and other consumers, adapt and use these resources, if appropriate.

Identify opportunities to improve the way that clinicians engage with patients in shared decision-making activities to reduce or manage the risk of healthcare-associated infections.

Review or develop resources to inform patients about infection prevention and control. Ensure that patients understand their own responsibilities in preventing and controlling healthcare-associated infections.

Ensure that patients and carers have enough information about treatment options to make informed choices about their medicines and adhere to treatment plans for antimicrobials. Action 4.11 includes specific strategies for providing information to patients about their individual medicines needs and risks.

Provide information in a format that is meaningful, easy to understand and use, and tailored to the diversity of the organisation's patient population. Consider the languages used in the local community when selecting and developing resources on heathcare-associated infections for patients.

Examples of evidence

Select only examples currently in use:

- Policy documents about partnering with consumers on infection prevention and control
- Observation of clinicians' practice that demonstrates use of the health service organisation's processes for partnering with consumers
- Records of interviews with clinicians that show that they understand the health service organisation's processes for partnering with consumers
- Evidence of consumer engagement in the health service organisation's program for infection prevention and control, such as inclusion of consumers on organisational committees and evaluation of consumer feedback
- Examples of resources to support patients' decision-making about infection prevention and control risks that have been developed with consumer partnership, such as brochures, newsletters and noticeboards in waiting areas
- Results of evaluation of consumer resources used in the health service organisation.

Surveillance

Action 3.4

The health service organisation has a surveillance strategy for healthcare-associated infections and antimicrobial use that:

a. Collects data on healthcare-associated infections and antimicrobial use relevant to the size and scope of the organisation

b. Monitors, assesses and uses surveillance data to reduce the risks associated with healthcare-associated infections and support appropriate antimicrobial prescribing

c. Reports surveillance data on healthcare-associated infections and antimicrobial use to the workforce, the governing body, consumers and other relevant groups

Reflective questions

How does the health service organisation collect surveillance data on healthcare-associated infections?

How are these data used to monitor, assess and reduce risks relating to healthcare-associated infections?

How are these data reported to the workforce, the governing body, consumers and other relevant groups?

Key tasks

- Use information from the organisational risk management system to decide appropriate surveillance activities for the size and scope of the organisation
- Review existing surveillance processes to identify any gaps, changes or variation in data
- Ensure that existing processes and supporting policies include reporting of infection and resistance data to the relevant workforce, the governing body, consumers and other relevant groups
- Ensure that surveillance activities use nationally agreed definitions (if available) and meet state or territory requirements
- Ensure that the workforce performing surveillance activities is adequately trained
- Develop new surveillance activities if there is a change in the services provided.

Strategies for improvement

Identify the types of surveillance activities to be used

Surveillance strategies should support infection prevention and control activities, and be used to identify gaps and set priorities for action to minimise the risk of preventable healthcare-associated infections. Surveillance activities are determined by the complexity of the day procedure service, the services it provides, and national and state or territory requirements. Surveillance activities may include continuous surveillance; targeted, process or signal surveillance; or unit-based activities based on local, national, and state or territory requirements.

Examples of surveillance activities include:

- Identification of infections
- Identification of patients who re-present to clinicians with infections after treatment
- Compliance with outbreak management processes in the health service organisation
- Review of new patient assessment forms for infection risk that may influence treatment
- Review of antimicrobial prescribing for consistency with evidence-based Australian therapeutic guidelines
- Participation in national surveillance activities relating to antimicrobial stewardship, including the National Antimicrobial Prescribing Survey.

Review the organisation's services, and identify opportunities for monitoring infections and resistance of microorganisms based on risk, national and state or territory requirements, or changes in the services provided by the organisation.

Assess and measure consistency with the policies, procedures and protocols of the overarching health service organisation or corporate group, if appropriate.

Review validation and training requirements

Use nationally agreed surveillance definitions (if available) and validate data collected (if applicable). Undertaking surveillance activities and validating data require the workforce involved to be trained in these techniques.

Communicate results of surveillance

Use the results of surveillance activities to inform the risk management process, and to review or develop policies, procedures and protocols to reduce the risk of healthcare-associated infections.

Ensure that processes are in place to interpret surveillance results and provide results to the relevant workforce, the organisation's governing body (through the committee responsible for infection prevention and control), consumers and any other relevant groups.

Further resources on surveillance systems and infection surveillance definitions are available at the National Surveillance Initiative of the Australian Commission on Safety and Quality in Health Care (the Commission).

Examples of evidence

Select only examples currently in use:

- Surveillance strategy for healthcare-associated infections based on the complexity of services provided in the health service organisation and assessment of risks
- Audit results of surveillance activities for healthcare-associated infections
- Reports of surveillance activities for healthcare-associated infections provided to the workforce, the governing body, consumers and other relevant groups
- Results from analysis of data on healthcare-associated infections
- Committee and meeting records in which surveillance data on healthcare-associated infections were reported or discussed.

CRITERION: Infection prevention and control systems

Evidence-based systems are used to prevent and control healthcare-associated infections. Patients presenting with, or with risk factors for, infection or colonisation with an organism of local, national or global significance are identified promptly, and receive the necessary management and treatment. The health service organisation is clean and hygienic.

Infection control is a health and safety issue. All people working in the day procedure service are responsible for providing a safe environment for consumers and the workforce.

Infectious agents transmitted during provision of health care come primarily from human sources, including patients, clinicians and visitors. Successful infection prevention and control measures involve implementing work practices that prevent the transmission of infectious agents using a two-tiered approach: standard precautions and transmission-based precautions.

Standard precautions are basic infection prevention and control strategies that apply to everyone, regardless of their perceived or confirmed infectious status. Strategies include hand hygiene, personal protective equipment, cleaning, and appropriate handling and disposal of sharps. These are a first-line approach to infection prevention and control in day procedure services, and are routinely applied as an essential strategy for minimising the spread of infections. Standard precautions minimise the risk of transmission of infectious agents from one person or place to another, even in high-risk situations, and render and maintain objects and areas as free as possible from infectious agents.[79]

Transmission-based precautions are specific interventions to interrupt the mode of transmission of infectious agents. They are used to control infection risk with patients who are suspected or confirmed to be infected with agents transmitted by contact, droplet or airborne routes. Transmission-based precautions are recommended as extra work practices in situations when standard precautions alone may be insufficient to prevent transmission. Transmission-based precautions are also used during outbreaks to help contain the outbreak and prevent further infection. Transmission-based precautions should be tailored to the infectious agent involved and its mode of transmission – this may involve a combination of practices.

Hand hygiene is an essential infection prevention and control strategy. The current National Hand Hygiene Initiative states that hand hygiene must be performed according to the World Health Organization's My 5 Moments for Hand Hygiene to prevent patient colonisation and infection. Although the concept of hand hygiene is straightforward, improving hand hygiene practices involves changing attitudes and behaviour among clinicians.

Aseptic technique, use of invasive medical devices, workforce immunisation and environmental cleaning are included in this criterion because they are part of infection prevention and control systems. Health service organisation managers are responsible for overseeing systems and processes to maintain a clean, hygienic environment, including maintenance and upgrading of buildings and equipment; environmental cleaning of buildings, infrastructure, new products and equipment; and handling and management of linen.

For further information on implementing systems for standard and transmission-based precautions, refer to Section A1.2 in the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*.[79]

Standard and transmission-based precautions

Action 3.5

The health service organisation has processes to apply standard and transmission-based precautions that are consistent with the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*[79], and jurisdictional requirements

Reflective question

How does the health service organisation ensure that its standard and transmission-based precautions are consistent with the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*, and with state or territory requirements?

Key tasks

- Use information from risk management systems to identify strategies to reduce the risks of healthcare-associated infections
- Review current policies, procedures and protocols to ensure that they align and comply with the *Australian Guidelines for the Prevention and Control of Infection in Healthcare* and state or territory requirements
- Provide access to the equipment, supplies and products required to comply with standard and transmission-based precautions
- Use the results of risk assessment processes to set priorities for assessment of workforce compliance with standard and transmission-based precautions
- Include the expectations of the workforce regarding infection prevention and control activities, including application of standard and transmission-based precautions, in the organisation's workforce orientation program.

Strategies for improvement

Ensure that the *Australian Guidelines for the Prevention and Control of Infection in Healthcare* and relevant state or territory requirements are available and accessible to the workforce when reviewing practice, policy and procedures.

Ensure that policies, procedures and protocols respond to areas in which there is the greatest risk of infection transmission. Work with individuals, services and committees to identify where risks have been identified, and where changes need to occur or improvements can be made to respond to risks.

Ensure that the equipment, supplies and products required by the workforce to work safely and minimise the risk of infection transmission are accessible, located where required and appropriate to the risks identified for that clinical area.

Based on information from the risk management systems, identify and set priorities for when, where and how compliance with standard and transmission-based precautions can be monitored, assessed and reviewed. Activities may include:

- Auditing hand hygiene
- Auditing putting on and removal of personal protective equipment
- Prioritising competency assessment for aseptic technique to members of the workforce who have been identified as high risk
- Assessing compliance with the requirements of transmission-based precautions when applied to a specific infection risk

- Reviewing surveillance data on healthcare-associated infections
- Reviewing incident reports relating to
  - infection prevention and control issues
  - intravascular devices
  - sharps and waste management
  - occupational exposures
  - environmental cleaning and biological spills.

Review or develop workforce education and orientation programs to include key aspects of standard and transmission-based precautions. Evaluate attendance at, and content of, the orientation or induction programs for the workforce.

Develop or review signage, alert systems, and information/reminder systems and resources to raise awareness of standard and transmission-based precautions, and ensure consistency with the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*.

Have a management plan that can operate during localised outbreaks or periods when infections may be common (for example, seasonal influenza or local outbreaks of viral gastroenteritis) that:

- Identifies possible cases
- Implements other treatment options (for example, rescheduling procedures)
- Advises about exclusion periods for elective procedures
- Suggests management options for suspected or confirmed infections that may be transmissible
- Reduces impacts on treatment and recovery
- Addresses workforce occupational risk.

Examples of evidence

Select only examples currently in use:

- Policy documents about standard and transmission-based precautions that are consistent with the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare* and are available to the workforce
- Audit results of workforce compliance with standard and transmission-based precautions
- Training documents about standard and transmission-based precautions
- Examples of improvement activities that have been implemented and evaluated to improve compliance with, and raise awareness of, standard and transmission-based precautions
- Committee and meeting records in which compliance with, and incidents relating to, standard and transmission-based precautions were discussed
- Observation of standardised signage and other information resources consistent with the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*.

Action 3.6

Clinicians assess infection risks and use transmission-based precautions based on the risk of transmission of infectious agents, and consider:

a. Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated when clinically required during care

b. Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance

c. Accommodation needs to manage infection risks

d. The need to control the environment

e. Precautions required when the patient is moved within the facility or to external services

f. The need for additional environmental cleaning or disinfection

g. Equipment requirements

Reflective questions

How do clinicians decide on the need to apply transmission-based precautions?

How do clinicians assess and manage infection risks when a patient presents for care?

Key tasks

- Use the results of the organisational risk assessment and gap analysis to identify priority areas for review, action or monitoring

- Review and use surveillance data to identify which communicable diseases, emerging risks, or infectious agents of local, national or international significance affect the health service organisation, patients and the workforce

- If available, use national systems and definitions to collect surveillance data on infectious agents

- Identify the systems that are already in place to manage the risk of transmission of these infectious agents

- Set up or review the processes for communicating risks and risk management strategies to clinical areas or units, services or facilities (internal and external) that may be involved in the care of the patient.

Strategies for improvement

Review and assess the organisation's processes that will inform risk management strategies to minimise exposure of patients, the workforce and the organisation to infectious agents. These include:

- How the risk of infection or communicable disease is assessed on admission, on referral or on presentation for care in the organisation

- What processes are in place to reassess the risks when clinically indicated during care

- How infection risks are acted on, if identified

- What processes are in place to inform the workforce or external services of a risk of an infectious agent or communicable disease

- How contracts and service performance of any external providers of goods and services are reviewed.

Information sources to help with this assessment may include:

- Data on waiting times for admission, rescheduling of procedures and delays in patient placement because of a lack of appropriate accommodation, resources and equipment

- Pathology reports on infectious agents of local, national or international significance that require transmission-based precautions

- Surveillance data and reports from the organisation and other sources (for example, corporate, national, or state and territory surveillance reports) that have been gathered using national systems and definitions (if available)
- Incident reports relating to possible transmission of infectious agents
- Consumer feedback reports
- Maintenance or service history and pathology reports to identify appropriate monitoring of air-handling systems, water supply systems and other relevant equipment
- Data on cleaning and disinfection regimes.

Develop strategies to respond to any risks identified as part of the review, or any risks identified as part of a public health response or pandemic planning.

Include identified risks in the organisation's quality improvement program so that actions and outcomes are monitored, measured, assessed and reported to leadership, the workforce and consumers. If appropriate, report recommendations to other services and clinicians that may be involved in the care of the patient.

If the day procedure service is part of a larger organisation or corporate group, refer to its policies, procedures and protocols for managing and communicating risk of infectious agents of local, national and international significance.

The *Australian Guidelines for the Prevention and Control of Infection in Healthcare*[79] provide detailed information about risk assessment processes for infection prevention and control.

Examples of evidence

Select only examples currently in use:
- Policy documents about the assessment of infection risks and implementation of transmission-based precautions to manage the risks
- Patient referral or admission documentation that demonstrates assessment of infection risks and precautions to manage risks
- Committee and meeting records in which infection risks and precautions to manage them were discussed

- Audit results of the use of precautions for infection risks
- Training documents about assessing infection risks and precautions to manage the risks
- Examples of activities that have been implemented and evaluated to improve assessment and management of infection risks
- Observation that relevant equipment, including personal protective equipment, is available to the workforce
- Observation of physical and environmental controls for managing the risk of transmission of infectious agents
- Cleaning schedules that outline further requirements associated with infection risk
- List of communicable diseases or infectious agents of local or national significance that affect the health service organisation, patients and the workforce
- Examples of communication with the workforce and patients about the risk of infectious agents and communicable diseases, and measures that can be used to reduce the risks.

Action 3.7

The health service organisation has processes for communicating relevant details of a patient's infectious status whenever responsibility for care is transferred between clinicians or health service organisations

Reflective question

How does the health service organisation communicate the patient's infectious status when care is transferred?

Key tasks

- Develop, review or implement a process to identify relevant pre-existing colonisation, infection or communicable diseases that will affect
  - patient placement pre- and post-procedure
  - the risk to the workforce, other patients and consumers
  - transfer of care
- Review systems and processes used by managers and the workforce on admission, at entry points or when care is transitioning, including
  - pre-admission information
  - alerts, flags and risk identification processes
  - protocols on how to assess patients for colonisation, infections or communicable diseases
  - processes for transporting patients within or outside the day procedure service.

Strategies for improvement

Review or develop processes to communicate relevant information relating to a patient's infection status whenever responsibility for care is transferred. This includes:

- Between members of the workforce
  - on admission
  - at every clinical handover
  - at any transition or transfer of care (for example, admission, radiology, operating theatre, recovery)
  - during clinical review or consultation
  - during transport both within and outside the day procedure service

- To other relevant clinicians or care providers, including
  - general practitioners
  - community nurse services
  - allied health providers
  - family and carers on discharge
- To other heath service organisations, including rehabilitation and aged care services.

Develop or use relevant information systems and materials to inform clinicians about infection risks and the requirements to minimise the risks. Infection prevention and control risks should be included on:

- Requests for admission
- Referral documentation
- Clinical handover reports
- Discharge or transfer summaries
- Notification, alert or flag systems for infection status, and precautions required for current and future care and treatment.

Develop or use resources to inform the workforce, patients and visitors of relevant infection risks, and infection prevention and control strategies to minimise risk to patients, visitors and the workforce.

Examples of evidence

Select only examples currently in use:

- Policy documents about communicating relevant information about any risks associated with a patient's infectious status when care is transferred between clinicians or health service organisations
- Clinical communication processes that include actions to communicate a patient's infectious status to clinicians

- Examples of clinical communication that highlights infectious status, such as handover sheets, discharge forms or electronic communication
- Audit results of compliance with the processes for communicating infectious status, such as reviewing clinical communication documents or related incident reports
- Resources for patients and visitors about infection risks, and infection prevention and control strategies.

Hand hygiene

Action 3.8

The health service organisation has a hand hygiene program that:

a. Is consistent with the current National Hand Hygiene Initiative, and jurisdictional requirements

b. Addresses noncompliance or inconsistency with the current National Hand Hygiene Initiative

Reflective questions

What processes are used to ensure that the health service organisation's hand hygiene program is consistent with the current National Hand Hygiene Initiative and with state or territory requirements?

How does the health service organisation measure compliance with the current National Hand Hygiene Initiative? What action has been taken to improve compliance?

Key tasks

- Implement systems and processes to meet the National Hand Hygiene Initiative and state or territory requirements
- Measure and report program outcomes, including hand hygiene compliance, if appropriate, according to the National Hand Hygiene Initiative and state or territory requirements
- Identify how the organisation has responded to inconsistency or noncompliance with the current National Hand Hygiene Initiative.

Strategies for improvement

The current National Hand Hygiene Initiative is coordinated by Hand Hygiene Australia. Assess compliance of the service's overall hand hygiene program using one or more measures applicable to the organisation's scope, size and activities.

In some day procedure services, auditing of hand hygiene practice by direct observation may not be practical. These services should check with their local health network, state or territory health department, or nearby larger hospital for their requirements as part of the National Hand Hygiene Initiative.

Ensure that a manager provides leadership, direction and support to the hand hygiene program by:

- Supporting the program to meet the requirements of the National Hand Hygiene Initiative and the state or territory
- Determining how the organisation's hand hygiene program will be resourced and managed.

The hand hygiene program in the health service organisation should include:

- Availability of alcohol-based hand sanitiser at the point of care
- Education of the workforce about hand hygiene

- Auditing of the hand hygiene program with performance feedback
- Development or review of a plan to respond to identified gaps, barriers and enablers that may help show improvement
- Identification of members of the workforce or work areas for which extra training and support are required (for example, medical officers, emergency department, anaesthetics department)
- Provision of feedback to clinicians on the overall performance of the program and results of hand hygiene activities, including hand hygiene compliance and other process audits
- Methods for evaluating the hand hygiene program when compliance auditing is not appropriate or not required – for example
    – review of the types of products used for hand hygiene
    – review of the availability of alcohol-based products at the point of care
    – evaluation of hand hygiene products used in the organisation
    – assessment of workforce knowledge of hand hygiene
    – completion of competency assessments for hand hygiene technique
    – completion of hand hygiene education and training
- Review or development of a process, policy or protocol to deal with issues of noncompliance or inconsistency with the National Hand Hygiene Initiative, which can include
    – identifying reasons for noncompliance and solutions to these issues
    – engaging with clinicians to identify possible solutions
    – modifying procedures, protocols or work practices to deal with issues of noncompliance or inconsistent practices in clinical services (for example, anaesthetics)
    – reviewing availability and workforce acceptance of equipment, supplies and products required for appropriate hand hygiene.

Examples of evidence

Select only examples currently in use:

- Policy documents about a hand hygiene program that is consistent with the current National Hand Hygiene Initiative and state or territory requirements
- Training documents about the hand hygiene program
- Audit results of compliance with the hand hygiene program, including clinician compliance, using passive or active assessment
- Strategies to reduce noncompliance or inconsistency with the current National Hand Hygiene Initiative in the health service organisation
- Committee and meeting records in which inconsistency and noncompliance with the hand hygiene program were discussed
- Communication with clinicians about the results of hand hygiene programs and compliance rates of the workforce
- Audit results of evaluation of the hand hygiene program, including use and availability of equipment, supplies and products for hand hygiene.

Aseptic technique

Action 3.9

The health service organisation has processes for aseptic technique that:

a. Identify the procedures where aseptic technique applies

b. Assess the competence of the workforce in performing aseptic technique

c. Provide training to address gaps in competency

d. Monitor compliance with the organisation's policies on aseptic technique

Reflective questions

What processes are used to ensure that the workforce is competent in aseptic technique?

How does the health service organisation ensure that clinicians routinely follow aseptic technique when required?

Key tasks

- Use risk management tools to identify the procedures for which aseptic technique is required
- Identify gaps where aseptic technique is not applied appropriately
- Provide training to reduce gaps in competence
- Give priority to compliance assessment and auditing for aseptic technique in the areas of highest risk and most frequent use.

Strategies for improvement

Identify procedures and risks

Identify the clinical procedures and activities for which aseptic technique needs to be assessed, such as:

- Surgical procedures, including invasive procedures performed in the operating or procedure room
- Venepuncture
- Insertion of vascular access devices such as peripheral or central lines

- Maintenance of vascular access devices, including line or dressing changes, or medicine administration through these devices
- Urinary catheterisation
- Simple dressings
- Complex or large dressings
- Gowning and gloving
- Collecting of swabs and other specimens.

Conduct a risk assessment to identify the areas of the organisation that have the highest risk when performing these procedures. Risks relate to the clinical context, the patient and the frequency at which the procedure is performed.

Provide the relevant workforce with current policies, procedures and protocols that provide guidance on aseptic technique and that have been developed or reviewed by members of the workforce who are competent in aseptic technique.

Assess training and competence

Identify the training needs of members of the workforce who perform procedures requiring aseptic technique. Consider the validity, currency and scope of previous training, and how often training should be repeated to maintain competence.

Assess the competence of members of the workforce who are required to perform aseptic technique and provide training to reduce gaps in competence. Set priorities for training based on risk assessment.

Identify opportunities to review practice to improve aseptic technique.

Use surveillance data, if available, for healthcare-associated infections, results of hand hygiene compliance audits and incident reports to help set priorities for assessment and training needs.

Support practice improvement

Consider technological advances to improve aseptic technique in practice, such as:

- Equipment bundles
- Sterile 'starter' packs
- Dedicated trolleys (for example, intravenous, dressing and urinary catheter trolleys).

Examples of evidence

Select only examples currently in use:

- Policy documents that identify clinical procedures and activities for which aseptic technique is required

- List of procedures undertaken in the health service organisation that require aseptic technique
- Evidence of the assessment of workforce competence in performing aseptic technique
- Skills appraisals and record of competencies of contractor, locum and agency workforce for aseptic technique
- Training documents about aseptic technique, including training to reduce gaps in competence
- Audit results of compliance with aseptic technique procedures
- Actions taken to reduce identified risks associated with aseptic technique
- List of invasive clinical procedures included in the aseptic technique assessment.

Invasive medical devices

Action 3.10

The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*[79]

Reflective question

How does the health service organisation ensure that the workforce selects, inserts, maintains and removes invasive devices safely?

Key tasks

- Review the organisation's compliance with relevant regulations, guidelines and state or territory requirements covering invasive medical devices
- Review, develop or implement processes to cover introduction, use, management and removal of invasive medical devices used in the organisation.

Strategies for improvement

As part of the organisational risk assessment, determine:

- Which invasive medical devices are used in the health service organisation
- Where they are used
- Which clinicians are using them
- Escalation pathways to manage difficult insertion of invasive devices
- Whether clinicians have been trained and assessed in appropriate selection, management and removal of the invasive medical devices they use
- Consistency with the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*[79]

- Compliance with relevant regulations, guidelines and state or territory requirements covering invasive medical devices.

Assess risks relating to indications for use, insertion and management of invasive medical devices in clinical and procedural areas, such as:
- Admission areas
- Interventional radiology
- Anaesthetics
- Operating theatres and procedure rooms
- Recovery.

Develop or review policies, procedures and protocols relating to the choice, insertion, maintenance and removal of invasive medical devices to cover:
- Product selection and evaluation, including cost, cost-effectiveness and patient preferences
- Supply and procurement
- Introduction into the organisation
- Education, training and competency assessments required before use
- Any requirements for reassessment of competence
- Strategies for individual inserters and departments to track their own complication rates
- Scope of use
- Reuse
- Disposal
- Storage
- Transportation from storage to place of use, including
  - maintaining integrity and sterility
  - transport safety and time frames
  - temperature and moisture control
  - disposal considerations
- Fault management
- Recall
- Evaluation of devices
- Documentation in the patient's healthcare record of time frames and reasons for insertion, management and removal of invasive medical devices, and patient assessment (including feedback and actions taken).

Identify the risks associated with the use and maintenance of invasive medical devices. This could include documenting:
- Criteria for insertion, and selection of the best device for patient indications and purpose
- Indications for the device to be left in place once inserted
- Assessment of aseptic technique used at insertion and for maintenance activities
- Use of evidence-based safety engineered technology
- Evaluation of how clinicians choose the most appropriate device
- Physical environment issues that affect insertion and maintenance of devices
- Patient monitoring activities to identify infections relating to invasive medical devices
- Use of the organisation's incident reporting process
- Review of incident reports relating to invasive medical devices for appropriateness, infection, referral, inconsistency or noncompliance with organisational policy, equipment failure and other adverse events
- Patient engagement and education about use and maintenance of invasive medical devices
- Indication for removal, evidence-based removal procedure and post-removal assessment of possible complications (for example, air emboli, bleeding from removal site).

Examples of evidence

Select only examples currently in use:
- Policy documents about the selection, insertion, maintenance and removal of invasive medical devices
- Committee and meeting records in which use of invasive medical devices was discussed
- Review of infection surveillance data about invasive medical devices
- Actions taken to manage identified risks with the selection, insertion, maintenance and removal of invasive medical devices
- List of invasive medical devices in use in the health service organisation and where they are used
- Audit results of workforce compliance with processes for the selection, insertion, maintenance and removal of invasive medical devices.

Clean environment

Action 3.11

The health service organisation has processes to maintain a clean and hygienic environment – in line with the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*[79], and jurisdictional requirements – that:

a. Respond to environmental risks

b. Require cleaning and disinfection in line with recommended cleaning frequencies

c. Include training in the appropriate use of specialised personal protective equipment for the workforce

Reflective questions

What processes are used to maintain a clean and hygienic environment in line with the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare* and with state or territory requirements?

How does the health service organisation ensure that the workforce is trained in the appropriate use of specialised personal protective equipment?

Key tasks

- Identify the environmental cleaning hazards in the organisation and include these in the organisation's risk management strategies
- Review or develop policies, procedures and protocols to include effective strategies to provide a clean environment in the organisation
- Use the implementation and evaluation strategies for environmental cleaning to ensure that cleaning and disinfection processes are in line with recommended cleaning frequencies appropriate to the day procedure service
- Provide training to the workforce performing environmental cleaning activities and include the use of specialised personal protective equipment, if required
- Evaluate environmental cleaning practices for compliance with policies, procedures and protocols, and measure outcomes of cleaning processes

- Review duty lists, position descriptions or contract specifications as part of the appraisal or contract review process, and provide feedback to the relevant person or group on achievements or areas for improvement.

Strategies for improvement

Include environmental cleaning risks in the organisation's risk management strategies, and ensure that cleaning processes have the support of the governing body and executive.

Implementation strategies for a clean environment should be evidence based and have a risk management focus. Strategies may include:

- Workforce and contractor education
- Version control and standardised formats for
  - policies
  - procedures
  - position descriptions
  - duty lists
  - contract specifications (for contracted cleaning services)
- Processes to assess effectiveness
- Evaluation of the cleaning program.

The governing body is responsible for overseeing contracted cleaning services. Contract development, documentation and record keeping should include consultation with key groups, including:

- The cleaning manager
- Infection prevention and control
- Corporate services
- Governance.

Develop cleaning and disinfection schedules that meet the requirements outlined in the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*[79] and relevant state or territory requirements. These schedules should include:

- Frequency and type of activity
- Products and equipment to be used
- Specialised personal protective equipment, if required
- Safety instructions.

Ensure that position descriptions and duty lists are current, and consistent with the environmental cleaning and disinfection schedules used in the organisation.

Monitor performance

Identify areas that require audit and evaluation of environmental cleaning and disinfection processes, and use audit and evaluation tools that effectively assess compliance with policies, procedures and protocols used in the organisation. Report to the governing body on improvements achieved and areas in which further improvement is needed as part of the quality improvement program.

Include environmental cleaning and a process to deal with any identified issues in the organisation's incident management and investigation system. Review the incident management and investigation system to identify any incidents relating to environmental cleaning activities and act to prevent incidents recurring.

It may be appropriate for some day procedure services to work with the overarching corporate organisation to identify the available resources that can support the environmental cleaning program.

Examples of evidence

Select only examples currently in use:

- Policy documents about a clean and hygienic environment
- Cleaning and disinfection schedules that meet the requirements outlined in the *Australian Guidelines for the Prevention and Control of Infection in Healthcare* and relevant state or territory requirements
- Audit results of cleaning and disinfection practices
- Committee and meeting records relating to cleaning and disinfection
- Contracts with external cleaning providers that outline the health service organisation's requirements for cleaning and disinfection
- Results of consumer experience surveys, and actions taken to deal with issues identified regarding cleaning and disinfection
- Training documents for the workforce about the use of specialised personal protective equipment
- Audit results of the use of specialised personal protective equipment.

Action 3.12

The health service organisation has processes to evaluate and respond to infection risks for:

a. New and existing equipment, devices and products used in the organisation

b. Maintaining, repairing and upgrading buildings, equipment, furnishings and fittings

c. Handling, transporting and storing linen

Reflective questions

How are infection risks for new and existing equipment, devices and products determined?

How is this information used to inform policies, procedures and protocols for preventing and controlling healthcare-associated infections?

What action has been taken to maintain cleaning standards and services?

Key tasks

- Develop or review the organisation's processes for introducing new technologies, devices, products or equipment
- Develop or review the organisation's risk management processes to include the need to identify and respond to infection risks that may be associated with repairs, refurbishment or upgrade of infrastructure, including during the planning stage
- Set up or review the processes for handling, transporting and storing linen used in the organisation.

Strategies for improvement

Develop processes for new products

Ensure that processes are in place to assess infection risks when introducing new devices, products or equipment into the organisation. This could be included in the role of a products committee, and may be coordinated by the health service organisation or at a group, corporate, or network or district level. Processes for introducing new technologies, devices, products or equipment should also consider:

- How new products will be trialled
- How new products will be introduced
- What training is required
- Whether items need to be removed or decommissioned
- Whether the maintenance program considers infection risks that need to be managed (for example, by using specialised personal protective equipment, extra cleaning or disinfection to reduce biofilm or microbial contamination, physical barriers)
- How product recalls will be coordinated
- How alerts will be managed and responded to
- How the introduction of a new product or technology aligns with the organisation's risk management system.

Consult with relevant services

Ensure that the organisation's risk management program includes the need to consult with relevant services, such as engineering, environmental cleaning, reprocessing of reusable medical devices, and infection prevention and control services:

- At the planning stage for any repairs, renovations, refurbishment or redevelopment within the organisation
- At each stage during any repairs, renovations, refurbishment or redevelopment to minimise or manage risks to patients, the workforce, departments and contractors involved both directly and indirectly.

Infection risks to be considered may include:

- Access
- Dust
- Aerosols
- Air handling
- Filters and filtration
- Water quality, biofilms and supply
- Sewerage and wastewater
- Infectious agents
- Waste materials
- Disruption of services and utilities
- Patient and workforce safety
- Extra cleaning and reprocessing requirements.

Review processes for linen handling

If linen is used, review the movement, supply and handling of clean and used linen in the health service organisation to minimise infection risks associated with linen for both patients and the workforce. This includes linen used for patient care, environmental linen (for example, privacy screens and curtains) and linen used by the workforce (for example, theatre scrubs, uniforms). Consider how to:

- Minimise excess handling
- Ensure effective containment and storage
- Optimise traffic flows to minimise contamination of clean linen
- Reprocess used linen (methods used, and whether this is done by the health service organisation or an external service).

Ensure that any external services are part of the systems for quality improvement and contracts review addressed in the Clinical Governance Standard.

Examples of evidence

Select only examples currently in use:

- Policy documents about evaluating and responding to the risks associated with linen, equipment, devices, products, buildings, furnishings and fittings in the health service organisation
- Audit results of the handling, transport and storage of linen

- Contracts with external linen providers that outline the health service organisation's requirements for managing clean and used linen to minimise infection risks
- Schedules for maintenance of buildings, equipment, furnishings and fittings
- Audit results of compliance with the maintenance schedules for buildings, equipment, furnishings and fittings
- Records of business decision-making about repairs and upgrades to buildings, equipment, furnishings and fittings.

Workforce immunisation

Action 3.13

The health service organisation has a risk-based workforce immunisation program that:

a. Is consistent with the current edition of the *Australian Immunisation Handbook*[81]

b. Is consistent with jurisdictional requirements for vaccine-preventable diseases

c. Addresses specific risks to the workforce and patients

Reflective question

Is the health service organisation's immunisation program consistent with the national immunisation guidelines and state or territory requirements?

Key tasks

- Review the organisation's immunisation program to ensure that it is consistent with the current edition of the *Australian Immunisation Handbook* and state or territory requirements for vaccination
- Ensure that policies, procedures and protocols are in place to cover employer and employee responsibilities for managing occupational risks for vaccine-preventable diseases.

Strategies for improvement

Conduct a risk assessment to measure consistency of the organisation's workforce immunisation program with the current edition of the *Australian Immunisation Handbook* and state or territory requirements.

Ensure that the policies, procedures and protocols for workforce immunisation include:

- Employer and employee responsibilities for managing occupational risks for vaccine-preventable diseases
- Relevant aspects relating to the organisation's infection prevention and control program
- A statement of the risks in the organisation and how the risks are to be managed, including identifying high-risk areas and at-risk members of the workforce

- How the program aligns with the organisation's workplace health and safety program
- Identification of appropriately qualified or trained personnel to manage the program
- The vaccination requirements for the workforce (including students and contractors) before they start work in the organisation
- The need to maintain current vaccination records for the workforce and a process to gain access to these records, if required
- How information about relevant vaccine-preventable diseases is provided to the workforce and patients
- A documented management process for vaccine refusal that includes reducing the risk to members of the workforce, and reducing the risk of a healthcare worker transmitting disease to vulnerable patients.

It may be appropriate for some day procedure services to work with the group corporate structure to identify the available resources within their organisation for workforce immunisation.

Examples of evidence

Select only examples currently in use:
- Policy documents about risk-based workplace immunisation
- Audit results of workforce vaccination compliance
- Committee and meeting records in which workforce vaccination compliance was discussed
- Communication with the workforce about workforce vaccination requirements
- Workforce vaccination schedule
- Workforce vaccination records.

CRITERION: Reprocessing of reusable medical devices

Reprocessing of reusable equipment, instruments and devices is consistent with relevant current national standards, and meets current best practice.

This criterion includes cleaning, disinfection and sterilisation of reusable medical devices, equipment and instrumentation used in the health service organisation.

Reprocessing of reusable medical devices, equipment and instruments should be consistent with the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*[79], and meet current relevant national and international standards.

Reprocessing of reusable devices

Action 3.14

Where reusable equipment, instruments and devices are used, the health service organisation has:

a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with manufacturers' guidelines

b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying

- the patient
- the procedure
- the reusable equipment, instruments and devices that were used for the procedure

Reflective questions

What processes are in place to ensure that reprocessing of reusable medical devices follows relevant national standards and manufacturers' instructions?

How does the health service organisation identify the patients, procedures, and reusable instruments and devices used during a procedure?

Key tasks

- Identify the organisation's need for reusable critical and semi-critical equipment, instruments and devices
- Review the organisation's infrastructure for reprocessing services, and workforce capacity to reprocess reusable equipment, instruments and devices

- Review policies, procedures and protocols used in sterilising services for reprocessing reusable equipment, instruments and devices
- Review policies, procedures and protocols for decontamination of reusable medical devices at the point of use before reprocessing
- Review the methods used to reprocess reusable equipment, instruments and devices to ensure that these processes are consistent with relevant national and international standards
- Implement or review processes for traceability or tracking of critical and semi-critical equipment, instruments and devices, and assess the processes' ability to identify the patient, the procedure, and the equipment, instrument or device that was used for the procedure.

Strategies for improvement

Identify requirements and processes

Identify the organisation's requirements for reusable equipment, instruments and devices (and associated consumables) as part of the organisational risk assessment.

Identify the organisation's infrastructure and workforce capacity to safely reprocess reusable equipment, instruments and devices. For day procedure services, reprocessing may be managed by the Local Hospital Network, state or territory health department, or private hospital ownership group.

If reusable equipment, instruments and devices are required, assess the processes used to provide appropriately reprocessed items to the workforce and patients, and ensure that these processes are covered in the organisation's policies, procedures and protocols. Questions to consider include the following:

- Does the organisation have the facilities and ability to reprocess the required reusable equipment, instruments and devices?
- Can sterilising services be centralised (for example, if there are several day procedure services under one administration)?
- Are specialised reprocessing techniques required for some reusable medical devices (for example, low-temperature sterilisation, ethylene oxide) and are processes in place to achieve this?
- Should the organisation purchase commercial, pre-sterilised single-use items to meet its needs?
- Could an external sterilising service be contracted to provide reprocessing services for critical or semi-critical equipment, instruments or devices?
- If services are contracted, are contract development, documentation and record keeping conducted in consultation with key groups, including
  - sterilising services manager
  - hospital theatre manager or endoscopy unit manager
  - infection prevention and control
  - corporate services
  - governance?

Review policies, procedures, protocols and systems

Develop or review policies, procedures and protocols that are consistent with relevant national or international standards to cover:

- Governance responsibility for the sterilising service
- Infrastructure, including
  - enough dedicated space for all required steps for reprocessing
  - reprocessing equipment requirements and replacement schedules
  - appropriate storage to maintain the integrity of reprocessed equipment, instruments and devices before use, in all areas where they are stored
  - decontamination and safe packaging for transporting reusable equipment, instruments and devices from clinical areas that may be located away from the sterilising services (for example, interventional radiology, clinical procedure areas)
- Quality improvement systems, which should include
  - appropriate storage requirements for reusable equipment, instruments and devices
  - a fault or variance reporting process that includes responsibility, actions and risk management strategies
  - document control and record-keeping processes that allow data to be retrieved at any time
  - environmental controls, including water quality, air handling, access, maintenance schedules and cleaning activities
  - consumables, including packaging materials and personal protective equipment
  - suitably trained members of the workforce who are available in sterilising services, and wherever decontamination of used reusable equipment, instruments or devices is undertaken.

Use incident management and investigation system to report any incidents relating to the reprocessing of reusable equipment, instruments and devices. Review the incident management and investigation system in the organisation to identify any variation between practice and policy, procedure or protocol, and act to rectify the risks.

Review systems for identification and tracking

Review the existing quality improvement systems used to identify and track reusable equipment, instruments and devices during reprocessing and use. Consider how the following are identified:

- Batch numbers
- Individual items or sets of items
- Patients
- Date of reprocessing
- Type of reprocessing undertaken
- Identification details of the steriliser or disinfector used
- Process cycle details
- Results of chemical and biological monitoring undertaken
- Operator responsible for the reprocessing and release of items for use
- Documentation, quality monitoring and tracking or traceability systems for reusable equipment, instruments and devices received from an external provider (for example, loan sets, clinicians' own reusable medical devices).

Evaluate the quality improvement systems used to identify and track reusable equipment, instruments and devices to check that processes are adequate to identify any items and affected patients in the event of a fault or recall.

Examples of evidence

Select only examples currently in use:

- Policy documents about reprocessing reusable equipment, instruments and devices
- Policy documents about tracing critical and semi-critical reusable equipment, instruments and devices
- List of critical and semi-critical equipment, instruments and devices used in the health service organisation
- Committee and meeting records in which reprocessing and tracing of reusable equipment, instruments and devices were discussed
- Audit results of the traceability system
- Training documents for the workforce about reprocessing and tracing of reusable equipment, instruments and devices.

CRITERION: Antimicrobial stewardship

The health service organisation implements systems for the safe and appropriate prescribing and use of antimicrobials as part of an antimicrobial stewardship program.

Safe and appropriate antimicrobial prescribing is a strategic goal of the clinical governance system.

Antimicrobial stewardship (AMS) is defined as an ongoing effort by a health service organisation to optimise antimicrobial use among patients 'to improve patient outcomes, ensure cost-effective therapy and reduce adverse sequelae of antimicrobial use (including antimicrobial resistance)'.[80] An AMS program involves strategies and interventions that aim to reduce unnecessary antimicrobial use and promote the use of agents that are less likely to select for resistant microorganisms. This is done in line with treatment guidelines and with consideration of local susceptibility patterns.[82]

The actions in this criterion should be considered in relation to the criteria and actions in the Medication Safety Standard.

Effective AMS programs reduce inappropriate antimicrobial use, improve patient outcomes and reduce adverse consequences of antimicrobial use (including antimicrobial resistance, toxicity and unnecessary costs).[83] Along with infection control,

hand hygiene and surveillance, AMS programs are a key strategy in preventing antimicrobial resistance and decreasing preventable healthcare-associated infections.

The content and implementation strategies for this criterion have been drawn from *Antimicrobial Stewardship in Australian Hospitals*[83], which summarises the evidence about AMS programs, and details strategies for implementing and sustaining these programs. It is recommended that health service organisations consult this publication when planning and implementing an AMS program. This publication is currently under revision; the second edition is expected to be published in 2018.

AMS programs may need to be tailored in each organisation. The types of strategies and activities used depend on the specific organisational context, and factors such as the complexity and size of the organisation, and the resources available for implementation, monitoring and evaluation.

The *Options for Implementing Antimicrobial Stewardship in Different Facilities* resource provides examples of how strategies to support AMS might be implemented in different contexts. These examples can be used as a starting point for health service organisations and AMS teams to consider ways in which different strategies can be applied to their own settings. This resource can be downloaded from the Commission's website.

Antimicrobial stewardship

Action 3.15

The health service organisation has an antimicrobial stewardship program that:

a. Includes an antimicrobial stewardship policy

b. Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing

c. Has an antimicrobial formulary that includes restriction rules and approval processes

d. Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard[84]

Reflective questions

What systems, processes and structures are in place to support appropriate prescribing and use of antimicrobials?

How does the health service organisation provide access to current endorsed therapeutic guidelines for clinicians who prescribe antimicrobials?

How is information about the antimicrobial formulary, restriction rules and approval processes communicated to prescribers and clinicians?

Key tasks

- Review the current AMS program to identify what is working well; identify gaps, risks and areas for improvement; set priorities; and inform review of the AMS program plan – use the results of this review to set priorities for AMS
- Identify the key membership of the AMS committee and the AMS team
- Develop or review an AMS policy that specifies that clinicians should follow current, evidence-based Australian therapeutic guidelines on antimicrobial prescribing, or evidence-based guidelines that have been endorsed by a state or territory AMS committee, and incorporates the principles of the Antimicrobial Stewardship Clinical Care Standard
- Develop, review and maintain antimicrobial prescribing policies and a formulary for specific procedures, as relevant to the size and complexity of the health service organisation
- Create or review an antimicrobial formulary and guidelines for treatment and prophylaxis that align with current evidence-based Australian therapeutic guidelines
- Review policies, clinical pathways, point-of-care tools and education programs to ensure that they incorporate the principles of the Antimicrobial Stewardship Clinical Care Standard.

Strategies for improvement

Review the AMS program

An AMS program is a combination of strategies and interventions that work together to optimise antimicrobial use.

All day procedure services that administer or prescribe antimicrobials are required to have an overarching AMS program. Depending on the governance arrangements for safety and quality, this program may be managed by an individual facility, local health network, state or territory, or private hospital ownership group. If the service is part of a broader network or ownership group, work with the governing organisation to identify the resources available to support AMS in the day procedure service and to develop the program.

Review the program to identify what is working well, and gaps and areas for improvement. This includes:

- Assessing current antimicrobial use, results of prescribing audits, available incident data, current AMS activities and resources to support AMS strategies
- Mapping current governance structures, systems and processes that currently support AMS, or could be further developed
- Using the results of this evaluation to identify risks, gaps and priorities for AMS, and to inform the AMS program plan.

Review governance arrangements

To ensure the best chance of program success, incorporate AMS within the service's quality improvement and patient safety plan.

Governance arrangements for the AMS program may involve coordination by the service's manager, with support from specialist credentialed medical and other practitioners, and/or a pharmacist, if available.

The committee overseeing AMS requires endorsement from the executive or governing body for formal structural alignment.

Review the AMS committee and team

The committee responsible for AMS oversees the effective implementation and ongoing function of the AMS program. Membership includes:

- A member of the executive as an executive sponsor, who can enable change
- Clinicians and other individuals who can provide day-to-day leadership.

The AMS team is the effector arm of the AMS program. Membership may include:

- The service's manager, a nurse, credentialed medical and other practitioners, a surgeon, an anaesthetic representative
- If available, a pharmacist; the pharmacist position may be part of a broader network or group, or contracted service, or accessed using telehealth systems.

Implement an AMS policy

Write or review, and implement, an AMS policy that:

- Specifies that prescribers must follow current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing, or evidence-based guidelines that have been endorsed by a state or territory AMS committee
- Incorporates processes for informing prescribers about prescribing requirements
- Incorporates the quality statements from the Antimicrobial Stewardship Clinical Care Standard
- Lists restricted antimicrobials and procedures for obtaining approval for use of these agents
- Specifies processes for monitoring antimicrobial use, resistance and appropriateness of prescribing, and providing feedback to prescribers
- References the health service organisation's policy on liaising with the pharmaceutical industry (see Action 4.1)
- Outlines systems for obtaining specialist advice for complex procedures or conditions
- Incorporates an audit and evaluation strategy for managing the policy's effectiveness, including assessment of AMS indicators that are relevant to the organisation, such as those suggested in the Antimicrobial Stewardship Clinical Care Standard
- Details governance arrangements; communication lines; and roles and responsibilities of facility leaders, the AMS committee and the AMS team
- Reflects the AMS program's integration within the organisation's safety and quality systems.

Decide on, and document, procedures for managing noncompliance with the policy.

Review policies relating to antimicrobial prescribing at least annually, or as changes in evidence or recommended practices are notified.

Plan the AMS program

The strategies below are aligned with those listed in Action 3.16.

Develop an AMS program plan based on the risks, gaps and priorities identified in the initial assessment and gap analysis. Ensure that the plan details:

- Procedures for prescription review and feedback to prescribers
- Goals, actions, time frames, and measurement and reporting activities
- Frequency of review and monitoring activities
- Process and outcome indicators or measures to monitor program effectiveness
- Roles, responsibilities and time frames for reporting on policy compliance, antimicrobial use and resistance, and prescribing according to guidelines
- Roles and responsibilities of governance, executive, leaders, managers and clinicians for meeting and evaluating identified priorities
- Resource allocation (for example, workforce, time, infrastructure) to support planned activities.

Ensure that clinicians who prescribe, dispense or administer antimicrobials are educated about the AMS program policy and plan at the start of their employment and at least annually.

Ensure access to current guidelines

Ensure that prescribing clinicians have access to, and follow, current guidelines and the local antimicrobial formulary for treatment and prophylaxis for common infections relevant to the patient population, the procedures performed and the local antimicrobial resistance profile. *Therapeutic Guidelines: Antibiotic*[85] is recognised as a national guideline for antimicrobial prescribing in Australia.

Provide clinicians with ready access to the current version of *Therapeutic Guidelines: Antibiotic* and the local antimicrobial formulary. To promote uptake, make guidelines available in print or online formats.

Ensure that any local clinical and prescribing guidelines are consistent with the recommendations in the latest version of *Therapeutic Guidelines: Antibiotic*, and take into account local microbial susceptibility patterns.

Review prescribing guidelines at least annually, or as changes are notified.

Review formulary, approval and restriction

Establish or review an antimicrobial formulary that aligns with recommendations in current evidence-based Australian therapeutic guidelines.

Specify restriction rules and approval processes within the formulary, including restriction of broad-spectrum and later-generation antimicrobials to patients in whom their use is clinically justified.

Ensure that the formulary specifies procedures for obtaining approval for use of restricted agents, and that systems are in place to inform prescribers of these procedures.

Incorporate the principles of the Antimicrobial Stewardship Clinical Care Standard into the AMS program

Review relevant clinical pathways to ensure that review of antimicrobial therapy and patient condition is included in the pathway. Set benchmarks for documenting in the patient's healthcare record the clinical reason; the medicine name, dose, route of administration and intended duration; and the treatment review plan.

Implement or review the process for reporting adverse events, incidents and near misses relating to antimicrobial use, including assessment and management of reported antibiotic–allergy mismatch.

Educate patients and carers about safe and appropriate use of antimicrobials, including potential adverse reactions and what to do in the event of a reaction.

Use process measures to monitor implementation of the AMS program, and to identify opportunities for improvement. Possible measures include Antimicrobial Stewardship Clinical Care Standard indicators[84] and quality use of medicines indicators.

Examples of evidence

Select only examples currently in use:

- Policy documents about the AMS program
- Examples of how the quality statements from the Antimicrobial Stewardship Clinical Care Standard have been incorporated into the AMS program
- Membership lists and role descriptions for the AMS committee and team
- Committee and meeting records in which performance of the AMS program was discussed
- Communication with the workforce promoting the use of current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing
- Observation that current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing are available to the workforce
- Training documents about AMS and attendance records
- Antimicrobial formulary that includes restrictions and approval procedures that align with current endorsed therapeutic guidelines
- Audit results of antimicrobial use, especially for high-risk antimicrobials or high-risk clinical areas
- List of high-risk antimicrobials used in the health service organisation or high-risk clinical areas.

Action 3.16

The antimicrobial stewardship program will:

a. Review antimicrobial prescribing and use

b. Use surveillance data on antimicrobial resistance and use to support appropriate prescribing

c. Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use

d. Report to clinicians and the governing body in relation to

- compliance with the antimicrobial stewardship policy
- antimicrobial use and resistance
- appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing

Reflective questions

What processes are in place to evaluate antimicrobial use?

How does the health service organisation use surveillance data on local antimicrobial resistance and use to support appropriate prescribing?

What actions have been taken to improve the effectiveness of the AMS processes?

How are data on prescribing and use of antimicrobials reported to clinicians and the governing body?

Key tasks

- Collect and regularly review data on antimicrobial use (volume and appropriateness) and local resistance to identify areas for improvement and ascertain the effectiveness of AMS interventions
- Monitor quality indicators to assess prescribing practice and AMS program effectiveness
- Use the results of monitoring activities to decide on priorities and actions for improvement
- Set up a system that ensures that feedback is provided to prescribers on results of monitoring and assessment activity
- Report routinely to the organisational governing body and the chief executive on AMS processes and outcomes.

Strategies for improvement

Monitoring and analysing antimicrobial use are critical to understanding patterns of prescribing, the impact on patient safety and antimicrobial resistance, as well as to measure the effectiveness of, and identify means to improve, the AMS program. Antimicrobial use can be measured in terms of quantity, quality (that is, appropriateness of prescribing according to guidelines) or expenditure.

Decide on areas for monitoring and improvement

Map current data collection systems to identify those that can be used to support monitoring and evaluation of AMS. Examples include:

- Pharmacy data collection systems – for information about trends in antimicrobial use
- Data on volume of use of antimicrobials
- Evaluation of medicines use
- Healthcare record systems
- Electronic medication management systems
- Pathology department audits
- Purchasing data for antimicrobials.

If possible, use data that are routinely collected to avoid duplication of effort.

Use the risk assessment principles outlined in Action 3.1 to decide on priority areas for monitoring and improvement. Monitor antimicrobial use appropriate to the scope of services and procedures undertaken in the day procedure service. Priorities

will include procedures associated with high levels of antimicrobial use or high-risk antimicrobials (for example, third-generation cephalosporins, carbapenems).

Conduct local audits and reviews as part of the AMS program plan, or participate in reviews and monitoring processes regarding antimicrobial use and resistance conducted by the Local Hospital Network, private hospital group, or state or territory.

Take part in state or territory, or national programs to monitor antimicrobial use and appropriateness that provide readily accessible audit and monitoring tools. Examples are:

- National Antimicrobial Utilisation Surveillance Program (NAUSP), which measures volume of antimicrobial use
- National Antimicrobial Prescribing Survey (NAPS), which measures appropriateness of prescribing, or the Surgical National Antimicrobial Prescribing Survey (SNAPS), which measures appropriateness of prescribing for surgical prophylaxis.

Work with clinical microbiology or pathology services to ensure reporting of selective susceptibilities, and review antimicrobial use data in association with resistance data to identify any patterns.

Act to improve prescribing

Support the AMS team to provide an AMS service that:

- Uses data from audits of prescribing and antimicrobial use to give feedback to clinicians on prescribing appropriateness, as part of AMS team or pharmacy review
- Publishes reports on antimicrobial use and appropriateness.

To inform local empirical therapy recommendations and formulary management, make antimicrobial susceptibility tables (antibiograms) available to clinicians and groups responsible for local antimicrobial therapy guidelines. Because antibiograms can be difficult to interpret, ensure appropriate expertise from clinical microbiologists or infectious diseases specialists to help analyse the antibiogram and plan appropriate actions. If antibiograms are used, they should be consistent with the national specifications for hospital-level cumulative antibiogram.[86]

Provide resources and tools at the point of care to promote appropriate antimicrobial prescribing, such as:

- Posters targeting both prescribers and patients
- Laminated cards or pocket cards.

Implement or review clinical pathways for specific procedures and conditions.

Require all new prescribers to complete the NPS MedicineWise antimicrobial modules.

Communicate about safe and appropriate use of antimicrobials:

- Provide regular updates about the AMS program to members of the clinical workforce using different methods, such as newsletters, screensavers, meetings and posters
- Take part in annual Antibiotic Awareness Week activities
- Ensure that patients and carers receive current Australian education materials on safe and appropriate use of antimicrobials.

Set up systems for communication about patient care and antimicrobial management with other treating clinicians and caregivers. This is particularly important for transitions of care, and includes internal communication, and external communication with general practitioners, members of the aged care workforce and other prescribers.

Monitor and evaluate the AMS program

Use the quality improvement framework outlined in Action 3.2 to evaluate the AMS program, and identify opportunities and actions for improvement.

Use process and outcome measures to monitor and evaluate the program. Possible process measures include:

- Antimicrobial Stewardship Clinical Care Standard indicators[84]
- Quality use of medicines indicators[87]
- Infection- or antimicrobial-related incidents (for example, sentinel events such as *Staphylococcus aureus* bacteraemia, or adverse events relating to antimicrobial administration or dosing).

Possible outcome measures include:

- *S. aureus* bacteraemia–related mortality
- Infection-related readmissions (for example, joint replacement surgery)
- Reduced antimicrobial expenditure.

Contribute data on antimicrobial use and appropriateness to relevant programs to enable benchmarking as part of program evaluation. Depending on the type of service, relevant programs could include:

- Programs undertaken between like services across provider groups
- State or territory programs
- National programs such as the Surgical NAPS or NAUSP.

Report on AMS program processes and outcomes

Responsibility for monitoring the effectiveness of the AMS program and ensuring accountability for actions lies with the governing body of the organisation. The governing body also has a role in allocating resources to achieve program goals and outcomes.

Provide a report every year to the chief executive and governance units that summarises:

- Current AMS resources
- AMS team activity
- Performance against process and outcome indicators for antimicrobial use, appropriateness and resistance
- Key areas of improvement
- Areas for further improvement or priority
- Areas in which guidance or support from the chief executive and the governing body is needed.

Refer to *Antimicrobial Stewardship in Australian Hospitals*[83] and *NSQHS Standards Guide for Hospitals* for more detailed implementation strategies for this action.

Examples of evidence

Select only examples currently in use:

- Committee and meeting records in which compliance with the AMS policy, and antimicrobial prescribing and use were discussed, including reviews of surveillance data
- Results of analysis of surveillance data on antimicrobial resistance and use
- Results of NAPS or other audits and surveys about appropriateness of prescribing
- Improvement activities for AMS that have been implemented and evaluated
- Communications with clinicians on antimicrobial use, resistance and stewardship in the health service organisation.

Resources

Healthcare-associated infection

Australian Commission on Safety and Quality in Health Care – National Surveillance Initiative

Hand Hygiene Australia

National Health and Medical Research Council – *Australian Guidelines for the Prevention and Control of Infection in Healthcare*

National Health and Medical Research Council – *The Australian Immunisation Handbook*

Antimicrobial stewardship

Australian Commission on Safety and Quality in Health Care – Antimicrobial Stewardship Clinical Care Standard

Australian Commission on Safety and Quality in Health Care – *Antimicrobial Stewardship in Australian Hospitals*

Australian Commission on Safety and Quality in Health Care – *Options for Implementing Antimicrobial Stewardship in Different Facilities*

National Antimicrobial Prescribing Survey (NAPS) and Surgical National Antimicrobial Prescribing Survey (SNAPS)

NPS MedicineWise antimicrobial modules

SA Health – National Antimicrobial Utilisation Surveillance Program (NAUSP)

Therapeutic Guidelines Limited – *Therapeutic Guidelines: Antibiotic*

4

Medication Safety Standard
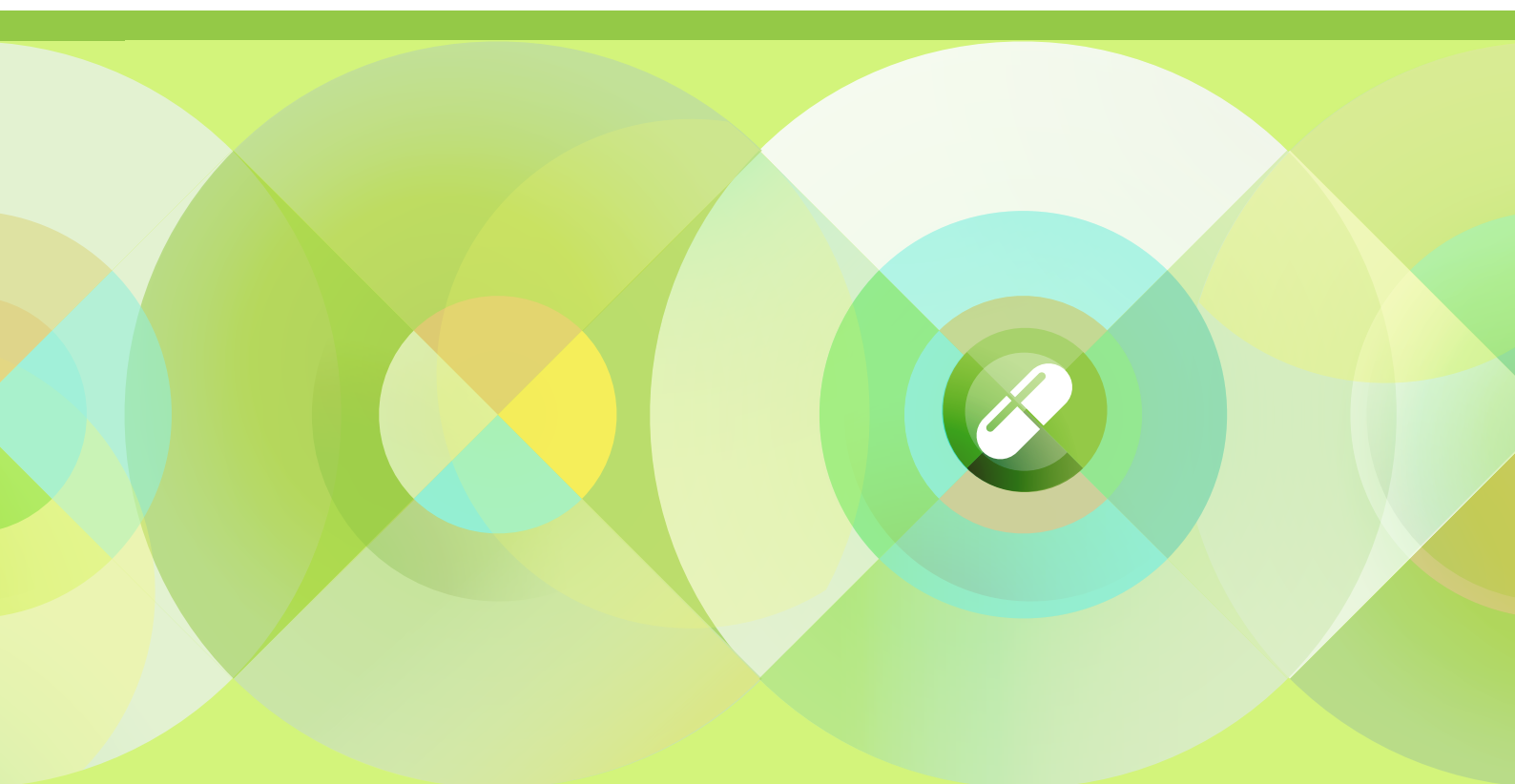
Medication Safety Standard

Leaders of a health service organisation describe, implement and monitor systems to reduce the occurrence of medication incidents, and improve the safety and quality of medication use. The workforce uses these systems.

Intention of this standard

To ensure clinicians are competent to safely prescribe, dispense and administer appropriate medicines and to monitor medicine use. To ensure consumers are informed about medicines and understand their individual medicine needs and risks.

Criteria

Clinical governance and quality improvement to support medication management

Documentation of patient information

Continuity of medication management

Medication management processes

Introduction

Medicines are the most common treatment used in health care. Although appropriate use of medicines contributes to substantial improvements in health, medicines can also be associated with harm.[88] Because they are so commonly used, medicines are associated with a higher incidence of errors and adverse events than other healthcare interventions. Some of these events are costly, in terms of morbidity, mortality and resources. Up to 50% are potentially avoidable.[89]

Scope of this standard

The Medication Safety Standard addresses areas of medication management that have a known risk of error, often as a result of unsafe processes and variation in clinician practices.

The Medication Safety Standard requires health service organisations to assess medication management, and implement processes and practices that:

- Provide for sound governance for the safe and quality use of medicines
- Minimise the occurrence of medicine-related incidents and the potential for patient harm from medicines
- Ensure that competent clinicians safely prescribe, dispense and administer medicines, and monitor their effects
- Inform patients about their medicines and involve them in decision-making.

Key links with other standards

The Medication Safety Standard should be applied in conjunction with other NSQHS Standards, including the Clinical Governance Standard and the Partnering with Consumers Standard.

Synergies with other NSQHS Standards will also need to be identified. This will ensure that medication safety and quality systems, and policies and processes for medication management are integrated, to reduce duplication of effort.

Medication management pathway

Medication management involves prescribing, dispensing, administering and monitoring medicines. Medication management is complex and involves several different clinicians. Often referred to as the medication management pathway, it comprises multiple activities and three system processes to manage the safe and effective use of medicines for patients at each episode of care (Figure 1).[90,91]

Safe processes and practices are required for all activities in the medication management pathway. These activities include procuring, supplying, storing, compounding, manufacturing, prescribing, dispensing, administering and monitoring the effects of medicines.

The consumer is the central focus of the medication management pathway. Health service organisations should apply the principles of partnering with consumers, health literacy and shared decision making when developing, reviewing and implementing processes or practices within the medication management pathway.

The pathway provides a framework for:

- Identifying when there is potential for errors or risk of harm
- Responding with strategies to reduce the opportunity for error.

To ensure safe and effective use of medicines within the health service organisation, identify opportunities for patient harm and implement strategies to prevent medicine-related errors. Steps taken early in the medication management pathway can prevent adverse events occurring later in the pathway.

Figure 1: Medication management pathway
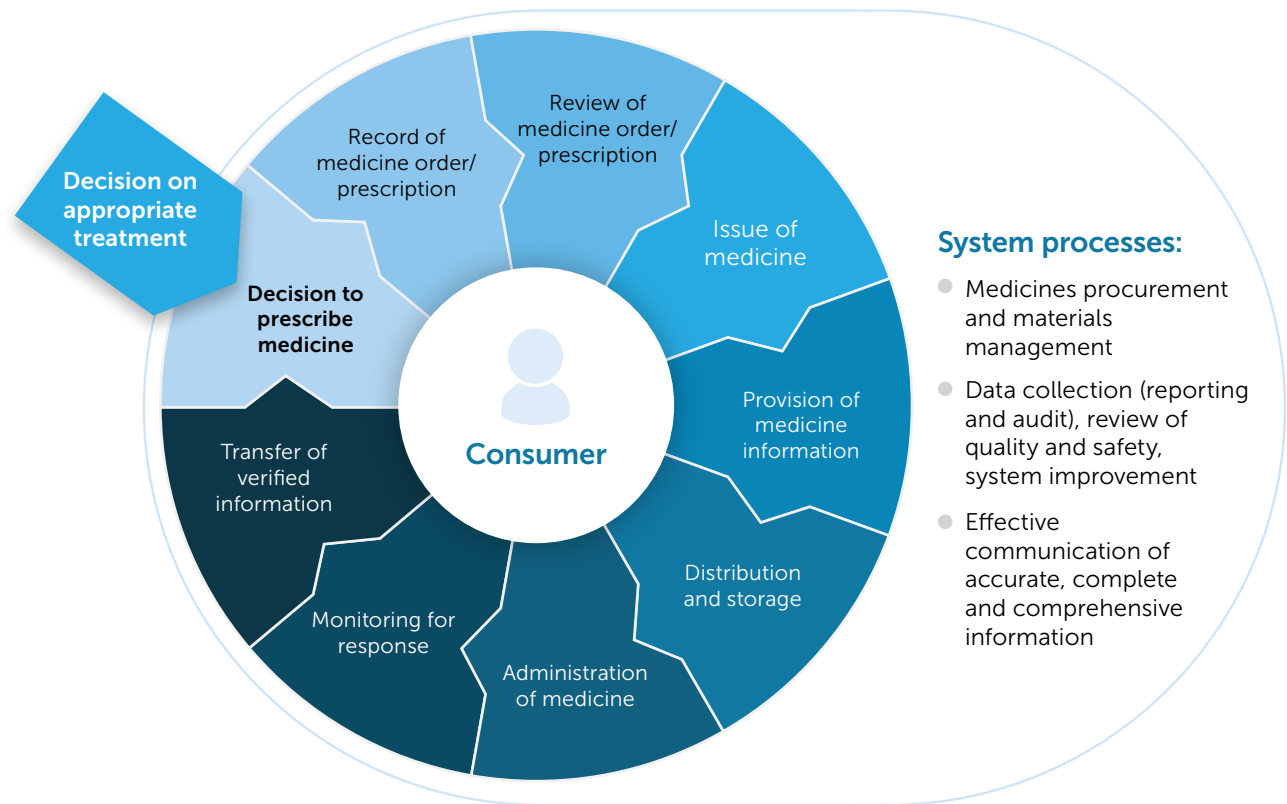
Source: Adapted from Australian Pharmaceutical Advisory Council[91]

CRITERION: Clinical governance and quality improvement to support medication management

Organisation-wide systems are used to support and promote safety for procuring, supplying, storing, compounding, manufacturing, prescribing, dispensing, administering, and monitoring the effects of, medicines.

This criterion requires organisation-wide governance, leadership and commitment to support the safe and effective use of medicines.

To meet this criterion, health service organisations are required to:

- Apply safety and quality systems to support medication management
- Use quality improvement systems to monitor, review and improve medication management

- Apply principles of partnering with consumers when designing and implementing systems for medication management
- Define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians
- Train, educate and support clinicians to understand their roles and accountabilities in delivering safe and effective use of medicines.

This criterion aligns closely with the Clinical Governance Standard and the Partnering with Consumers Standard.

Meeting the Medication Safety Standard may require the organisation to introduce new processes or modify existing processes and practices to reduce

the risk of medication error. This may require local project teams to oversee, plan and coordinate assessment, implementation and evaluation. Project teams should be multidisciplinary and include clinicians responsible for various medication management activities. Partnering with patients and carers in these processes can result in improved services and a higher level of satisfaction.[92]

Ongoing monitoring and evaluation of the safety, quality and performance of medication management systems are also necessary to track changes over time, ensure that systems continue to operate effectively and identify areas for improvement. Data from evaluation of medication management should be communicated back to clinicians. They can focus clinicians on areas that need improvement, and motivate them to change practice and take part in improvement activities.[93-95] Feedback processes also contribute to a culture of transparency and accountability.

Integrating clinical governance

Action 4.1

Clinicians use the safety and quality systems from the Clinical Governance Standard when:

a. Implementing policies and procedures for medication management

b. Managing risks associated with medication management

c. Identifying training requirements for medication management

Reflective questions

How are the health service organisation's safety and quality systems used to:

- Ensure appropriate governance of medication management
- Support development and implementation of policies and procedures for medication management
- Identify and manage risks associated with medication management
- Identify training requirements for medication management?

Key tasks

- Set up and implement governance structures for medication management
- Develop and implement policies and procedures for medication management
- Use organisation-wide risk management systems to identify, monitor, manage and review risks associated with medication management
- Provide access to training on medication management based on the specific needs of the workforce, including medicine-related information and decision support tools.

Strategies for improvement

The Clinical Governance Standard has specific actions relating to health service organisations' safety and quality systems.

Action 1.7 – policies and procedures

Action 1.10 – risk management systems

Actions 1.19, 1.20 and **1.21** – education and training

Health service organisations should:

- Use these and other established safety and quality systems to support policies and procedures, risk management, and training for medication management

- Ensure that current versions of all relevant policies and procedures are readily available and accessible to clinicians.

Policies may be developed or adapted at different levels within the organisation. However, all policy documents should be incorporated into a single, coherent set to maximise the effectiveness of the policy development process.

Review governance for medication management

Health service organisations are expected to have a governance group with responsibility for medication management, including formally reporting to the organisation's clinical governance or managers. This is usually a drug and therapeutics committee, or a committee with a similar name and intent (for example, quality use of medicines committee, medication safety committee, medication advisory committee).

The governance arrangements for day procedure services may be less formal, but owners still have the responsibility to ensure that appropriate systems are in place, so that the service provides safe and high-quality care.

A suitable medication management governance group could comprise the service's manager, specialist credentialed medical and other

practitioners (including an anaesthetist in day surgeries), a nurse and a pharmacist (if available).

If possible, the medication management governance group should:

- Be multidisciplinary
- Have membership that reflects the size of the organisation and the services provided
- Have consumer representation or membership.[96,97]

Medication management governance groups have an important role in:

- Developing, reviewing and overseeing medicine-related policy
- Developing the organisation's medication safety and quality improvement strategies
- Monitoring quality improvement activities.

Medication management governance groups should work to ensure organisation-wide safe and quality use of medicines, including:

- Monitoring occurrence of medicine-related incidents
- Implementing risk reduction strategies
- Implementing technology such as electronic medication management, 'smart' infusion pumps and medicine libraries
- Overseeing the evaluation and selection of medicines that are suitable for use in the day procedure service (for example, anaesthetics)
- Managing contract arrangements, including those with external organisations that provide medication management services (for example, community pharmacies).

Resources such as *Achieving Effective Medicines Governance: Guiding principles for the roles and responsibilities of drug and therapeutics committees in Australian public hospitals*[97] provide guidance for establishing and reviewing the structure, operation and processes (that is, the terms of reference); communications; and resources for an effective governance group responsible for medication management.

Review existing governance arrangements for medication management. Ensure that responsibility for implementing and monitoring the decisions of the medication management governance group is clearly defined.

High-risk medicines, and high-risk procedures involving medicines, pose considerable risk to patient safety and may require a specific resource that aims to minimise medicine-related risks. Consider designating a member of the workforce as the medication safety officer to liaise with external organisations contracted for medication management services to ensure safe procurement and supply of medicines (for example, anaesthetics).

In the absence of on-site pharmacy services, this responsibility would need to be assigned to a member of the governance group or the service's manager. It may be useful to approach the local community pharmacist who might be involved in the supply of medicines or the local hospital (public or private) for pharmacist expertise or input on a sessional basis.

Implement policies and procedures

Policies, procedures and guidelines for medication management should be built on the National Medicines Policy[98] and *Guiding Principles to Achieve Continuity in Medication Management*.[91] Policies and procedures should be consistent with legislative and evidence-based documentation as it relates to safe medicine:

- Procurement, supply, storage and disposal
- Prescribing, dispensing and administration
- Reconciliation, review and monitoring of effects, where required.

Other policies, procedures and guidelines may include:

- List of approved medicines (formulary)
- Procedures for managing high-risk medicines (for example, administration of medicines in high-risk domains such as paediatrics, anaesthetics and chemotherapy)
- Recording of a best possible medication history (BPMH)
- Use of standard forms such as national standard medication charts
- Provision of information about medicines to patients
- Liaison with the pharmaceutical industry
- Use of oral dispensers for administering oral medicines
- User-applied labelling

- Avoiding use of abbreviations
- Safe implementation and use of electronic medication management
- Use of standardised electronic display of clinical medicines information
- Management and reporting of medication incidents and suspected adverse drug reactions (ADRs)
- Management of services contracted with external pharmacy providers.

Ensure that current versions of all medicine-related policies, procedures and protocols are readily available and accessible to clinicians.

Manage risks

Use established risk management systems (Action 1.10) to identify, monitor, manage and review risks associated with medication management. Develop processes to manage clinical risks for different populations served by the organisation, clinical and workplace risks for the workforce, and organisational risks. Ensure that medication safety risks are recorded and can be identified in the organisation's risk management system.

Use information from the measurement and quality improvement system, adverse events, clinical outcomes and patient experiences to inform and update risk assessments and the risk management system.

The medication management pathway (Figure 1) provides a framework for idenfying and managing risks of harm and medicine-related errors.

Identify training requirements

Assess the competency and training needs of the workforce in line with the requirements of Actions 1.19, 1.20 and 1.21. Perform a risk assessment to inform the training schedule and to set priorities for the members of the workforce who require training. This will include clinicians and any other employed or contracted members of the workforce who are involved in medication management (for example, medicines procurement workforce). Develop or provide access to training and education resources to meet the needs of the workforce regarding medication management.

Training the workforce in risk identification, incident management and investigation systems and quality improvement will support safe use of medicines.

Use ongoing education programs to supplement existing knowledge and skills to inform clinicians about:

- Medication safety risks identified from incident monitoring, risk assessments, or national, state or territory medication safety directives, alerts and information
- Strategies to reduce the risks.

Ongoing education could cover medication safety topics and known risk mitigation strategies, such as:

- Using national standard medication charts
- Taking a BPMH
- Managing high-risk medicines
- Checking procedures (for example, independent double-check)
- Documenting known and new allergies and ADRs
- Preventing medication errors or incidents
- Safely preparing and administering medicines, including labelling injectable medicines, fluids and lines.

The local community pharmacy or the local hospital (public or private) could be approached for pharmacist expertise to participate in educating and training clinicians, including their orientation.

Review training programs for clinicians that relate to safe medication management practices. Ensure that training includes:

- Education on the common causes of medication incidents and how to make medicine use safer
- The different levels of knowledge and skills required by different clinicians
- How and where to access evidence-based medicine-related information and decision support tools
- Training on medication safety during orientation of new clinicians (for example, medical and nursing)
- Competency assessment.

See the Resources section at the end of this standard for links to further information.

Examples of evidence

Select only examples currently in use:

- Policy documents about medication management that are accessible to the workforce
- Observation of clinicians' practice that demonstrates use of the health service organisation's processes for medication management
- Records of interviews with clinicians that show that they understand the health service organisation's processes for medication management
- Committee and meeting records relating to medication safety
- Terms of reference and membership of the governance group or committee responsible for medication safety
- Documents that detail responsibilities for organisation-wide medication safety systems at all levels of the organisation
- Employment documents that outline the roles, responsibilities and accountabilities for clinical and organisational medication management activities
- Training documents about medication management and medication safety
- Reports from an incident management and investigation system, including analysis of incident data and trends relating to medication management
- Risk management system that includes actions to manage risks identified in medication management.

Applying quality improvement systems

Action 4.2

The health service organisation applies the quality improvement system from the Clinical Governance Standard when:

a. Monitoring the effectiveness and performance of medication management

b. Implementing strategies to improve medication management outcomes and associated processes

c. Reporting on outcomes for medication management

Reflective questions

How are the effectiveness and performance of medication management monitored and improved?

How are the outcomes of improvement activities communicated to the governing body, the workforce, consumers and other organisations?

Key tasks

- Review, measure, and assess the effectiveness and performance of, medication management strategies and practices
- Implement quality improvement strategies for medication management based on the outcomes of monitoring activities
- Provide information on the outcomes of quality improvement activities to the governing body, the workforce, consumers and other organisations.

Strategies for improvement

The Clinical Governance Standard has specific actions relating to health service organisations' quality improvement systems.

Action 1.8 – quality improvement systems

Action 1.9 – reporting

Action 1.11 – incident management and investigation systems

Health service organisations should use these and other established safety and quality systems to support monitoring, reporting and implementation of quality improvement strategies for medication management.

Safe medicine use requires:
- An understanding of the risks and barriers in the medication management pathway (Figure 1)
- Routine collection and monitoring of data to measure the performance of the medication management pathway, and act if required
- Mechanisms for learning from medication incidents and from identified risks in the medication management pathway that could jeopardise patient safety
- Mechanisms to show that the risk reduction strategies in place improve the safety and performance of medication management

- Careful planning when introducing new technology (for example, electronic medication management).

Monitor effectiveness and performance

Medication safety self-assessments are an important monitoring activity to identify structure, system and communication opportunities to proactively reduce harm and target risk mitigation strategies. Use the organisation's quality improvement systems to identify and prioritise the organisational and clinical strategies for medication management. Use assessment tools such as Medication Safety Self Assessment® for Australian Hospitals or other internationally or locally developed (and endorsed) tools, to self-assess all or part of the organisation's medication management pathway. Medication Safety Self Assessment® tools are also available in specialist domains such as oncology and antithrombotic therapy – two areas of high risk for medication error and adverse events (linked to Action 4.15).

Areas to assess may include:

- Practices associated with procurement through to storage and destruction of unwanted medicines (including high-risk medicines – Action 4.15)
- Quality of, and access to, medicine-related information resources, decision support tools and documentation (for example, BPMH – Action 4.5)
- Information for patients (Actions 4.3, 4.11 and 4.12).

Use a multidisciplinary team that includes frontline members of the workforce to conduct the assessment and obtain information on barriers to managing medicines safely. Review the results and compare them with any previous baseline assessments or audits to determine the impact of medication safety strategies.

Other monitoring actions may include:

- Establishing a list of medicine-related indicators that reflect the organisation's usual range of medicines and their risk, along with the performance of medication management; use validated indicators such as the National Quality Use of Medicine Indicators for Australian Hospitals.

- Using failure mode and effects analysis as a (prospective) proactive and 'preventive' process (see information from the Institute for Safe Medication Practices and the Institute for Healthcare Improvement)
- Auditing compliance with medication safety policies and procedures – for example, the use of cognitive impairment, delirium and falls assessment tools with respect to medicine use; or completion of venous thromboembolism risk assessment
- Conducting observation audits and walk-arounds to identify where corrective action might be required when breaches, violations or practice variations are observed
- Assessing the use of technology (for example, electronic medication management)
- Monitoring the occurrence of, analysing the frequency and causes of, and reporting on, medicine-related incidents, including ADRs (related to Actions 4.7–4.9)
- Capturing pharmacist interventions and using the data to identify further opportunities to improve medication management processes
- Collating feedback (including complaints) from surveys, focus groups, and the organisation's feedback and complaints management systems
- Seeking feedback on the quality, suitability and range of the medicine-related information provided to patients (for example, leaflets, brochures, medicines lists)
- Reassessing the system (or relevant components) regularly according to local, state or territory, or national requirements.

Implement quality improvement strategies

Use local, state or territory, national and international resources to identify solutions or risk mitigation strategies that might be useful, transferable and adaptable (links to Action 4.1).

Review the strategies for medication management to ensure that:

- Risks identified using the assessment, audit, survey and feedback mechanisms are logged in the risk management system
- Actions required to deal with any problems have been developed and included
- Responsibilities have been assigned.

Tools such as *Pathways for Medication Safety: Leading a strategic planning effort*[99] provide guidance on a model strategic plan for medication safety.

Eliminating error is a challenge. Strategies to reduce risks are detailed in Selecting the best error-prevention 'tools' for the job.[100]

Report on outcomes

Report evaluation findings, adverse events and quality improvement activities to the governing body and the workforce. Use the data to work with consumers, the workforce, clinical leaders and managers to identify and implement improvements to the system for comprehensive care.

Report on trend analysis (frequency and causes) of medicine-related incidents, including ADRs.

Examples of evidence

Select only examples currently in use:

- Results of trend analyses of incident data on medication management systems

- Results of workforce and patient experience surveys relating to medication management
- Quality measures and tools developed to evaluate medication management systems
- Reports to the highest level of governance and the workforce about the evaluation and assessment of performance of medication management systems
- Actions taken to improve the safety of medication management systems
- Evidence of risk assessments, evaluations and actions taken to implement new tools or processes for medication management (for example, implementation of electronic medication management)
- Audits of compliance with medication management policies and procedures
- Results of observation audits or walk-arounds
- Examples of action taken as a result of feedback (including complaints) from surveys or focus groups.

Partnering with consumers

Action 4.3

Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to:

a. Actively involve patients in their own care

b. Meet the patient's information needs

c. Share decision-making

Reflective questions

What processes from the Partnering with Consumers Standard do clinicians use to involve patients in planning and making decisions about their medication management?

How does the health service organisation ensure that patients are provided with medicine-related information tailored to their needs and health literacy?

Key tasks

- Review strategies in the Partnering with Consumers Standard to inform the implementation of actions in the Medication Safety Standard
- Provide information to patients about medication management tailored to their specific needs and level of health literacy.

Strategies for improvement

> The Partnering with Consumers Standard has specific actions (**Actions 2.3–2.10**) relating to health service organisations' processes for involving patients in their own care, shared decision making, informed consent and effective communication.

The patient is the focus of the medication management pathway (Figure 1). Health service organisations should apply the principles of partnering with consumers, health literacy and shared decision making when developing, reviewing and implementing processes or practices within the medication management pathway.

Health service organisations should use established processes to partner with patients at key points in the medication management pathway, including when:

- Taking a BPMH (Action 4.5)
- Documenting a patient's history of medicine allergies and ADRs (Action 4.7)
- Assessing a patient's clinical needs for medication review (Action 4.10)
- Providing information to patients on their individual medicines needs and risks (Action 4.11)
- Providing patients with a current medicines list on discharge (Action 4.12).

Refer to the implementation strategies under each relevant action for more details.

Provide information for patients

Ensure that patients and carers have enough information about treatment options to make informed choices about their medicines and to adhere to medicine-related treatment plans. Providing patient information is the responsibility of everyone involved in the administration and prescribing processes, and when a medicine is dispensed. Provision of medicine-related information to a patient should be recorded in the patient's healthcare record.

Provide information in a form that is meaningful, easy to understand and use, and tailored to the diversity of the organisation's patient population. Consider the different languages used in the local community when selecting and developing medicine-related information for patients.

Action 4.11 contains specific strategies relating to the provision of information to patients on their individual medicines needs and risks. Organisations should refer to strategies in Action 4.11 when implementing Action 4.3.

Shared decision making

Shared decision making can only occur when a patient understands what medicines are being proposed, the need for a new medicine, and why a change to therapy (including a dose change or ceasing a medicine) is being recommended.

Patients need to be involved in setting treatment goals and supported to understand the proposed outcomes of treatment.

Discussion about medicines should include:

- Duration of treatment
- Whether the medicine will cure their illness, or is required to control the symptoms of their chronic illness
- Untoward effects (for example, side effects, pain on administration) that the medicine may have.

Use the strategies outlined in Action 2.5 to identify and support patients who do not have the capacity to understand the risks of medicine use or make decisions about their care.

Examples of evidence

Select only examples currently in use:

- Policy documents that describe the processes for gaining patient consent, or consulting with substitute decision-makers, for the administration of medicines
- Policy documents about consumer engagement in medication management
- Observation of clinicians' practice that shows use of the health service organisation's processes for partnering with consumers

- Records of interviews with clinicians that show that they understand the health service organisation's processes for partnering with consumers
- Samples of medicine-related information resources for patients, carers and families that meet the requirements in the health literacy actions of the Partnering with Consumers Standard

- Examples of clinical documentation that provide evidence of shared decision making about medication management
- Results of patient experience surveys about medication management.

Medicines scope of clinical practice

Action 4.4

The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians

Reflective questions

What processes does the health service organisation use to ensure that only clinicians with the relevant authority prescribe, dispense or administer medicines?

What processes are used to ensure that clinicians are competent and operating within their individual scope of clinical practice?

Key tasks

- Identify all areas where specific authorisation is required to prescribe, dispense or administer medicines
- Use organisation-wide credentialing and scope of clinical practice processes to ensure that only authorised members of the workforce can prescribe, dispense or administer medicines
- Regularly assess qualifications, credentials and competence of the clinical workforce to safely prescribe, dispense and administer medicines.

Strategies for improvement

Credentialing and scope of clinical practice processes are key elements in ensuring patient safety. The aim is to ensure that only health practitioners who are suitably experienced, trained and qualified to practise in a competent and ethical manner can practise in health service organisations.[22]

The Clinical Governance Standard has specific actions for credentialing and scope of clinical practice.

Action 1.23 – scope of clinical practice

Action 1.24 – credentialing

Health service organisations should use these established systems and processes to support the implementation of this action.

Processes must be in place to ensure that only clinicians with the requisite authority prescribe, dispense and administer medicines. This authority is defined by both national and state and territory legislation. For many clinicians, this authority will be registration with the Australian Health

Practitioner Regulation Agency (AHPRA). In some circumstances, the authority to administer medicines may be given by a state or territory. For example, registered nurses might be able to initiate and administer a limited selection of medicines without a prescription as part of a nurse-initiated medicines list.

The health service organisation may be responsible for establishing the qualifications and competence required by clinicians and other members of the workforce working in extended roles – for example, nurses qualified to administer chemotherapy, clinicians authorised to administer intrathecal injection of chemotherapy, and nurses authorised to administer medicines against standing orders.

Clinicians' scope of clinical practice is likely to be defined by their professional background, qualifications, credentials or authority, acknowledged through AHPRA registration or endorsement.

An endorsement of registration recognises that a person has additional qualifications and expertise in an approved area of practice, and/or is provided for scheduled medicines.[101] See the AHPRA *Endorsement of Registration* fact sheet for more information.

Use organisation-wide credentialing and scope of clinical practice processes to support:

- Identification and description of all areas where specific authorisation is required to prescribe, dispense or administer medicines
- Assessment of qualifications and competencies at recruitment
- Inclusion of a clear definition of scope of clinical practice in job descriptions and contracts of employment
- Development and maintenance of a log or register for individual professions or positions for which an authority is required to prescribe, dispense or administer medicines.

Review organisational policies, procedures and guidelines to ensure regular assessment of qualifications and competence of clinicians to safely prescribe, dispense and administer medicines.

Consider strategies such as:

- Providing extra training and competency assessment when new medicines or formulations are introduced and when implementing electronic medication management

- Using simulation training for members of the workforce when they start work or if they are required to work under supervision.

Examples of evidence

Select only examples currently in use:

- Policy documents about scope of clinical practice for prescribing, dispensing and administering medicines
- List of the individual workforce members with authority to prescribe, dispense or administer medicines
- Employment documents that describe the responsibilities, accountabilities and scope of clinical practice of the workforce in medication management
- Records of competency assessments of the workforce where medication authority requires demonstration of competence
- Audit results of compliance with the authority to prescribe, dispense or administer medicines
- Committee and meeting records in which the scope of clinical practice for medicines was considered.

CRITERION: Documentation of patient information

A patient's BPMH is recorded when commencing an episode of care. The BPMH, and information relating to medicine allergies and ADRs are available to clinicians.

Ideally, all patients will receive a comprehensive medicines assessment before any decision to prescribe a new medicine.

Best possible medication history and medication reconciliation

A key component of this assessment is obtaining a thorough medication history, or a BPMH.

The BPMH is a snapshot of the patient's actual medication use, which may be different from information in their healthcare record, in the medicines list held by the patient, or provided by the patient's general practitioner. It is vital that the patient (or carer) is actively involved and that the health service organisation has a formal, systematic process in place for obtaining a BPMH.[102]

A BPMH is essential for:

- Ensuring continuity of medication management
- Identifying medicine-related problems
- Identifying potential medicine-related discrepancies
- Informing the decision-making process
- Optimising the use of medicines.

Medication histories are often incomplete, with medicines, strengths and doses missing, and over-the-counter and complementary medicines often omitted. Instituting a formal, systematic process for obtaining a BPMH on admission, and reconciling this history against the patient's medicines ordered on the medication chart reduces medication errors on admission by more than 50%.[103]

Reconciling medicines at care transition points has been shown to reduce medication errors by 50–94%.[104,105]

If not corrected, the errors can persist throughout the episode of care and after discharge. Inaccurate medication histories can lead to discontinuation of therapy, recommencement of medicines that have

been ceased, inappropriate orders and failure to identify a medicine-related problem.

For day procedure services, the BPMH can be documented as part of the pre-admission process.

The medication management plan (MMP) is designed to document the BPMH and record the key steps of medication reconciliation. It is suitable for use in both adult and paediatric settings. The 'Medicines taken prior to presentation to hospital' section on the front of the National Inpatient Medication Chart – day surgery (NIMC) may also be used to record the BPMH. Health service organisations may also develop alternative hard-copy or electronic forms – for example, within an electronic medication management system.

The MMP or equivalent form should be stored with the current NIMC throughout the episode of care.

Medicine allergies and adverse drug reactions

Medicine allergies and ADRs can be classified as:

- Known – those that have been previously experienced by the patient before their episode of care
- New – those that are experienced by patients during their episode of care and have not been previously experienced or documented.

The administration of medicines to patients with a known medicine allergy or previous ADR can be prevented by having mechanisms in place for alerting clinicians who prescribe, dispense and administer medicines. Information on a patient's known medicine allergies and ADRs can be collected on presentation to the health service organisation and recorded in the BPMH. Any new medicine allergies or ADRs should be recorded in the same place.

If there is any doubt about the nature of a medicine allergy (for example, an allergy to an antibiotic), there must be a process for clinicians to challenge and verify the diagnosis of true allergies. If a patient is not allergic, the patient's history and healthcare record will need to be modified, including removal of allergy alerts.[106]

Medicine allergies and ADRs are included in the definition of an adverse drug event. If a patient is given a medicine that is contraindicated (that is, there is a known allergy or ADR), they are at risk of experiencing preventable harm.[107]

To minimise the risk of preventable harm from adverse drug events, it is critical to ensure that clinicians understand their responsibility to refer to a patient's medicine allergy and ADR history before, or at the point of, decision-making when prescribing, dispensing or administering medicines.

All adverse drug events are expected to be reported using the organisation's incident monitoring system. Clinicians are also expected to report new suspected ADRs to the Therapeutic Goods Administration

(TGA) – this provides important information about possible adverse effects for the TGA's safety monitoring program.

Actions within this criterion require organisations to:

- Have a formal, systematic process in place for obtaining and recording a 'snapshot' of the patient's actual medicines use
- Ensure that clinicians reconcile the medicines and any discrepancies on presentation and at transitions of care
- Ensure that clinicians are supported to identify and document known and new medicine allergies and ADRs, and report adverse drug events and new or suspected ADRs.

Medication reconciliation

Action 4.5

Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care

Reflective questions

What processes are used to obtain and record a BPMH in the patient's healthcare record?

How does the health service organisation evaluate the quality of patient involvement in the process of obtaining a BPMH?

Key task

- Implement a systematic process for obtaining the patient's actual medicines use and recording a BPMH.

Strategies for improvement

Complete a BPMH as part of the pre-admission screening process or as early as possible on admission. At least two sources of information are needed to obtain and then confirm the patient's BPMH – for example, the patient and the referring clinician or community pharmacist.

A BPMH should be completed, or the process supervised, by a clinician with the required skills and expertise. Policies, procedures and guidelines for obtaining a BPMH should include:

- A structured interview process
- The key steps of the process
- Documentation requirements (where and what should be documented, such as use of the MMP or equivalent; paper or electronic)
- Roles and responsibilities of clinicians
- Training requirements for clinicians
- Involvement of patients and carers (links to Action 4.3).

Use a standard form for recording the BPMH. The BPMH can be documented on the 'Medicines taken prior to presentation to hospital' section on the front of the NIMC or in the preoperative medical record. It should be placed in a designated area of the patient's healthcare record. This creates 'one source of truth', and acts as an aid to reconciliation on admission and on discharge.

Consider training requirements to ensure that clinicians with responsibility for obtaining a BPMH are sufficiently competent. Learning modules and instructional videos are available from various state, national and international organisations – links are provided in the Resources section at the end of this standard. These can guide clinicians on using a systematic approach to obtain and record an accurate and complete history of the medicines taken by patients at home, noting that specific techniques for taking a BPMH can influence its accuracy.

In day procedure services, a BPMH may be taken during the pre-admission process. Pharmacists or specialist services could be contracted by the day procedure service to provide training for other clinicians.

Examples of evidence

Select only examples currently in use:

- Policy documents about obtaining and documenting a BPMH
- Audit results of healthcare records for documentation of a BPMH
- Evidence that BPMHs are documented in a standard place (hard copy or electronic), such as the MMP
- Evaluation report on the quality of patients' involvement in, and contribution to, the process of obtaining a BPMH
- Training documents about taking and documenting a BPMH
- Records of competency assessments of the workforce in taking and documenting a BPMH.

Action 4.6

Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care

This action will not be applicable for day procedure services that provide evidence that they are not changing or altering patients' medicines during an episode of care.

Reflective questions

What processes are in place to ensure that clinicians review their patients' current medication orders against the BPMH?

How and where are discrepancies with a patient's medicines documented and reconciled?

How are changes to a patient's medicines, and the reasons for change, documented and communicated at transfer of care or on discharge?

Key tasks

Review organisational policies, procedures and guidelines on medication reconciliation. These should include:

- Key steps of the medication reconciliation process when care is transferred
- Roles and responsibilities of clinicians
- Training requirements for clinicians who are responsible for reconciling medicines
- Involvement of patients and carers.

Only clinicians with the requisite knowledge, skills and expertise should conduct medication reconciliation. These clinicians should be able to show competence in each of the steps of medication reconciliation.

Refer to *NSQHS Standards Guide for Hospitals* for more detailed implementation strategies for this action.

Examples of evidence

Select only examples currently in use:

- Policy documents about medication reconciliation on admission, at transitions of care and on discharge

- Tool or form (hard copy or electronic) used for medication reconciliation
- Audit results of documentation of medication reconciliation
- Training documents about medication reconciliation and workforce training attendance records.

Adverse drug reactions

Action 4.7

The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation

Reflective questions

How does the health service organisation ensure that a patient's history of medicine allergies and ADRs is recorded when taking a BPMH on presentation?

How do clinicians who prescribe, dispense or administer medicines know that a patient has an existing medicine allergy or ADR?

Key task

- Document known patient medicine allergies and ADRs on presentation, and make this information available when clinicians prescribe, dispense and administer medicines.

Strategies for improvement

As part of a BPMH, clinicians must elicit and document known medicine allergies and ADRs experienced by a patient before their admission (see Actions 4.5 and 4.6).

Review organisational policies, procedures and guidelines on recording known medicine allergies

and ADRs in the patient healthcare record. These should:

- Identify the clinician responsible for recording information on known medicine allergies and ADRs
- Outline what information to include (for example, type of reaction experienced, its severity, how it was managed)
- Describe what action should be taken if the nature of the documented reaction needs to be challenged or verified (for example, as a result of immunologist consultation), including instances of allergy mismatch
- Include criteria for the appropriate use of a coloured (red) patient allergy/ADR wristband
- Determine where and when it is appropriate to record a known allergy or adverse reaction to substances other than medicines, such as food, in the patient's medicine allergy and ADR history.

Ensure that medicine allergies and ADRs are recorded:

- In the medication history (paper or electronic)
- On all forms on which medicines are ordered, such as national standard medication charts, ancillary charts and the anaesthesia record

- In electronic medication management and dispensing systems
- On ADR summary sheets or similar
- By using an alert sticker on hard-copy healthcare records
- By using electronic allergy/ADR alerts in digital healthcare records.

Provide orientation, training and education to clinicians, and review clinician work practices for:

- Determining and documenting known medicine allergies and ADRs in the patient's medicine allergy/ADR history, including the type of reaction, the severity and how it was managed
- Referring to a patient's medicine allergy/ADR history before, or at the point of, decision-making when prescribing, dispensing or administering medicines.

Conduct audits of documentation on medicine allergies and ADRs. These may focus on patients who have experienced previous medicine allergies or ADRs, the information that has been documented and where it has been documented (for example, in the medication chart, MMP or equivalent, discharge summary, medicines list, electronic medication management system) (linked to Action 4.8).

Collate and review audit trends, and provide information to clinicians through medication safety bulletins, in-service orientation sessions or case reports.

Examples of evidence

Select only examples currently in use:

- Policy documents about recording a patient's known medicine allergies and ADRs on presentation
- Audit results of healthcare records for documentation of known medicine allergies and ADRs on presentation
- Feedback to the workforce about compliance with documenting known medicine allergies and ADRs on presentation
- Training documents about taking and documenting a patient's history of medicine allergies and ADRs on presentation.

Action 4.8

The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system

Reflective questions

What processes are used to ensure that all medicine allergies and ADRs experienced by a patient during an episode of care are recorded in the patient's healthcare record, and reported in the incident management and investigation system?

How do clinicians who prescribe, dispense or administer medicines know that a patient has experienced a new medicine allergy or ADR?

What processes are used to ensure that clinicians document a patient's new medicine allergies or ADRs on their medicines list?

Key task

- Document and report medicine allergies and ADRs experienced by patients during their episode of care (see Actions 4.1 and 4.2).

Strategies for improvement

Document all new medicine allergies and ADRs by including them in the patient's existing history of medicine allergies and ADRs, to ensure that clinicians are alerted and can refer to this information when medicines are being prescribed, dispensed or administered.

Review organisational policies, procedures and guidelines on recording new medicine allergies and ADRs in the patient's healthcare record. These should:

- Identify the clinician responsible for managing and recording information on new medicine allergies and ADRs
- Ensure that all new medicine allergies and ADRs are reported within the organisation's incident management and investigation system
- Include criteria for the appropriate use of a coloured (red) patient allergy/ADR wristband
- Emphasise the importance of informing the patient about all new medicine allergies and ADRs, and informing other prescribers and members of their healthcare team
- Incorporate information on new allergies and ADRs at care transfer and handover
- Update the patient's medicines list (linked to Action 4.12)
- Inform the patient's general practitioner and other members of the patient's healthcare team (for example, community pharmacist) of all new medicine allergies and ADRs in the patient's transfer or discharge summary.

Ensure that new medicine allergies and ADRs are recorded in the organisation's incident reporting system and:

- In the medication history (paper or electronic)
- On all forms on which medicines are ordered, such as national standard medication charts, ancillary charts and the anaesthesia record
- In electronic medication management and dispensing systems
- On ADR summary sheets or similar
- By using an alert sticker on hard-copy healthcare records
- By using electronic allergy/ADR alerts in digital healthcare records.

Provide orientation, training and education to clinicians, and review clinician work practices for:

- Documenting new medicine allergies and ADRs in the patient's medicine allergies/ADR history, including the type of reaction, the severity and how it was managed

- Referring to a patient's medicine allergy/ADR history before, or at the point of, decision-making when prescribing, dispensing or administering medicines.

Audit documentation on medicine allergies and ADRs. These may include the medication chart, the MMP or equivalent, or the electronic medication management system. Data could be collected during an audit of the NIMC (linked to Action 4.7).

Collate and review trends in reported medicine allergies and audit results, and provide information to clinicians through medication safety bulletins, in-service orientation sessions or case reports.

Examples of evidence

Select only examples currently in use:

- Policy documents about recording new medicine allergies and ADRs experienced during an episode of care
- Audit results of workforce compliance with policies, procedures, protocols and guidelines for documenting new medicine allergies and ADRs
- Audit results of healthcare records for documentation of new medicine allergies and ADRs in places noted in policies, procedures, protocols and guidelines
- Feedback to the workforce about compliance with policies, procedures, protocols and guidelines for documenting new medicine allergies and ADRs
- Results of analysis of incident data relating to new medicine allergies and ADRs
- Orientation or training documents about documenting patients' new medicine allergies and ADRs.

Action 4.9

The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements

Reflective questions

What processes are used to report all new suspected ADRs experienced by patients during their episode of care to the TGA?

What resources, tools or information are provided to clinicians to encourage the reporting of ADRs?

How does the health service organisation use the information and reports on suspected ADRs experienced by its patients?

Key task

- Report all new suspected ADRs experienced by patients to the TGA.

Strategies for improvement

Any adverse event that may have been caused by a medicine is a suspected ADR. Suspected ADRs that patients experience during their episode of care that have not been previously experienced or documented are considered to be new. Report these new suspected ADRs to the TGA's adverse event reporting system via the TGA website.

Assist communication and feedback about ADR reports by enrolling the health service organisation as a registered user when completing and submitting a report to the TGA's adverse event reporting system.

Registered organisations have access to information about their own reports on the TGA website or by contacting the TGA directly. Reports sent by email will only be accessible if the organisation's name and address are included in the report, and the reporter type is designated as 'hospital'. This applies to day procedure services.

Review current information and training

Review current organisational policies, procedures and guidelines to ensure that all suspected ADRs that patients experience during their episode of care are reported to the TGA. Include or refer to specific TGA information about:

- What to report
- How to report suspected ADRs
- How to maintain a record of the suspected ADR in the patient's healthcare record
- The process for a copy of the report to be sent to the organisation's medication safety governance group.

The health service organisation can include the capability to report ADRs online to the TGA as part of its strategy for electronic medication management.

Provide orientation, training and education to clinicians on reporting suspected ADRs to the TGA. This should include the importance of providing comprehensive information about the patient, the medicine that is suspected of causing the reaction, the patient's concurrent medicines, the reaction they experienced and the organisation at which it was experienced.

Health service organisations can access online learning modules developed by the TGA for health professionals on reporting adverse events with medicines and vaccines.

Assess the quality, content and timeliness of ADR reports. Reports are most useful for detecting new safety issues if they are made soon after the reaction has occurred. Encourage clinicians to report ADRs by using awareness campaigns.

Access information on ADRs and medicine safety issues by:

- Reading the Database of Adverse Event Notifications
- Reading the bimonthly *Medicines Safety Update* publication
- Subscribing to the Medicines Safety Update email list
- Subscribing to the TGA Safety Information email list.

Communicate about ADRs

Collate and review ADRs that have been experienced and reported, and circulate information to clinicians through medication safety bulletins, in-service orientation sessions or case reports.

Include ADR reports for the relevant governance committee to consider as part of the review of the safety of the medication management pathway.

Provide patients with information about ADRs, how to recognise symptoms and how to self-report to the TGA. Both the TGA and NPS MedicineWise have information on their websites that is suitable for consumers.

Examples of evidence

Select only examples currently in use:

- Policy documents on recording and reporting suspected ADRs to the TGA
- Record of suspected ADR reports submitted to the TGA
- Communication to the workforce explaining the process for reporting suspected ADRs to the TGA
- Reports from audits of workforce compliance in using the process for reporting ADRs to the TGA
- Communication with the workforce and the highest level of governance summarising TGA reports of suspected ADRs experienced within the health service organisation
- Consumer resources outlining how they can self-report ADRs to the TGA
- Orientation or training documents about identifying and reporting suspected ADRs to the TGA.

CRITERION: Continuity of medication management

A patient's medicines are reviewed, and information is provided to them about their medicines needs and risks. A medicines list is provided to the patient and the receiving clinician when handing over care.

There are multiple points of vulnerability in the medication management pathway when communication and focused partnership with the patient and/or their carer can contribute to achieving the best treatment outcome.

Medication review

Health service organisations need to consider how medication review, including medication reconciliation, can be built into existing work practices.

Medication review is a multidisciplinary responsibility and should be person centred. It ensures ongoing safe and effective use of medicines at all stages of the medication management pathway, including at the point of prescribing, dispensing and administering a medicine. Clinicians need to have the skill and expertise to conduct medication review, and have sound practices and processes for communication to implement recommended changes.

A well-structured medication review will minimise medicine-related problems and optimise the intended therapeutic outcomes for patients. Delivery models will vary across health service organisations. Medication review may need to be given a higher priority for patients with a higher risk of experiencing a medicine-related problem.

Medication review includes[108]:

- Prescription review – a technical review of a patient's medicines (for example, anomalies with medicine orders or prescriptions)
- Concordance and compliance review – a structured review to consider issues relating to a patient's medicine-taking behaviour (also called review of medicines use)

- Clinical medication review – a structured review of medicines and clinical 'condition' with the patient (and/or their carer); an outcome of review could be cessation (or 'deprescribing') of a medicine.

Some reviews of a patient's medicines may be unstructured and opportunistic, with or without the patient's or carer's involvement.[109] These might include an isolated question or issue raised by a patient or clinician; clarification about a dose, formulation or name of a medicine; or monitoring requirements of a medicine.

Medication review provides a mechanism to partner with patients to optimise medicine use. This can help patients to:

- State their preferences and consider options to make fully informed decisions (links to Action 4.3)
- Manage their condition
- Improve their functional ability (for patients with long-term conditions)
- Reduce the time they spend in the health service organisation or the likelihood of readmission
- Increase their quality of life, such as for patients with mental illness.

Information for patients

Patients and carers should be provided with enough information about medicine-related treatment options. This information needs to be in a form that is easy to understand and useful.

Appropriate education and provision of written medicine-related information to patients are essential to encourage safe and effective medicine use, and promote adherence to treatment regimens. This may include the supply of a medicines list (or profile), education about the medicines and any changes, and consumer medicine information (CMI) leaflets.

When provided with quality information and education about medicines, many patients are able to:

- Participate in decision-making, and consider the options, benefits and risks of the proposed treatment
- Make informed choices about their medicines – this is especially important when informed consent is required

- Assist in medication reconciliation and prevention of errors by identifying medicine-related problems
- Alert clinicians to suspected ADRs.

Providing information to patients is a multidisciplinary (medical, nursing and pharmacy) responsibility to ensure continuity of medication management.

Medication review

Action 4.10

The health service organisation has processes:

a. To perform medication reviews for patients, in line with evidence and best practice

b. To prioritise medication reviews, based on a patient's clinical needs and minimising the risk of medication-related problems

c. That specify the requirements for documentation of medication reviews, including actions taken as a result

Reflective questions

What evidence-based policies, procedures or guidelines for medication review are in place for clinicians?

What processes are used to identify patients at risk of medicine-related problems or adverse events, and to set priorities for patients for medication review?

Key tasks

- Conduct evidence-based medication reviews on existing and newly prescribed medicines to optimise therapy for patients

- Set up processes for:
  - determining who is responsible at each point in the medication management pathway
  - prioritising medication reviews for, and in partnership with, patients who are most at risk of a medicine-related problem
  - documenting any recommendations and action taken as a result of a medication review
  - identifying and monitoring trends in medicine-related problems, including those that have been prevented.

Strategies for improvement

Conduct evidence-based medication reviews

Ensure that medication reviews are conducted or supervised by a clinician with the appropriate skills and expertise, acting as part of a multidisciplinary team.[110] In large health service organisations, pharmacists may be the main provider of medication review services (often referred to as a clinical pharmacy service).[111] Although medication review is considered an inherent role of a pharmacist, medicines should also be reviewed by clinicians whenever decisions are being made about prescribing, dispensing and administering medicines.

A patient's experience of using medicines and their medicines needs may change over time, especially given that a patient admitted or presenting to a day procedure service is likely to be prescribed and administered a range of new medicines during an episode of care. This may necessitate the need for a medication review in circumstances such as:

- When decisions are being made to cease medicines before surgery, including which medicines would be appropriate and suitable to continue
- Ceasing or deprescribing a medicine post-procedure, as part of the intended outcome of treatment
- Following an adverse event or reaction while undergoing care
- When targeting specific high-risk categories of patients (for example, those on high-risk medicines, of certain ages, and with particular disease states or conditions).

Use medication reviews to understand the patient's experience with their current medicines and any newly prescribed medicines, and ensure that their medicine use is as safe as possible. This might include discussion of:

- When, how and whether the patient has been taking their prescribed medicines before admission to the health service organisation
- The patient's satisfaction with the outcomes from their medicines (including those newly prescribed), as well as their care experience – for example, no avoidable medicine-related problems[107]

- The patient's quality of life and life expectancy (for patients with long-term conditions).

Medication review should include assessment of current (existing and newly prescribed) medicines; the history of all medicine-related orders and administration records, including oral and parenteral, and multiple- and single-dose medicines; anaesthetic and operative records; and ceased medicine orders.

When conducting a medication review, consider the following:

- Is there a documented reason or evidence base for use of a medicine?
- Does the patient still need the medicine?
- Is the medicine still working?
- What risks are associated with use of the medicine, and what monitoring is required?
- Are there any patient-specific issues that will affect use of the medicine?

Guidance on conducting structured medication review includes:

- Society of Hospital Pharmacists of Australia *Quick Guide: Assessment of current medication management*
- National Institute for Health and Care Excellence *Medicines Optimisation: The safe and effective use of medicines to enable the best possible outcomes*
- National Prescribing Centre *A Guide to Medication Review 2008*.[108]

Assess individual patient risk

Review the organisation's risk assessment criteria for patients admitted who might be at risk of a medicine-related adverse event. Include consideration of the patient's capacity to understand the risks of medicine use and make decisions about their medicines, and the need to involve carers or interpreters.

Assessment criteria for patients will depend on the patient casemix and services delivered by the organisation. For example, priority might need to be given to patients with a higher risk of experiencing a medicine-related adverse event.

Ensure that these criteria target patients who are most at risk, such as patients who:

- Are admitted as a result of a medicine-related problem
- Are taking multiple medicines or high-risk medicines
- Are taking medicines prescribed by multiple clinicians
- Have known or suspected adherence problems
- Have a chronic disease
- Have, or potentially have, a disability or impairment (for example, cognitive impairment)
- Are over 65 years old
- Have known allergies or ADRs.

Monitor the effectiveness of the organisation's risk assessment tool(s) by conducting audits using indicators.

Guidance for developing medicine-related risk assessment criteria includes:

- Society of Hospital Pharmacists of Australia's fact sheet *Risk Factors for Medication-Related Problems*[112]
- National Prescribing Centre *A Guide to Medication Review 2008* (page 33).[108]

Set up processes to set priorities for, and document, medication reviews

For medication review to be effective, health service organisations need to have a formal, structured process in place for medication review that is conducted in partnership with the patient, carer or family member, and in collaboration with relevant clinicians involved in the patient's care. Processes will depend on the infrastructure and resources available. A structured medication review will minimise medicine-related problems and optimise patients' therapeutic outcomes. Electronic medication management with integrated clinical decision support is useful in screening for at-risk patients (for example, those with medicine-related problems).

To ensure that patients admitted to a day procedure service will benefit from a medication review, review the existing policies, procedures and guidelines of the day procedure service, network or group to include the range of circumstances when patients would ideally receive a medication review. This may be part of the pre-admission process conducted by the patient's specialist clinician or anaesthetist.

Review organisational policies, procedures and guidelines to ensure that they outline:

- When a medication review is warranted
- The roles and responsibilities of clinicians in the process
- Training requirements for clinicians responsible for medication review
- Involvement of patients and carers (see Action 4.3 and the Partnering with Consumers Standard)
- Documentation requirements for recommendations or requests as a result of the medication review, and any subsequent action taken
- The role of electronic medication management, if available, in integrated clinical decision support
- How trends in medicine-related problems within the health service organisation are monitored
- Discharge referral processes for patients who did not receive a medication review while in the health service organisation (for example, refer to residential medication management review, home medicines review or non-admitted clinical pharmacy review; see the Independent Hospital Pricing Authority website for definitions).

Review risk assessment criteria for patients admitted to the health service organisation who might benefit from a structured medication review. Ensure that priority is given to patients with a higher risk of experiencing medicine-related problems or adverse drug events.

Assessment criteria for patients will depend on the patient casemix and services delivered by the organisation (see Action 4.11).

Guidance on developing risk assessment criteria includes the Society of Hospital Pharmacists of Australia's fact sheet *Risk Factors for Medication-Related Problems*.[112]

Use quality improvement methodology to monitor and implement change. This can be achieved by auditing and evaluating medication review processes using national, state or territory, or local indicators. Use validated indicators such as the National Quality Use of Medicines Indicators for Australian Hospitals (indicators 1.5 and 6.2).

Examples of evidence

Select only examples currently in use:

- Policy documents about undertaking, prioritising and documenting medication reviews
- Documented examples of actions taken as a result of medication review
- Orientation or training documents about medication review
- Employment documents that outline the roles, responsibilities and accountabilities for medication review
- Audit results of compliance with the system for medication review.

Information for patients

Action 4.11

The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks

Reflective questions

How do clinicians inform patients about options for their care, including use of medicines?

What information do clinicians provide to patients about the benefits and risks of medicine-related treatment options?

How do clinicians gain access to medicine-related information for patients?

Key tasks

- Provide patients and carers with enough information about treatment options for them to make informed choices about their medicines, and to adhere to medicine-related treatment plans
- Support clinicians to provide medicine-related information when treatment options are discussed and when treatment decisions have been made.

Strategies for improvement

Actions 2.3–2.10 and **Action 4.3** include requirements for organisation-wide processes for involving patients in their own care, shared decision making, informed consent and effective communication.

Refer to the strategies outlined for each of these actions when implementing Action 4.11.

This action may not be applicable for day procedure services that provide evidence that they are not changing or altering patients' medicines during an episode of care.

When medicines, such as prepacked medicines, are supplied by the service, patients should be counselled on how to take the medicines. Written information, such as CMI, should be provided.

When the patient is provided with a prescription to be dispensed in a community pharmacy, CMI should be provided by the dispensing pharmacist.

Provide patients and carers with enough information

Provide medicine-related information in a form that can be used and understood by patients, and is sensitive to individual patients' needs (for example, culturally appropriate). This includes providing a package to patients and carers on discharge that contains relevant medicine-related information (Action 4.12). Discuss the benefits and associated risks of any medicines, and use patient-specific written information (such as CMI) to help inform the patient about the medicine.

Include a section on medicines in patient information brochures about general care and services provided by the health service organisation, and patient charter documents. This will inform patients that medicine-related treatment options will be discussed and information will be provided about medicines prescribed.

Refer patients and carers to education programs that include medicine-related information relevant to the day procedure service, such as cardiac rehabilitation programs, or chemotherapy education sessions for oncology or haematology patients and carers.

Review policies, procedures and guidelines

Ensure that organisational policies, procedures and guidelines include the requirement to:

- Provide medicines information to patients and carers as part of any clinical consultation, using written information, if relevant, to help inform the patient about any new medicine
- Document in the healthcare record that patients and carers have been informed about the medicine; documentation may occur as a component of the consent process, within the patient's healthcare record (hard copy or digital), on the NIMC – day surgery or on the MMP (or equivalent).

Review policies governing patient consent (Action 2.4) to include specific situations that require informed consent for treatment with a medicine (for example, Special Access Scheme medicines, off-label use of medicines).

Ensure that medicine-related information is available to clinicians

Ensure that clinicians can access relevant, up-to-date, evidence-based medicine-related information (including reference materials and information tailored for patients) at all stages of the medication management pathway (Action 4.13). This includes:

- When clinicians discuss associated risks of any medicines, as well as treatment options, with patients (for example, before making a decision to prescribe or deprescribe)
- When clinicians are counselling patients on the use of their prescribed medicines (for example, on discharge)
- When medicines are being dispensed (for example, provide patients with CMI)
- When medicines are being administered (for example, to educate patients on self-administration techniques, such as for inhalers or subcutaneous injections).

Use medicine-related information that has been tailored for patients, which has either been developed locally or sourced from reliable sites. Medicine-related information and materials that have been developed locally to meet a specific need must be endorsed by the organisation's medication safety governance group.

Patient-specific medicine-related information can be found at:

- Medicines.org.au, which provides access to up-to-date CMI, as well as product information for medicines available in Australia
- NPS MedicineWise Consumer medicine information (CMI) explained, which includes information about how to use CMI.

Guidance for producing locally developed information includes:

- The Australian Self-Medication Industry *Writing about Medicines for People: Usability guidelines for consumer medicines,* 3rd edition
- The Australian Commission on Safety and Quality in Health Care (the Commission) *Tip Sheet 5: Preparing written information for consumers that is clear, understandable and easy to use*
- Medline Plus How to write easy-to-read health materials.

Promote the availability and use of consumer-specific medicine-related information, tools and resources to clinicians using communication strategies such as newsletters, presentations, in-service education sessions and awareness campaigns.

Evaluate medicine-related information

Evaluate the content and usefulness of locally developed consumer-specific resources by obtaining feedback from consumers and clinicians.

Audit healthcare records to determine whether provision of medicine-related information has been documented, and provide feedback to clinicians. This evaluation could target specific medicines or at-risk patient groups. Resources for guidance include:

- National Quality Use of Medicine Indicators for Australian Hospitals (in particular, indicators 5.4, 5.5 and 5.6)
- Local, or state or territory indicators.

Examples of evidence

Select only examples currently in use:

- Policy documents that define the roles, responsibilities and accountabilities of the clinical workforce in informing patients and carers about their individual medicines needs and risks
- Audit results of workforce compliance with policies, procedures, protocols and guidelines for informing patients and carers about their individual medicines needs and risks
- Observation that information about medicines needs and risks is available for clinicians to use during discussions with patients and carers
- Examples of resources that can be provided to support discussion about patients' medicines needs and risks
- Results from evaluation of the usefulness of locally produced medicine-related information, and patients' understanding of their medicines needs and risks
- Communication with the workforce that promotes the importance of discussing medicines needs and risks with patients.

Provision of a medicines list

Action 4.12

The health service organisation has processes to:

a. Generate a current medicines list and the reasons for any changes

b. Distribute the current medicines list to receiving clinicians at transitions of care

c. Provide patients on discharge with a current medicines list and the reasons for any changes

This action will not be applicable for day procedure services that provide evidence that they are not changing or altering patients' medicines during an episode of care.

Reflective questions

What processes are used by clinicians to document and maintain a current medicines list during a patient's episode of care?

How do clinicians generate a current medicines list, including reasons for any changes, to use at clinical handover and provide on discharge?

Strategies for improvement

Implement a policy whereby patients and carers are informed about any medicines they are required to take post-discharge and any changes made to their regular medicines.

When changes have been made to a patient's current therapy, inform the patient about the changes and update the medicines list to reflect the changes, where applicable.

Refer to *NSQHS Standards Guide for Hospitals* for more detailed implementation strategies for this action.

Examples of evidence

Select only examples currently in use:

- Policy documents that outline the generation, distribution and provision of a medicines list (with reasons for any changes) to patients and clinicians, including at transitions of care and on discharge
- Audit results of documenting medicines lists on admission
- Audit results of providing a medicines list to patients on discharge
- Orientation or training documents about generating and updating medicines lists
- Documented process to gain consent before sharing a patient's medicines list on discharge
- Examples where medicines lists have been tailored to the specific needs of recipients (patient, general practitioner, community pharmacist).

CRITERION: Medication management processes

Health service organisations procure medicines for safety. Clinicians are supported to supply, store, compound, manufacture, prescribe, dispense, administer, monitor and safely dispose of medicines.

Many of the risks associated with each part of the medication management pathway can be avoided by using systems and processes that are designed to improve safety and are based on evidence from initiatives that have demonstrated significant benefit. These initiatives focus on addressing the common contributing factors to medication errors, which include[113]:

- Lack of knowledge of the medicine
- Lack of information about the patient
- Slips and memory lapses
- Transcription errors
- Failure in communication
- Lack of patient education
- Poor medicines distribution practices.

Medication safety initiatives should focus on systems and standardisation to reduce unnecessary variation, coupled with judicious use of tools and resources that improve knowledge and skills.

The actions and strategies described in this criterion aim to achieve safe and effective medicines use through:

- Best use of information and decision support tools in clinical decision-making

- Compliance and safety in medicines distribution and storage systems
- Targeting of known risk areas (for example, high-risk medicines), and embedding processes, practices and tools within the organisation to prevent error
- Integration of work practices that underpin safe medication management (such as standardisation, monitoring and risk assessment)
- Use of medication safety strategies and tools to create an environment for the best communication of medicine-related information (for example, using an MMP).

Actions within this criterion require health service organisations to:

- Make a range of up-to-date and evidence-based medicine-related information and decision support tools available to clinicians
- Ensure the effectiveness of the supply chain in the safe delivery of medicines
- Ensure compliance with relevant requirements for maintaining the integrity of medicines, minimising wastage and disposing of medicines appropriately
- Implement strategies for safe and secure storage and selection of medicines, including high-risk medicines.

Information and decision support tools for medicines

Action 4.13

The health service organisation ensures that information and decision support tools for medicines are available to clinicians

Reflective question

How does the health service organisation ensure that medicine-related information and decision support tools are up to date and available to clinicians at the point of decision-making?

Key tasks

- Maintain a variety of up-to-date and evidence-based medicine-related information and decision support tools that assist clinicians with their responsibilities to provide safe and effective medication management
- Make up-to-date and evidence-based medicine-related information and decision support tools available to clinicians.

Strategies for improvement

Maintain a variety of up-to-date and evidence-based medicine-related information and decision support tools

Ensure that the content of medicine-related information and decision support tools is:

- Current, and consistent with evidence-based prescribing, dispensing, compounding and administration of medicines
- Suitable for the organisation's patient casemix, care delivery work practices and workflows
- Consistent with the organisation's policies, procedures and guidelines
- Available in several formats
- Integrated within the organisation's digital or electronic systems.

Decision support includes any functionality or resource that helps clinicians make the most appropriate decisions for patient care and provides guidance (for example, a medicine-related protocol) or incorporates knowledge (for example, an electronic database of medicine–medicine interactions).

Review the organisation's range of medicine-related information and decision support tools, including guidelines and protocols. Ensure that they are relevant to the organisation's range of clinicians, including those who prescribe medicines, dispense (and compound) medicines or administer medicines.

This review should be undertaken by the organisation's governance group responsible for medication safety, in consultation with clinicians. Any amendments to the existing range of resources could be recommended as a change at the state or territory level.

Ensure that processes are in place for maintaining up-to-date, evidence-based medicine-related information and decision support tools, and making available medicine-related information that is mandated by legislation. Ensure that these processes consider requirements for clinician training and education.

A minimum standard set of medicine-related reference materials could include current versions of:

- *Australian Medicines Handbook* (*AMH*) and *AMH Children's Dosing Companion*
- *Therapeutic Guidelines*
- *The Australian Immunisation Handbook*
- Australian product information and CMI, such as MIMS and AusDI
- Medicine interactions references, such as Micromedex or *Stockley's Drug Interactions*
- References on complementary and alternative medicines, such as MedlinePlus Drugs, herbs and supplements
- *Australian Injectable Drugs Handbook* or local injectable medicines administration guidelines
- *Don't Rush to Crush* handbook or local guidelines.

Examples of decision support tools are:

- Formulary information, prescribing requirements and approval systems
- Policy directives, protocols, guidelines and authorised standing orders
- Dosing calculators and medicine-interaction databases
- Reference texts, and telephone-based medicines information and advice services
- Guidelines for safe administration of specific medicines (for example, administering medicines via enteral tubes).

Make up-to-date and evidence-based medicine-related information and decision support tools available to clinicians

Access to relevant, up-to-date, evidence-based medicine-related information (reference materials) and decision support tools is essential at all stages of the medication management pathway. It improves clinical practice, improves work practice and workflow efficiencies, supports clinician learning and assists with the provision of information to patients.

A standard set of evidence-based reference materials may be available online through a centralised portal at the state or territory level and at the point of decision-making, including within clinicians' specialty areas of practice.

Explore and implement suitable technologies to deliver medicine-related information and decision support tools in clinical areas where medicines are prescribed, dispensed and administered – for example, smartphone apps, bedside/desktop computers, tablets and computers-on-wheels.

Include clinical decision support functionality when implementing electronic medication management systems. Comprehensive guidance on electronic decision support can be found in *Electronic Medication Management Systems: A guide to safe implementation.*

Implement electronic decision support tools as standalone modules when complete electronic medication management systems are not in place (for example, antibiotic approvals and antibiograms as components of antimicrobial stewardship) (see Actions 3.15 and 3.16).

Promote the availability and use of information sources (including how to contact medicines information services) and decision support tools using education and communication strategies, including newsletters, presentations, in-house education sessions, awareness campaigns and desktop icons.

Examples of evidence

Select only examples currently in use:

- Observation that up-to-date decision support tools such as protocols, guidelines and medicine-related information resources are accessible in clinical areas (in electronic or hard copy)
- Orientation or training documents about using decision support tools for medicines
- Communication with the workforce about medicine-related information and decision support tools
- Examples of medicine-related information and decision support tools.

Safe and secure storage and distribution of medicines

Action 4.14

The health service organisation complies with manufacturers' directions, legislation, and jurisdictional requirements for the:

a. Safe and secure storage and distribution of medicines

b. Storage of temperature-sensitive medicines and cold chain management

c. Disposal of unused, unwanted or expired medicines

Action 4.14b is not applicable when evidence is provided that the day procedure service does not procure and store temperature-sensitive medicines. Refer to *NSQHS Standards Guide for Hospitals* for more detailed implementation strategies for this element of the action.

Reflective questions

How does the health service organisation ensure that all medicines (including temperature-sensitive medicines) are stored and handled according to manufacturers' directions?

How does the health service organisation manage and report risks associated with the storage of medicines?

How does the health service organisation ensure that processes for medicines disposal are consistent with state or territory requirements and the manufacturer's instructions?

Key tasks

- Identify risks associated with medicines handling, storage and distribution across the organisation, and develop and implement evidence-based strategies aimed at reducing these risks
- Implement systems and equipment that continuously monitor, and maintain the integrity of, temperature-sensitive medicines
- Implement policies, procedures and guidelines for the disposal of unused, unwanted or expired medicines.

Strategies for improvement

Identify and reduce risks

Review the effectiveness of the supply chain to deliver medicines in a way that is timely and secure, and that complies with manufacturers' instructions, and legislative and state or territory requirements for medicines.

Establish appropriate governance and oversight to ensure that medicine storage systems are safe and inaccessible to the public, and the opportunity for diversion or theft is minimised (linked to Action 4.1).

Incorporate factors that reduce opportunity for 'look-alike, sound-alike' selection errors when considering (linked to Action 4.15):

- Product labelling, packaging and storage
- Listing of new medicines in the formulary
- Situations of temporary replacement of a formulary medicine (for example, when medicine shortages or supply chain interruptions occur)
- Contract specification and safe procurement (for example, anaesthetic medicines)
- Availability of medicines (review of ward stock or imprest lists)
- Design and layout (including workflow and safe access) of the dispensary and ward stock rooms or cupboards, their proximity (high- or low-traffic areas), and the labelling requirements in these areas.

Ensure that specific recommendations for the safe procurement and storage of anaesthetic medicines are included in any policies, procedures or protocols, to minimise risks from these medicines (linked to Action 4.15; also see *Guidelines for the Safe Management and Use of Medications in Anaesthesia*.[114]

Evaluate the use and implementation of storage and delivery systems (including automated systems) for safety, quality and security risks, including:

- 'End-to-end' delivery of accountable medicines, such as Schedule 8 medicines
- Automated dispensing cabinets (check these against essential requirements, such as those of the Institute for Safe Medication Practices in *Medication Safety Self Assessment® for Automated Dispensing Cabinets*)
- Limits on the range of medicines suitable for pneumatic tube delivery.

Day procedure services may choose to implement existing hospital policies, procedures or protocols for safe handling, storage and distribution of medicines through a day procedure network or group, rather than relying on internally developed documentation. It will be important to ensure that requirements developed via the network or group are tailored to the local environment. The procedures should be evidence based, and in accordance with legislative requirements, relevant directives and professional guidelines.

See the Society of Hospital Pharmacists of Australia website for standards of practice and related resources.

Perform a risk assessment of the processes in place for the handling, storage and distribution of medicines using validated or locally endorsed audit and risk tools (or relevant components), such as the Medication Safety Self Assessment® for Australian Hospitals.

Monitor and evaluate processes

Perform audits of compliance with policies, procedures and protocols for handling, storage and distribution of medicines. In particular, consider temperature-sensitive medicines and safety controls, such as separating look-alike packaging or using electronic alerts.

Monitor usage patterns of medicines to identify unusual fluctuations.

Conduct observation audits and walk-arounds to review security, workflow, workforce access, and approval processes for access to medicines storage areas. Take corrective action when breaches, violations or practice variations are observed.

Review incident reports for incidents associated with handling (including procurement), storage and distribution of medicines.

Review the potential for increased risk of error when changes to product labelling, packaging or storage requirements are introduced as a result of changes to procurement arrangements and contracts, product shortages, recalls or substitution. Review and implement work practices that ensure safe and secure handling (including procurement), storage and distribution of medicines (including high-risk, investigational and clinical trial medicines) – for example (also see Action 4.15):

- Making opioids available only to clinicians with authorised access
- Providing clinicians with timely access to required medicines, given the casemix and acuity of the health service organisation.

Implement policies, procedures and guidelines for disposal of unused, unwanted or expired medicines

Review and implement work practices and distribution systems that minimise wastage of medicines, such as by regular checking of stock expiry dates and stock rotation.

Set up inventory management practices to eliminate wastage of medicines. Take a proactive and planned approach to changes to formulary listing, and conduct routine reviews of medicines use.

Review and implement work practices (for example, compounding of high-risk medicines such as multiple doses of cytotoxic chemotherapy) that minimise waste, ensure safe handling and promote the efficient use of medicines.

Review organisational policies, procedures and protocols for disposal of unused, unwanted or expired medicines to ensure:

- Minimal risk to the workforce and the environment (for example, cytotoxic chemotherapy, vaccines, hazardous substances)

- Consistency with legislative, health and safety, and state or territory requirements (for example, secure disposal of recordable [Schedule 8] medicines only by those with the relevant authority)
- Assignment of responsibility and accountability
- Consideration of situations when only part of a tablet, capsule, ampoule or infusion is required
- Appropriate waste segregation (for example, use of purpose-designed disposal bins).

Obtain patient consent for disposal of patients' own medicines brought into the health service organisation that are not prescribed, required, or returned to patients at transfer of care or on discharge.

Include specific requirements for waste segregation and disposal of medicines in the organisation's waste management policies and contracts. For instance, special arrangements must be made for handling and disposal of cytotoxic chemotherapy. The community pharmacy servicing the day procedure service may be able to assist by disposing of medicines through its 'return unwanted medicines' bin.

Examples of evidence

Select only examples currently in use:

- Policy documents about the safe and secure distribution and storage of medicines (including Shedule 8 medicines, temperature-sensitive medicines and cold chain management)
- Policy documents about the disposal of unused, unwanted or expired medicines
- Audit results of compliance with the correct storage, distribution and disposal of medicines, including patients' own medicines
- Reports on medicine use and review of usage patterns
- Committee and meeting records in which the storage, distribution and disposal of medicines were considered
- Orientation or training documents about storage, distribution and disposal of medicines
- Examples of action taken to manage identified risks regarding the storage, distribution and disposal of medicines
- Results of analyses of incident reports relating to medicine storage and disposal.

High-risk medicines

Action 4.15

The health service organisation:

a. Identifies high-risk medicines used within the organisation

b. Has a system to store, prescribe, dispense and administer high-risk medicines safely

Action 4.15b will not be applicable for day procedure services that provide evidence as part of Action 4.15a that the service does not store, prescribe, dispense or administer high-risk medicines.

Reflective questions

What processes are in place to identify medicines that are considered to be high risk?

How does the organisation ensure safe and appropriate storage, prescribing, administration and distribution practices for high-risk medicines?

Key tasks

- Regularly assess the use and misuse of high-risk medicines, relating to storage, prescribing, dispensing and administration
- Develop and implement evidence-based risk reduction strategies for high-risk medicines.

Strategies for improvement

Day procedure services should use their incident reporting system to monitor and identify any medicines that have a high risk of causing significant patient harm if they are used in error.[115]

The Institute for Safe Medication Practices provides a number of examples of high-risk medicines outside the acute hospital setting.

Tools that have been developed to identify the organisation's list of high-risk medicines are available on the Commission website – High-risk medicines

Regularly assess use and misuse of high-risk medicines

Set up a structured framework for monitoring and review of high-risk medicines (and the frequency of these reviews) as part of routine governance of medication management (see Action 4.1). This could include:

- Monitoring and analysing incident reports and logs
- Monitoring occurrence of, and reporting on, ADRs (see Actions 4.7–4.9)
- Monitoring published literature, including websites and bulletins from medication safety and patient safety organisations, such as the Institute for Safe Medication Practices (which offers subscriptions to a regular bulletin)
- Assessing local situations in relation to alerts, advisories and reports
- Conducting risk assessments and audits
- Conducting a failure mode and effects analysis on, for example, a new high-risk medicine or a high-risk process associated with medicine use.

Refer to *NSQHS Standards Guide for Hospitals* for more detailed implementation strategies for this action.

Examples of evidence

Select only examples currently in use:

- Policy documents about identifying, storing, prescribing, dispensing, administering and monitoring high-risk medicines

- List of high-risk medicines used in the health service organisation
- Audit results of compliance with policies, procedures, protocols and guidelines for documenting, storing, prescribing, dispensing, administering and monitoring high-risk medicines
- Results of audits or risk assessments of high-risk medicines
- Examples of implementation of alerts or advisories relating to high-risk medicines

- Committee and meeting records in which high-risk medicines were discussed
- Results of analysis of incidents involving high-risk medicines
- Orientation or training documents about high-risk medicines
- Feedback to the workforce about incidents associated with high-risk medicines and risk prevention strategies
- Examples of communication (including education) with patients and carers about high-risk medicines.

Resources

Governance, policies and procedures

Australian Government Department of Health – National Medicines Policy

Australian Pharmaceutical Advisory Council – *Guiding Principles to Achieve Continuity in Medication Management*

Council of Australian Therapeutic Advisory Groups – *Achieving Effective Medicines Governance: Guiding principles for the roles and responsibilities of drug and therapeutics committees in Australian public hospitals*

SA Health – Continuity in medication management

Training

Australian Commission on Safety and Quality in Health Care – *National Patient Safety Education Framework*

Australian Commission on Safety and Quality in Health Care – National standard medication charts course

NPS MedicineWise – Prescribing Competencies Framework

World Health Organization – *Patient Safety Curriculum Guide: Multi-professional edition*, Topic 11: Improving medication safety

State and territory medication safety sites

NSW Clinical Excellence Commission – Medication safety and quality

Queensland Health – Medication safety

SA Health – Medication safety

Tasmanian Department of Health and Human Services – *Medication Systems and Management Policy*

Victorian Department of Health and Human Services – Quality use of medicines

Western Australian Department of Health – Medication safety alerts

Assessment and performance of the medication management pathway

Australian Commission on Safety and Quality in Health Care, and NSW Therapeutic Advisory Group – *National Quality Use of Medicine Indicators for Australian Hospitals*

Institute for Healthcare Improvement – Failure Modes and Effects Analysis Tool

NSW Clinical Excellence Commission – Medication Safety Self Assessment® for Australian Hospitals

Reducing medicine-related risks

American Hospital Association, Health Research and Educational Trust, Institute for Safe Medication Practices – *Pathways for Medication Safety: Leading a strategic planning effort*

Institute for Safe Medication Practices – Selecting the best error-prevention 'tools' for the job

Society of Hospital Pharmacists of Australia – *Fact Sheet: Risk factors for medication-related problems*

Scope of clinical practice and credentialing

NPS MedicineWise – Prescribing Competencies Framework

Nursing and Midwifery Board of Australia – Framework for assessing standards for practice for registered nurses, enrolled nurses and midwives

Pharmaceutical Society of Australia – *National Competency Standards Framework for Pharmacists in Australia*

Information for consumers

Medicines.org.au

NPS MedicineWise – Medical info

Pharmaceutical Society of Australia – *Guide to Providing Pharmacy Services to Aboriginal and Torres Strait Islander People*

Society of Hospital Pharmacists of Australia – SHPA Standards of Practice for Medicines Information Services

Medication reconciliation

Agency for Healthcare Research and Quality – *Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation*

Australian Commission on Safety and Quality in Health Care – Medication reconciliation

Institute for Safe Medication Practices Canada – Medication reconciliation

NPS MedicineWise – Get it right! Taking a best possible medication history

NSW Clinical Excellence Commission – Comprehensive Audit Tool

Society of Hospital Pharmacists of Australia – *Quick Guide: Facilitating the continuity of medication management on transition between care settings*

Society of Hospital Pharmacists of Australia – *Quick Guide: Medication reconciliation*

Victorian Department of Health – Medication reconciliation

World Health Organization – *High 5s Fact Sheet: The High 5s assuring medication accuracy at transitions of care – medication reconciliation standard operating protocol*

Assessment and monitoring of allergy and ADR recording

Australian Commission on Safety and Quality in Health Care – medication charts and user guides

NPS MedicineWise – Safety through adverse event reporting

Society of Hospital Pharmacists of Australia – *Quick Guide: Clinical review, therapeutic drug monitoring (TDM) and adverse drug reactions (ADRs)*

Sydney Children's Hospitals Network – *Adverse Drug Reaction Practice Guideline*

Therapeutic Goods Administration – Database of Adverse Event Notifications

Therapeutic Goods Administration – Reporting adverse drug reactions

Medication review

National Health Service – *A Guide to Medication Review 2008*

SA Health – *Continuity in Medication Management: A handbook for South Australian hospitals*, Principle 5: Medication review and reconciliation

Society of Hospital Pharmacists of Australia – *Quick Guide: Assessment of current medication management*

Society of Hospital Pharmacists of Australia – Standards of Practice for Clinical Pharmacy Services, Chapter 1: Medication reconciliation

Western Australian Department of Health – Pharmaceutical review

Medicines list

Australian Commission on Safety and Quality in Health Care – National Medication Management Plan

NPS MedicineWise – Keeping a medicines list

Information for clinicians and decision support tools

Australian Commission on Safety and Quality in Health Care – Electronic medication management (EMM) resources

Australian Government Department of Health – *The Australian Immunisation Handbook*

Institute for Safe Medication Practices Canada and Canadian Patient Safety Institute – *Paper to Electronic MedRec Implementation Toolkit*

Royal Australian College of General Practitioners, Pharmaceutical Society of Australia, and Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists – *Australian Medicines Handbook*

Therapeutic Guidelines Limited – *Therapeutic Guidelines*

Storage, distribution and disposal

Australian and New Zealand College of Anaesthetists – *Guidelines for the Safe Management and Use of Medications in Anaesthesia*

Australian Commission on Safety and Quality in Health Care – *National Standard for User-Applied Labelling of Injectable Medicines, Fluids and Lines*

Australian Commission on Safety and Quality in Health Care – *National Tall Man Lettering List*

Australian Government Department of Health and Ageing – *National Vaccine Storage Guidelines: Strive for 5*

Institute for Safe Medication Practices – *Medication Safety Self Assessment for Automated Dispensing Cabinets*

Western Australian Department of Health – Safe storage of medications

High-risk medicines

Australian Commission on Safety and Quality in Health Care – High-risk medicines

Institute for Safe Medication Practices – ISMP high-alert medications

NSW Clinical Excellence Commission – Medication safety and quality: high-risk medicines

Victorian Department of Health – High-risk medicines

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Comprehensive Care Standard
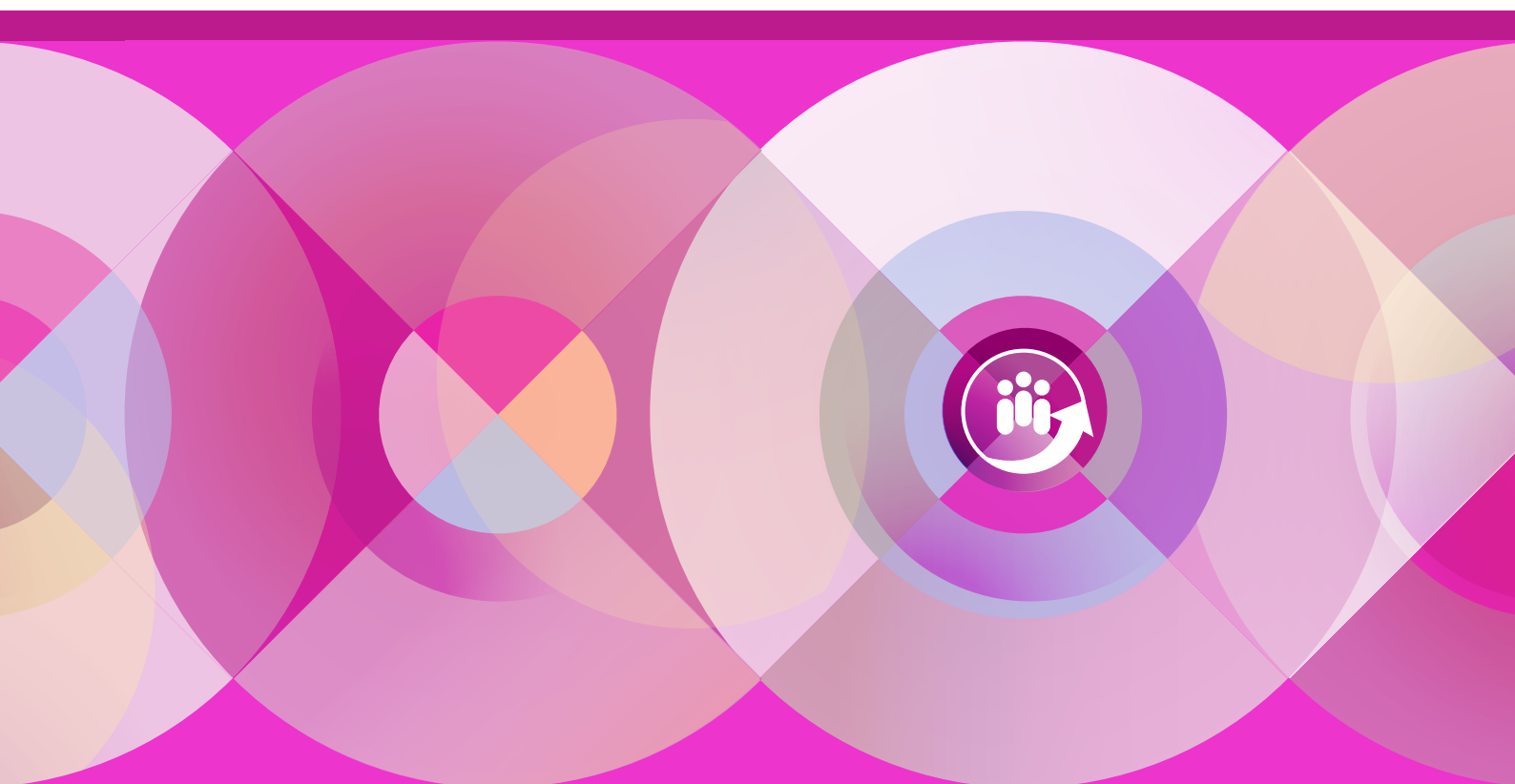
Comprehensive Care Standard

Leaders of a health service organisation set up and maintain systems and processes to support clinicians to deliver comprehensive care. They also set up and maintain systems to prevent and manage specific risks of harm to patients during the delivery of health care. The workforce uses the systems to deliver comprehensive care and manage risk.

Intention of this standard

To ensure that patients receive comprehensive care – that is, coordinated delivery of the total health care required or requested by a patient. This care is aligned with the patient's expressed goals of care and healthcare needs, considers the effect of the patient's health issues on their life and wellbeing, and is clinically appropriate.

To ensure that risks of harm for patients during health care are prevented and managed. Clinicians identify patients at risk of specific harm during health care by applying the screening and assessment processes required in this standard.

Criteria

Clinical governance and quality improvement to support comprehensive care

Developing the comprehensive care plan

Delivering comprehensive care

Minimising patient harm

Introduction

Safety and quality gaps are frequently reported as failures to provide adequate care for specific conditions, or in specific situations or settings, or to achieve expected outcomes in certain populations. The purpose of this standard is to address the cross-cutting issues underlying many adverse events. These issues often include failures to:

- Provide continuous and collaborative care
- Work in partnership with patients, carers and families to adequately identify, assess and manage patients' clinical risks, and determine their preferences for care
- Communicate and work as a team (that is, the healthcare team).

Comprehensive care is the coordinated delivery of the total health care required or requested by a patient. This care is aligned with the patient's expressed goals of care and healthcare needs, considers the impact of the patient's health issues on their life and wellbeing, and is clinically appropriate.

In day procedure services, a comprehensive care plan is likely to be brief and focused on the care required for a specific procedure.

Although a day procedure service may provide a single episode of patient care, it is essential that each single episode or period of care is considered to be part of the continuum of care for a patient. Meaningful implementation of this standard requires attention to the processes for partnering with patients in their own care and for safely managing transitions between episodes of care. This requires that the systems and processes necessary to meet the requirements of this standard also meet the requirements of the Partnering with Consumers Standard and the Communicating for Safety Standard.

Implement targeted, best-practice strategies to prevent or minimise the risk of specific harms identified in this standard. Strategies for managing specific care needs or clinical risks should be documented as part of the pre-admission assessment process.

Patient screening processes should be used to identify risks relating to pressure injuries, falls, poor nutrition, cognitive impairment and unpredictable behaviour. Patients who have specific conditions and risks of harm identified in screening processes may be referred elsewhere if further assessment and care are required. Day procedure services should have admission protocols or policies that clearly outline criteria for admission.

To implement systems that meet the requirements of the Comprehensive Care Standard, identify areas of synergy with the other NSQHS Standards. This will help to ensure that the organisation's safety and quality systems, policies and processes are integrated, and will reduce duplication of effort.

Clinical governance and quality improvement to support comprehensive care

Systems are in place to support clinicians to deliver comprehensive care.

Taking an organisation-wide and systematic approach to the delivery of comprehensive care will help to ensure consistent experiences of comprehensive care for patients, and consistent expectations for clinicians and other members of the workforce about how to deliver comprehensive care.

This criterion requires organisation-wide governance, leadership and commitment to support delivery of comprehensive care and minimise patient harm.

To meet this criterion, health service organisations are required to:

- Integrate clinical governance and apply quality improvement systems
- Apply principles of partnering with consumers, health literacy and shared decision making when developing and implementing organisational processes for comprehensive care and minimising patient harm
- Implement organisational systems and processes to support effective delivery of comprehensive care and minimise patient harm.

This criterion aligns closely with the Clinical Governance Standard and the Partnering with Consumers Standard.

Integrating clinical governance

Action 5.1

Clinicians use the safety and quality systems from the Clinical Governance Standard when:

a. Implementing policies and procedures for comprehensive care

b. Managing risks associated with comprehensive care

c. Identifying training requirements to deliver comprehensive care

Reflective questions

How are the health service organisation's safety and quality systems used to:

- Support implementation of policies and procedures for the delivery of comprehensive care
- Identify and manage risks associated with the delivery of comprehensive care
- Identify training requirements for the delivery of comprehensive care?

Key tasks

- Establish and implement governance structures for comprehensive care and minimising patient harm
- Develop and implement policies and procedures for comprehensive care and minimising patient harm
- Use organisation-wide risk management systems to identify, monitor, manage and review risks associated with comprehensive care and minimising patient harm

- Deliver or provide access to training on comprehensive care and minimising patient harm based on the patient population and the specific needs of the workforce.

Strategies for improvement

The Clinical Governance Standard has specific actions relating to health service organisations' safety and quality systems.

Action 1.7 – policies and procedures

Action 1.10 – risk management systems

Actions 1.19, 1.20 and **1.21** – education and training

Health service organisations should:

- Use these and other established safety and quality systems to support the policies and procedures, risk management and training for comprehensive care and minimising patient harm

- Ensure that current versions of all relevant policies and procedures are readily available and accessible to clinicians.

Policies may be developed or adapted at different levels within the organisation. However, all policy documents should be incorporated into a single, coherent set to maximise the effectiveness of the policy development process.

Implement policies and procedures

Provide guidance about aspects of comprehensive care in policies and procedures, such as:

- Performing a risk assessment of the population served and the services provided to inform decisions about required screening and assessment processes
- Following requirements for pre-admission screening and assessment
- Using processes relating to the management of the specific harms identified in the 'Minimising patient harm' criterion of this standard.

Manage risks

Use established risk management systems (see Action 1.10) to identify, monitor, manage and review risks associated with comprehensive care. Use information from measurement and quality improvement systems, adverse events, clinical outcomes and patient experiences to inform and update risk assessments and the risk management system.

Identify training requirements

Assess the competency and training needs of the workforce in line with the requirements of Actions 1.19, 1.20 and 1.21. Perform a risk assessment to inform the training schedule and to set priorities for the members of the workforce who require training. Develop or provide access to training and education resources to meet the needs of the workforce in relation to comprehensive care.

Consider the training the workforce may need to effectively use the clinical incident management and investigation system to inform risk management, and to plan and implement quality improvement processes to mitigate risks.

Examples of evidence

Select only examples currently in use:

- Policy documents or by-laws that provide guidance on aspects of comprehensive care, including
  - organisation-wide screening and assessment processes
  - documentation of screening and assessment findings, the outcome of shared decision-making processes, agreed goals of care and comprehensive care plans
  - roles, responsibilities and accountabilities of the multidisciplinary team in delivering comprehensive care
  - processes for identifying patients at the end of life and managing their care appropriately
  - processes relating to the specific harms identified in the 'Minimising patient harm' criterion of this standard
- Risk management system to identify, monitor, manage, review and manage risks associated with comprehensive care

- Audit results of clinical practice in the delivery of comprehensive care
- Results from audits, prevalence surveys and incident reporting relating to comprehensive care
- Documentation of governance structures, including committees or other bodies, to discuss planning and delivery of comprehensive care
- Committee and meeting records in which planning and delivery of comprehensive care were discussed
- Risk assessment of workforce competency and training needs, and actions taken to manage risks
- Training documents relating to planning and delivering comprehensive care, including care at the end of life, and care relating to falls, pressure injuries, mental health, nutrition and hydration, and cognitive impairment.

Applying quality improvement systems

Action 5.2

The health service organisation applies the quality improvement system from the Clinical Governance Standard when:

a. Monitoring the delivery of comprehensive care

b. Implementing strategies to improve the outcomes from comprehensive care and associated processes

c. Reporting on delivery of comprehensive care

Reflective questions

How are the strategies to improve the outcomes of comprehensive care and associated processes continuously evaluated and improved?

How are the outcomes of improvement activities communicated to the governing body, the workforce and consumers?

Key tasks

- Review, measure, and assess the effectiveness and performance of, organisational and clinical strategies to deliver comprehensive care and minimise patient harm
- Implement quality improvement strategies for comprehensive care and minimising patient harm based on the outcomes of monitoring activities
- Provide information on the outcomes of quality improvement activities to the governing body, the workforce, consumers and other organisations.

Strategies for improvement

The Clinical Governance Standard has specific actions relating to health service organisations' quality improvement systems.

Action 1.8 – quality improvement systems

Action 1.9 – reporting

Action 1.11 – incident management and investigation systems

Health service organisations should use these and other established safety and quality systems to support monitoring, reporting and implementation of quality improvement strategies for comprehensive care.

Monitor effectiveness and performance

Use the organisation's quality improvement systems to identify and set priorities for the organisational and clinical strategies to deliver comprehensive care and minimise patient harm.

Review these systems to ensure that they include requirements for:

- Intermittent audits of documentation on screening and assessment processes, patient preferences and goals, and shared decision making
- Ongoing data collection about indicators such as clinical deterioration, cancellation of procedures on the day, delayed discharges, unplanned transfers or overnight stays, and returns to theatre[116]
- Periodic surveys of workforce attitudes and patient experiences of using the system for comprehensive care
- Regular, informal quality checks of patient, carer and family experiences and perspectives (for example, conducting five-minute interviews at the bedside or in the waiting room).

Implement quality improvement strategies

Use the results of monitoring activities to show improvements, or areas in which improvement is required. If appropriate, use quality improvement activities that are consistent and measurable across the corporate group.

Use the results of organisational risk assessments to identify gaps, plan, and set priorities for areas for investigation or action.

When adverse events occur, specifically investigate to identify any issues in the performance or use of the system for comprehensive care. Use this information to make improvements.

Report outcomes

Report evaluation findings to the governing body and the workforce. Use the data to work with consumers, the workforce, clinical leaders and managers to identify and implement improvements to the system for comprehensive care.

Strategies for monitoring, preventing and minimising specific risks of harm can be found in the 'Minimising patient harm' criterion of this standard.

Examples of evidence

Select only examples currently in use:

- Record of quality improvement activities relating to comprehensive care
- Administrative and clinical data that are used to determine risk, priorities for improvement and effectiveness of improvement interventions for provision of comprehensive care
- Audit results of healthcare records for documentation of screening, assessment and shared decision-making processes, and comprehensive care plans
- Schedules for planned audits of issues associated with delivery of comprehensive care
- Committee and meeting records in which quality performance and improvement strategies for delivery of comprehensive care were discussed
- Results of data analysis on outcomes such as discharge delays, the alignment of documented patient preferences with actual care and the prevalence of adverse events associated with identified risks
- Actions taken to manage identified risks associated with delivery of comprehensive care
- Reports to the highest level of governance, consumers and the workforce on delivery of comprehensive care, or other documented information on trends relating to identified risks
- Communication with the workforce and patients about improvement activities and outcomes
- Documentation from incident monitoring that captures data relating to delivery of comprehensive care
- Examples of improvement activities that have been implemented and evaluated to improve teamwork, screening assessment or shared decision making
- Feedback provided to the workforce about the results of audits relating to delivery of comprehensive care and actions to deal with issues identified

- Results of consumer and carer experience surveys, and actions taken to deal with issues identified
- Results of workforce surveys for attitudes regarding delivery of care that is based on a patient's identified goals for the episode of care

- Adverse events register that includes actions taken to improve performance in relation to adverse events associated with delivery of care that is based on a patient's identified goals for the episode of care.

Partnering with consumers

Action 5.3

Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to:

a. Actively involve patients in their own care

b. Meet the patient's information needs

c. Share decision-making

Reflective questions

What processes from the Partnering with Consumers Standard do clinicians use to involve patients when providing comprehensive care?

How does the health service organisation collect feedback from patients about information provided on comprehensive care?

Key tasks

- Review strategies in the Partnering with Consumers Standard to inform the implementation of actions in the Comprehensive Care Standard
- Provide information to patients about comprehensive care and minimising patient harm tailored to their specific needs and level of health literacy.

Strategies for improvement

The Partnering with Consumers Standard has specific actions (**Actions 2.3–2.10**) related to health service organisations' processes for involving patients in their own care, shared decision making, informed consent and effective communication.

Day procedure services should use established processes to partner with patients in the delivery of comprehensive care and minimising patient harm.

Use patient experience data to evaluate whether clinicians are actively involving patients in their own care, meeting patient information needs and making shared decisions when providing comprehensive care.

Actions in the 'Minimising patient harm' criterion require specific strategies for partnering with patients in their care, including:

- Providing information to patients, carers and families about preventing pressure injuries (Action 5.23) and falls (Action 5.26)
- Collaborating with patients, carers and families to manage or minimise risks of
  - delirium (Action 5.30)
  - self-harm and suicide (Action 5.31)
  - aggressive or violent behaviour (Action 5.33).

Examples of evidence

Select only examples currently in use:

- Audit results of healthcare records that include
  - documentation of patients' nominated substitute decision-makers or support people they want involved in care decisions
  - patient and carer involvement in screening, assessment and comprehensive care delivery
  - patient and carer involvement in discharge planning
- Observation of patients and carers participating in decision-making about their care
- Feedback from patients and carers regarding their involvement in care, the extent to which their needs were met and participation in shared decision making.

Designing systems to deliver comprehensive care

Action 5.4

The health service organisation has systems for comprehensive care that:

a. Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment

b. Provide care to patients in the setting that best meets their clinical needs

c. Ensure timely referral of patients with specialist healthcare needs to relevant services

d. Identify, at all times, the clinician with overall accountability for a patient's care

Reflective questions

What systems and processes are in place to support clinicians to communicate, deliver and document comprehensive care in the setting that best meets patients' needs?

What systems and processes are in place to ensure the timely referral of patients to relevant services?

What systems and processes are used to identify the clinician with overall responsibility for the patient? How is this communicated to the patient and the team?

Key tasks

- Work with clinicians and consumers to design and implement systems for developing, documenting and communicating comprehensive care plans
- Implement systems to ensure that patients receive care in the setting that best meets their clinical needs
- Work with internal and external services to implement timely referral processes
- Develop processes for ensuring that the clinician with overall accountability for a patient's care is identifiable at all times.

Strategies for improvement

Given the short length of stay for most patients using day procedure services, the requirements for this action may be achieved through robust by-laws setting out:

- The responsibilities of all clinicians, including referring clinicians, in relation to patient care
- Pre-admission screening and assessment processes that identify individual care needs and clinical risks, which lead to appropriate planning.

For example, pre-admission screening and assessment processes may identify that a patient is at risk of falls and has a new diagnosis of cognitive impairment. This would require a plan to manage these issues during the episode of care, and ensure that the referring clinician refers the patient to other services (for example, general practitioner) for further investigation and management of their cognitive impairment.

Design systems to develop, document and communicate comprehensive care plans and processes to ensure that patients receive care that best meets their needs

In the day procedure setting, a comprehensive care plan is likely to be brief and focused on the care required for a specific procedure. Strategies for managing specific care needs or clinical risks should be documented as part of the pre-admission assessment process. For example, a patient with falls risk and cognitive impairment (as described above) may need to leave their shoes on to reduce the risk of falls, and have their carer present throughout the procedure to reduce anxiety.

An example of a standardised template for comprehensive care planning is a clinical pathway for management of a specific procedure. If the day procedure service uses clinical pathways, these must include the capacity to individualise aspects of care, as required.

Set up systems for identifying the clinician with overall accountability

Although all clinicians are accountable for the care they provide to patients, the clinician carrying overall accountability for an individual patient's care must have the seniority to make time-sensitive or complex clinical decisions. Confusion about which clinician

has overall accountability for a patient's care can lead to communication issues and delays in clinical decision-making.[117,118] Ensure that by-laws identify who carries overall accountability for a patient's care when more than one specialist is involved.

Develop guidance about:

- The roles and responsibilities of the clinician with overall accountability for a patient's care
- Processes for managing circumstances when the clinician with accountability for a patient's care is not available
- Orientation of new, agency or locum clinicians to the process for identifying who has overall accountability for a patient's care

Examples of evidence

Select only examples currently in use:

- Policy documents or by-laws that outline processes for
  - pre-admission screening, shared decision making and goal-setting with patients, and triggers for review of comprehensive care plans
  - managing patient flow, including flagging patients with clinical priorities that need urgent or special consideration
  - referral to other services, including clinical or other criteria for referral
  - determining and transferring accountability for a patient's care
- Observation of clinicians' practice that demonstrates use of the health service organisation's processes for comprehensive care
- Records of interviews with clinicians that demonstrate that they understand the health service organisation's processes for comprehensive care
- Roles and responsibilities for the workforce and referring clinicians
- Training documents about
  - shared decision making and goal-setting
  - screening and clinical assessment processes for comprehensive care
  - multidisciplinary teamwork and collaboration
  - delivering comprehensive care, including at the end of life
  - strategies for minimising risks of harm

- Committee and meeting records in which the placement of populations of patients in settings appropriate to their clinical needs was discussed
- Examples of improvement activities that have been implemented and evaluated to better match patients' care settings to their clinical needs
- Memorandums of understanding or other agreements with external organisations that outline services for transfer of patients
- Communication with the workforce that provides guidance about referral processes to different services
- Audit results of healthcare records for documented accountability for patient care
- Standardised referral tools and processes, including documented referral criteria for specialist services within the organisation and in the community
- Feedback from patients and carers about whether they can identify the clinician with overall responsibility for the patient.

Collaboration and teamwork

Action 5.5

The health service organisation has processes to:

a. Support multidisciplinary collaboration and teamwork

b. Define the roles and responsibilities of each clinician working in a team

Reflective questions

How do multidisciplinary collaboration and teamwork operate in the health service organisation?

How are the roles and responsibilities of each clinician working in a team defined? How is this communicated to team members and the patient?

Key task

- Develop structured processes to support multidisciplinary teamwork and collaboration.

Strategies for improvement

A substantial proportion of potentially preventable adverse events are underpinned by failures in communication and teamwork.[119-123] Improvements in multidisciplinary collaboration and teamwork have been associated with outcomes such as reduced risk of complications of medical care and reduced risk of surgical complications or death.[124,125] To deliver comprehensive care that is safe and continuous, effective communication and teamwork are critical. Implement this action with consideration of the requirements of the Communicating for Safety Standard.

Examples of tools and processes that can help to structure and facilitate effective teamwork are:

- Structured opportunities for multidisciplinary team communication
- The surgical safety checklist
- Evidence-based scoring systems, such as the Aldrete or PADDS score
- Structured communication tools such as ISBAR (see Action 6.7).

In a day procedure service, the multidisciplinary team may include the referring clinician, anaesthetist and nurse involved in delivering care for the patient.

Consider providing formal training in teamwork and communication.[126,127] Skills in communication, collaboration and team behaviours can be developed through simulation, workshops or lectures.

Strategies to improve clinical communication are discussed in more detail in the Communicating for Safety Standard.

Examples of evidence

Select only examples currently in use:

- Policy documents or by-laws that outline structured communication processes that are used to ensure that members of the workforce understand their delegated roles and responsibilities when working as a multidisciplinary team

- Audits on clinical handover
- Employment documents that describe the roles, responsibilities and accountabilities of the workforce
- Organisational chart and delegations policy that show clinical governance reporting lines and relationships.

Action 5.6

Clinicians work collaboratively to plan and deliver comprehensive care

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Reflective question

How are clinicians supported to collaborate with each other, patients, carers and families in planning and delivering comprehensive care?

Key task

- Ensure that clinicians use organisational processes and collaborate with each other, and with patients, carers and families, to plan and deliver comprehensive care.

Strategies for improvement

Use the Partnering with Consumers Standard to guide the development of processes for comprehensive care.

Collaborate with patients, carers and families

Pre-admission screening and assessment processes require collaboration with patients, carers and family members to ensure that essential baseline information about a patient's condition is established. This is so that deterioration, improvement and strategies for comprehensive care

can be identified. For example, the carer of a person with advanced dementia is likely to be the most accurate source of information about that patient's usual capabilities, behaviours, preferences and medical history.[128]

Carers may be able to assist in providing strategies for managing a patient's care during a procedure, and may wish to be actively involved in the provision of care.

Implement shared decision making

Shared decision making is a critical strategy for effectively collaborating with patients, carers and families during pre-admission assessment and comprehensive care planning. Shared decision making may occur between the referring clinician and the patient before admission to the day procedure service. However, do not assume that this has happened: include requirements relating to shared decision making in by-laws and screening processes, and provide information about shared decision making to all clinicians, including referring clinicians.

Shared decision making is a process of incorporating the best available clinical evidence into a discussion about a patient's values and preferences to make

decisions about care.[129] Shared decision making offers a framework for working jointly with patients (and carers and families, if the patient chooses to have them involved) to make decisions about the comprehensive care plan that are based on a shared understanding of the patient's goals of care, and the risks and benefits of clinically appropriate options for diagnostic tests, treatments, procedures and care.[130]

One model for shared decision making describes five questions that clinicians can use to guide the process[130,131]:

1. What will happen if the patient waits and watches?

2. What are the test or treatment options?

3. What are the benefits and harms of each option?

4. How do the benefits and harms weigh up for the patient?

5. Does the patient have enough information to make a choice?

Another model, framed from the patient perspective, is Ask Share Know, which encourages patients to ask three questions about their care.

Use decision support tools

Decision aids are a type of decision support tool that clinicians, patients, carers and families can work through together. Specific decision aids have been developed for some health topics, and an online inventory of existing tools is available.

A generic decision aid tool has also been developed to help clinicians, patients, carers and families work together to make decisions if no specific decision aid is available.

Strengthen teamwork processes

No single clinician can deliver all aspects of the care that a patient needs.[132] Different clinician groups bring specific expertise and need to work together to provide the complete health care that a patient requires. Effective teamwork and collaboration rely on establishing and communicating clear and shared goals. These goals should have meaning for each team member who contributes to the effort to achieve them.[133]

Use processes for clinical handover, communicating critical information and documenting information (described in the Communicating for Safety Standard) to ensure that clinicians collaborate effectively to plan and deliver comprehensive care.

The professional cultures associated with different disciplines and specialty groups can strongly influence the way that clinicians approach goal-setting and decision-making.[133] These cultures contribute to differing degrees of engagement in working collaboratively with other disciplines and professions.[133,134] Set up processes to support clinicians (including credentialed medical and other practitioners) to understand their own accountabilities in relation to planning and delivering comprehensive care, and those of other members of the team.[135]

By-laws should address the expectations for clinicians' participation in teamwork for comprehensive care. Suboptimal collaboration and communication can be particularly apparent in the relationships between clinicians, and between clinicians and other professional groups.[136-139] Such problems have been attributed to issues arising from traditional professional hierarchies and cultures, and the relative seniority of the clinicians involved.[133] Improving the organisation of care delivery routines (such as structured multidisciplinary bedside rounds) within the workflow can help provide opportunities for more effective communication and collaboration between clinicians and other professional groups.[140-142]

Monitor, analyse and report on system effectiveness

Develop systems consistent with the requirements of the Clinical Governance Standard for reporting and analysing adverse events relating to failures of teamwork and communication, and for ensuring that clinicians are professionally accountable for working collaboratively with patients, carers, families and each other in the planning and delivery of comprehensive care.

Examples of evidence

Select only examples currently in use:

- Resources and tools, including decision aids or pathways, that outline accountabilities of clinicians and promote collaborative practice (for example, whiteboards, electronic journey boards)
- Examples of activities that have been implemented and evaluated to improve organisation of care delivery routines and workflow
- Observation of collaborative work to plan and deliver care
- Feedback from consumers about how clinicians worked together to deliver care
- Data from patient and carer experience surveys about collaboration and teamwork among clinicians.

CRITERION: Developing the comprehensive care plan

Integrated screening and assessment processes are used in collaboration with patients, carers and families to develop a goal-directed comprehensive care plan.

Every patient receiving health care in Australian health service organisations deserves comprehensive care, but some patient groups are particularly vulnerable; for them, comprehensive care has a substantial role in helping to prevent harm. Consider the groups of vulnerable patients that use the organisation's services and ensure that systems for comprehensive care address the needs of these groups.

The population served by the health service organisation and the nature of the services provided will determine the approach to screening and assessment.

Planning for comprehensive care

Action 5.7

The health service organisation has processes relevant to the patients using the service and the services provided:

a. For integrated and timely screening and assessment

b. That identify the risks of harm in the 'Minimising patient harm' criterion

Reflective question

How does the health service organisation ensure that screening and assessment processes used to identify the risks of harm are integrated and timely?

Key tasks

- Assess the risks and clinical requirements of the patients who use the health service organisation, and agree on relevant screening and assessment processes – for example, pre-admission screening

- Ensure that the risks of harm identified in the 'Minimising patient harm' criterion of this standard are addressed in these processes.

Strategies for improvement

Develop screening processes

Screening is used to identify existing conditions or issues that may predispose a patient to further harm, and to identify the level of risk for potential new harms to occur. The conditions, issues and risks identified through screening need to be properly assessed to determine what actions should be taken to manage them. Screening should shape the care delivered to a patient.

In day procedure services, different emphases will be placed on pre-admission screening and comprehensive assessment. Services may use a detailed preoperative screening process to identify anaesthetic and surgical risks. The day procedure service may not need comprehensive assessment processes if clinical conditions and risks identified through the screening process are largely managed by referring the patient to other services. Services will need to develop clear guidance about processes for refusing service when a patient's clinical risks cannot be safely managed.

Many different conditions, issues and risks can potentially be identified through screening.

To develop appropriate screening processes for the health service organisation, consider:

- The cognitive, behavioural, mental and physical conditions and risks encountered by the patient population served by the organisation
- The relevant risks of harm identified in the 'Minimising patient harm' criterion of this standard
- Feedback from quality improvement processes
- The capacity and type of services that the organisation provides.
- Other aspects requiring screening (for example, medication safety, Aboriginal and Torres Strait Islander consumers, diversity under the Partnering with Consumers Standard).

Use this information to work with clinicians and consumers to develop screening and assessment processes that are appropriate to the needs of patients and the clinical service being provided, and are integrated into clinical workflow.

Patients who have specific conditions and risks of harm identified in screening processes may be referred elsewhere if further assessment and care are required. Develop admission protocols or policies that clearly outline criteria for admission.

Identify expectations about the timing of initial screening and assessment processes, and indications for repeated screening and assessment, in relevant policies, guidelines and procedures.

Integrate screening and assessment

Integrate processes for screening and assessment, wherever possible. This means developing strategies to integrate:

- The multiple tools used to screen for common conditions and risks
- Screening activities with clinical assessment activities
- The input of multiple clinicians.

Link screening activities to clinical decision-making and action when clinical risks are identified. This might mean ensuring that screening tools direct clinicians to the relevant assessments and interventions for managing an identified risk. For example, if a patient is identified as having cognitive impairment, specific assessments and clinical management strategies are recommended.[143]

Examples of evidence

Select only examples currently in use:

- Organisational assessment of the risks relevant to the population serviced by the health service organisation
- Policy documents or by-laws that outline processes for conducting screening for, and assessment of, identified clinical conditions and risks, including those outlined in the 'Minimising patient harm' criterion, if relevant
- Resources and tools developed for pre-admission screening and assessment of clinical conditions and risks that are relevant to the health service organisation and risks outlined in the 'Minimising patient harm' criterion
- Employment documents that describe the roles, responsibilities and accountabilities for the workforce in relation to screening and assessment
- Training documents about the identification and assessment of at-risk patients
- Audit of screening and, if necessary, assessment processes on admission and at appropriate intervals during an episode of care.

Action 5.8

> The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems

Reflective questions

What processes are in place for patients to identify as being of Aboriginal or Torres Strait Islander origin?

How is this information recorded in administrative information systems and transferred to clinical information systems?

Key tasks

- Develop policies, protocols and processes for confirming Aboriginal and Torres Strait Islander identification status
- Train the workforce to build competence in working with diverse population groups and specifically for collecting identification information
- Include Aboriginal and Torres Strait Islander identifiers in administrative and clinical datasets.

Strategies for improvement

Day procedure services may have a small Aboriginal and Torres Strait Islander patient population. For many Aboriginal and Torres Strait Islander people receiving care in a day procedure service, their risk of harm will be similar to that of the general patient population using the service. However, a day procedure service cannot determine this without a system for identifying which of its patients identify as Aboriginal or Torres Strait Islander and what, if any, additional risks they face.

Encouraging Aboriginal and Torres Strait Islander people to be comfortable identifying themselves may require day procedure services to:

- Provide patients with easy-to-understand information about why the service is asking them to identify themselves

- Establish mechanisms to improve the cultural competency and reflective practice of the workforce that collects identifying information.

Evidence provided under this action will determine the applicability of other actions that relate to Aboriginal and Torres Strait Islander health (Actions 1.2, 1.4, 1.33 and 2.13).

Further strategies are available in *NSQHS Standards Users Guide for Aboriginal and Torres Strait Islander Health*.

Examples of evidence

Select only examples currently in use:

- Policy documents or by-laws that outline processes for identifying Aboriginal and Torres Strait Islander patients, and recording this information in administrative and clinical information systems
- Admission registration form on which patients can identify as being of Aboriginal or Torres Strait Islander origin
- Comparison of patient healthcare and admission records that shows that Aboriginal and Torres Strait Islander patients are identified consistently
- Communication material displayed in admission areas that provides patients with information about why they will be asked if they identify as being of Aboriginal or Torres Strait Islander origin
- Training documents about obtaining information about Aboriginal and Torres Strait Islander patients
- Communication with the workforce about the importance of identifying Aboriginal and Torres Strait Islander patients.

Action 5.9

Patients are supported to document clear advance care plans

Given the very short length of stay for most patients using day procedure services, this action will not be applicable for most services.

Action 5.17 regarding receiving and documenting advance care plans remains applicable. Further strategies and examples of evidence are available in *NSQHS Standards Guide for Hospitals* and *NSQHS Standards Accreditation Workbook.*.

Screening of risk

Action 5.10

Clinicians use relevant screening processes:

a. On presentation, during clinical examination and history taking, and when required during care

b. To identify cognitive, behavioural, mental and physical conditions, issues, and risks of harm

c. To identify social and other circumstances that may compound these risks

Reflective questions

What processes are used for screening patients at presentation, during clinical examination, at history taking and at other appropriate times?

Are the tools that are used validated, and do these screening processes have the capacity to identify cognitive, behavioural, mental and physical conditions, issues or risks of harm?

Do these screening processes have the capacity to identify social and other circumstances that may compound the risks?

Key tasks

- Work with clinicians to integrate screening processes into their workflow
- Develop information about screening processes to include in orientation, education and training programs

- Develop strategies and processes for clinicians to provide feedback about the usability and effectiveness of screening processes.

Strategies for improvement

Work with clinicians to integrate the use of screening processes into their workflow. In the day procedure setting, this largely relates to processes for pre-admission screening. Referring clinicians may be required to use specific screening tools during clinic appointments before a planned episode of care. The service may also need processes for nurses undertaking pre-admission screening to refer patients for further specialist screening – for example, to identify anaesthetic risks.

Ensure that processes identify:

- When routine screening will occur in an episode of patient care
- The roles and responsibilities of those who are responsible for screening individual patients
- The process for ensuring that action is taken when conditions or risks are identified through the screening process
- Indications for repeating the screening process.

Tailor orientation, education and training for clinicians so that they understand their individual roles, responsibilities and accountabilities in using relevant screening processes. Clinicians require training about organisational processes, as well as more specific training about the day procedure service's processes.

Topics to cover in education for clinicians include:

- When and how to use relevant screening processes and tools
- How to partner with patients, carers and families to optimise the identification of relevant information
- Criteria for admission to the service, and processes for referring patients who do not meet these criteria for alternative care
- What assessments and actions to take when cognitive, behavioural, mental or physical conditions, issues or risks of harm are identified
- When to repeat screening processes to identify evolving conditions, issues or risks of harm
- How to provide feedback about any issues with screening tools and processes.

Involve clinicians and consumers in reviewing the effectiveness and usefulness of screening processes. Develop processes for ensuring that updates and changes to screening tools and processes are effectively communicated to clinicians. This may involve developing specific, targeted implementation strategies to ensure that clinicians understand how to use and apply newly developed processes in their work, and have opportunities to provide feedback about usefulness and effectiveness of these processes.

Examples of evidence

Select only examples currently in use:

- Policy documents or by-laws that outline processes for conducting screening and identify
  - when routine screening will occur in an episode of patient care
  - the roles and responsibilities of members of the workforce who screen patients
  - the process for taking action when risks are identified
  - indications for repeating the screening process
- Observation of clinicians' practice that shows use of relevant screening processes
- Records of interviews with clinicians that show that they understand the health service organisation's screening processes
- Training documents about organisational screening processes
- Communication with clinicians about updates to screening processes
- Tools or a healthcare record that include prompts to clinicians to conduct routine screening
- Risk assessment tool that is in use throughout the health service organisation
- Audit results of healthcare records for screening at presentation, during clinical examination and history taking, and when required during care; the audit should be done in collaboration with patients, carers and families
- Audit results of healthcare records for completion of history taking for patients that demonstrate that social or other circumstances that may increase a patient's risk are recorded
- Observation of clinicians screening patients according to the health service organisation's policies, procedures or protocols
- Feedback from patients and carers about screening.

Clinical assessment

Action 5.11

Clinicians comprehensively assess the conditions and risks identified through the screening process

Reflective questions

What processes are in place for clinicians to ensure comprehensive assessment of patients' conditions and risks that were identified through the screening process?

How does the health service organisation ensure that clinicians use these processes?

Key tasks

- Ensure that clinicians talk to patients, carers and families about conditions and risks identified through screening processes, and work in partnership to comprehensively assess these conditions and risks
- Involve clinicians in evaluating and improving processes for comprehensive assessment.

Strategies for improvement

Comprehensive assessment relies on clinicians working with patients, carers and families to understand a patient's current health status, and its effect on their life and wellbeing. In day procedure services, this may mean a focused assessment of the presenting issue and associated risks, rather than an in-depth assessment of a patient's entire healthcare needs.

Clinicians from different professions and in different services may need to work together to develop a full picture of the patient's needs. Use the processes for communicating critical information that are described in the Communicating for Safety Standard to ensure that assessment findings are effectively communicated.

Provide orientation, education and training for clinicians on topics such as:

- Professional roles, responsibilities and accountabilities in comprehensive assessment processes

- When and how to use relevant assessment processes and tools
- How to partner with patients, carers and families to optimise the identification of relevant information
- How to communicate and document comprehensive assessment findings
- When to repeat assessment processes to address evolving conditions, issues or risks of harm
- How to provide feedback about any issues with comprehensive assessment tools and processes.

Involve clinicians and consumers in reviewing the effectiveness and usefulness of assessment processes. Develop processes for ensuring that updates and changes to assessment tools and processes are effectively communicated to clinicians. This may involve developing specific, targeted implementation strategies to ensure that clinicians understand how to use and apply newly developed processes in their work, and have opportunities to provide feedback about the usefulness and effectiveness of these processes.

Examples of evidence

Select only examples currently in use:
- Policy documents or by-laws that address
  – processes for assessing patients' health status
  – identification of risks and actions required
- Audit results of healthcare records for assessment of conditions and risks, for patients for whom screening was indicated
- Assessment tools and resources for clinicians
- Training documents about clinical assessment and assessment tools
- Results of a workforce survey, and actions taken to address feedback on assessment processes, tools and resources

- Standardised templates or forms for communicating critical information identified during assessment, such as email alerts or discharge summaries

- Observation of the use of standardised assessment processes, tools and resources
- Feedback from patients and carers about assessment.

Developing the comprehensive care plan

Action 5.12

Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record

Reflective questions

What systems and processes are in place for documenting the findings of screening and assessment processes in the healthcare record?

What processes are used to ensure that, if appropriate, information about the identified risks is shared with all members of the workforce who have contact with the patient?

Key tasks

- Support clinicians to use organisational and local processes to document the findings of the screening and assessment processes
- Involve clinicians in evaluating and improving documentation processes.

Strategies for improvement

This action should align with the requirements of the Communicating for Safety Standard. Work with clinicians to develop processes for documenting the findings of screening and assessment processes. In day procedure services, a generic pathway is likely to be appropriate for most patients, with exceptions or individual clinical requirements based on patient risk. This may include formalising existing processes, and developing or adapting specific paper or electronic tools. Ensure that alert processes include the capacity for alerts to be documented during pre-admission screening and assessment.

Clinicians require training about the use of these processes. Provide orientation, education and training for clinicians on topics such as:

- Professional roles, responsibilities and accountabilities in documenting the findings of screening and assessment processes
- How to use paper or electronic tools to document screening and assessment findings
- How to document alerts in the healthcare record
- How to provide feedback about any issues with documentation tools and processes.

Involve clinicians and consumers in reviewing the effectiveness and usefulness of comprehensive care documentation processes. Develop strategies to ensure that updates and changes to relevant tools and processes are effectively communicated to clinicians. This may involve developing specific, targeted implementation strategies to ensure that clinicians understand how to use and apply newly developed processes in their work, and have opportunities to provide feedback about usefulness and effectiveness of these processes.

Examples of evidence

Select only examples currently in use:

- Policy documents for recording
  - findings of screening and clinical assessment processes, risks and alerts
  - medical reviews or reassessments and their outcomes
  - changes to the care plan

- Audit results of healthcare records for the use of a screening and clinical assessment form, and relevant alerts
- Templates and forms for medical review assessment, risk assessment or care variation
- Training documents about patient healthcare record documentation, including electronic and paper-based documentation
- Observation of workforce computer access to healthcare records in clinical areas.

Action 5.13

Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that:

a. Addresses the significance and complexity of the patient's health issues and risks of harm

b. Identifies agreed goals and actions for the patient's treatment and care

c. Identifies the support people a patient wants involved in communications and decision-making about their care

d. Commences discharge planning at the beginning of the episode of care

e. Includes a plan for referral to follow-up services, if appropriate and available

f. Is consistent with best practice and evidence

Reflective questions

What processes are used for shared decision making between clinicians and the patient, carer and support people?

How do clinicians elicit patient preferences and goals of care, including social and wellbeing goals?

What processes are in place for developing a comprehensive and individualised plan that addresses the significance and complexity of the patient's health issues and risk of harm, and identifies the agreed goals of care?

Key tasks

- Support clinicians to use shared decision-making processes in the context of planning and delivering comprehensive care
- Provide guidance about the requirements for comprehensive care plans in the health service organisation.

Strategies for improvement

This action requires clinicians to use the processes described in the Partnering with Consumers Standard to work with patients or substitute decision-makers to reach shared decisions about the comprehensive care plan. It also requires clinicians to use the processes described in the Communicating for Safety Standard to document the comprehensive care plan and communicate its content to relevant members of the workforce.

The level of detail in a comprehensive care plan should reflect the significance and complexity of a patient's clinical situation, and the type of intervention provided. In day procedure services, a generic pathway is likely to be appropriate for most patients, with exceptions or individual clinical requirements noted.

Regardless of the type of process the service uses to document the comprehensive care plan, it should include the capacity to document:

- Agreed goals of care and actions required to achieve them
- Actions required to manage identified risks of harm

- Actions required to ensure safe discharge from the day procedure service.

Identify support people

A person-centred healthcare system is one that supports patients to make informed decisions, and successfully manage their own health and care. This includes giving patients choice about when to let support people, such as family or carers, be involved in their decision-making or to make decisions on their behalf.[144] Family or carers know the patient best, and their presence can help to reassure patients in times of uncertainty, anxiety or vulnerability.

To identify support people a patient wants involved in their care, develop effective processes that include:

- Asking the patient during initial conversations or admission processes to identify any support people they wish to be involved in communications and decision-making about their care
- Allowing the patient to nominate or change their nominated support people at any time throughout their care
- Documenting the contact details for a patient's support people in their healthcare record and treatment notes.

In some cases, a patient may need the organisation to put them in contact with someone who can provide support for communication and decision-making. Provide:

- Access to interpreters or interpreting services that can be involved in discussions about health and healthcare options
- Access to cultural support service or cultural liaison officers, such as Aboriginal health workers.

Support people cannot be part of a patient's healthcare decision-making if they are not present. Review the organisation's visiting policies to identify opportunities to allow a patient's support people to be present throughout care.

Plan for discharge

Part of the comprehensive care planning process is planning for discharge from the day procedure service. This includes identifying any services,

equipment and follow-up that may be needed to safely discharge the patient.

Examples of evidence

Select only examples currently in use:

- Training documents about
  - shared decision making
  - comprehensive care
- Audit results of comprehensive care plans for documenting
  - goals for the patient's treatment and care
  - details of the patient's nominated substitute decision-maker, carers and other support people to be involved in care decisions
  - actions to achieve goals
  - review date for goals
  - discharge plan
- Observation of clinicians' practice that shows use of the health service organisation's processes for shared decision making
- Records of interviews with clinicians that show that they understand the health service organisation's processes for shared decision making
- Observation of patients and carers participating in making decisions about their care
- Observation of accessibility of communication resources for clinicians to provide contact details for support services, such as local consumer health advocates, interpreters, or cultural support or liaison services
- Feedback from patients on the extent to which decisions were shared, goals were developed, support people were involved in discussions, and discharge planning was undertaken.

CRITERION: Delivering comprehensive care

Safe care is delivered based on the comprehensive care plan, and in partnership with patients, carers and families. Comprehensive care is delivered to patients at the end of life.

This criterion outlines strategies for the delivery of comprehensive care for all patients. It includes specific actions about providing care to those at the end of life.

Comprehensive care at the end of life is consistent with the principles of person-centred, goal-directed and compassionate care that are articulated in the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care*.[145]

Using the comprehensive care plan

Action 5.14

The workforce, patients, carers and families work in partnership to:

a. Use the comprehensive care plan to deliver care

b. Monitor the effectiveness of the comprehensive care plan in meeting the goals of care

c. Review and update the comprehensive care plan if it is not effective

d. Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur

Reflective questions

What processes are in place to ensure that the care delivered is consistent with the patient's comprehensive care plan?

What processes are in place to ensure that the workforce monitors the effectiveness of a patient's care plan, including reviewing and updating the plan when necessary, in collaboration with the patient, carer and family?

Key tasks

- Develop processes to ensure that clinicians and other members of the workforce are aware of their obligation to provide care in accordance with the comprehensive care plan, and in collaboration with patients, carers and family members
- Develop processes to ensure that the effectiveness and currency of the comprehensive care plan are routinely reviewed

- Develop guidance about indications to reassess the patient's care needs, preferences and goals, and revise the comprehensive care plan.

Strategies for improvement

Provide education and training

Provide orientation, education and training for clinicians so that they understand their individual roles, responsibilities and accountabilities in delivering care in accordance with the comprehensive care plan. Training for auxiliary members of the workforce involved in delivering patient care may also be needed.

Tailor education and training according to the complexity of the day procedure service and the patient population. Considering the short contact time that most day procedure services have with

patients, it is likely that the focus of education and training will be on:

- Expectations for the care delivered by the workforce
- When and how to access the comprehensive care plan
- Assessment, documentation and communication of patient progress compared with the goals of care
- How to partner with patients, carers and families to optimise the delivery of comprehensive care.

Involve carers

Carers may have an official role that goes beyond that of other family members. Accurately identify carers to ensure that any legal considerations relating to consent and decision-making are established.[146,147] For example, carers for children and young people may have identification cards that establish their role as legal guardians, which need to be sighted.

For Aboriginal and Torres Strait Islander people, there may be a collective approach to carer responsibilities. Confirming who is responsible for different aspects of care is important for ensuring that carer engagement is effective. More information is available in *Comprehensive Care for Aboriginal and Torres Strait Islander Consumers*.

Review processes

Involve the workforce and consumers in reviewing the effectiveness and usefulness of comprehensive care delivery processes. Develop processes for ensuring that updates and changes to comprehensive care planning tools and processes are effectively communicated to clinicians. This may involve developing specific, targeted implementation strategies to ensure that clinicians understand how to use and apply newly developed processes in their work.

The Recognising and Responding to Acute Deterioration Standard contains more information about how to reassess the patient's needs when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported (Action 8.5).

Examples of evidence

Select only examples currently in use:

- Policy documents that describe the requirements for routinely reviewing the effectiveness of the comprehensive care plan
- Audit results of
  - the effectiveness of the comprehensive care plan in meeting goals of care
  - whether comprehensive care plans are being reviewed when necessary, including after significant changes in the patient's diagnosis, behaviour, cognition, mental state or condition
  - whether information is provided to patients, carers and families about their proposed treatment
  - whether case conferences with patients, carers and families are held when necessary
- Training documents about using the comprehensive care plan, including roles and responsibilities, and how to partner with patients, carers and families to deliver care
- Results of patient and carer experience surveys
- Interviews with patients and carers about participation in ongoing review and reassessment of the patient's comprehensive care plan
- Patient and carer information packages that provide information to enable them to participate in their care
- Forms that patients review, sign and receive as a copy that relate to their clinical management
- Feedback from patients, carers and families about their inclusion in delivering care
- Observation of clinicians, carers and patients working together to deliver a comprehensive care plan, including monitoring and reviewing the plan as needed.

Comprehensive care at the end of life

Action 5.15

The health service organisation has processes to identify patients who are at the end of life that are consistent with the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care*[145]

This action will not be applicable for most day procedure services. It is unlikely that day procedure services will be providing care to patients at the end of life because of the nature of the service and pre-admission screening.

Refer to *NSQHS Standards Guide for Hospitals* and *NSQHS Standards Accreditation Workbook* for detailed implementation strategies and examples of evidence for this action.

Action 5.16

The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice

This action will not be applicable for most day procedure services. It is unlikely that day procedure services will be providing care to patients at the end of life because of the nature of the service and pre-admission screening.

Refer to *NSQHS Standards Guide for Hospitals* and *NSQHS Standards Accreditation Workbook* for detailed implementation strategies and examples of evidence for this action.

Action 5.17

The health service organisation has processes to ensure that current advance care plans:

a. Can be received from patients

b. Are documented in the patient's healthcare record

Reflective questions

How does the health service organisation receive advance care plans from patients?

How does the health service organisation ensure that advance care plans are documented in the patient's healthcare record and that care is provided in accordance with these plans?

Key task

- Develop processes to receive, document and provide access to advance care plans.

Strategies for improvement

In this action, advance care planning refers to the process of preparing for likely clinical scenarios near the end of life. Advance care planning can help to ensure that patients' preferences are known if they are no longer able to speak for themselves, and can reduce the likelihood of unwanted or inappropriate treatment.

The outcome of advance care planning processes may be the documentation of an advance care plan, which may include a formal advance care directive and nomination of a substitute decision-maker. Legislation and policy governing the documentation of advance care directives and nomination of substitute decision-makers vary in each state and territory. The Advance Care Planning Australia website includes information for consumers and clinicians, and links to state and territory resources to guide advance care planning and the documentation of advance care directives.

Ensuring access to a patient's advance care plan means that, if a serious complication arises and the patient requires transfer for ongoing care, the advance care plan will be available to direct care if the patient is no longer able to speak for themselves.

Develop standardised processes for:

- Determining whether a patient has a pre-existing and up-to-date advance care plan during the pre-admission screening and admission process, and, if so, ensuring that a copy is available in the healthcare record
- Ensuring that advance care plans are readily available in the healthcare record
- Providing access to documented advance care plans if care is transferred to another service and in emergency situations.

Examples of evidence

Select only examples currently in use:

- Policy documents that describe the requirements for documenting advance care plans in the patient's healthcare record
- Reviews of the use of advance care plans
- Audit results of healthcare records for documentation of advance care plans
- Reports of incidents of noncompliance with the use of advance care plans (for example, when advance care plans were unavailable, illegible or not used to guide care when they should have been) and actions taken to deal with these incidents.

Action 5.18

The health service organisation provides access to supervision and support for the workforce providing end-of-life care

This action will not be applicable for most day procedure services. It is unlikely that day procedure services will be providing care to patients at the end of life because of the nature of the service and pre-admission screening.

Refer to *NSQHS Standards Guide for Hospitals* and *NSQHS Standards Accreditation Workbook* for detailed implementation strategies and examples of evidence for this action.

Action 5.19

The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care

This action will not be applicable for most day procedure services. It is unlikely that day procedure services will be providing care to patients at the end of life because of the nature of the service and pre-admission screening.

Refer to *NSQHS Standards Guide for Hospitals* and *NSQHS Standards Accreditation Workbook* for detailed implementation strategies and examples of evidence for this action.

Action 5.20

Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care*[145]

This action will not be applicable for most day procedure services. It is unlikely that day procedure services will be providing care to patients at the end of life because of the nature of the service and pre-admission screening.

Refer to *NSQHS Standards Guide for Hospitals* and *NSQHS Standards Accreditation Workbook* for detailed implementation strategies and examples of evidence for this action.

CRITERION: Minimising patient harm

Patients at risk of specific harm are identified, and clinicians deliver targeted strategies to prevent and manage harm.

The screening actions in this standard aim to identify the patients who are at the greatest risk of harm while receiving health care. The specific risks identified in this criterion are areas in which at-risk patients are commonly harmed. Implementing targeted, best-practice strategies can prevent or minimise the risk of these specific harms.

Patients who have specific conditions and risks of harm identified in screening processes may be referred elsewhere if further assessment and care are required. Day procedure services should have admission protocols or policies that clearly outline criteria for admission.

Preventing and managing pressure injuries

Action 5.21

The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines

Reflective questions

How are decision-making and management processes described for preventing pressure injuries and for wound management?

What processes are in place to ensure that evidence-based documents and tools for preventing pressure injuries and wound management are current and consistent with best-practice guidelines?

How does the health service organisation ensure that the workforce is following best-practice guidelines and tools for the prevention of pressure injuries?

Key tasks

- Use information from screening and assessment processes to prevent and manage pressure injuries
- Develop or adapt a wound management system that is based on best-practice guidelines
- Identify individuals or groups with responsibility for overseeing this system.

Strategies for improvement

For many day procedure services, pressure injuries may not be a major area of patient harm. However, pressure injuries can happen to older patients, or patients of any age who have one or more of the following risk factors: immobility, lack of sensory perception, poor nutrition or hydration, excess moisture or dryness, poor skin integrity, reduced blood flow, limited alertness, or muscle spasms. Even treatments of short duration may cause or contribute to a pressure injury.

Evidence-based strategies to prevent pressure injuries exist and should be applied if screening identifies patients that are at risk, procedures or recovery take an extended time, or there have been incidents of pressure injuries in the service in the past 12 months.

Screening processes (see Action 5.10) should identify those patients at risk. Monitoring of pressure injuries will allow day procedure services to understand the risks and causal factors leading to pressure injuries, thus allowing prevention and harm minimisation strategies to be implemented.

Examples of evidence

Select only examples currently in use:

- Data on pressure injuries from the previous 12 months
- Pre-admission screening documents addressing pressure injury risk
- Policy documents about preventing and managing pressure injuries that are consistent with best-practice guidelines
- Training documents about managing pressure injuries

- Committee and meeting records regarding responsibilities for overseeing the wound management system
- Reports from clinical data systems that capture progress or outcomes relating to pressure injury wounds
- Audit results of healthcare records for compliance with policies, procedures or protocols on management of pressure injuries and wounds
- Feedback provided to the workforce about the results of audits, and actions to deal with issues identified
- Observation of best-practice guidelines that are used by the clinical workforce.

Action 5.22

Clinicians providing care to patients at risk of developing, or with, a pressure injury conduct comprehensive skin inspections in accordance with best-practice time frames and frequency

Reflective questions

What assessment tools or processes are used by the workforce to complete a comprehensive skin inspection for at-risk patients?

What processes are in place to ensure that prevention plans (including skin inspections) for patients at risk of a pressure injury are consistent with best-practice guidelines?

Key task

- Develop or adapt a process to prompt clinicians to perform and document comprehensive skin inspections as part of routine patient care.

Strategies for improvement

This action is not applicable for day procedure services that can demonstrate that they have had no pressure injury incidents in the past 12 months.

For other services, comprehensive skin assessment for patients screened as high risk for pressure injury should generally be incorporated into routine admission and discharge processes.

Refer to *NSQHS Standards Guide for Hospitals* for more detailed implementation strategies, as required.

Examples of evidence

- Data on pressure injuries from the previous 12 months
- Pre-admission screening documents addressing pressure injury risk.

Action 5.23

The health service organisation providing services to patients at risk of pressure injuries ensures that:

a. Patients, carers and families are provided with information about preventing pressure injuries

b. Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries

Reflective questions

What processes are in place to ensure that equipment, devices and products are being used in line with best-practice guidelines to prevent and effectively manage pressure injuries?

What information and support are provided to patients about the prevention and management of pressure injuries?

Key tasks

- Provide information for patients and carers about the prevention and management of pressure injuries
- Facilitate access to equipment and devices for the prevention and management of pressure injuries.

Strategies for improvement

This action is not applicable for day procedure services that can demonstrate that they have had no pressure injury incidents in the past 12 months.

For other services, patients or carers should be provided with practical information about the factors that contribute to pressure injuries and how pressure injuries can be prevented.

Where day procedure services routinely provide care to patients who are at risk of developing a pressure injury, devices and strategies to prevent pressure injuries may be required.

Examples of actions that can be considered to facilitate access to equipment and devices include:

- Evaluating requirements for, use of, and effectiveness of, equipment and devices
- Developing guidelines on how to obtain required equipment (for example, rental options).

Refer to *NSQHS Standards Guide for Hospitals* for more detailed implementation strategies for this action.

Examples of evidence

Select only examples currently in use:

- Register of equipment and devices
- Guidelines for use of, and access to, equipment to prevent pressure injuries
- Register of workforce training in the use and allocation of equipment and devices to manage pressure injuries
- Reports of equipment use
- Clinical audit of equipment use
- Register of equipment maintenance and safety checks
- Inventories of equipment, or guidelines on how to obtain required equipment (for example, rental options)
- Committee and meeting records about the use of equipment and devices, and evaluation of the efficacy of products, equipment and devices
- Patient and carer information packages or resources about preventing pressure injuries
- Results of patient and carer experience surveys, and organisational responses, in relation to information provided about preventing and managing pressure injuries.

Preventing falls and harm from falls

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Action 5.24

The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for:

a. Falls prevention

b. Minimising harm from falls

c. Post-fall management

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Reflective question

How does the health service organisation ensure that falls prevention, harm minimisation and post-fall management plans are consistent with best-practice guidelines?

Key task

- Identify all areas in the organisation that present falls risks and develop a risk management approach to implementing evidence-based improvement strategies.

Strategies for improvement

For many day procedure services, falls may not be a major area of patient harm. However, falls do occur in these settings, and prevention strategies will need to be in place.

Falls prevention and harm minimisation plans based on best practice and available evidence can improve patient outcomes.

Screening processes (see Action 5.10) should identify at-risk patients. Monitoring of falls reported through the incidents management system (see Action 1.11) will allow day procedure services to understand the risks and causal factors leading to falls, and allow prevention and harm minimisation strategies to be implemented.

Where the harm from falls is significant, post-falls management may occur at another health service organisation.

Delirium should be considered a risk factor for falls.[148] Refer to Action 5.29 and the Delirium Clinical Care Standard for strategies to manage risks of harm related to delirium.

Refer to Action 1.29 for strategies to ensure that the built environment supports safe and high-quality care, and reflects the patient's clinical needs.

Examples of evidence

Select only examples currently in use:

- Policy documents that
  - are consistent with best-practice guidelines
  - include processes for post-fall management
- Data on falls from the previous 12 months
- Tools and resources to prevent falls and minimise harm from falls
- Audit results of healthcare records to determine whether patients at risk of falls are assessed and managed in line with best-practice guidelines
- Templates for falls prevention, harm minimisation and post-fall management plans
- Observation of the use of falls prevention plans
- Feedback from patients to evaluate falls prevention plans against care provided.

Action 5.25

The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls

Reflective question

What equipment and devices are available for patients to prevent harm from falls or to manage patients who are at risk of falling?

Key tasks

- Identify, and facilitate access to, the equipment and devices required for the organisation's patient population
- Develop a log to register equipment and devices used in falls prevention and management, and record their maintenance.

Strategies for improvement

Where the risk of falls or harm from falls is low, the need for equipment and devices will be limited.

Adjust the environment in line with the patient risk profile and make equipment available for the patient to reduce the risk of falling. This may include:

- Adjusting chair and bed heights
- Using lighting that is even and activated by sensors, particularly over stairs and at night
- Providing slip-resistant surfaces
- Providing well-maintained walking aids and wheelchairs
- Reducing clutter and trip hazards around the patient
- Cleaning up spills and urine promptly
- Providing stable furniture for handholds
- Ensuring effective brakes on beds, wheelchairs and commodes
- Reducing the use of physical restraints
- Placing call bells within reach.

Best-practice guidelines and guides for preventing falls and harm from falls in older people are available on the website of the Australian Commission on Safety and Quality in Health Care.[149-151]

Refer to Action 1.29 for strategies to ensure that the built environment supports safe and high-quality care, and reflects the patient's clinical needs.

Examples of evidence

Select only examples currently in use:

- Inventories of equipment and audit of clinical use
- Maintenance logs of equipment and devices
- Policy documents about equipment procurement and provision
- Documented systems for reviewing and procuring equipment and devices
- Committee and meeting records that note responsibilities for evaluating the effectiveness of products, equipment and devices.

Action 5.26

Clinicians providing care to patients at risk of falls provide patients, carers and families with information about reducing falls risks and falls prevention strategies

Reflective question

What information and support are provided to patients and carers about falls risk and prevention?

Key tasks

- Provide information to, and have discussions with, patients, families and carers about falls risks
- Seek feedback on information provided to patients and carers, and amend it to improve the information
- Ensure that the discharge planning protocol prompts the workforce to consider referral to appropriate services.

Strategies for improvement

Provide patient information

For patients who are at risk of falling or sustaining harm from a fall during care at a day procedure service, or immediately after an episode of care, provide patients or their carers with practical information about the factors that contribute to falls and how to prevent falls.

Fact sheets for patients are available that describe a range of aspects relating to falls.

Examples of evidence

Select only examples currently in use:

- Consumer and carer information packages or resources about falls risks
- Audit results of healthcare records to determine whether information about falls risks and prevention strategies was provided to the patient
- Results of patient and carer experience surveys, and organisational responses, in relation to information provided about falls risks and falls prevention strategies.

Nutrition and hydration

Action 5.27

The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice

Most day procedure services do not admit patients overnight. However, services may care for patients who are at risk of malnutrition or undernutrition, which adversely affect patient outcomes. There may be a need to refer such patients for nutrition assessment and to consider including nutritional care in the patient's care plan. These services, or those that admit patients overnight (for example, those with 23-hour licences), should refer to *NSQHS Standards Guide for Hospitals* and *NSQHS Standards Accreditation Workbook* for detailed implementation strategies and examples of evidence for this action.

Action 5.28

The workforce uses the systems for preparation and distribution of food and fluids to:

a. Meet patients' nutritional needs and requirements

b. Monitor the nutritional care of patients at risk

c. Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone

d. Support patients who require assistance with eating and drinking

Nutrition risk screening may be required before, or on, presentation at day procedure services such as chemotherapy or dialysis units. Patients using these services may need to be referred for nutrition assessment. Consider including nutritional planning in the patient's healthcare plan. Refer to *NSQHS Standards Guide for Hospitals* and *NSQHS Standards Accreditation Workbook* for detailed implementation strategies and examples of evidence for this action.

Preventing delirium and managing cognitive impairment

Action 5.29

The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to:

a. Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard[152], where relevant

b. Manage the use of antipsychotics and other psychoactive medicines, in accordance with best practice and legislation

Reflective questions

What processes are in place to manage safety and quality issues for patients with, or at risk of, developing cognitive impairment?

How is the use of antipsychotics and other psychoactive medicines monitored, and how is feedback provided to clinicians?

What supports are available for clinicians to use non-pharmacological approaches in response to behavioural and psychological symptoms of dementia?

Key tasks

- Use screening processes to identify patients with cognitive impairment or at risk of delirium
- Review, revise or develop a system for providing high-quality care for patients with cognitive impairment, as required.

Strategies for improvement

Implement a system

Pre-admission screening should identify patients with cognitive impairment or at risk of delirium, to trigger strategies to keep the patient safe and to minimise potential distress. Strategies include:

- Reviewing communication systems to ensure that risk and identified cognitive impairment are flagged, communicated and documented during pre-admission and admission processes

- Providing consumer information in an easy-to-understand format, including information about the risk of delirium
- Involving family members or carers to support patients in pre-admission screening, or consulting with a substitute decision-maker
- Communicating effectively with patients with cognitive impairment
- Consulting with family members on strategies to minimise distress
- Involving family members or carers in the care episode, including reporting any concerns they raise about the patient
- Providing information to other health services (for example, referring clinician) regarding any delirium and further follow-up.

Pre-admission screening should include screening for risk factors for postoperative delirium, including age greater than 65 years, chronic cognitive decline or dementia, certain medicines or multiple medicines, and poor vision or hearing.[153,154]

A Better Way to Care: Safe and high-quality care for patients with cognitive impairment (dementia and delirium) in hospital[144] and the Delirium Clinical Care Standard[152] set out suggested strategies for health service organisations in early recognition, prevention, treatment and management of cognitive impairment. *A Better Way to Care* also provides links to further resources that are useful in implementing this action.

Examples of evidence

Select only examples currently in use:

- Policy documents that outline processes for
  - recognising, preventing, treating and managing cognitive impairment, including through pre-admission screening for cognitive impairment
  - obtaining early primary care input about a patient's cognitive difficulties to aid diagnosis, treatment and ongoing management decisions
- Validated tools and resources used to screen for, and assess, cognitive impairment
- Training documents about communicating with, and providing support to, patients with cognitive impairment, and assessing and responding to distress
- Examples of activities that have been implemented and evaluated to improve the environment for people with cognitive impairment
- Examples of non-pharmacological approaches that have been implemented to respond to behavioural symptoms of dementia
- Patient, carer and family information packages that provide information to enable them to participate in the system for caring for patients with cognitive impairment
- Committee and meeting records that show the health service organisation's involvement in dementia pathway initiatives to integrate primary, community and acute care.

Action 5.30

Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to:

a. Recognise, prevent, treat and manage cognitive impairment

b. Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care

Pre-admission screening should identify patients with cognitive impairment or at risk of delirium, to trigger strategies to keep the patient safe and to minimise potential distress.

If the day procedure service admits patients who have cognitive impairment or are identified as being at risk of developing delirium, the service should have processes to ensure that clinicians are aware of the systems outlined in Action 5.29.

Refer to *NSQHS Standards Guide for Hospitals* and *NSQHS Standards Accreditation Workbook* for detailed implementation strategies and examples of evidence for this action.

Predicting, preventing and managing self-harm and suicide

Action 5.31

The health service organisation has systems to support collaboration with patients, carers and families to:

a. Identify when a patient is at risk of self-harm

b. Identify when a patient is at risk of suicide

c. Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed

Reflective questions

What processes are in place to ensure that the workforce can work collaboratively to identify patients at risk of self-harm or suicide?

How does the health service organisation ensure that clinicians know how to respond safely and effectively to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed?

How do members of the workforce gain access to specialist mental health expertise to provide care to patients who have thoughts of self-harm or suicide, or have self-harmed?

Key tasks

- Implement screening for thoughts of self-harm or suicide for people who present with self-harm, mental illness or acute emotional distress
- Set up a system for response according to the level of risk.

Strategies for improvement

Day procedure services conduct pre-admission screening to determine whether it is currently safe to undertake a procedure in this setting.

Members of the workforce may become aware that a person is experiencing thoughts of self-harm or suicide. Day procedure services typically do not have resources on site to conduct comprehensive psychosocial and risk assessments. It is therefore critical that the organisation has referral mechanisms for this information to be provided

to the referring clinician and, where possible, to establish links with relevant local agencies that can provide these services.

Make the workforce aware of the local referral processes and how to use them when they have identified a person who is at risk of self-harm or suicide.

Refer to *NSQHS Standards Guide for Hospitals* for detailed implementation strategies for this action.

Examples of evidence

Select only examples currently in use:

- Policy documents that outline collaborative processes for identifying and treating patients at risk of self-harm or suicide, or who have self-harmed, including pre-admission screening
- Risk assessment tools for patients at risk of self-harm or suicide
- Training documents about identifying and treating patients at risk of self-harm or suicide, or who have self-harmed
- Consumer and carer information packages or resources about strategies for managing self-harm, or risks of self-harm or suicide, and escalation protocols
- Clinical incident monitoring system that includes information on self-harm and suicide
- Resources for the workforce to help identify patients who require close monitoring
- Audit results of healthcare records for identifying carers and engaging them in shared decision making when a person is identified as at risk of self-harm

- Patient and carer experience surveys, a complaints management system and a consumer participation policy for patients at risk of self-harm or suicide

- Observation that information about referring patients to specialist mental health services is accessible to clinicians.

Action 5.32

The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts

Day procedure services do not generally provide health care for treatment of self-harm or suicidal thoughts. In the rare event that a person discloses thoughts of self-harm or suicide in the day procedure setting, ensure that members of the workforce have access to local processes for notifying the referring doctor or referring the patient to specialist mental health services.

As identified in the endorsed national Living is for Everyone (LIFE) framework[155], suicide prevention requires a whole-of-community approach. If a workforce member at a day procedure service recognises that a person has thoughts of self-harm or suicide, ensure that follow-up is arranged. Do not assume that someone else or another agency has responsibility for this.

Refer to *NSQHS Standards Guide for Hospitals* and *NSQHS Standards Accreditation Workbook* for detailed implementation strategies and examples of evidence for this action.

Predicting, preventing and managing aggression and violence

Action 5.33

The health service organisation has processes to identify and mitigate situations that may precipitate aggression

Many of the factors that can precipitate aggression within health services are not relevant in day procedure services, because people are typically admitted for only a few hours, and may be sedated for much of this time. Admission is also typically voluntary, and interactions with others are minimal.

Some people experience a period of confusion after anaesthesia. In rare instances, they may behave aggressively while in this agitated state. Members of the workforce should be trained in recognising the signs of postoperative delirium, and implement environmental and supportive measures to prevent the onset of delirium and shorten its duration (see Action 5.29).

Refer to *NSQHS Standards Guide for Hospitals* and *NSQHS Standards Accreditation Workbook* for detailed implementation strategies and examples of evidence for this action.

Action 5.34

The health service organisation has processes to support collaboration with patients, carers and families to:

a. Identify patients at risk of becoming aggressive or violent

b. Implement de-escalation strategies

c. Safely manage aggression, and minimise harm to patients, carers, families and the workforce

There is low prevalence of violence in day procedure services. Day procedure services should use screening processes to identify patients at risk of becoming aggressive or violent.

Pre-admission screening can identify if there is a potential risk for someone to become confused or agitated when admitted for a brief procedure (for example, someone with dementia). Mitigating strategies begin with collecting clear and comprehensive information about triggers for the individual, and optimal management strategies. If a risk is identified, a management strategy can be formulated before admission. This typically consists of arranging for a family member or carer known to the person to accompany them.

Members of the workforce can communicate in a specific way to assist the person. Appropriate and safe use of medicine can help when conducting procedures on people who may become agitated.

Refer to *NSQHS Standards Guide for Hospitals* and *NSQHS Standards Accreditation Workbook* for detailed implementation strategies and examples of evidence for this action.

Minimising restrictive practices: restraint

Action 5.35

Where restraint is clinically necessary to prevent harm, the health service organisation has systems that:

a. Minimise and, where possible, eliminate the use of restraint

b. Govern the use of restraint in accordance with legislation

c. Report use of restraint to the governing body

For many day procedure services, restraint will rarely be clinically necessary to prevent harm. Strategies to minimise restraint should be applied if pre-admission screening identifies that patients are at risk.

Restraint is practised in mental health services and other health service organisations. Minimising and, if possible, eliminating the use of restraint and seclusion were identified as a national safety priority for mental health services in Australia in 2005.[156]

The key to minimising use of restrictive practices is to be alert to changes in a person's behaviour or demeanour that may suggest a deterioration in their mental state. Be receptive to information from the person themselves, and from their carers and families. People who have experienced mental health issues, or cared for someone who does, often have detailed knowledge about what can lead to a deterioration in their mental state, and what strategies are most effective for restoring their capacity to manage their mental state without the use of restrictive practices. These principles are outlined in the *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state*.[157]

Refer to *NSQHS Standards Guide for Hospitals* and *NSQHS Standards Accreditation Workbook* for detailed implementation strategies and examples of evidence for this action.

Minimising restrictive practices: seclusion

Action 5.36

Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that:

a. Minimise and, where possible, eliminate the use of seclusion

b. Govern the use of seclusion in accordance with legislation

c. Report use of seclusion to the governing body

This action is not applicable for day procedure services. Day procedure services are not gazetted under relevant legislation to use seclusion.

Resources

Nutrition and hydration

Nutrition standards

Dietitians Association of Australia – *Nutrition Manual*, 9th edition, 2014

NSW Agency for Clinical Innovation – *Nutrition Standards for Adult Inpatients in NSW Hospitals*

NSW Agency for Clinical Innovation – *Nutrition Standards for Consumers of Inpatient Mental Health Services in NSW*

Queensland Health – *Nutrition Standards for Meals and Menus*

The Nutrient Reference Values for Australia and New Zealand, the *Australian Dietary Guidelines* and the *Australian Guide to Healthy Eating* are intended for use with healthy populations but may be relevant to some groups receiving care in hospitals and day procedure services

Victorian Department of Human Services – *Nutrition Standards for Menu Items in Victorian Hospitals and Residential Aged Care Facilities*

Western Australian Department of Health – *Nutrition Standards for Adult Inpatients in WA Hospitals*

Nutrition risk screening and assessment tools

Lady Cilento Children's Hospital – Paediatric Nutrition Screening Tool

Malnutrition Screening Tool

Malnutrition Universal Screening Tool

Mini Nutritional Assessment

Subjective Global Assessment

Other tools

- Discharge report
- Food and fluid consumption chart
- Food diary

Preventing delirium and managing cognitive impairment

Australian Commission on Safety and Quality in Health Care resources

A Better Way to Care: Safe and high-quality care for patients with cognitive impairment (dementia and delirium) in hospital

Delirium Clinical Care Standard

Implementing systems for cognitive impairment

Care of Confused Hospitalised Older Persons (CHOPS)

Dementia Care in Hospitals Program

Acute care e-learning course for dementia

The View from Here

Delirium

Australasian Delirium Association

Delirium awareness video

Health Research & Educational Trust (United States) – Preventing and Managing Iatrogenic Delirium Change Package

Hospital Elder Life Program (HELP) for Prevention of Delirium

Queensland University of Technology – Learn about delirium

Responding to distress

Dementia Support Australia – Resources library

NPS MedicineWise and Alzheimer's Australia resource on medicines and dementia (includes a fact sheet on *Strategies to Address Distress*)

NSW Agency for Clinical Innovation – Volunteer Dementia and Delirium Care program

Royal Australian and New Zealand College of Psychiatrists – *Assessment and Management of People with Behavioural and Psychological Symptoms*

of Dementia (BPSD): A handbook for NSW health clinicians

University of Sydney – *Clinical Practice Guidelines and Principles of Care for People with Dementia in Australia*

Communication

Alzheimer's Australia – *Dementia Language Guidelines*

Alzheimer's Australia – *Talk to Me: Good communication tips for talking to people with dementia*

Alzheimer's Society – *This is Me*

Centre for Developmental Disability Health – *Working with People with Intellectual Disabilities in Healthcare Settings*

Focus on the Person

NSW Agency for Clinical Innovation – Sunflower Tool

Queensland Health – Communication changes after ABI

Stroke Foundation – Communication after stroke

Environment

Dementia Enabling Environments

Dementia Training Australia

Partnering with patients, carers and family

NSW Clinical Excellence Commission – Top 5 Initiative

Predicting, preventing and managing self-harm and suicide

National Health and Medical Research Council – *Care After a Suicide Attempt*

Predicting, preventing and managing aggression and violence

CPI – *Nonviolent Crisis Intervention®* training program

MTU Training Concepts – *Predict, Assess and Respond to Challenging Behaviour (PART)*

NSW Health – *Violence Prevention and Management Training Framework for the NSW Public Health System*

Communicating for Safety Standard
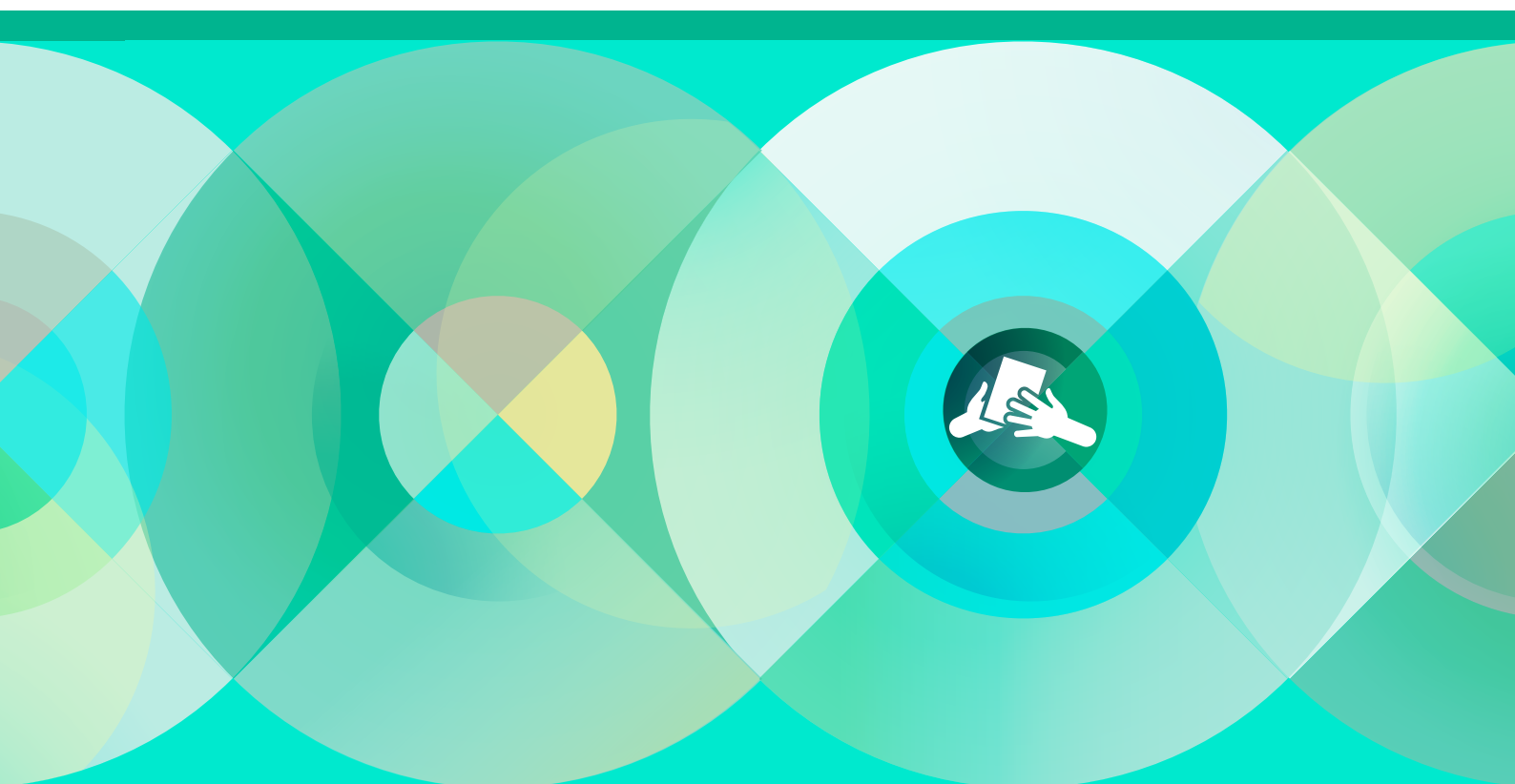
Communicating for Safety Standard

Leaders of a health service organisation set up and maintain systems and processes to support effective communication with patients, carers and families; between multidisciplinary teams and clinicians; and across health service organisations. The workforce uses these systems to effectively communicate to ensure safety.

Intention of this standard

To ensure timely, purpose-driven and effective communication and documentation that support continuous, coordinated and safe care for patients.

Criteria

Clinical governance and quality improvement to support effective communication

Correct identification and procedure matching

Communication at clinical handover

Communication of critical information

Documentation of information

Introduction

Communication is a key safety and quality issue, and is critical to the delivery of safe patient care. Communication failures, and inadequate or poor documentation of clinical information can result in errors, misdiagnosis, inappropriate treatment and poor care outcomes.[120,158-163] Communication errors are also a major contributing factor in sentinel events in health service organisations[164], and communication issues are identified as one of the most common underlying factors in complaints about the Australian healthcare system.[165,166,167]

This standard recognises the importance of effective communication in health care, and the essential role that communication plays in ensuring safe, coordinated and continuous care. Actions in this standard focus on three high-risk areas in which communication is critical to patient safety:

- When patient identification and procedure matching should occur
- When all or part of a patient's care is transferred
- When critical information or risks emerge or change throughout the course of care.

Contemporaneous documentation and recording of information that supports the provision of health care are also essential.

Communication is inherent to patient care, and informal communications will occur throughout care delivery. This standard is not intended to apply to all communications within the organisation. Rather, it aims to ensure that systems and processes are in place at key times when effective clinical communication and documentation are critical to patient safety.

About this standard

The standard requires health service organisations to implement systems and processes to support effective clinical communication and documentation.

This standard is informed by research and other work undertaken in Australia and internationally, which recognises the importance of effective clinical communication and documentation to the delivery of safe and high-quality health care.[161-163] This includes work by the Australian Commission on Safety and Quality in Health Care (the Commission) on the Ensuring Correct Patient, Correct Site, Correct Procedure Protocol[181]; the National Clinical Handover Initiative Pilot Program[163]; the *OSSIE Guide to Clinical Handover Improvement*[162]; and the Implementation Toolkit for Clinical Handover Improvement.[169] The Commission has also supported research on improving transitions of care[170], patient–clinician communication[171] and documentation.

Links with other standards

Communication is important across all aspects of care. Implementation of this standard will depend on the organisation-wide systems required under the Clinical Governance Standard and the Partnering with Consumers Standard. These two standards set the overarching requirements for effective implementation of actions within this Communicating for Safety Standard. There are also strong links with actions in the Medication Safety Standard, the Comprehensive Care Standard, and the Recognising and Responding to Acute Deterioration Standard. If appropriate, these standards should be applied in conjunction with this standard.

For example, the Clinical Governance Standard requires organisations to integrate multiple information systems, where they are used (Action 1.16e), and have in place a healthcare records system that makes the healthcare record available to clinicians at the point of care (Action 1.16a). By ensuring that clinicians have access to all the relevant information, these actions support clinicians to effectively communicate. In turn, this standard requires organisations to have systems to contemporaneously document relevant information in the healthcare record, ensuring that the most up-to-date information is available to clinicians.

CRITERION: Clinical governance and quality improvement to support effective communication

Systems are in place for effective and coordinated communication that supports the delivery of continuous and safe care for patients.

This criterion requires organisation-wide governance, leadership and commitment to support effective clinical communication with patients, carers and families; between clinicians and multidisciplinary teams; and across organisations. To meet this criterion, health service organisations are required to:

- Integrate clinical governance and apply quality improvement systems

- Apply principles of partnering with consumers, health literacy and shared decision making when developing and implementing organisational clinical communication processes
- Implement safety and quality systems and processes to support effective clinical communication during high-risk situations.

Organisations will need to understand their priorities; identify their risks in relation to clinical communications; and consider how to best deal with these within their given resources, and workforce and organisational structures.

This criterion aligns closely with the Clinical Governance Standard and the Partnering with Consumers Standard.

Integrating clinical governance

Action 6.1

Clinicians use the safety and quality systems from the Clinical Governance Standard when:
a. Implementing policies and procedures to support effective clinical communication
b. Managing risks associated with clinical communication
c. Identifying training requirements for effective and coordinated clinical communication

Reflective questions

How are the health service organisation's safety and quality systems used to:

- Support implementation of policies and procedures for effective clinical communication
- Identify and manage risks associated with clinical communication
- Identify training requirements for the delivery of effective clinical communication?

Key tasks

- Establish and implement governance structures for clinical communication
- Develop and implement policies and procedures for clinical communication
- Use organisation-wide risk management systems to identify, monitor, manage and review risks associated with clinical communication
- Deliver or provide access to training on clinical communication based on the specific needs of the workforce.

Strategies for improvement

The Clinical Governance Standard has specific actions relating to health service organisations' safety and quality systems.

Action 1.7 – policies and procedures

Action 1.10 – risk management systems

Actions 1.19, 1.20 and **1.21** – education and training

Health service organisations should:

- Use these and other established safety and quality systems to support policies and procedures, risk management and training for clinical communications

- Ensure that current versions of all relevant policies and procedures are readily available and accessible to clinicians.

Policies may be developed or adapted at different levels within the organisation. However, all policy documents should be incorporated into a single, coherent set to maximise the effectiveness of the policy development process.

Implement policies and procedures

Policies and procedures should outline how organisation-wide systems support effective clinical communication.

Organisations vary significantly, depending on the size of the service, settings and circumstances. This highlights the need for a flexible approach to implementation.[162] Implementation of policies and procedures to improve clinical communications therefore requires consideration of the existing organisational structure and governance framework, and how the policies and procedures fit within the organisation's context. Development of separate policies or procedures is not necessarily required – it may be more efficient and effective to have an overarching policy framework, supported by a flexible standardisation approach that is fit for purpose and accommodates specific localised environments (for example, communication in a general ward compared with an emergency department).

Policies and processes could include:

- An organisation-wide strategy that outlines clinical communication processes, and the flow of information to patients, carers, families and clinicians responsible for providing care

- Situations when identification, procedure matching, structured clinical handover and communication of critical information are required (linked to Actions 6.4 and 6.11)

- Agreed processes for communicating in these situations, including the structure and method of communication, and relevant information to be communicated – for example
  - points of care at which communication is required
  - appropriate communication methods
  - roles and responsibilities of the workforce

- Guidance on how to engage with, and support, patients (and carers) to communicate about their care.

Ensure that policies and procedures describe patients as key participants in clinical communication, and how patients, carers and families can be involved in clinical communication strategies and associated processes.

Document the policies, processes, resources and tools for clinical communications. Make these available to the workforce to ensure that a consistent approach is taken across the organisation and members of the workforce understand what is required of them when using the organisation's clinical communication processes. This can be done through the organisation's website, at meetings, through newsletters or noticeboards, or by displaying communication techniques and processes in the service on charts or tools.

Set up governance and reporting structures to support effective clinical communication across the organisation, and effective collaboration between patients and clinicians. This could involve setting up committees with governance oversight for improving or monitoring clinical communication.

Ensure that membership of committees reflects the different disciplines that work in the organisation and are involved in delivering patient care. In particular, ensure that consumer advisors reflect the organisation's day-to-day patient community (see Action 2.11).

Manage risks

Consider the types of risks that may be associated with clinical communications, such as[172]:

- Contextual risks (for example, noise, interruptions, inadequate space and time, absent participants)
- Informational risks (for example, information that is not integrated, unavailable, inaccessible, unstructured, incomplete, irrelevant, inaccessible, inaccurate or not up to date)
- Interactional risks (for example, failure to design communication processes that are accessible, legible and intelligible to recipients; and to which recipients can actively contribute).

Ensure that the organisation-wide risk management system can identify, assess, manage and document organisational risks associated with poor clinical communication or communication errors (see Action 1.10). These risks could include:

- Failure to correctly identify patients or match procedures
- Miscommunication or loss of clinical information at transitions of care, such as failure to communicate information gathered at pre-admission to the treating clinician
- Failure to communicate critical results that arise during a procedure to the admitting clinician or the patient's general practitioner
- Risks associated with poor documentation.

Consider potential clinical risks associated with electronic health systems (hardware and software) that are intended to aid or enable communication processes. For example, electronic health systems and new technology have the potential to enable faster, more effective communication; however, information systems and technology can also present challenges for privacy, and risks to clinical safety and quality if they are poorly implemented or integrated.

Consider the interaction between non-technical dimensions of healthcare (workflow, policies and personnel) and technical dimensions (software, hardware, content and user interface).[173] Patient safety issues can occur when one or more technical dimensions interact unexpectedly with non-technical dimensions. For example, a change in the way that one system presents information to a clinician may lead to incorrect interpretation if the

clinician is unaware of that change. Ensure that the organisation considers, monitors and manages these risks.

Carefully consider the planning and implementation of electronic handover solutions, such as electronic discharge summary systems. Use the *Electronic Discharge Summary Systems Self-Evaluation Toolkit*[174] and *National Guidelines for On-Screen Presentation of Discharge Summaries*.[175]

Identify training requirements

Assess the competency and training needs of the workforce in line with the requirements of Actions 1.19, 1.20 and 1.21. Perform a risk assessment to inform the training schedule and to set priorities for the members of the workforce who need training. Develop, or provide access to, training and education resources to meet the needs of the workforce in relation to clinical communication.

Provide ongoing education and training to new and existing members of the workforce about the organisation's clinical communication policies, processes and tools. This should include information about what is required, roles and responsibilities, and the structure or standardised format to be used for communicating when identification, procedure matching, clinical handover and communication of critical information are required.

Provide information through orientation, training, regular updates at workforce and management meetings, mentorship programs, and feedback or debriefing sessions with members of the project workforce or clinicians.

Ensure that performance management processes established in Action 1.22 give priority to continuous development of the workforce's communication skills. Identify any communication skills that need to be improved or refined, and incorporate these into the organisation's training system.

Examples of evidence

Select only examples currently in use:

- Organisation-wide strategy that outlines clinical communication processes

- Policy documents for clinical communication that deal with identified risks relevant to the health service organisation, including
  - points of care when communication is required
  - appropriate communication methods
  - roles and responsibilities of the workforce
  - engagement of patients, carers and families
- Observation of clinicians' practice that shows use of the health service organisation's clinical communication processes
- Records of interviews with clinicians that show that they understand the health service organisation's clinical communication processes
- Training documents about clinical communication systems and processes
- Terms of reference and membership of committees responsible for developing and implementing the organisation-wide clinical communication strategy and associated processes, and monitoring their effectiveness

- Committee and meeting records in which clinical communication issues and actions were discussed
- Organisation-wide risk register that identifies clinical communication risks, and describes mitigation strategies and risk monitoring
- Reports, investigations and feedback from the organisation-wide incident management and investigation system that identifies adverse events, incidents and near misses relating to clinical communication and associated processes
- Schedule of routine review of the organisation-wide clinical communication strategy and relevant policy documents, and updates in line with changes in best practice, emerging evidence, and reports of audits and investigations.

Applying quality improvement systems

Action 6.2

The health service organisation applies the quality improvement system from the Clinical Governance Standard when:

a. Monitoring the effectiveness of clinical communication and associated processes

b. Implementing strategies to improve clinical communication and associated processes

c. Reporting on the effectiveness and outcomes of clinical communication processes

Reflective questions

How is the effectiveness of clinical communication and associated processes continuously evaluated and improved?

How are the outcomes of improvement activities communicated to the governing body, the workforce, consumers and other organisations?

Key tasks

- Review, measure, and assess the effectiveness and performance of, organisational and clinical strategies for clinical communications
- Implement quality improvement strategies for clinical communications based on the outcomes of monitoring activities
- Provide information on the outcomes of quality improvement activities to the governing body, the workforce, consumers and other organisations.

Strategies for improvement

The Clinical Governance Standard has specific actions relating to health service organisations' quality improvement systems.

Action 1.8 – quality improvement systems

Action 1.9 – reporting

Action 1.11 – incident management and investigation systems

Health service organisations should use these and other established safety and quality systems to support monitoring, reporting and implementation of quality improvement strategies for clinical communications.

Strategies to improve effective communication will take time, leadership, commitment (across the whole organisation) and resources.[162]

Identify a suitable individual, group or committee to take responsibility for monitoring and evaluating organisation-wide clinical communication systems. Consider how monitoring and evaluation in relation to improving clinical communications inform and feed into existing evaluation processes in the organisation.

Monitor effectiveness and performance

Ensure that quality improvement and incident management and investigation systems include monitoring and evaluation of incidents, adverse events and near misses relating to patient identification, procedure matching, clinical handover at transitions of care, failure to communicate critical information, and inadequate or poor documentation. These incidents could include:

- Failure to escalate
- Mismatching events
- Clinical handover incidents
- Unplanned transfers to overnight stays
- Delays in discharge
- Return to theatre
- Other key performance indicators developed in consultation with the workforce.

Ongoing monitoring of adverse events allows organisations to keep track of whether there are safety gaps in their clinical communication processes, and to modify these processes to suit the service context. Evaluation allows organisations to measure the progress and impact of clinical communication processes and improvement strategies. Ensure that members of the clinical workforce know about the processes to monitor and review incidents and adverse events.

Safe Communication[176], developed by the Quality Improvement Clinic (United Kingdom), and the *OSSIE Guide to Clinical Handover Improvement*[162] provide useful guides to measuring the effectiveness of clinical communication processes.[162,176]

Implement quality improvement strategies

Implementation of quality improvement strategies is essential to ensure that clinical communication systems and processes continue to operate effectively, and any areas for improvement are identified and acted on. Quality improvement systems can also help to identify where communication is being done well in the organisation. Ongoing monitoring and regular evaluations are necessary to track changes over time, and to report on adverse incidents or risks that may relate to clinical handover or other communication failures.

Use the results of monitoring activities to show improvements, or areas in which improvement is required. If appropriate, use quality improvement activities that are consistent and measurable across the corporate group.

Use the results of organisational risk assessments to identify gaps, plan, and set priorities for areas for investigation or action.

When adverse events or near misses occur, specifically investigate to identify any issues in the performance or use of the system. Use this information to make improvements.

One model to implement strategies to improve clinical communications is the plan–do–study–act (PDSA) cycle.[169,176] The PDSA cycle is an iterative feedback process that allows improvements to respond to changing circumstances or consequences, as well as ensuring continual and increasing engagement of clinicians. Engagement of clinicians and other relevant workforce members is essential to any quality improvement process.[162]

Report outcomes

Ensure that processes are in place to facilitate feedback, and provide review findings to relevant committees or meetings about governance and leadership. Members of the relevant committee or the individual responsible for governance arrangements should ensure that actions are taken to improve clinical communication systems.

Examples of evidence

Select only examples currently in use:

- Policy documents that describe the processes for monitoring the organisation-wide clinical communication strategy and adverse events relating to clinical communication, such as
  - schedule of regular audits
  - risk-based schedule of reports provided to managers, relevant committees or the governing body
- Risk register that identifies clinical communication risks, and describes mitigation strategies and risk monitoring
- Key performance indicators relating to clinical communication that have been developed in consultation with the workforce
- Audit results of workforce compliance with policies for clinical communication and associated processes
- Formalised, structured processes that are used when developing quality initiatives to improve clinical communication (for example, PDSA cycle)
- Audit results of healthcare records for documentation that critical information has been recorded and acted on
- Quality improvement plan that includes activities to manage risks identified in clinical communication and associated processes
- Terms of reference and membership of committees responsible for developing and implementing the communication strategy and associated processes, and monitoring their effectiveness
- Committee and meeting records in which clinical communication issues were discussed
- Structured communication tools, forms and guidelines that are implemented and updated in line with identified risks, consumer feedback and committee recommendations
- Communication with the workforce, patients, carers and families about strategies to improve clinical communication
- Schedule of routine reviews of clinical communication policy documents, and updates in line with changes in best practice, emerging evidence, and results of audits and investigations.

Partnering with consumers

Action 6.3

Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to:

a. Actively involve patients in their own care

b. Meet the patient's information needs

c. Share decision-making

Reflective questions

What processes from the Partnering with Consumers Standard do clinicians use to effectively communicate with patients, carers and families during high-risk situations, to involve patients in planning and making decisions about their own care?

How does the health service organisation collect feedback from patients about information provided about clinical communication?

Key tasks

- Review strategies in the Partnering with Consumers Standard to inform the implementation of actions in the Communicating for Safety Standard
- Provide information to patients about clinical communications tailored to their specific needs and level of health literacy.

Strategies for improvement

> The Partnering with Consumers Standard has specific actions (**Actions 2.3–2.10**) related to health service organisations' processes for involving patients in their own care, shared decision making, informed consent and effective communication.

Effective clinical communication requires the active participation of patients, carers and families.

Ensure that policies and procedures describe patients as key participants in their care, and how patients, families and carers can be involved in clinical communication strategies and associated processes. This involvement could include:

- Consumer membership on relevant committees
- Complaints, compliments and feedback systems
- Administration of regular patient feedback or experience surveys
- Processes to review internally developed patient information (see Action 2.9).

Although contact time with patients in day procedure services is likely to be short, it is still important to consider how systems and processes support effective communication with patients, including listening to them. This is particularly important for situations when a high risk for communication errors exists, such as patient identification, procedure matching, communication at transitions of care (handover), and communication when there is new or emerging critical information on admission or post-discharge.

Support clinicians to communicate with patients, families and carers at the times identified as high risk. Where appropriate, support patients, families and carers to actively participate in communications about care.

Ensure that the organisation has support systems for patients who need assistance to communicate. This could include ensuring that interpreters are available, and putting in place processes to support patients with hearing or vision problems.

Ensure that communication with, and information provided to, patients, carers and families about procedures, treatments and care (including follow-up care after discharge) reflect health literacy principles (see Actions 2.8–2.10).

Examples of evidence

Select only examples currently in use:

- Training documents about person-centred care, patient partnerships and communication strategies
- Observation of clinicians' practice that shows use of the health service organisation's processes for partnering with consumers
- Records of interviews with clinicians that show that they understand the health service organisation's processes for partnering with consumers
- Policy documents about clinical communications that are based on principles of consumer engagement, health literacy and shared decision making
- Policy documents that describe mechanisms for consumer involvement in organisation-wide clinical communication strategies and associated processes, including
  - membership on relevant committees
  - complaints, compliments and feedback systems
  - administration of regular patient feedback or experience surveys
  - processes to review internally developed patient information

- Terms of reference and membership of the consumer advisory committees responsible for providing input and feedback on the organisation-wide communication strategy and associated processes, including internally developed patient information
- Committee and meeting records in which consumer input or advice on the health service organisation's clinical communication processes was discussed, including any actions taken as a result of this advice
- Structured communication processes that include an opportunity for patient, carer and family engagement
- Records of the use of interpreters and other support services for consumers who need help to communicate
- Information for patients and carers about their roles in clinical communication processes.

Organisational processes to support effective communication

Action 6.4

The health service organisation has clinical communications processes to support effective communication when:

a. Identification and procedure matching should occur

b. All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge

c. Critical information about a patient's care, including information on risks, emerges or changes

Reflective questions

What processes are in place for patient identification, procedure matching, clinical handover and communication of critical information or risks?

How is the workforce supported to use these processes?

What are the high-risk situations in which patient identification, procedure matching, and the communication or sharing of information are critical to ensuring safe, continuous patient care?

Key tasks

- Identify the situations within the organisation in which identification, procedure matching, structured clinical handover and communication of critical information are required

- Review the organisation's policies and processes to determine whether they support and enable effective communication at these times
- If there are gaps, or improvements can be made, revise or develop policies and processes to address these gaps
- Provide resources and tools to encourage effective communication processes at these times.

Strategies for improvement

Some states and territories may have mandated tools and approaches for patient identification, procedure matching, clinical handover and communication of critical information.
Comply with relevant state and territory policies.
Governance arrangements, such as associated by-laws, rules or regulations, may also outline required processes, approaches or tools.

Identify situations when safe communication is required

Consider all the situations and times in the organisation when identification, procedure matching and information about a patient's care need to be communicated or transferred to ensure that the patient receives the right care. This includes communication with the patient, carer and family (if appropriate). Situations can include:

- During pre-admission screening
- When care, treatment or medicine is provided to a patient
- When a patient is undergoing a procedure (consider the perioperative and postoperative pathways)
- When there is a change of clinician (for example, between operating workforce and recovery workforce)
- When a patient is moved between different levels of care in the same location
- When follow-up on patient referrals and communication of test results to the admitting clinician are required
- When a patient is transferred to an acute hospital because of acute deterioration
- When a patient is discharged from the day procedure service.

Clinical communication policies should describe what is expected and required of the workforce at key high-risk situations. These should be tailored to the service context.

Review policies and processes

Actions to identify the health service organisation's clinical communication needs may include:

- Reviewing or mapping the organisation's current clinical communication processes
- Analysing patient flow patterns and work processes that require information to be shared (inside and outside the organisation)
- Collecting baseline data about the clinical communication issues or needs of the organisation by interviewing, surveying or observing the workforce and consumers
- Performing a risk assessment to determine clinical communication gaps, areas for improvement and good practice.

Engage management, clinicians and consumers to ensure that there is a comprehensive understanding of the gaps and issues, that the workforce is aware of existing communication processes, and that they are using them.

Where gaps are identified, revise or develop policies and processes to address these gaps. Do this in collaboration with clinicians, consumers and other members of the workforce to ensure that policies and processes are user centred and meet the needs of the people involved. This may include consultations, small pilots to test a process or small working groups.

Provide resources and tools to facilitate effective communication processes

Provide information about the policies, processes, resources and tools for communicating during key high-risk situations to all members of the workforce.

Educate, train and support the workforce about the use of these tools and their responsibilities to effectively communicate during key high-risk situations.

Consider the role of non-clinicians

Consider the role that non-clinicians play in communicating with patients about their care or transfers. Non-clinicians (such as ward, reception and administration workforce) communicate regularly with patients about appointments, tests, referrals and transfers. They therefore have a role in patient care. Implement policies, directives or memorandums that outline the expectations and requirements for non-clinicians when they are communicating with patients (including maintaining patient confidentiality).

Examples of evidence

Select only examples currently in use:

- Review of organisational process mapping that identifies the situations when patient identification, procedure matching, clinical handover, and communication of emerging or changing critical information are required
- Policy documents that describe the processes for the internal transfer of patients, including temporary or time-limited transfers

- Policy documents that describe the processes for the external transfer or discharge of patients, including prioritisation and eligibility criteria, referral processes and required documentation
  - Audit results of healthcare records for completed patient journey risk assessments
  - Risk register that includes identified risks for
    – patient identification
    – procedure matching
    – transfer and handover of patient care
    – receipt and distribution of critical information to responsible clinicians and the multidisciplinary care team
  - Activities to manage identified risks with patient identification, transfer and handover of patient care, and receipt and distribution of critical information
  - Reports, investigations and feedback from the incident management and investigation system that identifies adverse events, incidents and near misses relating to patient identification, transfer and handover of patient care, or receipt and distribution of critical information
  - Documentation about structured processes for communicating critical information to the responsible clinicians when all or part of care is transferred
  - Documented processes for communicating critical information when there is an unexpected change in a patient's status or when new critical information becomes available
  - Standardised and structured templates to support clinical communication, such as referral forms, 'timeout' procedures, procedure matching checklists and discharge summaries, that are updated in line with identified risks, consumer feedback and committee recommendations
  - Evidence of a paging system or other communication method for alerting clinicians who can make decisions about care when there is a change in a patient's condition or new critical information is received
  - Audit results of healthcare records for completed standardised discharge or referral forms.

CRITERION: Correct identification and procedure matching

Systems to maintain the identity of the patient are used to ensure that the patient receives the care intended for them.

Correctly identifying patients and implementing processes to match patients to their intended care is critical to ensuring patient safety. Risks to patient safety occur when there is a mismatch between a patient and components of their care. This includes diagnostic, therapeutic and supportive care.

Patient identification is performed often in all care settings, and can be seen as a relatively unimportant or routine task. The development of safety routines for common tasks (such as patient identification) provides a powerful defence against simple mistakes that may cause harm. Routines allow the workforce to focus their attention on activities that require more cognitive processing and judgement, such as providing clinical care.[177] The design and implementation of routines should consider human factors such as human capabilities, limitations and

characteristics.[178] It is also important to educate and remind the workforce about the use of routines, including who does what, when and how.

Correct identification is particularly important at transitions of care, when there is an increased risk of information being miscommunicated or lost.[170,179] At these times, information about a person's identity is critical to ensuring safe patient care. Consider actions under this criterion alongside other actions within this standard (in particular, Actions 6.7 and 6.8)

Tools such as the WHO Surgical Safety Checklist[180] and the Commission's Ensuring Correct Patient, Correct Site, Correct Procedure Protocol[181] provide a basis for developing these routines.

This criterion does not relate to establishing the legally correct identity of people who choose to use an alias. The criterion is to ensure that a person's declared identity can be matched with any care, therapy, medicine or service that is provided within the organisation.

Correct identification and procedure matching

Action 6.5

The health service organisation:

a. Defines approved identifiers for patients according to best-practice guidelines

b. Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated

Reflective questions

What processes are used to ensure consistent and correct identification at any point in a patient's admission, care, treatment or transfer?

How are the requirements to use at least three approved patient identifiers described and monitored?

Key tasks

- Define the approved patient identifiers for use in the organisation, according to best-practice guidelines
- Develop or confirm an organisation-wide system for patient identification
- Implement policies and processes that require at least three approved identifiers to be used at registration and on admission; when care, medicine, therapy or other services are provided; and whenever clinical handover or transfer occurs, or discharge documentation is generated.

Strategies for improvement

Develop a patient identification system

An organisation-wide patient identification system is a set of written policies, procedures and protocols that ensure the consistent and correct identification of a patient at any time during an episode of care. This system is at the core of efforts to ensure correct patient identification and procedure matching. Policies, procedures and protocols for specific activities (such as patient registration, or generating and checking identification bands) should be included within, or linked to, this system.

Patient identifiers may include:

- Patient name (family and given names)
- Date of birth
- Gender
- Address (including postcode)
- Healthcare record number
- Individual Healthcare Identifier (IHI) (see Action 1.17 for more information).

Specify the data items approved for patient identification in the organisation, and use at least three identifiers:

- On admission or at registration
- When matching a patient's identity to care, medicine, therapy or services
- Whenever clinical handover or patient transfer occurs
- Whenever discharge documentation is generated
- In specific service settings, if they are different from those generally used across the organisation.

Standardise patient identification bands (if used)

Ensure that patient identification bands are standardised and comply with the *Specifications for a Standard Patient Identification Band*. These specifications apply to bands that have the primary purpose of identifying the patient within the health service organisation. They do not apply to bands or bracelets that have other purposes (such as triggering an alarm when a patient leaves a certain area). Neither the NSQHS Standards nor the specifications require all people receiving care to wear identification bands.

The Commission recommends using identification bands as described in the specifications, and not to vary the specifications. The specifications were developed to minimise adverse events associated with patient identification and procedure matching, and using identification bands that do not comply with the specifications may increase the risk of such events. If it is considered necessary to use a band that differs from the specifications, assess the potential risks associated with any proposed changes, identify strategies to reduce these risks and document this process.

When disposing of patient identification bands, consider issues relating to maintaining the confidentiality and privacy of patient details.

Assess the use of coloured patient identification bands (if used)

The Commission recommends that no coloured bands are used to alert clinicians to specific clinical information (such as falls risk, allergies or resuscitation status). Using colour-coded bands to indicate clinical risk:

- Is based on tradition rather than evidence of any patient safety benefit[182,183]
- Can cause confusion and error because of inconsistencies in meaning for different colours across different organisations, especially when members of the workforce work across different health service organisations[184-186]
- May not accurately reflect the patient's clinical situation or be synchronised with the healthcare record.[182,184]

If it is considered necessary to have a colour system for identifying a known allergy or other known risk, the patient identification band should be red only (see *Specifications for a Standard Patient Identification Band*).

Take a multi-factorial approach if patient identification bands are used to manage clinical risk for patients with specific characteristics or conditions. For example:

- Check the medication record for allergies before prescribing, dispensing or administering medicines (see the Medication Safety Standard)
- Use a multi-factorial prevention program that involves surveillance, together with interventions such as reviewing medicines (see Action 4.10), making the environment safe (see Action 1.29), screening for infections (see Action 3.6) and minimising the use of restraints (see Action 5.35).

Consider other methods of patient identification

Some services may have specific needs regarding patient identification and procedure matching. For example, in dialysis units, patient identification bands may be inappropriate, and other methods such as photographic identification may be required. Determine which methods for patient identification and procedure matching will be most appropriate for the service. Consider privacy when adopting a particular method of patient identification (for example, asking for verbal confirmation of a patient's address in an open waiting room may not be appropriate).

Examples of evidence

Select only examples currently in use:

- Policy documents for patient identification and procedure matching that
  - reference best-practice guidelines
  - specify points of care at which patient identification must occur
  - specify the three approved patient identifiers to be used on each occasion
  - require three approved patient identifiers to be recorded in the healthcare record, including the IHI

- Policy documents that outline requirements for patient identification using at least three approved patient identifiers for
  - patient registration or admission
  - administration of care, therapy or medicines
  - clinical handover, transfer and discharge
- Committee and meeting records that show that information about the performance of patient identification processes is routinely reported and reviewed
- Audit results of medication management (including adverse events, incidents and near misses relating to medication errors) in relation to correct patient identification
- Communication with the workforce about new or revised policy documents or protocols for patient identification.

Action 6.6

The health service organisation specifies the:

a. Processes to correctly match patients to their care

b. Information that should be documented about the process of correctly matching patients to their intended care

Reflective questions

How are the processes for matching a patient to their intended care described?

How does the health service organisation ensure that the workforce is using these processes?

Key tasks

- Develop explicit, documented protocols that outline the process of matching a patient to their intended treatment, tailored to the procedure and organisation
- Check that these processes align with nationally agreed policies, if they exist
- Ensure that policies specify which information should be documented about the process of identification and procedure matching.

Strategies for improvement

The type of patient identification and procedure-matching process will depend on the type of procedure and the risks for the patient. Clearly document the process for how patient identification and procedure matching are performed in each specialist area to ensure that no requirements are overlooked. For example, in most procedural areas, 'timeouts' are required with the whole team before a procedure can commence. In other situations (such as radiology, where there may be only a single operator), this could be done as a 'stop to verify' that all requirements are correct.

Align protocols with agreed policies, where they exist. A set of procedure-matching protocols for specific therapeutic and diagnostic areas such as surgery, nuclear medicine and radiation therapy is available on the Commission's website.

The WHO Surgical Safety Checklist has been demonstrated to improve patient safety[187] and is widely used in Australia. This checklist includes elements relating to patient identification and procedure matching, and can be used as the patient–procedure matching protocol. There is also an Australian and New Zealand version of this checklist.

The key steps that underlie these protocols of care are:

- If necessary, mark the site of the procedure
- Verify the identity of the patient
- Verify the details of the procedure being undertaken, including the site of the procedure
- Take a timeout or similar stop with all members of the team to do a final check before starting the procedure
- Confirm all documentation, samples, and other information and materials following completion of the procedure.

To develop protocols for other clinical situations, involve those with local knowledge of the process to adapt the patient identification and procedure-matching protocols for their specific requirements.

Support communication among clinicians and with patients

Supporting team participation and communication in safety checks is key to achieving a shared understanding of what is required and improving patient safety. Communication strategies used during the checking processes could include 'making sure, double checking', 'verbalising information' and 'deliberate confirmation of checklist items with oral validation'.[136] These strategies promote closed-loop communication and allow an opportunity for participants to ask questions or clarify concerns.[136,188,189]

Incorporate patient identification and procedure matching into structured clinical handover systems, as required under Actions 6.6 and 6.7. Ensure that the documentation required for patient identification at handover, transfer and discharge is determined by these policies, procedures and protocols, and reflected in the organisation-wide patient identification and procedure-matching system.

If appropriate, support patients, carers and families to take part in the processes to correctly match patients to their care. This may include asking the patient to confirm details about their identity; or asking the patient, family or carer to confirm details about care. For surgical safety checks, the timeout check could be done while the patient is still awake to enable them to contribute to the conversation, rather than performing it after the anaesthetic is given.[136]

Specify the information that needs to be documented about the processes to correctly match patients to their intended care

Ensure that policies describe what documentation is needed about the processes to correctly match a patient to their intended care. The requirements for documentation will depend on the situation. For example, it is not feasible or necessary to record that three identifiers have been used to check the identity of each patient who has been administered a medicine. However, if the surgical safety checklist is used in operating theatres, documented confirmation that it has been used, or the completed checklist itself, can be kept in the patient's healthcare record.

Examples of evidence

Select only examples currently in use:
- Policy documents that outline
  - the points of care when procedure matching is required
  - processes for matching patients to their care, including the use of three approved identifiers
  - the documentation to be included in the patient's healthcare record that demonstrates correct procedure matching

- Standardised templates for documenting procedure-matching processes, such as surgical safety checklists, consent forms, medication management plans and handover checklists, that are updated in line with identified risks, consumer feedback and committee recommendations
- Training documents about processes to correctly match patients to their intended care, therapy or treatment
- Communication with the workforce about new or revised policy documents for procedure matching.

CRITERION: Communication at clinical handover

Processes for structured clinical handover are used to effectively communicate about the health care of patients.

Structured clinical handover has been shown to reduce communication errors within and between health service organisations, and to improve patient safety and care, because critical information is more likely to be accurately transferred and acted on.[162,169] This is especially important at transitions of care, when communication errors are more likely and there is an increased risk of information being miscommunicated or lost. Ineffective communication at clinical handover is also associated with clinicians spending extensive time attempting to retrieve relevant and correct information.[190] This can result in inappropriate care, and the possibility of misuse or poor use of resources.[191,192]

Structured clinical handover at transitions of care

Implement and support the use of structured clinical handover processes in the organisation's service context. This criterion is linked to Action 6.4b, which requires organisations to have clinical communication processes at transitions of care, across all levels of the organisation. Transitions of care occur when all or part of a patient's care is transferred between healthcare locations, clinicians, or different levels of care within the same location. Patients in day procedure services may not experience the number or complexity of transitions of care as with larger acute hospitals. Transitions of care in a day procedure service may occur when:

- A patient is moved within the service (for example, admission to procedure, procedure to recovery)
- A patient's care is transferred to another clinician
- A patient is transferred to another healthcare service (for example, an acute hospital)
- A patient is discharged.

Transitions of care are not limited to these times, but consider these situations as a minimum requirement for clinical handover policy and processes, if they occur in the organisation.

Under an effective standardised and structured clinical handover process, all relevant participants know the minimum information that needs to be communicated when handovers take place, the purpose of the handover, the structured format to help communication, and how responsibility and accountability are transferred.[162]

Communication can be a highly variable process, which poses a high risk for patient safety. Variability can result from:

- The situation, such as during patient
  - admission
  - procedure
  - recovery
  - discharge
- The method, such as
  - face to face
  - by telephone
  - using written orders
  - aided by electronic handover tools or systems
- The place in which clinical handover takes place, such as
  - in an interview room used for pre-admission
  - in a common staff area
  - at reception
- The people who are involved in the clinical handover process, such as
  - individual clinicians within the same organisation (for example, nurses and consultants, including credentialed medical and other practitioners)
  - a clinician and a patient with their family or carer
  - clinicians from other organisations (for example, ambulance officers, referring general practitioners).

Therefore, although standardisation improves the efficiency and effectiveness of clinical handover, there needs to be some flexibility. Processes should not minimise communication or set guidelines that interfere with what the workforce deems to be the most critical information. A flexible, standardised approach will provide the structure for handover and allow for flexibility to fit the service context and work practices.

Defining the minimum information content

The minimum information content for a particular handover will depend on the context and the reason for handover. Be guided by best practice, and determine the minimum information content in consultation and collaboration with the patients, carers and clinicians who are active participants in the clinical handover process.

When defining the minimum information content, consider actions across the NSQHS Standards that require and support communication of relevant information at transitions of care (see Table 1 for examples of relevant actions).

Key principles of clinical handover

The purpose of clinical handover is to ensure that relevant, accurate and current information about a patient's care is transferred to the right person or people, action is taken (when necessary) and continuity of patient care is maintained. To ensure that these events occur, all clinical handover policies and processes need to reflect the key principles of clinical handover. This is required under Action 6.8 and includes:

a. Preparing and scheduling clinical handover

b. Having the relevant information at clinical handover

c. Organising relevant clinicians and others to participate

d. Being aware of the patient's goals and preferences

Table 1: Actions in the NSQHS Standards that support communication of relevant information at transitions of care

Information to be communicated	Actions in the NSQHS Standards
Patient identification	Action 6.5b
Diagnosis (provisional or principal), clinical assessment (including any relevant alerts) and current clinical condition (e.g. stable, improving, deteriorating)	Actions 5.11–5.13, Action 6.8b, Action 8.5e, Action 8.9
Risks of harm, worry or clinical concerns	Action 5.7b, Action 5.10, Actions 5.21–5.36, Action 8.6e
Medication history and current medicines list (e.g. adverse drug reactions, reasons for any changes to medicines)	Actions 4.5–4.7, Actions 4.10–4.12
Emerging or new critical information (e.g. changes in patient condition, new results, results outstanding or needing follow-up, critical information arising post-discharge)	Actions 6.9 and 6.10
Agreed care plan, priorities for care (e.g. further reviews, treatments or procedures; discharge planning; referrals; follow-up)	Actions 5.13 and 5.14
Infectious state (if relevant)	Action 3.7
Transfusion history, blood management and transfusion details (if relevant)	Action 7.5
Identity and confirmation of clinician or healthcare team responsible and accountable for patient care (transfer of responsibility and accountability)	Action 6.8f

e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient

f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care.

Clinical handover is more than the transfer of information, which is 'irrelevant unless it results in action that is appropriate to the patients' needs'[193] – it is about maintaining continuity of care.

Effective communication and teamwork between all the people involved in providing patient care, including the patient and their carer, are vital to ensuring effective clinical handover.[194] Actions under this criterion are closely linked to Actions 5.5 and 5.6 in the Comprehensive Care Standard, which require systems to be in place to support collaboration, teamwork and comprehensive care planning.

Engaging patients and carers in clinical handover processes

Patients, carers and family members are key participants in transition communication processes, and the patient's preferences and choices should be known and respected. Patients can have important insights into their conditions, and the circumstances that may affect their ongoing care and needs. Patient engagement and communication at transitions of care improve patient care outcomes, prevent adverse events during care and reduce readmissions to hospital after discharge.[171,195,196]

If practicable, implement systems to engage patients early, and support patients, carers and families to participate in clinical handover and transition of care processes. Consider the organisation's processes, including when handover is occurring, and identify opportunities to engage with patients, carers and families. Ensure that participation is in accordance with the patient's wishes, and include careful consideration of the patient's level of health literacy, language barriers and culture.[171] Consider how actions link to requirements in the Partnering with Consumers Standard.

Resources to support patient–clinician communication at transitions of care are available on the Commission's website.

Communication at transitions for patients with cognitive impairment

The importance of communication at transitions is highlighted for people with cognitive impairment, particularly if they are unable to communicate required information. Information from a person's general practitioner, family, carer or substitute decision-maker, and healthcare record about the patient's medical history, medicines list, recent cognitive changes, advance care plans and goals of care is crucial for accurate diagnosis, medication reconciliation and appropriate treatment decisions (see Actions 5.29 and 5.30). During a hospital stay, family members may be the first to notice changes in cognition and behaviour that should prompt assessment for delirium (see Actions 8.5 and 8.7).

Any diagnosis of delirium or concern about ongoing cognitive impairment needs to be communicated so that arrangements can be put in place for post-discharge assessment, management and support.

A Better Way to Care[197] sets out suggested strategies for health service organisations in early recognition, prevention, treatment and management of cognitive impairment.

Clinical handover

Action 6.7

The health service organisation, in collaboration with clinicians, defines the:

a. Minimum information content to be communicated at clinical handover, based on best-practice guidelines

b. Risks relevant to the service context and the particular needs of patients, carers and families

c. Clinicians who are involved in the clinical handover

Reflective questions

How does the health service organisation describe the minimum information content to be communicated at each clinical handover?

What processes are used to ensure that the health service organisation collaborates with the clinicians who are involved in clinical handover when determining the minimum information content for different handovers?

Key task

- Collaborate with clinicians to define the minimum information content to be communicated for each type of clinical handover identified within the organisation (see Action 6.4).

Strategies for improvement

Define the minimum information content for all clinical handovers relevant to the service. The minimum information required may differ, depending on the type of clinical handover and the situation in which clinical handover is occurring.

One way to define the minimum information content is by 'dot voting'. This is a simple way to collect opinions from the whole team involved in the transfer of care about what information should be included.[198]

Document the minimum information content for different clinical handovers, and make this easily available to the workforce to ensure that all participants involved in a handover are aware of what the minimum information content is for that

handover, and their roles and responsibilities for communicating and receiving this information. Provide orientation and training to support the workforce in effectively transferring the correct information (see Action 6.1). Provide guidance on the overarching minimum information required for all handovers, and allow this to be adapted and refined to the different contexts in which handovers occur in the organisation. At a minimum, consider the information that is required to be communicated across the NSQHS Standards (see Table 1).

Use of structured handover tools can help to provide a framework for communicating the minimum information content for clinical handovers. The iSoBAR framework is an example (Table 2).[172]

A 'patient safety check' process at the end of a handover can help to focus on the patient's safety as a priority. This may include raising or reiterating any safety concerns, such as socioeconomic factors, alerts, allergies or risks.

Other examples of tools to help structure handover are:

- ISBAR (Identify, Situation, Background, Assessment and Recommendation)
- SBAR (Situation, Background, Assessment, Recommendation)
- SHARED (Situation, History, Assessment, Risk, Expectation, Documentation)
- I PASS the BATON (Introduction, Patient, Assessment, Situation, Safety concerns, Background, Actions, Ownership, Timing, Next).

These tools are designed to be flexible and adapted to suit local workforce environments and culture, and the purpose of the handover. They are available on the Commission's website.

Examples of evidence

Select only examples currently in use:

- Policy documents for clinical handover that specify the minimum information content to be communicated at each clinical handover relevant to the organisation

- Structured communication tools that are used to effectively communicate the agreed minimum information content (for example, iSoBAR, ISBAR, SBAR)

- Evidence that clinicians were involved in developing the minimum information content to be communicated at each clinical handover

- Feedback from the workforce on the use of clinical handover policies, procedures or protocols.

Table 2: iSoBAR framework

i	Identification	Introduce or identify patient, self and team
S	Situation	Provide current working diagnosis, specific clinical problems, concerns and critical laboratory results
o	Observation	Check, update and discuss recent vital signs
B	Background history	Update and discuss relevant medical and support information
A	Agree to a plan (actions)	Outline plan for assessment, treatment and discharge
R	Responsibility and risk management	Confirm shared understanding; clarify tasks (read back critical information to check understanding), timing and responsibility is transferred

Action 6.8

Clinicians use structured clinical handover processes that include:

a. Preparing and scheduling clinical handover

b. Having the relevant information at clinical handover

c. Organising relevant clinicians and others to participate in clinical handover

d. Being aware of the patient's goals and preferences

e. Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient

f. Ensuring that clinical handover results in the transfer of responsibility and accountability for care

Reflective questions

How does the health service organisation describe the different situations in which structured clinical handover should take place, the method of communication, who should be involved and the structured communication tools to assist with handover?

How are the patient's goals and preferences communicated to those involved in clinical handover?

How does the health service organisation ensure that discharge summaries are provided to the relevant people involved in a patient's ongoing care?

Key tasks

- Document the structured clinical handover processes required in the organisation, ensuring that they are consistent with the key principles for clinical handover
- Clearly communicate the clinical handover policies and processes to the workforce, including expectations for using clinical handover processes
- Provide access to structured clinical handover tools
- Support the workforce, patients and carers to use structured clinical handover processes and tools.

Strategies for improvement

Conduct clinical handover using a structured format. Document clear, structured processes for transferring relevant patient information, accountability and responsibility of care in the organisation's policy, using the steps outlined in this action.[169,199] This is to ensure that everyone knows the process for clinical handover, their roles and responsibilities, and what is expected.

Prepare for, and schedule, clinical handover

Consider the organisation's environment and decide on the best time for clinical handovers to take place. This may include assessing the environment that the handover is taking place in (for example, ensuring that participants can hear and see each other without interruptions), and setting an agreed time, duration and frequency for clinical handover.[172] Day procedure services that have limited patient contact time still need to consider these factors in planning clinical handover.

Nominate all key participants for clinical handovers. Consider the need for multidisciplinary input, including clinical and non-clinical workforce members.

Inform participants of the clinical handover processes, and expectations for participating in handover.

If possible, involve patients, carers and families as key participants in handover.

Allocate specific roles to members of the workforce during handover to ensure continuity of patient care and reduce disruptions. This includes nominating a leader at each clinical handover.

Set the method and location for clinical handover, preferably face to face and in the patient's presence, if appropriate.

Make structured communication tools, such as iSoBAR, ISBAR, SBAR or SHARED, available to the workforce. These tools are designed to be flexible and adaptable to the local workforce environment. Resources including videos and templates are available on the Commission's website.

Support clinicians and the workforce to have situational awareness. This refers to maintaining an awareness of the 'big picture', and thinking ahead to plan and discuss contingencies. Ensure an open and ongoing dialogue as part of the handover, which keeps members of the team up to date with what is happening and how they will respond if the situation changes. This includes informing the workforce about:

- Patient risks identified during pre-admission screening
- Potential patient movements
- The condition of the work environment and staffing numbers that may affect safety (for example, high workload, busy environment).[120,161]

Have relevant information at clinical handover

To ensure that the most up-to-date and relevant information is communicated, put systems and processes in place to enable clinicians to obtain the necessary documents and information before handover. This information may include the healthcare record, advance care plans, progress notes, prepared handover sheets, test results, and information written on electronic journey boards or patient care whiteboards.

This action links to, and is supported by, Action 1.16 in the Clinical Governance Standard and Action 6.11. It requires organisations to integrate multiple information systems (where they are in use), enable access to the healthcare record at the point of care, and ensure that systems are in place to contemporaneously document relevant information in the healthcare record.

Organise relevant clinicians and others to participate

All relevant participants should be present before handover begins. This will depend on the situation of the handover.

Ensure that all participants in the handover are aware of the patient's goals and preferences (see Action 5.13).

If unsure, check with the patient, or their family or carer, where appropriate.

Support patient, carer and family involvement

It is essential to consider how the privacy of a patient and confidentiality of patient information are maintained during transfers of care. This includes when patients are engaged in clinical handover in or near a waiting area. If sensitive information is to be discussed, consider options for conducting aspects of the handover in a private area. Sensitive information may also be recorded on the handover sheet.

Mechanisms to signpost the service's processes, particularly when a patient is moved within the service (for example, admission to procedure, procedure to recovery), may be helpful. This could include information about the steps the patient is likely to go through and the different demands that may be made of them along the way.

Provide patients (and families and carers, if appropriate) with discharge information, including information about:

- How to manage their care when they leave the organisation
- Medicines
- Any follow-up appointments or referrals.

Ensure transfer of responsibility and accountability of care

Key objectives of clinical handover are to maintain continuity of care, and to transfer professional responsibility and accountability for some or all aspects of patient care. This requires a clear understanding of who is responsible for tasks that need to be performed at any given time, and who may be held accountable for the decisions made and directions specified for a patient's care.[172]

The importance of ensuring the transfer of responsibility and accountability for patient care is emphasised in structured communication tools such as SBAR, ISBAR, iSoBAR and SHARED (see Action 6.7). These provide an opportunity for

clinicians to request, recommend, read back/check back and communicate expectations. For example:

- What do I recommend or request to be done?
- What am I asking them (the recipient) to do?
- Has the person I am communicating to confirmed receipt of information? – ask participants to confirm understanding (check back) and provide an opportunity for participants to ask questions
- Does everyone understand what is going to happen next, who is doing what and by when?[200]

Put processes in place to clearly document the transfer of responsibility and accountability across the patient's journey, who is responsible and accountable for patient care, and what has been agreed on. Examples of documentation that shows effective handover of responsibility of care could include:

- Completed transfer forms
- Referral letters or discharge summaries
- Information on changes to patient comprehensive care plans and pathways.

When a patient is discharged from the organisation, ensure timely communication of critical information to the patient, their general practitioner and/or their primary carer. This may be in the form of a discharge summary (see Actions 6.4 and 6.7). Consider the significance and complexity of the patient's health issues and risks of harm (see Action 5.13), and ensure that the discharge summary is provided to all the relevant people involved in the patient's ongoing care.[201] This includes ensuring that patients, carers and families understand the discharge plans, and (if relevant) who their ongoing care providers are, especially if English is not their first language (see Action 2.10). Ensure that documentation in the discharge summary has correct and up-to-date contact details of all relevant clinicians, and reflects the most current communications about care.

Examples of evidence

Select only examples currently in use:

- Policy documents that describe a structured clinical handover process, taking into account the setting, the minimum information content to be transferred, the relevant workforce to be involved, patient needs and care goals, and accountability for care
- Observation of clinicians' practice that shows use of structured clinical handover processes and tools
- Records of interviews with clinicians that show that they understand the health service organisation's structured clinical handover processes
- Records of workforce attendance at regularly scheduled meetings in which structured clinical handover takes place
- Audit results of completed documentation that demonstrates effective handover of responsibility for care, such as
  – standardised transfer (intra- and inter-organisation) forms
  – completed transfer forms
  – standardised referral letters or discharge summaries
  – checklists for ward rounds
  – changes to patient care plans and pathways
- Audit results of workforce compliance with clinical handover policies, procedures or protocols
- Training documents about responsibilities and processes for clinical handover
- Communication with the workforce regarding clinical handover processes
- Information provided to consumers, carers and families that outlines their role in clinical handover processes, such as a patient charter of rights or patient admission information sheet
- Results of a patient experience survey, and patient feedback about their participation in clinical handover
- Results from workforce satisfaction surveys and feedback about referral and use of clinical handover processes.

CRITERION: Communication of critical information

Systems to effectively communicate critical information and risks when they emerge or change are used to ensure safe patient care.

When critical information emerges or there is a risk to patient care, timely communication of this information to the appropriate person(s) is essential to ensuring patient safety and delivery of the right care.

How critical information is defined in an organisation will depend on the type of services provided and the needs of the patients using the service. It may be helpful to consider what clinical and non-clinical information is time critical or significant to patient care, such as:

- Patient risks identified during pre-admission screening
- New critical diagnostic or test results that require a change to care
- Changes in a patient's physical and psychological condition, including unexpected deterioration or development of complications (linked to the Recognising and Responding to Acute Deterioration Standard)
- Errors in diagnosis
- Missed test results
- Predetermined alerts and triggers
- Follow-up communication following a review of results.

This criterion recognises that critical information can arise at any point during a patient's care. These times can occur outside formal clinical handover, and can be closely linked to the formal processes of recognising and escalating acute deterioration, if escalation is required.

This criterion is closely linked to clinical handover (Action 6.8) and recognising acute deterioration (Actions 8.4–8.13). It addresses a communication gap by ensuring that the 'in-between times' are captured, and that organisations have systems and processes in place to support communication of critical communication, whenever it emerges or changes. This is essential because problems in communication at in-between times can result in failure to rescue, inappropriate treatment, care that does not align with a patient's goals or preferences, and poor coordination of care.[202,203]

New critical information can come from several sources, including patients, families and carers.

For timely action to occur, information must be communicated to the right person – that is, a clinician(s) who can make decisions about care. It is important to determine who this is, and to have processes that enable the workforce, patients, carers and families to know who this person is at any given time. What is 'timely' will depend on how important or time critical the information is to a patient's health, wellbeing or ongoing care. Day procedure services that have limited patient contact time still need to consider these factors when planning communication processes.

This standard does not apply to all informal communications. The intention is for organisations to consider and define what critical information means for their particular service, and put in place formal processes to ensure that this critical information is communicated whenever it emerges or changes. Ensure that policies and processes include:

- When communication should occur (for example, flags, triggers, alerts, defined criteria or critical values for diagnostic tests, referral criteria)
- Expectations about the time frame in which communication should occur (emphasising timely communication that is relevant to the criticality of the information)
- Who to communicate with, and how to escalate in the event of no response
- The preferred method of communication.

Documenting critical information in the patient's healthcare record is also essential to ensure patient safety, and to support subsequent communications and decisions about care. It is therefore important to consider the requirements under Action 6.11.

In developing processes, consider ways to support closed-loop communication.[202] This is when the person who is communicating the information knows that the message has been received, and there is a response that lets them know that action will be taken to deal with the communication need.[204] Closed-loop communication is especially important if communication occurs through tools or technologies that do not allow two-way communication, such as pagers, email or letters.

Communicating critical information

Action 6.9

Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to:

a. Clinicians who can make decisions about care

b. Patients, carers and families, in accordance with the wishes of the patient

Reflective questions

What processes are used to identify the clinician(s) who can make decisions about care and take action if needed?

How do clinicians effectively communicate critical information to other clinicians who can make decisions about care, and patients and carers, in a timely way?

Key tasks

- Define what 'critical information' and 'risks to patient's care' mean for the service context
- Implement processes to identify the clinicians who are responsible for a patient's care and can make decisions about care at any given time
- Identify when and to whom communication of critical information, alerts or risks should occur when the information emerges or changes, including when communication with the patient, carers or families should occur
- Develop and implement standardised processes that describe how communication of critical information, alerts or risks should occur.

Strategies for improvement

Identify critical information

The nature of critical information or a risk to patient care for the organisation depends on a number of factors, including the type of procedure and any identified patient risks. In defining what critical information means in the service context, consider the type of services the organisation provides and the needs of the patients using the service.

Types of critical information could include:

- Changes to medicines
- Missed results
- Wrong diagnosis
- Change in patient goals
- Allergies or adverse drug reactions
- Issues with equipment or medical supplies
- Information that requires follow-up with another clinician (for example, the general practitioner) or the patient (or family or carer, where appropriate).

Review policies for communicating critical information

Ensure that policies and processes clearly define:

- The types of critical information that need to be communicated
- The method for communicating critical information to the responsible clinician or multidisciplinary team
- The method for communicating critical information to the patient (or family or carer, if appropriate)
- The expected time frames for this communication
- How the information is documented (see Action 6.11).

Policies for communicating critical information to patients, families and carers should also consider whether open disclosure is relevant. Organisations are required to have open disclosure processes as part of Action 1.12.

Use specific strategies and frameworks

Strategies to enable clinicians to communicate critical information could include:

- Implementing daily or triggered 'safety huddles', which is a mechanism for everyone to discuss potential risks and identify safety issues
- Having in place 'critical language', which is an agreed set of terms or common language that indicates to all members of the team that there is a problem or concern – for example, phrases such as 'I need some clarity' or 'I am worried about'; teams that respond to critical language know that, when this type of phrase is spoken, they need to stop, take a moment, pay attention and ensure that everyone on the team is on the same page
- Establishing agreed communication processes and pathways between admission, operating theatre and recovery so that the workforce is clear about who to communicate new critical results to, and who is responsible for the action or follow-up.

Examples of evidence

Select only examples currently in use:

- Policy documents that outline the
  - types of critical information that are likely to be received and actions to be taken in response
  - method for communicating critical information to the responsible clinician and the multidisciplinary team
  - method for communicating critical information to the patient, carer and family
  - time frames for communicating critical information
- Policy documents for identifying the clinicians responsible for a patient's care, and for notifying the workforce, the patient, carers and family
- Schedule of regular multidisciplinary team meetings in which new critical information alerts and risks are discussed and actions are agreed, such as 'safety huddles', bed rounding or patient journey board meetings

- Standardised templates to support communication of critical information, such as doctor communication books, shared crisis management plans, email alerts or discharge summaries that are updated in line with identified risks, consumer feedback and committee recommendations
- Evidence of communication methods or systems for alerting clinicians who can make decisions about care when there is a change in a patient's condition or new critical information is received
- Audit results of workforce compliance with policies relating to communicating critical information.

Action 6.10

The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians

Reflective questions

What processes are in place to support patients and carers to communicate critical information about their care to clinicians?

What feedback processes are in place to let patients and carers know that they have been heard and action has been taken, if necessary?

Key tasks

- Develop and implement processes for patients and carers to communicate critical information and risks about their care
- Support patients and carers to understand and use these processes.

Strategies for improvement

Consider actions in the Partnering with Consumers Standard when implementing this action.

Ensure that policies describe the processes for patients, carers and families to communicate critical information that has emerged or changed to the clinicians who are responsible for the patient's care:

- Before admission
- At different points of care
- After discharge.

This could include:

- Informing patients, carers and families about what could be considered critical information
- Informing patients, carers and families about their role in communicating this information
- Providing access to resources or communication tools to support patients, carers and families to communicate critical information to clinicians.

Examples of mechanisms could include information provided on admission, posters, notices around patient areas, and messages on waiting-room TVs and the organisation's website. Ensure that information is displayed in a way that can be easily noticed and read by patients, carers and families.

Processes to inform patients, carers and families about who they can communicate critical information to when it emerges or changes, at any time, are also important. This may involve displaying information about how, and to whom, patients, carers and families can communicate critical information in patient rooms and common areas. The information could include:

- A photo board of care team members with their names and responsibilities
- A phone number for patients, carers and families to call if they are concerned, particularly if they have been discharged from the organisation.

Examples of evidence

Select only examples currently in use:

- Policy documents that outline how patients, carers and families are informed about the processes for communicating concerns to clinicians
- Examples of information provided to patients, carers and families about processes for communicating concerns to the clinicians responsible for care
- Resources or tools for patients, carers or families to use to communicate with clinicians, such as bedside whiteboards and dedicated free telephone services in waiting areas
- Patient notes that identify critical information provided by the patient or family and how this information was acted on
- Records of patient focus groups or minutes of patient-initiated team meetings
- Results of a patient experience survey or patient, carer and family feedback about their communication with clinicians and, where necessary, how these results have informed improvement strategies.

CRITERION: Documentation of information

Essential information is documented in the healthcare record to ensure patient safety.

Documentation is an essential component of effective communication. Given the complexity of health care and the fluidity of clinical teams, healthcare records are one of the most important information sources available to clinicians. Undocumented or poorly documented information relies on memory, and is less likely to be communicated and retained. This can lead to a loss of information, which can result in misdiagnosis and harm.[205,206]

The intent of this criterion is to ensure that relevant, accurate, complete and up-to-date information about a patient's care is documented, and clinicians have access to the right information to make safe clinical decisions and to deliver safe, high-quality care.

Documentation can be paper based, electronic or a mix of both. It can also take a number of forms, including the care plan, handover notes, checklists, pathology results, operation reports and discharge summaries. For this criterion, organisations are required to have in place systems to ensure that essential information about a person's care is documented in the healthcare record. For documentation to support the delivery of safe, high-quality care, it should[207]:

- Be clear, legible, concise, contemporaneous, progressive and accurate
- Include information about assessments, action taken, outcomes, reassessment processes (if applicable), risks, complications and changes
- Meet all necessary medico-legal requirements for documentation.

Regardless of who records information in the healthcare record, organisations need to ensure that their systems and processes for documentation meet the requirements of this standard. This involves supporting the workforce to document information correctly, and could include policies or training that clearly describe:

- The workforce's roles, responsibilities and expectations regarding documentation
- When documentation is required
- How to gain access to the healthcare record, and templates, checklists or other tools and resources that support best-practice documentation.

Clinical information systems and technologies play an increasingly important role in documentation in the healthcare system. It is essential to consider the safety and quality issues that may arise when designing, implementing or integrating digital health solutions. Any digital health record system that is implemented should meet the elements of best-practice documentation and support effective clinical communication.

This criterion is supported by actions in the Clinical Governance Standard that require organisations to make the healthcare record available to clinicians at the point of care, support the workforce to maintain accurate and complete healthcare records, and integrate multiple information systems if they are used (Action 1.16).

Documentation of information

Action 6.11

The health service organisation has processes to contemporaneously document information in the healthcare record, including:

a. Critical information, alerts and risks

b. Reassessment processes and outcomes

c. Changes to the care plan

Reflective questions

How does the health service organisation describe the roles, responsibilities and expectations of the workforce regarding documenting information?

What processes are in place to ensure that complete, accurate and up-to-date information is recorded in the healthcare record and is accessible to clinicians?

Key tasks

- Develop and implement systems to support the contemporaneous documentation of critical information in the healthcare record
- Record the organisation's documentation policies, and make them available to the workforce
- Communicate to the workforce their roles and responsibilities for documentation.

Strategies for improvement

Consider and comply with relevant state and territory policies on documentation requirements in relation to clinical information.

Develop policies and processes that encourage a shared understanding of the organisation's documentation requirements. These could outline:

- When documentation is required
- What needs to be documented (that is, information from pre-admission screening, alerts, risks, medical reviews, reassessment processes and outcomes, and changes to the care plan or pathway)
- What format of documentation is required

- Expectations regarding information being recorded (that is, contemporaneous, accurate, legible and up to date)
- Where information should be documented, and how to gain access to and use the organisation's information management systems
- Roles and responsibilities relating to documentation
- Processes for transferring information relevant to patient care, including critical information, between clinicians responsible for care, both internally and externally.

The following 'CARE' elements[208] provide a useful guide when considering what good written documentation may look like in practice. They apply equally to digital information.

Compliant and complete

- All electronic and written documentation adheres to the standards and procedures of the health services and professional bodies concerned; this includes the use of approved abbreviations, and rules for clinician and patient identification
- Documentation is complete and current (for example, new or emerging information is recorded, daily progress notes or care plans are documented, a discharge summary is completed on discharge)
- Clinicians provide the right documents and use them correctly.

Accessible and accurate

- Paper and electronic documents are available to clinicians who need them, when they need them, and in a language that the intended readership can easily understand
- Relevant, up-to-date information is immediately at hand and easy to locate or searchable (physical accessibility)
- The documents consider the needs and capabilities of those who will use the information (deferred accessibility); clinicians should not use language that excludes the people who will be using the information (such as the patient, carers, families and other clinicians across disciplines)
- The information recorded correctly reflects the event being documented.

Readable

- Documents are legible and can be understood; electronic and paper forms and checklists should provide enough space so that they can be completed accurately and legibly, and include clear instructions about how they should be completed
- Acronyms and abbreviations are avoided (in both design and completion) if there is any potential for ambiguity
- Documents are as specific as possible.

Enduring

- Documents are materially durable, not loose paper that is likely to slip out or fade
- The meaning of the documents is maintained, and they are completed in such a way that someone who is not present at the time of the recording can interpret the information – written information restricts the immediacy of feedback, so predict the reader's need to know, and try to anticipate their queries by providing enough information and justification to explain recommendations and instructions (actions to be taken and why), rather than just listing them.[172]

Implement standardised and structured templates, checklists or forms that are based on best practice and developed in collaboration with clinicians, to support documentation of clinical information.[208] Ensure that the workforce has easy access to these resources, and training about documentation protocols and how to use any standardised forms.

For electronic discharge summaries, core information components have been specified by the Australian Digital Health Agency. The Commission's *National Guidelines for On-Screen Presentation of Discharge Summaries* provides recommendations on the best on-screen view of a discharge summary and other strategies to deal with presentation inconsistencies.

If electronic health systems are implemented to support documentation (for example, digital healthcare records, information-sharing systems, electronic patient journey boards), consider requirements under the Clinical Governance Standard (particularly Actions 1.16–1.18), and actions related to managing risks for clinical communication (Action 6.1), and monitoring and reporting incidents (Action 1.11).

Examples of evidence

Select only examples currently in use:

- Integrated patient healthcare record, either electronic or paper based, with capacity to incorporate information from multiple sources
- Information management system that
  - includes care pathways and risk alerts as key components
  - provides reports for monitoring patient care
- Policy documents about the information management system that specify the time frames and formats for documenting
  - critical information, alerts and risks
  - any medical reviews or reassessments and their outcomes
  - changes to the care plan
- Standardised templates, such as medical review assessment forms, comprehensive risk assessment forms and care variation forms, for documenting in the healthcare record critical information and the actions taken
- Observation that the workforce has computer access to healthcare records in clinical areas
- Audit results of healthcare records for evidence of updated care plans, reassessments and alerts
- Training documents about the information management system.

Resources

Quality improvement for clinical communication

Australian Commission on Safety and Quality in Health Care – Implementation Toolkit for Clinical Handover Improvement, evaluation plan and evaluation framework (pages 51–52)

Quality Improvement Clinic – *Handover & Transfers of Care: Step-by-step measurement guide*

Clinical communication and handover

Although many of these resources were developed in the context of clinical handover, the framework and principles are helpful when considering how to improve clinical communications more broadly at transitions of care:

- Agency for Healthcare Research and Quality – CUSP Toolkit, 'Implement teamwork and communication' module
- Australian Commission on Safety and Quality in Health Care – Implementation Toolkit for Clinical Handover Improvement
- Australian Commission on Safety and Quality in Health Care – *OSSIE Guide to Clinical Handover Improvement*
- Institute for Healthcare Improvement – *How-to Guide: Multidisciplinary rounds*
- NHS England – *Safe Communication: Design, implement and measure*
- NSW Clinical Excellence Commission – In safe hands
- NSW Health – *Implementation Toolkit: Standard key principles for clinical handover*
- Primary Health Tasmania – *Sharing Points* videos
- SA Health – TeamSTEPPS
- SA Health and NSW Health clinical handover tool – Know the Plan, Share the Plan, Review the Risk

Communicating with transport services

Queensland Ambulance Service – *Clinical Practice Procedures: Other/clinical handover*

Royal Flying Doctor Service – *Transporting Your Patient: Guidelines for organizing and preparing patients for transfer by air*

Victorian Department of Health – *Protocol for the Clinical Handover of Ambulance Patients into the Emergency Department*

Blood Management Standard
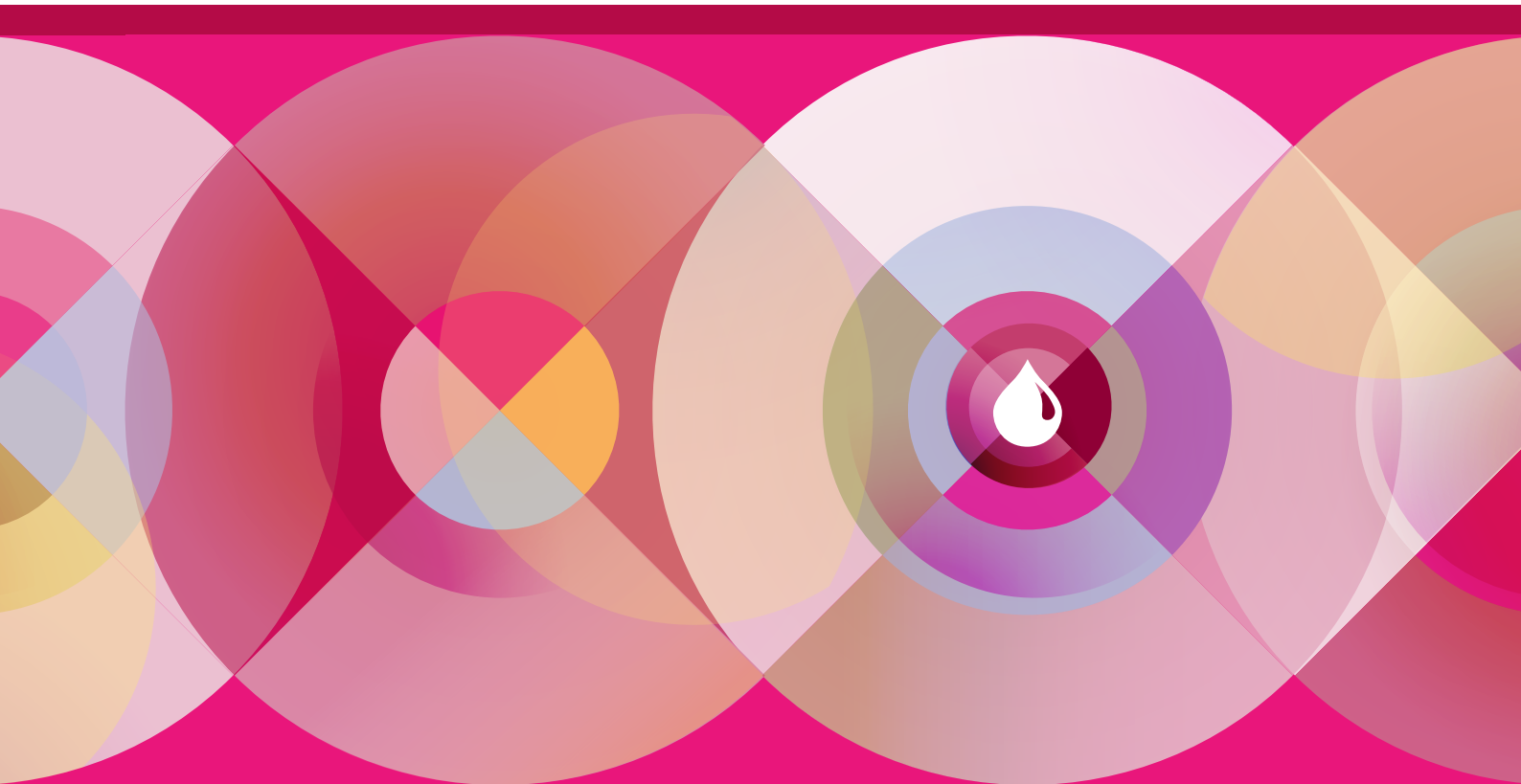
Blood Management Standard

Leaders of a health service organisation describe, implement and monitor systems to ensure the safe, appropriate, efficient and effective care of patients' own blood, as well as other blood and blood products. The workforce uses the blood product safety systems.

Applicability of actions

The actions in the Blood Management Standard will not be applicable for day procedure services that do not use blood or blood products.

These services should provide evidence that they do not use, receive, store, collect or transport any of the blood or blood products listed below.

Services using blood or blood products should refer to *NSQHS Standards Guide for Hospitals* and *NSQHS Standards Accreditation Workbook* for implementation strategies for blood management and examples of evidence for actions in this standard.

Scope of this standard

The Blood Management Standard covers all elements in the blood management and clinical transfusion process, including the principles of patient blood management. Patient blood management includes avoiding unnecessary exposure to blood components through appropriate clinical management of the patient and the use of other, non-blood treatments.

The Blood Management Standard aims to ensure that patients (and carers) are engaged in decisions about their management and, if they receive blood and blood products, they do so appropriately and safely.

The Blood Management Standard requires clinician leaders and managers of a health service organisation to implement systems to ensure the safe, appropriate, efficient and effective use of blood and blood products. Clinicians and other members of the workforce should use the blood and blood product safety and quality systems.

The term 'transfusion' in this guide covers the administration of all blood and blood products, regardless of their route of administration. The blood and blood products covered under this standard include:

- Fresh blood components, such as
  - red blood cells
  - platelets
  - clinical fresh, frozen plasma
  - cryoprecipitate
  - cryodepleted plasma
- Plasma derivatives and recombinant products, such as
  - albumin
  - immunoglobulins, including immunoglobulin replacement therapy (for example, intravenous immunoglobulin) and hyperimmune globulins
  - coagulation proteins
  - coagulation and complement inhibitors.

Other products that are made or derived from human blood or plasma, such as some types of fibrin sealants (including Tisseel and Artiss) or autologous collections in an intraoperative cell salvage machine for infusion within four hours, could be considered blood products. However, these products are not included in the scope of this standard, and it is not necessary to apply the actions of this standard to these products. However, ensuring safety and quality is important for all patient treatments. These products should meet safety and quality standards identified in the Medication Safety Standard, as well as any other relevant standards, including those relating to patient consent.

The Blood Management Standard relates to the management of patients' own blood, pre-administration (including assessment of the patient's bleeding risk) and administration, and management and use of blood and blood products.

8

Recognising and Responding to Acute Deterioration Standard
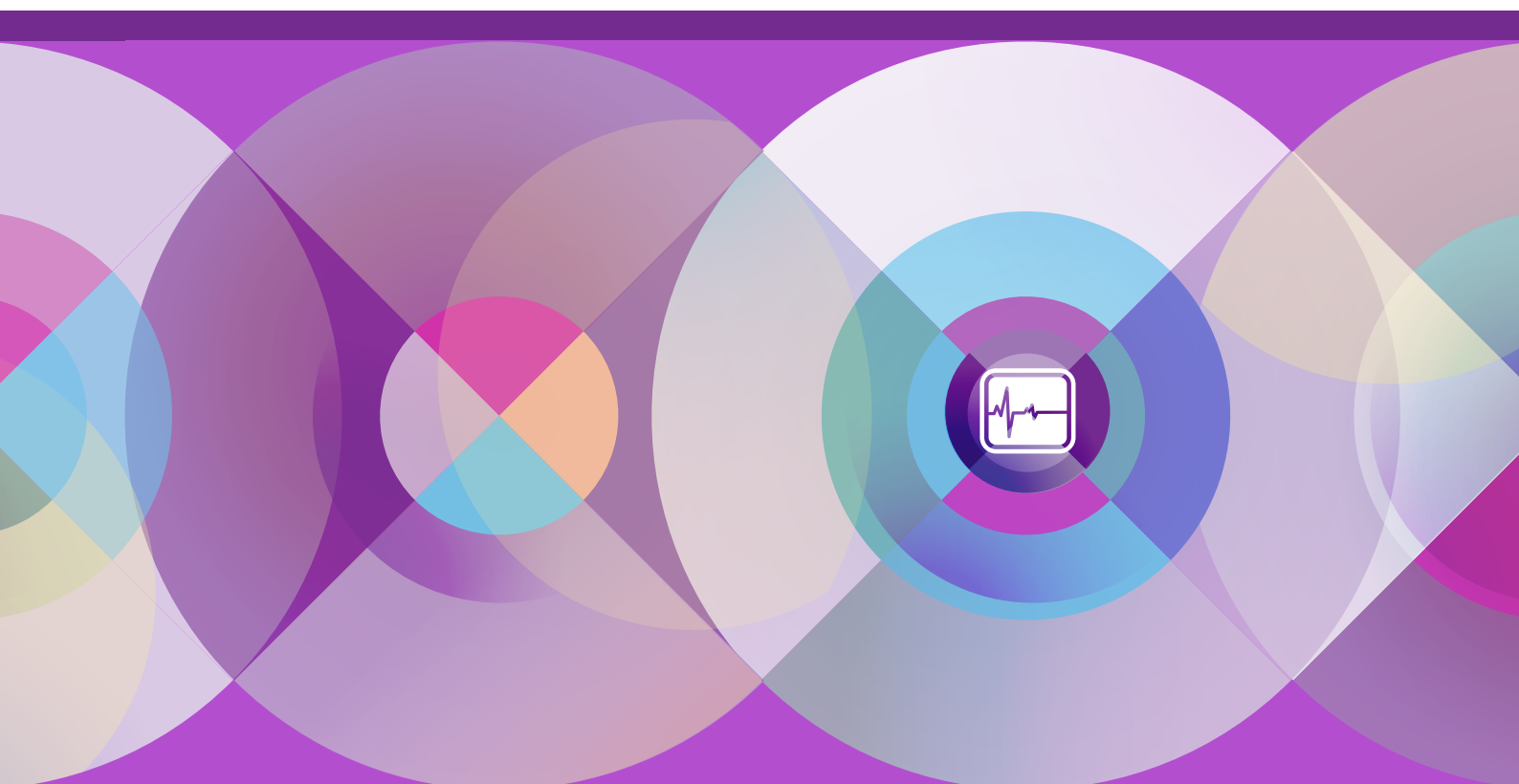
Recognising and Responding to Acute Deterioration Standard

Leaders of a health service organisation set up and maintain systems for recognising and responding to acute deterioration. The workforce uses the recognition and response systems.

Intention of this standard

To ensure that a person's acute deterioration is recognised promptly and appropriate action is taken. Acute deterioration includes physiological changes, as well as acute changes in cognition and mental state.

Criteria

Clinical governance and quality improvement to support recognition and response systems

Detecting and recognising acute deterioration, and escalating care

Responding to acute deterioration

Introduction

Serious adverse events, such as unexpected death and cardiac arrest, are often preceded by observable physiological and clinical abnormalities.[209] Other serious events, such as suicide and aggression, are also often preceded by observed or reported changes in a person's behaviour or mood that can indicate deterioration in their mental state.

Early identification of deterioration may improve outcomes and lessen the intervention required to stabilise patients whose condition deteriorates in a health service organisation.[210]

The warning signs of clinical deterioration are not always identified or acted on appropriately.[211] The organisational and workforce factors that contribute to a failure to recognise and respond to a deteriorating patient are complex and overlapping, and include[212-214]:

- Not monitoring physiological observations consistently, or not understanding changes in physiological observations
- Lack of knowledge of signs and symptoms that could signal deterioration
- Lack of awareness of the potential for a person's mental state to deteriorate
- Lack of awareness of delirium, and the benefits of early recognition and treatment[215]
- Lack of formal systems for responding to deterioration
- Lack of skills to manage patients who are deteriorating
- Failure to communicate clinical concerns, including in handover situations
- Attributing physical or mental symptoms to an existing condition, such as dementia or a mental health condition.[216,217]

Systems to recognise deterioration early and respond to it appropriately need to deal with these factors, and need to apply across the health service organisation. The *National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration*[218] has been endorsed by Australian health ministers as the national approach for recognising and responding to clinical deterioration in acute care facilities in Australia. It provides a consistent national framework to support clinical, organisational and strategic efforts

to improve recognition and response systems. This standard builds on the national consensus statement to drive implementation in acute care facilities.

The Australian Commission on Safety and Quality in Health Care (the Commission) has developed the *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state*.[157] This outlines the principles that underpin safe and effective responses to deterioration in a person's mental state, and provides information about the interrelated components that a health service organisation can implement to provide appropriate care.

The Commission's Delirium Clinical Care Standard[152] highlights the importance of being alert to, and assessing, delirium with any reported or observed changes in a person's mental state.

This standard supports the provision of appropriate and timely care to patients whose condition is acutely deteriorating. It requires that systems are in place to detect, recognise and respond to acute deterioration in physiological or mental state. It applies to all patients in the health service organisation: adults, adolescents, children and babies, and medical, surgical, maternity and mental health patients.

The strategies outlined will be applicable for most day procedure services. Services should refer to *NSQHS Standards Guide for Hospitals* for more detailed implementation strategies, as required.

CRITERION: Clinical governance and quality improvement to support recognition and response systems

Organisation-wide systems are used to support and promote detection and recognition of acute deterioration, and the response to patients whose condition acutely deteriorates. These systems are consistent with the National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration[219]*, the* National Consensus Statement: Essential elements for safe and high-quality end-of-life care[145]*, the* National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state[157]*, and the* Delirium Clinical Care Standard.[152]

This criterion requires organisation-wide governance, leadership and commitment to support recognition of, and response to, acute deterioration in physiological and/or mental state.

To meet this criterion, health service organisations are required to:

- Apply safety and quality systems to support timely and appropriate recognition of, and response to, acute physiological or mental deterioration
- Use quality improvement systems to monitor, review and improve recognition and response systems
- Apply principles of partnering with consumers when designing and implementing systems to recognise and respond to acute physiological or mental deterioration.

This criterion aligns closely with the Clinical Governance Standard and the Partnering with Consumers Standard.

Integrating clinical governance

Action 8.1

Clinicians use the safety and quality systems from the Clinical Governance Standard when:

a. Implementing policies and procedures for recognising and responding to acute deterioration

b. Managing risks associated with recognising and responding to acute deterioration

c. Identifying training requirements for recognising and responding to acute deterioration

Reflective questions

How are the health service organisation's safety and quality systems used to:

- Support implementation of policies and procedures for recognising and responding to acute deterioration

- Identify and manage risks associated with recognising and responding to acute deterioration
- Identify training requirements for recognising and responding to acute deterioration?

Key tasks

- Establish and implement governance structures for recognising and responding to acute deterioration
- Develop and implement policies and procedures for recognising and responding to acute deterioration
- Use risk management systems to identify, monitor, manage and review risks associated with recognising and responding to acute deterioration
- Develop and provide training to the workforce on recognising and responding to acute deterioration.

Strategies for improvement

The Clinical Governance Standard has specific actions relating to health service organisations' safety and quality systems.

Action 1.7 – policies and procedures

Action 1.10 – risk management systems

Actions 1.19, 1.20 and **1.21** – education and training

Health service organisations should:

- Use these and other established safety and quality systems to support policies and procedures, risk management and training for recognising and responding to acute deterioration
- Ensure that current versions of all relevant policies and procedures are readily available and accessible to clinicians.

Policies may be developed or adapted at different levels within the organisation. However, all policy documents should be incorporated into a single, coherent set to maximise the effectiveness of the policy development process.

Implement policies and procedures

Ensure that policies and procedures provide guidance about aspects of recognising and responding to acute deterioration, such as:

- Screening, assessment and comprehensive care planning processes that are required as part of the Comprehensive Care Standard to identify patients at risk of acute deterioration, and develop appropriate monitoring and escalation plans
- Escalation and emergency assistance processes
- Patient and family escalation processes
- Requirements for communicating and documenting the outcomes of episodes of acute deterioration
- Roles, responsibilities and accountabilities of multidisciplinary team members in recognising and responding to acute deterioration
- Processes for referral to services required to definitively manage episodes of acute deterioration in physical or mental state.

Manage risks

Use established risk management systems (see Action 1.10) to identify, monitor, manage and review risks associated with recognising and responding to acute deterioration that align with the requirements of the Clinical Governance Standard.

Develop processes to manage clinical risks for the population served by the organisation, clinical and workplace risks for the workforce, and organisational risks.

Use information from measurement and quality improvement systems, adverse events, clinical outcomes and patient experiences to inform and update risk assessments and the risk management system. Consider the training the workforce may need to effectively use the incident management and investigation system to inform risk management, and to plan and implement quality improvement processes to mitigate the risks.

Assess training and competency needs

Assess the competency and training needs of the workforce in line with the requirements of Actions 1.19, 1.20 and 1.21. Perform a risk assessment to inform the training schedule and to set priorities for the members of the workforce who

need training. Develop, or provide access to, training and education resources to meet the needs of the workforce regarding recognising and responding to acute deterioration.

Examples of evidence

Select only examples currently in use:

- Policy documents about recognising and responding to acute deterioration
- Observation of clinicians' practice that shows use of the health service organisation's processes for recognising and responding to acute deterioration
- Records of interviews with clinicians that show that they understand the health service organisation's processes for recognising and responding to acute deterioration

- Risk management system that includes actions to manage risks identified in recognising and responding to acute deterioration
- Documentation of requirements for reporting failures to recognise, escalate or respond to acute deterioration
- Reports from the incident management and investigation system about incidents relating to recognising and responding to acute deterioration
- Education plan for recognising and responding to acute deterioration.

Applying quality improvement systems

Action 8.2

The health service organisation applies the quality improvement system from the Clinical Governance Standard when:

a. Monitoring recognition and response systems

b. Implementing strategies to improve recognition and response systems

c. Reporting on effectiveness and outcomes of recognition and response systems

Reflective questions

How are the health service organisation's recognition and response systems continuously evaluated and improved?

How are the outcomes of improvement activities communicated to the governing body, the workforce, consumers and other organisations?

Key tasks

- Review, measure, and assess the effectiveness and performance of, recognition and response systems
- Implement quality improvement strategies for recognition and response systems based on the outcomes of monitoring activities
- Provide information on the outcomes of quality improvement activities to the governing body, the workforce, consumers and other organisations.

Strategies for improvement

> The Clinical Governance Standard has specific actions relating to health service organisations' quality improvement systems.
>
> **Action 1.8** – quality improvement systems
>
> **Action 1.9** – reporting
>
> **Action 1.11** – incident management and investigation systems
>
> Health service organisations should use these and other established safety and quality systems to support monitoring, reporting and implementation of quality improvement strategies for recognising and responding to acute deterioration.

Monitor effectiveness and performance

Use the organisation's quality improvement systems to identify and set priorities for the organisational and clinical strategies for recognition and response systems.

Review these systems to ensure that they include processes to monitor the effectiveness of recognition and response systems, such as:

- Intermittent audits of practices such as vital sign documentation
- Ongoing data collection about escalation processes, or outcomes such as unplanned patient transfer to another healthcare service
- Periodic surveys of workforce attitudes and patient experiences of using the recognition and response systems.

Specifications for quality measures, and other tools for evaluating systems for recognising and responding to acute physiological deterioration are available for download from the Commission's website.

When adverse events occur, investigate them to identify any issues with the performance or use of recognition and response systems. Data sources for review include use of restrictive practices and unplanned transfers to mental health units. Use this information to make improvements.

Implement quality improvement strategies

A Guide to Support Implementation of the National Consensus Statement: Essential elements for recognising and responding to clinical deterioration[118] provides detailed information about how to develop, implement, evaluate and improve systems for recognising and responding to acute physiological deterioration.

Report on outcomes

Report evaluation findings to the highest level of governance in the organisation and to the workforce. Use the data to work with consumers, the workforce, clinical leaders and managers to identify and implement improvements to recognition and response systems.

Examples of evidence

Select only examples currently in use:

- Documented data collection processes for the recognition and response systems
- Workforce survey results and patient experience data relating to recognising and responding to acute deterioration
- Quality measures and tools for evaluating the recognition and response systems
- Reports to the highest level of governance and the workforce on evaluation findings
- Improvements made to the recognition and response systems
- Evidence of local quality improvement projects based on investigation of reported incidents and evaluation data, and from the recognition and response systems
- Evidence of risk assessment and evaluation processes undertaken when implementing new tools and processes as part of the recognition and response systems (for example, electronic systems for monitoring vital signs and escalating care).

Partnering with consumers

Action 8.3

Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to:

a. Actively involve patients in their own care

b. Meet the patient's information needs

c. Share decision-making

Reflective questions

What processes from the Partnering with Consumers Standard do clinicians use to involve patients in planning and making decisions about recognising and responding to acute deterioration?

How does the health service organisation collect feedback from patients about information provided on recognising and responding to acute deterioration?

Key tasks

- Review strategies in the Partnering with Consumers Standard to inform the implementation of actions in the Recognising and Responding to Acute Deterioration Standard
- Provide information to patients about recognition and response systems tailored to their specific needs and level of health literacy.

Strategies for improvement

The Partnering with Consumers Standard has specific actions (**Actions 2.3–2.10**) relating to health service organisations' processes for involving patients in their own care, shared decision making, informed consent and effective communication.

Seek consent for non-urgent treatment in line with policies that reflect relevant legislation, as outlined in the guidance for the Partnering with Consumers Standard.

Although clinicians are not legally required to seek consent from substitute decision-makers for urgent treatment, it is recommended that they consult with them, if possible, to avoid starting treatment that is contrary to a person's expressed wishes.

If patients have the capacity to take part in the decision-making process when an episode of acute deterioration occurs, ensure that clinicians use the processes for involving patients in their own care, shared decision making, and meeting patients' information needs that are described in the Partnering with Consumers Standard.

If patients do not have the capacity to participate and do not have a documented advance care plan, but a substitute decision-maker is available, ensure that clinicians seek information from the substitute decision-maker about the patient's previously expressed preferences for care. Use this information to decide how to respond.

When patients lack the capacity to take part in decision-making and a substitute decision-maker is not available, clinicians should determine how to respond to acute clinical deterioration using documented information such as current advance care plans, goals of care, treatment-limiting orders, and information from carers and family.

Provide information to patients about recognition and response systems in a format that is easily understood and meaningful, and ensure that patients are given the opportunity to ask questions. Ensure that the information for patients is current and that clinicians have ready access to it.

Examples of evidence

Select only examples currently in use:

- Policy documents about gaining patient consent or consulting with substitute decision-makers for treatment in response to acute deterioration
- Observation of clinicians' practice that shows use of the health service organisation's processes for partnering with consumers
- Records of interviews with clinicians that show that they understanding the health service organisation's processes for partnering with consumers
- Information resources for patients, carers and families about recognition and response systems
- Examples of clinical documentation of shared decision making in relation to recognising and responding to acute deterioration (such as advance care plans; documented goals of care; comprehensive care plans; and documented discussions with patients, carers and families).

CRITERION: Detecting and recognising acute deterioration, and escalating care

Acute deterioration is detected and recognised, and action is taken to escalate care.

Monitoring and tracking changes in vital signs and other observations over time play a significant role in detecting acute deterioration. Acute deterioration may occur at any time during a patient's admission. If monitoring is intermittent or infrequent, or does not include the right parameters, acute deterioration may not be detected, and recognition and appropriate treatment may be delayed. This can result in serious adverse outcomes for patients.[214,220-222]

Frequency of monitoring often varies[223], perhaps because of differences in individual clinicians' clinical judgement, poor communication among teams, varying views about the importance of monitoring, and a lack of guidelines to inform practice.[224-226] It is therefore necessary to develop systems to ensure that vital signs and other parameters for detecting deterioration in a patient's physical, mental or cognitive condition are being measured. These systems need to ensure that the right parameters are monitored for each patient, and that monitoring occurs at the appropriate frequency (number of times per day) and for the appropriate duration (number of days or weeks). Consistent documentation of measured vital signs and other observed indicators is important for changes to be tracked over time.

Recognising acute deterioration relies on detecting, understanding and interpreting abnormal vital signs and other observations, and escalating care appropriately. This is a complex process that requires knowledge of:

- How to conduct the appropriate observations
- What indicates acute deterioration for individual patients
- Appropriate treatment for the cause of the acute deterioration
- Which clinicians have the skills to provide this treatment
- Who is available to provide this treatment, considering the time of day or day of the week

- How to contact the appropriate clinicians and communicate information about the abnormality
- The appropriate time frame for clinicians to respond
- Alternative or backup options for obtaining a response.

Recognition systems include identifying the requirements for escalating care. These may be documented on vital sign observation charts, in policies and guidelines, and in escalation protocols. Escalation protocols provide details of the criteria, parameters and thresholds that indicate acute deterioration, the action to be taken when deterioration is detected, the process for calling for help and the expected responses.

A graded response to acute deterioration is needed. Patients whose acute deterioration is detected and recognised during the early stages need clinical care and treatments to prevent further deterioration. Patients who deteriorate very suddenly or severely need a rapid response from providers with advanced skills.

It is vital to the effectiveness of recognition and response systems that escalation protocols are developed with local knowledge of the day procedure service. Criteria for escalation that are appropriate for a large tertiary metropolitan hospital will not necessarily be appropriate for a day procedure service. The availability of resources and clinical expertise also means that response actions vary considerably from one organisation to another. Different protocols may be needed for escalation of acute physiological deterioration and escalation for deterioration in a person's mental state.

Recognising acute deterioration

Action 8.4

The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to:

a. Document individualised vital sign monitoring plans

b. Monitor patients as required by their individualised monitoring plan

c. Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient

Reflective questions

What systems are in place for documenting vital sign monitoring plans?

What processes are used to ensure that there is enough equipment for patient monitoring?

How does the health service organisation ensure that clinicians have the skills to monitor patients according to their monitoring plan?

What processes are in place for documenting vital sign observations graphically and over time?

Key tasks

- Implement a system for documenting vital sign monitoring plans
- Ensure that clinicians have the necessary skills and equipment to monitor patients as required by their individualised monitoring plans
- Implement an observation chart or other mechanism for graphically documenting vital sign observations and tracking changes over time.

Strategies for improvement

Develop monitoring plans

Develop individualised vital sign monitoring plans to address the clinical risks and needs of each patient. Work with clinicians to design systems for developing and documenting these plans, and to ensure that the systems align with workflow and effectively meets patients' needs. Include capacity to document the frequency, duration and types of vital signs or other physiological parameters.

Monitoring plans may be included in clinical pathways for specific patient groups who have similar clinical risks and needs, but provide prompts for clinicians to consider whether the monitoring plan meets the needs of each patient, and capacity for them to review and modify the monitoring plan.

Describe the minimum expectations for vital sign monitoring in policy. The *National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration*[219] identifies a core set of six vital signs, and recommends that these be monitored at least once per eight-hour shift:

- Respiratory rate
- Oxygen saturation
- Heart rate
- Blood pressure
- Level of consciousness
- Temperature.

The frequency of required monitoring may vary between individual patients, and as a patient's clinical situation, clinical risks and goals of care change. For example, patients who have received sedation or general anaesthesia will require more frequent and prolonged monitoring than those who

received local anaesthetic only. Some patients may not need all the core vital signs to be monitored at the same frequency (for example, young children may not need blood pressure monitored as often as respiratory rate and oxygen saturation).

Include the core vital signs in monitoring plans for most patients. Specific groups of patients may have extra monitoring requirements (for example, Aldrete scores or the Post Anaesthetic Discharge Scoring System, respiratory distress, capillary refill, pupil size and reactivity).

Work with clinicians to make a clinical risk assessment and reduce the monitoring requirements for some groups of patients (such as young, otherwise healthy patients having a simple procedure such as mole removal). Develop guidelines for these patients specifying alternative criteria for recognising clinical deterioration and escalating care, and indications to commence core vital sign monitoring.

Ensure appropriate skills and equipment

Develop processes to ensure that clinicians are trained to use monitoring equipment correctly, and are competent in measuring and interpreting vital signs accurately. Educate clinicians about the clinical significance of normal and abnormal vital sign observations in the context of acute physiological deterioration. Strategies might include self-directed learning packages, competency-based skills assessment, face-to-face training sessions, simulation and peer review.

Use an audit of vital sign observation charts to evaluate whether vital sign monitoring practices align with policy, and provide feedback to clinicians about their practice. An observation chart audit tool is available on the Commission's website.

Ensure that equipment for measuring and monitoring vital signs and other physiological parameters is readily available and in good working order. Conduct a risk assessment to determine how much equipment is needed. Set up systems for regular checking and maintenance of monitoring equipment. If possible, provide consistent monitoring equipment across the organisation – this reduces the burden of training required and can help to avoid errors introduced by small differences

in correct use of equipment. For example, if multiple types of cardiac monitoring equipment are used across an organisation, it can be more difficult for clinicians to use the equipment and troubleshoot, especially in emergency situations.

Document and track vital signs

For patients whose monitoring plans indicate that vital sign observations are not required (as determined by the risk assessment process described above), this action is not applicable.

For all other patient groups, put a system in place to document and track vital signs. Regardless of the type of system used to document vital signs, it should include:

- The capacity to display documented vital signs graphically
- The capacity to track changes in vital signs over time
- Thresholds for each vital sign parameter or combination of parameters that indicate abnormality
- Information about the response or action needed when thresholds are reached or physiological deterioration is identified
- The potential to document the normal range for the patient.

Many Local Hospital Networks, state and territory health departments, and private hospital groups have developed and implemented track-and-trigger observation charts. Specialist vital sign observation charts have been developed for use in a range of populations, including children of different age groups, obstetrics and adults.

Electronic systems for tracking vital sign observations may be used, and may improve the detection of deterioration and escalation of care.[227] When implementing these systems, organisations need to:

- Test usability from both the clinical and human factors perspectives
- Develop strategies for mitigating the risk of human errors associated with issues such as workarounds arising from slow data-entry processes[228] and alarm fatigue from frequent automatic alerts[229,230]

- Provide training to ensure that the electronic systems are used correctly
  - Establish processes to evaluate the safety and quality of the electronic systems as they are implemented.

Although many electronic systems have automatic triggering of alarms or message prompts when thresholds indicating acute deterioration are reached, human factors testing of paper charts shows that clinicians' ability to detect vital sign trends that indicate deterioration improves when vital signs are presented graphically.[231-233] Set the default display of electronic vital sign monitoring systems so that clinicians can document and review vital sign observations graphically.

If the organisation is planning and implementing electronic systems (for example, electronic vital sign monitoring and escalation systems), ensure that these systems are consistent with the principles underlying paper-based processes and protocols. Also ensure that appropriate clinical and organisational governance experts inform the development of electronic systems for recognising and responding to acute deterioration, and are involved in ongoing monitoring of the safety and quality of these systems.

Examples of evidence

Select only examples currently in use:

- Policy documents that align with the *National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration*[219] and describe the minimum requirements for
  - development and documentation of individualised monitoring plans
  - frequency of monitoring for core vital signs
  - vital sign documentation
- Training documents about using monitoring equipment, monitoring and documenting vital signs, and developing and documenting monitoring plans

- Documented protocols that outline the requirements of monitoring plans for different patient groups (for example, patients in an inpatient surgical ward are likely to have different monitoring requirements from patients in an outpatient chemotherapy unit)
- Audit results of compliance with monitoring policies, procedures or protocols
- Maintenance logs and checklists for equipment used for monitoring vital signs
- Results of skills and competency evaluation for detecting acute physiological deterioration
- Examples of completed monitoring plans, track-and-trigger observation charts, and clinical pathways that are appropriate for the setting
- Local guidelines for vital sign monitoring in specialist areas.

Action 8.5

The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to:

a. Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium

b. Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan

c. Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported

d. Determine the required level of observation

e. Document and communicate observed or reported changes in mental state

Reflective questions

How does the health service organisation ensure that clinicians are trained to be alert for the signs of acute deterioration in a person's mental state?

How does this apply to people who have not been identified as being at high risk of deterioration in mental state?

Key task

- Ensure that members of the workforce:
  - are alert to signs of deterioration in a person's mental state, including for people who have not been previously identified as being at high risk
  - are alert to the signs of delirium
  - can implement an initial response and keep the person safe until arrangements are made for specialist review.

Strategies for improvement

Although there is low prevalence of episodes of acute deterioration in a person's mental state in day procedure services, members of the healthcare workforce need to be alert to signs indicating that a person may be experiencing acute deterioration in mental state, and know what to do when they recognise these signs.

The health service organisation needs to ensure that, if a person does experience acute deterioration in their mental state, members of the workforce have the skills to initiate an immediate response to ensure safety, and communicate their concerns to relevant parties.

Engagement with families and carers can help to maintain safety for the person experiencing deterioration in their mental state and others, while arrangements for specialist intervention are in train.

Use screening processes to identify patients with cognitive impairment or at risk of delirium to trigger strategies to keep the patient safe and minimise potential distress (see Action 5.29).

Examples of evidence

Select only examples currently in use:

- Policy documents about recognising, documenting and observing acute deterioration in mental state
- Screening and assessment policies and procedures for mental health in line with the Comprehensive Care Standard
- Training documents about recognising acute deterioration in mental state and how to deal with reports of deterioration from the patient, carer or family
- Documentation of patient involvement in developing individualised monitoring plans
- Audit results of compliance with the monitoring plan systems for mental state.

Escalating care

Action 8.6

The health service organisation has protocols that specify criteria for escalating care, including:

a. Agreed vital sign parameters and other indicators of physiological deterioration

b. Agreed indicators of deterioration in mental state

c. Agreed parameters and other indicators for calling emergency assistance

d. Patient pain or distress that is not able to be managed using available treatment

e. Worry or concern in members of the workforce, patients, carers and families about acute deterioration

Reflective question

What protocols are used to specify the criteria for escalating care?

Key tasks

- Work with clinical groups to agree on parameters that indicate acute deterioration and require escalation of care
- Develop and implement protocols for escalating care when acute deterioration in a patient's condition is detected.

Strategies for improvement

Delays in treatment can occur in the absence of clear criteria for escalating care.[203,234] Escalation protocols provide clear, objective criteria that prompt clinicians to call for help, and endorse calling for help when clinicians, patients, family members or carers are subjectively concerned about a patient acutely deteriorating.

Identify parameters for escalation

Although there is low prevalence of episodes of acute deterioration in a person's mental state in day procedure services, the health service organisation needs to ensure that, if a person does experience acute deterioration in their mental state, members of the workforce have the skills to initiate an immediate response to ensure safety, and communicate their concerns to relevant parties.

Use a graded response system within the escalation protocol. This means that the escalation protocol includes at least two levels of response to acute deterioration:

- An emergency response (for example, urgent review by a consultant anaesthetist, a call to the ambulance service) to criteria that indicate severe acute deterioration
- At least one other level of response (for example, from a senior nurse) for criteria that indicate less severe deterioration.

The two levels are recommended because early treatment of acute deterioration is better – patients who trigger medical emergency calls have high mortality rates[235,236], and delayed calls to medical emergency teams are associated with poorer outcomes.[210,237]

Work with clinicians to agree on the criteria that indicate acute deterioration in physiological and mental state. Identify the thresholds to trigger escalation of care before acute deterioration becomes severe, and thresholds to trigger a call for emergency assistance when acute deterioration is severe. Consider the extra time necessary to transfer patients whose condition acutely deteriorates to a tertiary referral hospital when planning an escalation protocol. Use the escalation mapping tool available from the Commission's website to match the thresholds and parameters that indicate acute physical deterioration to the appropriate response. The mapping tool can also be used for deterioration in mental state to determine what should trigger a response, and required actions to keep patients and the workforce safe.

Patient pain and distress that are unable to be managed using available treatments may indicate acute deterioration that needs urgent treatment. Include pain and distress as a criterion for escalation in the protocol.

Patients may show signs of clinical deterioration other than those identified in the escalation protocol, and there is evidence that clinician worry or concern may precede deterioration in vital signs.[238] Include clinician worry or concern as a criterion for escalation in the protocol.

Escalation protocols can be complex, involving multiple steps and different communication pathways. Develop a flow diagram to summarise escalation processes and provide clinicians with a quick reference tool. Display posters of the escalation flow diagram near telephones in clinical areas, or provide clinicians with identification tag cards for quick reference.

Refer to the 'Minimising patient harm' criterion in the Comprehensive Care Standard for further details on preventing delirium and managing cognitive impairment; predicting, preventing and managing self-harm, suicide, aggression and violence; and minimising restrictive practices.

Examples of evidence

Select only examples currently in use:

- Policy documents that identify agreed criteria that indicate acute deterioration in physical, mental or cognitive condition that trigger escalation of care, and the expected responses
- Policy documents that include consideration of the organisation's size, role, location and services provided; localised escalation strategies; and tailored escalation for specialist patient groups
- Documented protocols that are available to the workforce for escalating care when acute deterioration in a patient's condition is detected
- Documented localised escalation protocols
- Escalation flow diagrams
- Audit results of compliance with the escalation protocols
- Committee and meeting records in which clinicians agreed on the parameters that indicate acute deterioration for escalation
- Resources or tools that help clinicians to use the escalation protocols.

Action 8.7

The health service organisation has processes for patients, carers or families to directly escalate care

Reflective question

What processes are in place for patients, carers or families to directly escalate care?

Key task

- Develop and implement a system for patients, carers and families to directly escalate care.

Strategies for improvement

Develop a system for patients, carers and families to obtain access to help when they are concerned that a patient is acutely deteriorating.

Work with consumer advisors and clinicians to identify the criteria for escalating care, the mechanism for calling for help, and the response that will be provided. Examples of criteria for escalating care are:

- Concern about a patient in the service who is getting worse, not doing as well as expected or not improving
- Concern that 'something is not right'.[58]

Ensure that the system can be activated easily and independently. Methods for activating the system might include using an emergency call button, or using a designated phone number that is only for patient, carer and family escalation.

Provide written and verbal information about the system for patient, carer and family escalation on admission, and display details about when and how to use the system in public areas.

Depending on the mechanisms used for patients, carers and families to escalate care, it may be necessary to train non-clinical members of the workforce (such as reception workforce) to ensure that calls are directed to the appropriate responder(s). Developing scripted questions can help non-clinical members of the workforce triage calls correctly.

Several Australian states have established patient, carer and family member escalation systems, such as the New South Wales REACH program and Queensland's Ryan's Rule.

Examples of evidence

Select only examples currently in use:

- Observation of an escalation system that supports patients, carers and families to directly escalate care
- Consumer and carer resources that outline how they can directly escalate care
- Relevant documentation from committees with consumer advisors and clinicians in which the criteria for, mechanism of, and response to, direct patient, carer and family escalation of care were decided
- Evaluation of the effectiveness and usability of the patient, carer and family escalation protocol and associated quality improvement projects
- Training documents about the system for patients, carers and families to directly escalate care, including how the non-clinical workforce should forward calls for assistance.

Action 8.8

The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance

Reflective question

What mechanisms are in place for the workforce to escalate care and call for emergency assistance?

Key task

- Provide the workforce with mechanisms to escalate care and call for emergency assistance.

Strategies for improvement

Provide mechanisms to escalate care and call for emergency assistance, and ensure that these are consistent and effective. Multiple mechanisms may be necessary in escalation systems to allow different responses to varying levels or types of deterioration. These mechanisms may include:

- Paging systems

- Dedicated mobile, on-call and emergency telephone numbers
- Bedside or centralised alarms.

Consider the following issues when deciding on the mechanisms to use:

- Avoid changes in the system at different times of the day and on different days of the week
- Develop processes for responders to hand over shared equipment, such as pagers and mobile phones, between shifts
- Provide backup systems in the event of equipment failure
- Develop processes for maintaining equipment
- Provide training about how to use the mechanisms for escalating care, including for new, casual, locum and agency members of the workforce.

Examples of evidence

Select only examples currently in use:

- Policy documents about escalating care and calling for emergency assistance
- Audit results of equipment functionality and maintenance, including paging systems, electronic alerting systems, alarms and dedicated mobile phones
- Training documents about mechanisms for escalating care and calling for emergency assistance
- Audit results of compliance with the mechanisms for escalating care and calling for emergency assistance
- Evidence of investigations into failures of the mechanisms for escalation and emergency assistance calls, and associated quality improvement projects.

Action 8.9

The workforce uses the recognition and response systems to escalate care

Reflective question

How does the health service organisation ensure that the workforce knows how and when to use the recognition and response systems?

Key task

- Escalate care when acute deterioration is recognised.

Strategies for improvement

Provide orientation, education and training for the workforce so that they understand their individual roles, responsibilities and accountabilities in the recognition and response systems. Use evaluation data to identify trends and potential training gaps, so that training and education can be effectively targeted.

Topics to cover in education for non-clinical members of the workforce (such as reception workforce, porters, cleaners and food service workers) include how to escalate care if they are concerned about a patient, and how to respond if a patient or family member asks for help.

Topics to cover in education for clinicians include:

- Recognising parameters and thresholds that indicate acute deterioration, including criteria for patient pain and distress, and clinician concern or worry
- Identifying escalation actions when thresholds indicating acute deterioration are reached
- Processes and mechanisms for escalating care
- The role and capacity of responders
- What to do if the expected response is delayed or does not adequately deal with the problem
- Communication skills such as graded assertiveness
- Professional behaviours in successfully operating recognition and response systems.

Effective escalation of care relies on effective communication. A large amount of information may be communicated to many clinicians when acute deterioration occurs. There are risks to patient safety if information is not comprehensive, relevant and clearly understood.[162] Develop standardised and structured communication prompts and tools for clinicians to use when escalating care, in accordance with the requirements of the Communicating for Safety Standard.

Resources to support handover of critical information are available from the Commission's website.

Provide processes for members of the workforce to routinely give feedback about their experiences of escalating care, and use this information to improve escalation protocols.

Examples of evidence

Select only examples currently in use:

- Training documents about the roles, responsibilities and accountabilities of the workforce for using the recognition and response systems
- Examples of communication prompts and tools used for escalating care
- Audit results of the use of communication prompts and tools when escalating care
- Quality improvement system that includes analysis of feedback on the workforce's experiences of escalating care, to improve escalation protocols
- Feedback provided on the recognition and response systems
- Audit results of compliance with the use of recognition and response systems
- Reports on investigations into incidents associated with failure to use recognition and response systems, and associated quality improvement projects.

CRITERION: Responding to acute deterioration

Appropriate and timely care is provided to patients whose condition is acutely deteriorating.

In addition to ensuring that monitoring and escalation systems are in place and working well, response systems must be in place. Response systems ensure that all patients who acutely deteriorate receive a timely and appropriate response. Timeliness should be determined by a risk assessment process that weighs up the clinical risks for patients when acute deterioration occurs and the frequency with which episodes of acute deterioration occur in the organisation. Appropriateness should also be determined by a risk assessment process that weighs up the clinical risks for patients and the capacity of the organisation to respond when acute deterioration occurs. This means that response systems in acute tertiary hospitals will differ substantially from response systems in day procedure services.

Regardless of setting, most response systems will include at least two levels of response as part of the graded escalation process. When acute deterioration is recognised early, senior nurses or attending doctors (or both) may respond. For more serious deterioration, a rapid response from clinicians with advanced skills in the management of acute deterioration is required. This rapid response might be provided by a single clinician with advanced clinical assessment and resuscitation skills, or an external service such as the ambulance service.

Develop partnerships with other relevant organisations if responding to acute deterioration in a person's mental state is outside the scope of the day procedure service.

When acute deterioration in a person's mental state occurs, rapid referral to a consultation liaison psychiatry service is required. If consultation liaison is not locally available, the health service organisation needs to work with relevant specialist services to provide this response.

Further resources may be needed to ensure that the chosen response system is effective and that responders are competent in the necessary skills. Consider scope of clinical practice when designing the response system, and the roles and responsibilities of response providers.

As a minimum, the outline of the roles and responsibilities of response providers should identify the person who:

- Is responsible for ensuring that equipment for providing emergency assistance will reach the patient
- Is responsible for directing and coordinating the multiple activities and treatments needed when providing emergency assistance
- Is responsible for communicating the outcome of the call to the healthcare team, the patient, and their carers and family
- Has authority to make transfer decisions and refer to other clinicians, as required
- Is responsible for documenting the care provided
- Is accountable for handing over critical information for ongoing care.

Also identify the roles and responsibilities of the clinicians who escalate care. These may include:

- Remaining with the patient and starting further assessments, emergency interventions and other therapies while awaiting the response provider(s)
- Providing structured handover of information on the patient's clinical condition and reasons for escalating care
- Ensuring that all relevant clinicians are aware of the patient's acute deterioration and attend to assist, if possible.

Include information about the roles and responsibilities of response providers and clinicians who escalate care in education programs and orientation sessions about the recognition and response systems.

Responding to deterioration

Action 8.10

The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration

Reflective question

How does the health service organisation ensure that clinicians are competent in the skills required to respond to patients whose condition is acutely deteriorating?

Key task

- Develop systems to ensure that clinicians are competent in the skills required to respond to patients whose condition is deteriorating.

Strategies for improvement

This action means different things for people in different roles and settings. It applies to both the workforce providing the initial response while awaiting help, and to the response team who bring extra skills to the patient. Take a risk assessment approach to identify and set priorities for training needs.

Clinicians who provide clinical care need skills in providing essential emergency interventions for common causes and symptoms of life-threatening physiological deterioration while awaiting help. These include skills in essential emergency management of conditions such as airway obstruction, hypoxia, respiratory distress or suppression, arrhythmia, hypotension, fluid overload and seizures.

If the response to acute deterioration is provided by clinicians within the day procedure service (rather than an external service such as an ambulance), ensure that responders are competent in the required skills. These include advanced clinical assessment skills and other, non-technical skills, such as graded assertiveness and team leadership.[228]

Examples of evidence

Select only examples currently in use:

- Employment documents that describe roles and responsibilities in the event of episodes of acute deterioration
- Training documents about emergency interventions in the event of acute deterioration, including specialist training for responders, such as members of medical emergency teams
- Evidence of clinician competency assessment (for example, through simulation exercises, peer review or formal assessments)
- Records indicating that clinicians have met the ongoing professional development requirements of a specialist college in relation to responding to acute deterioration (for example, through the College of Intensive Care Medicine).

Action 8.11

The health service organisation has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support

Reflective question

What processes are in place to ensure that clinicians who are competent in providing advanced life support are available to respond to patients who acutely deteriorate?

Key task

- Provide a system to ensure rapid access to advanced life support for patients who acutely deteriorate.

Strategies for improvement

Ensure that response systems include provision for rapid access to at least one clinician with advanced life support skills at all times. Depending on the size, location and type of day procedure service, options to provide this access include:

- Supporting senior nurses to complete advanced life support training
- Developing agreements with anaesthetists who provide services in the organisation
- Accessing external ambulance services.

If advanced life support is to be provided by members of the workforce, establish clinicians' competence in advanced life support with evidence of relevant qualifications (for example, advanced life support certification compliant with Australian Resuscitation Council guidelines[239] or medical qualifications in specialities such as anaesthesia and critical care). Establish competence in paediatric advanced life support for responders in services that provide care to children. More clinicians may require training so that this level of care can be provided when key clinicians are absent.

Clinicians need regular opportunities to practise and maintain their skills so that they retain competence.[240,241] Put systems in place to provide evidence of clinicians' ongoing competence in advanced life support. This may require the organisation to provide access to formal advanced life support training for clinicians. Additional benefits can be gained by providing opportunities for members of rapid response teams to train together, and practise using non-technical skills such as leadership, teamwork and communication while managing simulated scenarios of acute deterioration.

Examples of evidence

Select only examples currently in use:

- Rosters of clinicians who can provide advanced life support
- Audit results of episodes requiring advanced life support, to determine whether members of the workforce who can provide advanced life support were available
- Employment documents that describe advanced life support roles, responsibilities and accountabilities
- Evidence of qualifications or up-to-date certification for the provision of advanced life support
- Policy documents for rapidly gaining access to a clinician who can provide advanced life support
- Records of ongoing competency assessments for advanced life support
- Training documents about non-technical skills relating to advanced life support, such as teamwork, team leadership and communication.

Action 8.12

The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated

Reflective questions

How does the health service organisation ensure that the workforce knows the local processes for escalating care to mental health specialists?

What partnerships are in place to help patients gain access to mental health services if they are not provided within the health service organisation?

How are patients, carers and families informed about rapid referral to mental health services?

Key task

- Develop partnerships with other relevant organisations if responding to acute deterioration in a person's mental state is outside the scope of the health service organisation.

Strategies for improvement

Because of the short duration of stay in day procedure services and the use of pre-admission screening to determine that it is currently safe for a person to undergo a procedure, there is very low prevalence of acute deterioration in a person's mental state in day procedure services.

Day procedure services do not typically have workforce members with mental health expertise on site. It is therefore recommended that services develop partnerships with local services that can provided emergency mental health assistance in the rare instances that it is needed. Maintain these partnerships, and ensure that all members of the workforce can escalate care appropriately.

Examples of evidence

Select only examples currently in use:

- Policy documents about rapid referral to mental health services
- Audit results of episodes when patients' mental states have acutely deteriorated, to determine whether rapid referrals were made to mental health services
- Document that identifies areas of the health service organisation where the risk of acute deterioration in mental state is highest.

Action 8.13

The health service organisation has processes for rapid referral to services that can provide definitive management of acute physical deterioration

Reflective questions

What services may be required by patients who acutely deteriorate but cannot be safely provided?

What referral mechanisms are in place to ensure that patients whose acute deterioration cannot be definitively managed within the health service organisation are rapidly referred to other organisations?

Key tasks

- Map the causes of acute deterioration against the capacity of the health service organisation to provide for their definitive management
- If the organisation is not able to provide definitive care, develop systems for rapid referral of patients with acute deterioration to other services.

Strategies for improvement

Definitive management means that the patient receives the best possible treatment for decisively resolving the cause of their acute deterioration. Acute deterioration may be the outcome of a disease process, medical intervention or condition that is not able to be effectively managed by the day procedure service. This means that systems need to be developed to rapidly refer patients to other services.

Identify common causes of acute deterioration using data from the recognition and response systems. These may include common presentations and causes of acute physiological deterioration, such as:[210,242-244]

- Post-anaesthetic airway obstruction and respiratory depression
- Altered level of consciousness associated with issues such as neurological events or abnormal blood glucose
- Respiratory distress associated with issues such as fluid overload or exacerbations of existing lung disease
- Arrhythmias
- Hypotension associated with conditions such as
  - dehydration
  - post-surgical bleeding
  - cardiac failure
- Medicine side effects or interactions, or related complications such as allergies or errors.

Map the most likely causes of acute deterioration in the day procedure service against the capacity of the service to provide definitive management for each of them. For example, post-anaesthetic airway obstruction may be a routine scenario that is easily managed in the recovery room. However, fluid overload associated with cardiac failure may indicate serious deterioration that cannot be safely managed in the service. For these cases, develop a system for rapid referral to acute care services.

If the day procedure service is attached to an acute hospital, the system may involve referral and transfer to the affiliated emergency department. If the service is a standalone facility, an option is to rely on referral for ongoing care through emergency ambulance services.

Examples of evidence

Select only examples currently in use:

- Audit results of the common causes of deterioration from the recognition and response systems mapped to organisational capacity
- Policy documents about referral to other services for definitive management
- Memorandums of understanding with external services that enable rapid referral for definitive management
- Documented processes for safe transport to other services for definitive management
- Evaluation of referral processes and patient outcomes, and evidence of associated quality improvement projects.

Resources

Key Commission documents for implementing recognition and response systems

A Better Way to Care: Safe and high-quality care for patients with cognitive impairment (dementia and delirium) in hospital

Delirium Clinical Care Standard

National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration

A Guide to Support Implementation of the National Consensus Statement

National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state

National Consensus Statement: Essential elements for safe and high-quality end-of-life care

National Consensus Statement: Essential elements for safe and high-quality paediatric end-of-life care

Observation charts

ACT Health – Compass

Australian Commission on Safety and Quality in Health Care – Observation and response charts

NSW Health – Standard observation charts

SA Health – Sample observation charts

Victorian Children's Tool for Observation and Response (ViCTOR)

Acronyms and abbreviations

Term	Definition
ADR	adverse drug reaction
AMS	antimicrobial stewardship
BPMH	best possible medication history
CMI	consumer medicine information
Commission	Australian Commission on Safety and Quality in Health Care
IT	information technology
MMP	medication management plan
NAPS	National Antimicrobial Prescribing Survey
NIMC	National Inpatient Medication Chart
NSQHS Standards	National Safety and Quality Health Service Standards
TGA	Therapeutic Goods Administration

Glossary

If appropriate, glossary definitions from external sources have been adapted to fit the context of the NSQHS Standards.

acute deterioration: physiological, psychological or cognitive changes that may indicate a worsening of the patient's health status; this may occur across hours or days.

advance care plan: a plan that states preferences about health and personal care, and preferred health outcomes. An advance care planning discussion will often result in an advance care plan. Plans should be made on the person's behalf and prepared from the person's perspective to guide decisions about care.[245]

advanced life support: the preservation or restoration of life by the establishment and/or maintenance of airway, breathing and circulation using invasive techniques such as defibrillation, advanced airway management, intravenous access and drug therapy.[219]

adverse drug event: harm associated with any dose of a medicine.

adverse drug reaction: a response to a medicine that is noxious and unintended, and occurs at doses normally used or tested in humans for the prophylaxis, diagnosis or therapy of disease, or for the modification of physiological function.[246] An allergy is a type of adverse drug reaction.

adverse event: an incident that results, or could have resulted, in harm to a patient or consumer. A near miss is a type of adverse event. *See also* near miss

alert: warning of a potential risk to a patient.

allergy: occurs when a person's immune system reacts to allergens in the environment that are harmless for most people. Typical allergens include some medicines, foods and latex.[247] An allergen may be encountered through inhalation, ingestion, injection or skin contact.[248] A medicine allergy is one type of adverse drug reaction.

antimicrobial: a chemical substance that inhibits or destroys bacteria, viruses or fungi, and can be safely administered to humans and animals.[82]

antimicrobial resistance: failure of an antimicrobial to inhibit a microorganism at the antimicrobial concentrations usually achieved over time with standard dosing regimens.[82]

antimicrobial stewardship: an ongoing effort by a health service organisation to reduce the risks associated with increasing antimicrobial resistance and to extend the effectiveness of antimicrobial treatments. It may incorporate several strategies, including monitoring and review of antimicrobial use.[82]

approved identifiers: items of information accepted for use in identification, including family and given names, date of birth, sex, address, healthcare record number and Individual Healthcare Identifier. Health service organisations and clinicians are responsible for specifying the approved items for identification and procedure matching. Identifiers such as room or bed number should not be used.

aseptic technique: a technique that aims to prevent microorganisms on hands, surfaces and equipment from being introduced to susceptible sites. Unlike sterile techniques, aseptic techniques can be achieved in typical ward and home settings.[249]

assessment: a clinician's evaluation of a disease or condition based on the patient's subjective report of the symptoms and course of the illness or condition, and the clinician's objective findings. These findings include data obtained through laboratory tests, physical examination and medical history; and information reported by carers, family members and other members of the healthcare team. The assessment is an essential element of a comprehensive care plan.[197]

audit (clinical): a systematic review of clinical care against a predetermined set of criteria.[250]

Australian Charter of Healthcare Rights: specifies the key rights of patients when seeking or receiving healthcare services. It was endorsed by health ministers in 2008.[39]

Australian Open Disclosure Framework: endorsed by health ministers in 2013, it provides a framework for health service organisations and clinicians to communicate openly with patients when health care does not go to plan.[9]

best possible medication history: a list of all the medicines a patient is using at presentation. The list includes the name, dose, route and frequency of the medicine, and is documented on a specific form or in a specific place. All prescribed, over-the-counter and complementary medicines should be included. This history is obtained by a trained clinician interviewing the patient (and/or their carer) and is confirmed, where appropriate, by using other sources of medicines information.[251]

best practice: when the diagnosis, treatment or care provided is based on the best available evidence, which is used to achieve the best possible outcomes for patients.

best-practice guidelines: a set of recommended actions that are developed using the best available evidence. They provide clinicians with evidence-informed recommendations that support clinical practice, and guide clinician and patient decisions about appropriate health care in specific clinical practice settings and circumstances.[252]

blood management: a process that improves outcomes for patients by improving their medical and surgical management in ways that boost and conserve their own blood, and ensure that any blood and blood products they receive are appropriate and safe.

blood products: the products derived from fresh blood – red blood cells and platelets, fresh frozen plasma, cryoprecipitate and cryodepleted plasma, plasma-derived blood products, and recombinant blood products.

business decision-making: decision-making regarding service planning and management for a health service organisation. It covers the purchase of building finishes, equipment and plant; program maintenance; workforce training for safe handling of equipment and plant; and all issues for which business decisions are taken that might affect the safety and wellbeing of patients, visitors and the workforce.

care pathway: a complex intervention that supports mutual decision-making and organisation of care processes for a well-defined group of patients during a well-defined period.[253]

carer: a person who provides personal care, support and assistance to another individual who needs it because they have a disability, medical condition (including a terminal or chronic illness) or mental illness, or they are frail or aged. An individual is not a carer merely because they are a spouse, de facto partner, parent, child, other relative or guardian of an individual, or live with an individual who requires care. A person is not considered a carer if they are paid, a volunteer for an organisation, or caring as part of a training or education program.[254]

clinical care standards: nationally relevant standards developed by the Australian Commission on Safety and Quality in Health Care, and agreed by health ministers, that identify and define the care people should expect to be offered or receive for specific conditions.

clinical communication: the exchange of information about a person's care that occurs between treating clinicians, patients, carers and families, and other members of a multidisciplinary team. Communication can be through several different channels, including face-to-face meetings, telephone, written notes or other documentation, and electronic means. *See also* effective clinical communication, clinical communication process

clinical communication process: the method of exchanging information about a person's care. It involves several components, and includes the sender (the person who is communicating the information), the receiver (the person receiving the information), the message (the information that is communicated) and the channel of communication. Various channels of communication can be used, including verbal (face to face, over the phone, through Skype), written and electronic.[255] Sending and receipt of the information can occur at the same time, such as verbal communication between two clinicians, or at different times, such as non-verbal communication during which a clinician documents a patient's goals, assessments and comprehensive care plan in the healthcare record, which is later read by another clinician.

clinical governance: an integrated component of corporate governance of health service organisations. It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of safe, effective and high-quality services. Clinical governance systems provide confidence to the community and the healthcare organisation that systems are in place to deliver safe and high-quality health care.

clinical handover: the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.[256]

clinical information system: a computerised healthcare record and management system that is used by clinicians in healthcare settings. Clinical information systems are typically organisation-wide, have high levels of security and access, and have roles and rights (for example, prescribing medicines, reviewing laboratory results, administering intravenous fluids) specified for each clinical and administrative user. Clinical information systems enable computerised data entry and data retrieval by clinicians.[257]

clinical leaders: clinicians with management or leadership roles in a health service organisation who can use their position or influence to change behaviour, practice or performance. Examples are directors of clinical services, heads of units and clinical supervisors.

clinician: a healthcare provider, trained as a health professional, including registered and non-registered practitioners. Clinicians may provide care within a health service organisation as an employee, a contractor or a credentialed healthcare provider, or under other working arrangements. They include nurses, midwives, medical practitioners, allied health practitioners, technicians, scientists and other clinicians who provide health care, and students who provide health care under supervision.

cognitive impairment: deficits in one or more of the areas of memory, communication, attention, thinking and judgement. This can be temporary or permanent. It can affect a person's understanding, their ability to carry out tasks or follow instructions, their recognition of people or objects, how they relate to others and how they interpret the environment. Dementia and delirium are common forms of cognitive impairment seen in hospitalised older patients.[197] Cognitive impairment can also be a result of several of other conditions, such as acquired brain injury, a stroke, intellectual disability, licit or illicit drug use, or medicines.

cold chain management: the system of transporting and storing temperature-sensitive medicines and other therapies, such as blood and blood products, within their defined temperature range at all times,

from point of origin (manufacture) to point of administration, to ensure that the integrity of the product is maintained.

communicable: an infection that can be transferred from one person or host to another.

comprehensive care: health care that is based on identified goals for the episode of care. These goals are aligned with the patient's expressed preferences and healthcare needs, consider the impact of the consumer's health issues on their life and wellbeing, and are clinically appropriate.

comprehensive care plan: a document describing agreed goals of care, and outlining planned medical, nursing and allied health activities for a patient. Comprehensive care plans reflect shared decisions made with patients, families and carers about the tests, interventions, treatments and other activities needed to achieve the goals of care. The content of comprehensive care plans will depend on the setting and the service that is being provided, and may be called different things in different health service organisations. For example, a care or clinical pathway for a specific intervention may be considered a comprehensive care plan.

consumer: a person who has used, or may potentially use, health services, or is a carer for a patient using health services. A healthcare consumer may also act as a consumer representative to provide a consumer perspective, contribute consumer experiences, advocate for the interests of current and potential health service users, and take part in decision-making processes.[258]

contemporaneously (documenting information): recording information in the healthcare record as soon as possible after the event that is being documented.[259]

credentialing: the formal process used by a health service organisation to verify the qualifications, experience, professional standing, competencies and other relevant professional attributes of clinicians, so that the organisation can form a view about the clinician's competence, performance and professional suitability to provide safe, high-quality healthcare services within specific organisational environments.[260]

critical equipment: items that confer a high risk for infection if they are contaminated with any microorganism, and must be sterile at the time of use. They include any objects that enter sterile tissue or the vascular system, because any microbial contamination could transmit disease.[79]

critical information: information that has a considerable impact on a patient's health, wellbeing or ongoing care (physical or psychological). The availability of critical information may require a clinician to reassess or change a patient's comprehensive care plan.

current medicines list: *See* medicines list

decision support tools: tools that can help clinicians and consumers to draw on available evidence when making clinical decisions. The tools have a number of formats. Some are explicitly designed to enable shared decision making (for example, decision aids). Others provide some of the information needed for some components of the shared decision-making process (for example, risk calculators, evidence summaries), or provide ways of initiating and structuring conversations about health decisions (for example, communication frameworks, question prompt lists).[131] *See also* shared decision making

de-escalation strategies: psychosocial techniques that aim to reduce violent or disruptive behaviour. They are intended to reduce or eliminate the risk of violence during the escalation phase, using verbal and non-verbal communication skills. De-escalation is about establishing rapport to gain the patient's trust, minimising restriction to protect their self-esteem, appearing externally calm and self-aware in the face of aggressive behaviour, and intuitively identifying creative and flexible interventions that will reduce the need for aggression.[261]

definitive management: the treatment plan for a disease or disorder that has been chosen as the best one for the patient after all other choices have been considered.[262]

delirium: an acute disturbance of consciousness, attention, cognition and perception that tends to fluctuate during the day.[263] It is a serious condition that can be prevented in 30–40% of cases, and should be treated promptly and appropriately. Hospitalised older people with existing dementia are at the greatest risk of developing delirium. Delirium can be hyperactive (the person has

heightened arousal; or can be restless, agitated and aggressive) or hypoactive (the person is withdrawn, quiet and sleepy).[94]

deterioration in mental state: a negative change in a person's mood or thinking, marked by a change in behaviour, cognitive function, perception or emotional state. Changes can be gradual or acute; they can be observed by members of the workforce, or reported by the person themselves, or their family or carers. Deterioration in a person's mental state can be related to several predisposing or precipitating factors, including mental illness, psychological or existential stress, physiological changes, cognitive impairment (including delirium), intoxication, withdrawal from substances, and responses to social context and environment.

diversity: the varying social, economic and geographic circumstances of consumers who use, or may use, the services of a health service organisation, as well as their cultural backgrounds, religions, beliefs, practices, languages spoken and sexualities (diversity in sexualities is currently referred to as lesbian, gay, bisexual, transgender and intersex, or LGBTI).

effective clinical communication: two-way, coordinated and continuous communication that results in the timely, accurate and appropriate transfer of information. Effective communication is critical to, and supports, the delivery of safe patient care.

emergency assistance: clinical advice or assistance provided when a patient's condition has deteriorated severely. This assistance is provided as part of the rapid response system, and is additional to the care provided by the attending clinician or team.[219]

end of life: the period when a patient is living with, and impaired by, a fatal condition, even if the trajectory is ambiguous or unknown. This period may be years in the case of patients with chronic or malignant disease, or very brief in the case of patients who suffer acute and unexpected illnesses or events, such as sepsis, stroke or trauma.[264]

environment: the physical surroundings in which health care is delivered, including the building, fixtures, fittings, and services such as air and water supply. Environment can also include other patients, consumers, visitors and the workforce.

episode of care: a phase of treatment. There may be more than one episode of care within the one hospital stay. An episode of care ends when the principal clinical intent changes or when the patient is formally separated from the facility.[265]

escalation protocol: the protocol that sets out the organisational response required for different levels of abnormal physiological measurements or other observed deterioration. The protocol applies to the care of all patients at all times.[219]

fall: an event that results in a person coming to rest inadvertently on the ground or floor, or another lower level.[266]

goals of care: clinical and other goals for a patient's episode of care that are determined in the context of a shared decision-making process.

governance: the set of relationships and responsibilities established by a health service organisation between its executive, workforce and stakeholders (including patients and consumers). Governance incorporates the processes, customs, policy directives, laws and conventions affecting the way an organisation is directed, administered or controlled. Governance arrangements provide the structure for setting the corporate objectives (social, fiscal, legal, human resources) of the organisation and the means to achieve the objectives. They also specify the mechanisms for monitoring performance. Effective governance provides a clear statement of individual accountabilities within the organisation to help align the roles, interests and actions of different participants in the organisation to achieve the organisation's objectives. In the NSQHS Standards, governance includes both corporate and clinical governance.

governing body: a board, chief executive officer, organisation owner, partnership or other highest level of governance (individual or group of individuals) that has ultimate responsibility for strategic and operational decisions affecting safety and quality in a health service organisation.

guidelines: clinical practice guidelines are systematically developed statements to assist clinician and consumer decisions about appropriate health care for specific circumstances.[267]

hand hygiene: a general term referring to any action of hand cleansing.

health care: the prevention, treatment and management of illness and injury, and the preservation of mental and physical wellbeing through the services offered by clinicians, such as medical, nursing and allied health professionals.[9]

healthcare-associated infections: infections that are acquired in healthcare facilities (nosocomial infections) or that occur as a result of healthcare interventions (iatrogenic infections). Healthcare-associated infections may manifest after people leave the healthcare facility.[79]

healthcare record: includes a record of the patient's medical history, treatment notes, observations, correspondence, investigations, test results, photographs, prescription records and medication charts for an episode of care.

health literacy: the Australian Commission on Safety and Quality in Health Care separates health literacy into two components – individual health literacy and the health literacy environment.

Individual health literacy is the skills, knowledge, motivation and capacity of a consumer to access, understand, appraise and apply information to make effective decisions about health and health care, and take appropriate action.

The health literacy environment is the infrastructure, policies, processes, materials, people and relationships that make up the healthcare system, which affect the ways in which consumers access, understand, appraise and apply health-related information and services.[62]

health service organisation: a separately constituted health service that is responsible for implementing clinical governance, administration and financial management of a service unit or service units providing health care at the direction of the governing body. A service unit involves a grouping of clinicians and others working in a systematic way to deliver health care to patients. It can be in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' homes, community settings, practices and clinicians' rooms.

higher risk (patients at higher risk of harm): a patient with multiple factors or a few specific factors that result in their being more vulnerable to harm from health care or the healthcare system. Risk factors may include having chronic clinical conditions; having language barriers; being of

Aboriginal or Torres Strait Islander background; having low health literacy; being homeless; or being of diverse gender identities and experiences, bodies, relationships and sexualities (currently referred to as lesbian, gay, bisexual, transgender and intersex, or LGBTI).

high-risk medicines: medicines that have an increased risk of causing significant patient harm or death if they are misused or used in error. High-risk medicines may vary between hospitals and other healthcare settings, depending on the types of medicines used and patients treated. Errors with these medicines are not necessarily more common than with other medicines. Because they have a low margin of safety, the consequences of errors with high-risk medicines can be more devastating.[113,115] At a minimum, the following classes of high-risk medicines should be considered:

- Medicines with a narrow therapeutic index
- Medicines that present a high risk when other system errors occur, such as administration via the wrong route.

hygienic environment: an environment in which practical prevention and control measures are used to reduce the risk of infection from contamination by microbes.

incident (clinical): an event or circumstance that resulted, or could have resulted, in unintended or unnecessary harm to a patient or consumer; or a complaint, loss or damage. An incident may also be a near miss. *See also* near miss

infection: the invasion and reproduction of pathogenic (disease-causing) organisms inside the body. This may cause tissue injury and disease.[82]

informed consent: a process of communication between a patient and a clinician about options for treatment, care processes or potential outcomes. This communication results in the patient's authorisation or agreement to undergo a specific intervention or participate in planned care.[268] The communication should ensure that the patient has an understanding of the care they will receive, all the available options and the expected outcomes, including success rates and side effects for each option.[269]

injury: damage to tissues caused by an agent or circumstance.[270]

invasive medical devices: devices inserted through skin, mucosal barrier or internal cavity, including central lines, peripheral lines, urinary catheters, chest drains, peripherally inserted central catheters and endotracheal tubes.

involuntary treatment: when people are detained in hospital or compulsorily treated in the community under mental health legislation, for assessment or provision of appropriate treatment or care.[271]

jurisdictional requirements: systematically developed statements from state and territory governments about appropriate healthcare or service delivery for specific circumstances.[267] Jurisdictional requirements encompass a number of types of documents from state and territory governments, including legislation, regulations, guidelines, policies, directives and circulars. Terms used for each document may vary by state and territory.

leadership: having a vision of what can be achieved, and then communicating this to others and evolving strategies for realising the vision. Leaders motivate people, and can negotiate for resources and other support to achieve goals.[272]

local community: the people living in a defined geographic region or from a specific group who receive services from a health service organisation.

mandatory: required by law or mandate in regulation, policy or other directive; compulsory.[273]

medication management: practices used to manage the provision of medicines. Medication management has also been described as a cycle, pathway or system, which is complex and involves a number of different clinicians. The patient is the central focus. The system includes manufacturing, compounding, procuring, dispensing, prescribing, storing, administering, supplying and monitoring the effects of medicines. It also includes decision-making, and rules, guidelines, support tools, policies and procedures that are in place to direct the use of medicines.[274]

medication reconciliation: a formal process of obtaining and verifying a complete and accurate list of each patient's current medicines, and matching the medicines the patient should be prescribed to those they are actually prescribed. Any discrepancies are discussed with the prescriber, and reasons for changes to therapy are documented and communicated when care is transferred. Medication review may form part of the medication reconciliation process.

medication review: a systematic assessment of medication management for an individual patient that aims to optimise the patient's medicines and outcomes of therapy by providing a recommendation or making a change.[275] Medication review may be part of medication reconciliation.

medicine: a chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease, or otherwise improving the physical or mental wellbeing of people. These include prescription, non-prescription, investigational, clinical trial and complementary medicines, irrespective of how they are administered.[91]

medicine-related problem: any event involving treatment with a medicine that has a negative effect on a patient's health or prevents a positive outcome. Consideration should be given to disease-specific, laboratory test–specific and patient-specific information. Medicine-related problems include issues with medicines such as:

- Underuse
- Overuse
- Use of inappropriate medicines (including therapeutic duplication)
- Adverse drug reactions, including interactions (medicine–medicine, medicine–disease, medicine–nutrient, medicine–laboratory test)
- Noncompliance.[276,277]

medicines list: prepared by a clinician, a medicines list contains, at a minimum:

- All medicines a patient is taking, including over-the-counter, complementary, prescription and non-prescription medicines; for each medicine, the medicine name, form, strength and directions for use must be included[91]

- Any medicines that should not be taken by the patient, including those causing allergies and adverse drug reactions; for each allergy or adverse drug reaction, the medicine name, the reaction type and the date on which the reaction was experienced should be included.

Ideally, a medicines list also includes the intended use (indication) for each medicine.

It is expected that the medicines list is updated and correct at the time of transfer (including clinical handover) or when services cease, and that it is tailored to the audience for whom it is intended (that is, patient or clinician).[87]

mental state: *See* deterioration in mental state

minimum information content: the content of information that must be contained and transferred in a particular type of clinical handover. What is included as part of the minimum information content will depend on the context and reason for the handover or communication.[169]

multidisciplinary team: a team including clinicians from a multiple disciplines who work together to deliver comprehensive care that deals with as many of the patient's health and other needs as possible. The team may operate under one organisational umbrella or may be from several organisations brought together as a unique team. As a patient's condition changes, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient.[278] Multidisciplinary care includes interdisciplinary care. (A discipline is a branch of knowledge within the health system.[279])

My Health Record (formerly known as a personally controlled electronic health record): the secure online summary of a consumer's health information, managed by the System Operator of the national My Health Record system (the Australian Digital Health Agency). Clinicians are able to share health clinical documents to a consumer's My Health Record, according to the consumer's access controls. These may include information on medical history and treatments, diagnoses, medicines and allergies.[280]

national patient identifier: a unique 16-digit number that is used to identify individuals who receive, or may receive, health care in the Australian healthcare system. Also known as an Individual Healthcare Identifier (IHI).[280]

national provider identifier: a unique 16-digit number that is used to identify individual clinicians or organisations that deliver health care in the Australian healthcare setting. For individuals, it is also known as a Healthcare Provider Identifier – Individual (HPI-I); for organisations, it is also known as a Healthcare Provider Identifier – Organisation (HPI-O).[280]

near miss: an incident or potential incident that was averted and did not cause harm, but had the potential to do so.[281]

open disclosure: an open discussion with a patient and carer about an incident that resulted in harm to the patient while receiving health care. The criteria of open disclosure are an expression of regret, and a factual explanation of what happened, the potential consequences, and the steps taken to manage the event and prevent recurrence.[282]

organisation-wide: intended for use throughout the health service organisation.

orientation: a formal process of informing and training a worker starting in a new position or beginning work for an organisation, which covers the policies, processes and procedures applicable to the organisation.

outcome: the status of an individual, group of people or population that is wholly or partially attributable to an action, agent or circumstance.[270]

partnership: a situation that develops when patients and consumers are treated with dignity and respect, when information is shared with them, and when participation and collaboration in healthcare processes are encouraged and supported to the extent that patients and consumers choose. Partnerships can exist in different ways in a health service organisation, including at the level of individual interactions; at the level of a service, department or program; and at the level of the organisation. They can also exist with consumers and groups in the community. Generally, partnerships at all levels are necessary to ensure that the health service organisation is responsive to patient and consumer input and needs, although the nature of the activities for these different types of partnership will depend on the context of the health service organisation.

patient: a person who is receiving care in a health service organisation.

person-centred care: an approach to the planning, delivery and evaluation of health care that is founded on mutually beneficial partnerships among clinicians and patients.[283] Person-centred care is respectful of, and responsive to, the preferences, needs and values of patients and consumers. Key dimensions of person-centred care include respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of carers and family, and access to care.[34] Also known as patient-centred care or consumer-centred care.

point of care: the time and location of an interaction between a patient and a clinician for the purpose of delivering care.

policy: a set of principles that reflect the organisation's mission and direction. All procedures and protocols are linked to a policy statement.

pressure injuries: injuries of the skin and/or underlying tissue, usually over a bony prominence, caused by unrelieved pressure, friction or shearing. They occur most commonly on the sacrum and heel, but can develop anywhere on the body. Pressure injury is a synonymous term for pressure ulcer.

procedure: the set of instructions to make policies and protocols operational, which are specific to an organisation.

procedure matching: the processes of correctly matching patients to their intended care.

process: a series of actions or steps taken to achieve a particular goal.[284]

program: an initiative, or series of initiatives, designed to deal with a particular issue, with resources, a time frame, objectives and deliverables allocated to it.

protocol: an established set of rules used to complete a task or a set of tasks.

purpose-driven communication: communication in which all the parties involved in the communication process have a shared understanding of why the communication is taking place (for example, to gather, share, receive or check information), what action needs to be taken and who is responsible for taking that action.

quality improvement: the combined efforts of the workforce and others – including consumers, patients and their families, researchers, planners and educators – to make changes that will lead to better patient outcomes (health), better system performance (care) and better professional development.[285] Quality improvement activities may be undertaken in sequence, intermittently or continually.

regularly: occurring at recurring intervals. The specific interval for regular review, evaluation, audit or monitoring needs to be determined for each case. In the NSQHS Standards (2nd ed.), the interval should be consistent with best practice, risk based, and determined by the subject and nature of the activity.

responsibility and accountability for care: accountability includes the obligation to report and be answerable for consequences. Responsibility is the acknowledgement that a person has to take action that is appropriate to a patient's care needs and the health service organisation.[193]

restraint: the restriction of an individual's freedom of movement by physical or mechanical means.[286]

reusable device: a medical device that is designated by its manufacturer as suitable for reprocessing and reuse.[287]

risk: the chance of something happening that will have a negative impact. Risk is measured by the consequences of an event and its likelihood.

risk assessment: assessment, analysis and management of risks. It involves recognising which events may lead to harm in the future, and minimising their likelihood and consequences.[226]

risk management: the design and implementation of a program to identify and avoid or minimise risks to patients, employees, volunteers, visitors and the organisation.

safety culture: a commitment to safety that permeates all levels of an organisation, from the clinical workforce to executive management. Features commonly include acknowledgement of the high-risk, error-prone nature of an organisation's activities; a blame-free environment in which individuals are able to report errors or near misses without fear of reprimand or punishment; an expectation of collaboration across all areas and levels of an organisation to seek solutions to

vulnerabilities; and a willingness of the organisation to direct resources to deal with safety concerns.[288]

scope of clinical practice: the extent of an individual clinician's approved clinical practice within a particular organisation, based on the clinician's skills, knowledge, performance and professional suitability, and the needs and service capability of the organisation.[260]

screening: a process of identifying patients who are at risk, or already have a disease or injury. Screening requires sufficient knowledge to make a clinical judgement.[289]

seclusion: the confinement of a patient, at any time of the day or night, alone in a room or area from which free exit is prevented.[286]

self-harm: includes self-poisoning, overdoses and minor injury, as well as potentially dangerous and life-threatening forms of injury. Self-harm is a behaviour and not an illness. People self-harm to cope with distress or to communicate that they are distressed.[290]

semi-critical equipment: items that come into contact with mucous membranes or non-intact skin, and should be single use or sterilised after each use. If this is not possible, high-level disinfection is the minimum level of reprocessing that is acceptable.[79]

service context: the particular context in which care is delivered. Health service delivery occurs in many different ways, and the service context will depend on the organisation's function, size and organisation of care regarding service delivery mode, location and workforce.[162]

shared decision making: a consultation process in which a clinician and a patient jointly participate in making a health decision, having discussed the options, and their benefits and harms, and having considered the patient's values, preferences and circumstances.[131]

standard: agreed attributes and processes designed to ensure that a product, service or method will perform consistently at a designated level.[270]

standard national terminologies: a structured vocabulary used in clinical practice to accurately describe the care and treatment of patients. Healthcare providers around the world use specialised vocabulary to describe diseases, operations, clinical procedures, findings, treatments and medicines. In Australia, terminologies include SNOMED CT-AU and Australian Medicines Terminology.[291] Standard national terminologies are also referred to as clinical terminologies.

standard precautions: work practices that provide a first-line approach to infection prevention and control, and are used for the care and treatment of all patients.[287]

structured clinical handover: a structured format used to deliver information (the minimum information content), enabling all participants to know the purpose of the handover, and the information that they are required to know and communicate.[250]

substitute decision-maker: a person appointed or identified by law to make health, medical, residential and other personal (but not financial or legal) decisions on behalf of a patient whose decision-making capacity is impaired. A substitute decision-maker may be appointed by the patient, appointed for (on behalf of) the patient, or identified as the default decision-maker by legislation, which varies by state and territory.[197]

surveillance: an epidemiological practice that involves monitoring the spread of disease to establish progression patterns. The main roles of surveillance are to predict and observe spread; to provide a measure for strategies that may minimise the harm caused by outbreak, epidemic and pandemic situations; and to increase knowledge of the factors that might contribute to such circumstances.[82]

system: the resources, policies, processes and procedures that are organised, integrated, regulated and administered to accomplish a stated objective. A system:

- Brings together risk management, governance and operational processes and procedures, including education, training and orientation
- Deploys an active implementation plan; feedback mechanisms include agreed protocols and guidelines, decision support tools and other resource materials

- Uses several incentives and sanctions to influence behaviour and encourage compliance with policy, protocol, regulation and procedures.

The workforce is both a resource in the system and involved in all elements of systems development, implementation, monitoring, improvement and evaluation.

timely (communication): communication of information within a reasonable time frame. This will depend on how important or time critical the information is to a patient's ongoing care or wellbeing, the context in which the service is provided and the clinical acuity of the patient.

traceability: the ability to trace the history, application or location of reusable medical devices. Some professional groups may refer to traceability as tracking.[287]

training: the development of knowledge and skills.

transfusion history: a list of transfusions a patient has had before presentation, including details of any adverse reactions to the transfusion and any special transfusion requirements. The completeness of the history will depend on the availability of information. It is expected that information will be obtained by reviewing any available referral information and interviewing the patient or their carer.

transitions of care: situations when all or part of a patient's care is transferred between healthcare locations, providers, or levels of care within the same location, as the patient's conditions and care needs change.[292]

transmission-based precautions: extra work practices used in situations when standard precautions alone may not be sufficient to prevent transmission of infection. Transmission-based precautions are used in conjunction with standard precautions.[79]

workforce: all people working in a health service organisation, including clinicians and any other employed or contracted, locum, agency, student, volunteer or peer workers. The workforce can be members of the health service organisation or medical company representatives providing technical support who have assigned roles and responsibilities for care of, administration of, support of, or involvement with patients in the health service organisation.

References

1. Australian Commission on Safety and Quality in Health Care. National Model Clinical Governance Framework. Sydney: ACSQHC; 2017.

2. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards guide for governing bodies. Sydney: ACSQHC; forthcoming.

3. Edwards M, Clough R. Corporate governance and performance: an exploration of the connection in a public sector context. Canberra: University of Canberra; 2005. (Issues Series Paper No. 1.)

4. Bismark MM, Studdert DM. Governance of quality of care: a qualitative study of health service boards in Victoria, Australia. BMJ Qual Saf 2014;23(6):474–82.

5. Taylor N, Clay-Williams R, Hogden E, Braithwaite J, Groene O. High performing hospitals: a qualitative systematic review of associated factors and practical strategies for improvement. BMC Health Serv Res 2015;15:244.

6. Australian Commission on Safety and Quality in Health Care. Windows into safety and quality in health care 2011. Sydney: ACSQHC; 2011:46–55.

7. Australian Commission on Safety and Quality in Health Care. Windows into safety and quality in health care 2010. Sydney: ACSQHC; 2010.

8. Anderson JE, Kodate N, Walters R, Dodds A. Can incident reporting improve safety? Healthcare practitioners' views of the effectiveness of incident reporting. Int J Qual Health Care 2013;25(2):141–50.

9. Australian Commission on Safety and Quality in Health Care. Australian Open Disclosure Framework. Sydney: ACSQHC; 2013. www.safetyandquality.gov.au/publications/australian-open-disclosure-framework (accessed Oct 2017).

10. Medical Board of Australia. Good medical practice: a code of conduct for doctors in Australia. Melbourne: Medical Board of Australia; 2014.

11. NSW Ministry of Health. Records – principles for creation, management, storage and disposal of health care records. Sydney: NSW Ministry of Health; 2005.

12. SA Health. Medical record documentation and data standards. Adelaide: SA Health; 2000.

13. Australian Government Department of Health. Healthcare Identifiers Service – frequently asked questions [Internet]. Canberra: DoH; 2015 [cited 2017 Mar 22]. Available from: www.health.gov.au/internet/main/publishing.nsf/Content/pacd-ehealth-consultation-faqs

14. Braithwaite J, Healy J, Dwan K. The governance of health safety and quality. Canberra: Australian Council for Safety and Quality in Health Care; 2005.

15. Starey N. What is clinical governance? Fordham (UK): Hayward Medical Communications; 1999.

16. Hyde JK, Shortell SM. The structure and organization of local and state public health agencies in the US: a systematic review. Am J Prevent Med 2012;42(5 Suppl 1):S29–41.

17. Australian Commission on Safety and Quality in Health Care. Clinical care standards [Internet]. Sydney: ACSQHC; 2017 [cited 2017 Mar 22]. Available from: https://www.safetyandquality.gov.au/our-work/clinical-care-standards

18. Dudgeon P, Wright M, Coffin J. Talking it and walking it: cultural competence. J Aus Indig Iss 2010;13(3):29–44.

19. Ware VA. Improving the accessibility of health services in urban and regional settings for Indigenous people. Canberra: Australian Institute of Health and Welfare; 2013. https://www.aihw.gov.au/reports/indigenous-australians/improving-the-accessibility-of-health-services-in-urban-and-regional-settings-for-indigenous-people/contents/table-of-contents (accessed Oct 2017).

20. Dwyer J, Kelly J, Willis E, Glover J, Glover J, Mackean T, et al. Managing two worlds together: city hospital care for country Aboriginal people. Melbourne: Lowitja Institute; 2011.

21. Australian Commission on Safety and Quality in Health Care. Cultural competence in caring for Aboriginal and Torres Strait Islander consumers. Sydney: ACSQHC; 2016. https://www.safetyandquality.gov.au/wp-content/uploads/2016/10/02-Cultural-competence-in-caring.docx (accessed Sep 2017).

22. Australian Commission on Safety and Quality in Health Care. Credentialing health practitioners and defining their scope of clinical practice: a guide for managers and practitioners. Sydney: ACSQHC; 2015.

23. Australian Council for Safety and Quality in Health Care. Standard for credentialling and defining the scope of clinical practice: a national standard for credentialling and defining the scope of clinical practice of medical practitioners, for use in public and private hospitals. Canberra: Australian Council for Safety and Quality in Health Care; 2004. https://www.safetyandquality.gov.au/our-work/credentialling (accessed Sep 2017).

24. Office of Safety and Quality in Health Care WA. Clinical governance standards for Western Australian health services. Perth: WA Department of Health; 2005.

25. Australian Commission on Safety and Quality in Health Care. Framework for Australian clinical quality registries. Sydney: ACSQHC; 2014. https://www.safetyandquality.gov.au/publications/framework-for-australian-clinical-quality-registries (accessed Sep 2017).

26. Australian Commission on Safety and Quality in Health Care. Australian atlas of healthcare variation [Internet]. Sydney: ACSQHC; 2017 [cited 2017 Mar 22]. Available from: https://www.safetyandquality.gov.au/atlas

27. Huisman ER, Morales E, van Hoof J, Kort HS. Healing environment: a review of the impact of physical environmental factors on users. Build Environ 2012;58:70–80.

28. Reiling J, Hughes R, Murphy M. The impact of facility design on patient safety. In: Hughes RG, editor. Patient safety and quality: an evidence-based handbook for nurses. Rockville (MD): Agency for Healthcare Research and Quality; 2008.

29. Queensland Health. Queensland Health wayfinding design guidelines. Brisbane: Queensland Health; 2010.

30. Consumers Health Forum of Australia. 'Unique and essential': a review of the role of consumer representatives in health decision-making. Canberra: CHF; 2015.

31. Dalton J, Chambers D, Harden M, Street A, Parker G, Eastwood A. Service user engagement and health service reconfiguration: a rapid evidence synthesis. J Health Serv Res Pol 2015;21(3):195–205.

32. Johnson A. Consumer and community engagement in health services: a literature review to support the development of an evidence-based consumer and community engagement strategy for the Women's and Children's Health Network, South Australia. Adelaide: Health Consumers Alliance of South Australia and SA Health; 2015.

33. Harding E, Wait S, Scrutton J. The state of play in person-centred care. London: The Health Policy Partnership; 2015. www.healthpolicypartnership.com/wp-content/uploads/State-of-play-in-person-centred-care-full-report-Dec-11-2015.pdf (accessed Sep 2017).

34. Australian Commission on Safety and Quality in Health Care. Patient-centred care: improving quality and safety through partnerships with patients and consumers. Sydney: ACSQHC; 2011.

35. Luxford K, Newell S. New South Wales mounts 'patient based care' challenge. BMJ 2015;350:g7582.

36. Lewis M, Pettersson G. Governance in health care delivery: raising performance. Washington (DC): The World Bank; 2009.

37. World Health Organization. WHO global strategy on people-centred and integrated health services: interim report. Geneva: WHO; 2015.

38. Nicholson C, Jackson C, Marley J. Best-practice integrated health care governance – applying evidence to Australia's health reform agenda. Med J Aust 2014;201(3 Suppl):S64–6.

39. Australian Commission on Safety and Quality in Health Care. Australian Charter of Healthcare Rights. Sydney: ACSQHC; 2008.

40. Australian Commission on Safety and Quality in Health Care. Using the Australian Charter of Healthcare Rights in your health service. Sydney: ACSQHC; 2008.

41. Australian Health Practitioners Regulation Authority. Code of conduct for registered health practitioners. Melbourne: AHPRA; 2014.

42. National Health and Medical Research Council. General guidelines for medical practitioners on providing information to patients. Canberra: NHMRC; 2004.

43. Queensland Health. Guide to informed decision-making in health care. 2nd ed. Brisbane: Queensland Health; 2017.

44. ACT Health. Standard operating procedure: consent and treatment – capacity and substitute decision making. Canberra: ACT Health; 2012.

45. SA Health. Impaired decision-making factsheet. Adelaide: SA Health; 2014. www.sahealth.sa.gov.au/wps/wcm/connect/8a241b804459db088a0daa76d172935c/Assessing+Capacity+Fact+Sheet+PC+20140613.pdf (accessed Sep 2017).

46. Victoria Department of Environment and Primary Industries. The engagement toolkit – version 4. Melbourne: DEPI; 2014.

47. Scottish Health Council. The participation toolkit. Edinburgh: SHC; 2010.

48. Sarrami-Foroushani P, Travaglia J, Debono D, Braithwaite J. Implementing strategies in consumer and community engagement in healthcare: results of large-scale, scoping meta-review. BMC Health Serv Res 2014;14:402.

49. Rozenveig A, Kuspinar A, Daskalopoulou SS, Mayo NE. Toward patient-centered care: a systematic review of how to ask questions that matter to patients. Medicine (Baltimore) 2014;93(22):e120.

50. Prey JE, Woollen J, Wilcox L, Sackeim AD, Hripcsak G, Bakken S, et al. Patient engagement in the inpatient setting: a systematic review. J Am Med Inform Assoc 2014;21(4):742–50.

51. National Patient Safety Foundation (US). Free from harm: accelerating patient safety improvement fifteen years after *To err is human*. Boston (MA): NPSF; 2015. www.npsf.org/?page=freefromharm (accessed Sep 2017).

52. Agency for Healthcare Research and Quality (US). Guide to patient and family engagement in hospital quality and safety [Internet]. Washington (DC): ARHQ; 2013 [cited 2016 Dec 16]. Available from: www.ahrq.gov/professionals/systems/hospital/engagingfamilies/guide.html

53. SA Health. Guide for engaging with consumers and the community. Adelaide: SA Health; 2013.

54. Healthdirect Australia. Question builder [Internet]. 2017 [cited 2017 Mar 22]. Available from: https://www.healthdirect.gov.au/question-builder

55. Australian Commission on Safety and Quality in Health Care. Top tips for safe health care. Sydney: ACSQHC; 2017. https://www.safetyandquality.gov.au/publications/top-tips-for-safer-health-care (accessed Sep 2017).

56. Point of Care Foundation. Patient and family-centred care toolkit [Internet]. London: The Point of Care Foundation; 2016 [cited 2016 Apr 10]. Available from: https://www.pointofcarefoundation.org.uk/resource/patient-family-centred-care-toolkit

57. Health Issues Centre. Health staff training [Internet]. Melbourne: Health Issues Centre; 2016 [cited 2016 Mar 20]. Available from: www.healthissuescentre.org.au/training-events/draft-health-staff-training

58. Clinical Excellence Commission. Partnering with patients [Internet]. Sydney: CEC; 2016 [cited 2016 Sep 28]. Available from: www.cec.health.nsw.gov.au/quality-improvement/people-and-culture/person-centred-care/partnering-with-patients

59. Agency for Healthcare Research and Quality (US). Strategy 2: communicating to improve quality. Washington (DC): AHRQ; 2013. https://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/strategy2/index.html (accessed Sep 2017).

60. Australian Commission on Safety and Quality in Health Care. National statement on health literacy. Sydney: ACSQHC; 2014.

61. Australian Bureau of Statistics. Australian social trends. Canberra: ABS; 2009. (ABS Cat No. 4102.0.)

62. Australian Commission on Safety and Quality in Health Care. Health literacy: taking action to improve safety and quality. Sydney: ACSQHC; 2014.

63. Wilson-Stronks A, Lee KK, Cordero CL, Kopp AL, Galvez E. One size does not fit all: meeting the healthcare needs of diverse populations. Oakbrook Terrace (IL): The Joint Commission; 2008.

64. Centre for Culture, Ethnicity & Health. Supportive systems for health literacy [Internet]. Melbourne: CEH; 2014 [cited 2016 Mar 15]. Available from: www.ceh.org.au/supportive-sysealth-literacy/?_sft_category=health-literacy

65. Agency for Healthcare Research and Quality (US). Health literacy universal precautions toolkit. 2nd ed. [Internet]. Washington (DC): ARHQ; 2016 [cited 2016 Mar 15]. Available from: www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html

66. Centers for Disease Control and Prevention (US). Simply put: a guide for creating easy-to-understand materials. Atlanta: Centers for Disease Control and Prevention; 2009. www.cdc.gov/healthliteracy/pdf/Simply_Put.pdf (accessed Sep 2017).

67. Plain Language Action and Information Network (US). PlainLanguage.gov [Internet]. Plain Language Action and Information Network; 2016 [cited 2016 Mar 15]. Available from: www.plainlanguage.gov

68. Eastern Health Victoria. Cue cards in community languages [Internet]. Melbourne: Eastern Health Victoria; 2014 [cited 2016 Mar 15]. Available from: www.easternhealth.org.au/services/language-services/cue-cards/item/152

69. Centers for Disease Control and Prevention (US). Health literacy [Internet]. Atlanta (GA): Centers for Disease Control and Prevention; 2016 [cited 2016 Mar 15]. Available from: www.cdc.gov/healthliteracy/index.html

70. Nilsen ES, Myrhaug HT, Johansen M, Oliver S, Oxman AD. Methods of consumer involvement in developing healthcare policy and research, clinical practice guidelines and patient information material. Cochrane Database Syst Rev 2006;(3):CD004563.

71. Osborne H. Can they understand? Testing patient education materials with intended readers. Boston Globe's On Call Magazine. 2001 Nov 1.

72. Health Consumers Queensland. Consumer representatives program: agency handbook. Brisbane: Queensland Health; 2009.

73. Centre for Culture, Ethnicity & Health. Training programs to improve health outcomes for migrants and refugees [Internet]. Melbourne: CEH; 2016 [cited 2016 Mar 15]. Available from: www.ceh.org.au/training

74. Murray Z. Community representation in hospital decision making: a literature review. Aust Health Rev 2015;39(3):323–8.

75. Health Issues Centre. Getting Started toolkit [Internet]. Melbourne: Health Issues Centre; 2016 [cited 2016 Mar 3]. Available from: www.healthissuescentre.org.au/health-services/consumer-engagement-guide/getting-started-toolkit

76. Queensland Health. Health care providers' guide to engaging multicultural communities and consumers. Brisbane: Queensland Health; 2012.

77. Cancer Australia. Consumer involvement toolkit [Internet]. Sydney: Cancer Australia; 2016 [cited 2016 Mar 15]. Available from: consumerinvolvement.canceraustralia.gov.au

78. Health Issues Centre. Accredited training [Internet]. Melbourne: Health Issues Centre; 2016 [cited 2016 Mar 15]. Available from: www.healthissuescentre.org.au/training-events/accredited-training

79. National Health and Medical Research Council. Australian guidelines for the prevention and control of infection in healthcare. Canberra: NHMRC; 2010. www.nhmrc.gov.au/guidelines/publications/cd33 (accessed Sep 2017).

80. MacDougall C, Polk R. Antimicrobial stewardship programs in health care systems. Clin Microbiol Rev 2005;18(4):638–56.

81. Australian Technical Advisory Group on Immunisation. The Australian immunisation handbook. 10th ed. Canberra: Australian Government Department of Health; 2017. www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home (accessed Oct 2017).

82. Cruickshank M, Ferguson J, editors. Reducing harm to patients from health care associated infection: the role of surveillance. Sydney: Australian Commission on Safety and Quality in Health Care; 2008.

83. Australian Commission on Safety and Quality in Health Care. Antimicrobial stewardship in Australian hospitals. Sydney: ACSQHC; 2011.

84. Australian Commission on Safety and Quality in Health Care. Antimicrobial stewardship clinical care standard. Sydney: ACSQHC; 2014.

85. Therapeutic Guidelines Ltd. Therapeutic guidelines: antibiotic. Melbourne: Therapeutic Guidelines Ltd; 2014.

86. Australian Commission on Safety and Quality in Health Care. Specification for a hospital cumulative antibiogram. Sydney: ACSQHC; 2013.

87. Australian Commission on Safety and Quality in Health Care, NSW Therapeutic Advisory Group Inc. National quality use of medicines indicators for Australian hospitals. Sydney: ACSQHC; 2014.

88. Roughead EE, Semple SJ, Rosenfeld E. Literature review: medication safety in Australia. Sydney: Australian Commission on Safety and Quality in Health Care; 2013. https://www.safetyandquality. gov.au/wp-content/uploads/2013/08/Literature-Review-Medication-Safety-in-Australia-2013.pdf (accessed Sep 2017).

89. Roughead E, Semple S. Medication safety in acute care in Australia: where are we now? Part 1: a review of the extent and causes of medication problems 2002–2008. Aust New Zealand Health Policy 2009;6(1):18.

90. Stowasser D, Allinson YM, O'Leary K. Understanding the medicines management pathway. J Pharm Pract Res 2004;34(4):293–6.

91. Australian Pharmaceutical Advisory Council. Guiding principles to achieve continuity in medication management. Canberra: APAC; 2005.

92. Crawford MJ, Rutter D, Manley C, Weaver T, Bhui K, Fulop N, et al. Systematic review of involving patients in the planning and development of health care. BMJ 2002;325(7375):1263.

93. Flottorp SA, Jamtvedt G, Gibis B, McKee M. Using audit feedback to health professionals to improve the quality and safety of health care. Geneva: WHO; 2010. www.euro.who.int/en/data-and-evidence/evidence-informed-policy-making/publications/2010/using-audit-and-feedback-to-health-professionals-to-improve-the-quality-and-safety-of-health-care (accessed Sep 2017).

94. National Institute for Health and Clinical Excellence (UK). How to change practice: understand, identify and overcome barriers to change. London: NICE; 2007.

95. Jamtvedt G, Young JM, Kristoffersen DT, O'Brien MA, Oxman AD. Audit and feedback: effects on professional practice and health care outcomes. Cochrane Database Syst Rev 2006;(2):CD000259.

96. Holloway K, Green T, editors. Drug and therapeutics committees: a practical guide. Geneva: World Health Organization; 2003.

97. Council of Australian Therapeutic Advisory Groups. Achieving effective medicines governance: guiding principles for the roles and responsibilities of drug and therapeutics committees in Australian public hospitals. Sydney: CATAG; 2013. www.catag.org.au/wp-content/uploads/2012/08/OKA9964-CATAG-Achieving-Effective-Medicines-Governance-final1.pdf (accessed Sep 2017).

98. Australian Government Department of Health and Ageing. National medicines policy. Canberra: DoHA; 2000.

99. American Hospital Association, Health Research and Educational Trust, Institute for Safe Medication Practices. Pathways for medication safety: leading a strategic planning effort. Horsham (PA): ISMP; 2002.

100. Institute for Safe Medication Practices (US). Selecting the best error-prevention 'tools' for the job. ISMP Medication Safety Alert. 2006 Feb. https://www.ismp.org/newsletters/ambulatory/archives/200602_4.asp

101. Australian Health Practitioner Regulation Agency. Fact sheet: endorsement of registration. Melbourne: AHPRA; 2010.

102. Institute for Safe Medication Practices Canada. Medication reconciliation [Internet]. Toronto (ON): ISMP Canada; 2017 [cited 2017 Oct 23]. Available from: https://www.ismp-canada.org/medrec

103. Kwan Y, Fernandes OA, Nagge JJ, Wong GG, Huh J-H, Hurn DA, et al. Pharmacist medication assessments in a surgical preadmission clinic. Arch Intern Med 2007;167:1034–40.

104. Vira T, Colquhoun M, Etchells EE. Reconcilable differences: correcting medication errors at hospital admission and discharge. Qual Saf Health Care 2006;15(2):122–6.

105. Rozich JD, Resar RK. Medication safety: one organization's approach to the challenge. J Clin Out Manag 2001;8(10):27–34.

106. Knezevic B, Sprigg D, Seet J, Trevenen M, Trubiano J, Smith W, et al. The revolving door: antibiotic allergy labelling in a tertiary care centre. Intern Med J 2016;46(11):1276–83.

107. National Coordinating Council for Medication Error Reporting and Prevention (US). Contemporary view of medication-related harm. A new paradigm.: NCC MERP; 2015.

108. Clyne W, Blenkinsopp A, Seal R. A guide to medication review. Liverpool (UK): National Prescribing Centre; 2008. www2.cff.org.br/userfiles/52%20-%20CLYNE%20W%20A%20guide%20to%20medication%20review%202008.pdf (accessed Sep 2017).

109. Task Force on Medicines Partnership, National Collaborative Medicines Management Services Programme. Room for review. A guide to medication review: the agenda for patients, practitioners and managers. London: Medicines Partnership; 2002.

110. Clinical Excellence Commission, NSW Therapeutic Advisory Group Inc., Institute for Safe Medication Practices. Medication safety self assessment® for Australian hospitals. Sydney: CEC; 2015. www.cec.health.nsw.gov.au/patient-safety-programs/medication-safety/mssa/mssa-australian-hospitals (accessed Sep 2017).

111. Taylor G. Clinical pharmacy COSP – standards of practice for clinical pharmacy services. J Pharm Pract Res 2013;43(2):91–3.

112. Society of Hospital Pharmacists of Australia. Fact sheet: risk factors for medication-related problems. Melbourne: SHPA; 2015. https://www.shpa.org.au/sites/default/files/uploaded-content/website-content/Fact-sheets-position-statements/shpa_fact_sheet_risk_factors_for_medication_related_problems_june_2015.pdf (accessed Sep 2017).

113. Cohen MR, editor. Medication errors. 2nd ed. Washington (DC): American Pharmacists Association; 2007.

114. Australian and New Zealand College of Anaesthetists. Guidelines for the safe management and use of medications in anaesthesia. Melbourne: ANZCA; 2017. www.anzca.edu.au/Documents/ps51-2009-guidelines-for-the-safe-administration-o (accessed Sep 2017).

115. Institute for Safe Medication Practices (US). ISMP's list of high-alert medications in acute care settings [Internet]. Horsham (PA): ISMP; 2014 [cited 2017 Oct 5]. Available from: www.ismp.org/Tools/highalertmedications.pdf

116. Australian Council on Healthcare Standards. Day patient clinical Indicator user manual, version 5. Sydney: ACHS; 2016.

117. Australian Commission on Safety and Quality in Health Care. Safety and quality of end-of-life care in acute hospitals: a background paper. Sydney: ACSQHC; 2013.

118. Australian Commission on Safety and Quality in Health Care. A guide to support implementation of the national consensus statement: essential elements for recognising and responding to clinical deterioration. Sydney: ACSQHC; 2011.

119. Alvarez G, Coeira E. Interdisciplinary communication: an uncharted source of medical error? J Crit Care 2006;21(3):236–42.

120. Leonard M, Graham S, Bonacum D. The human factor: the critical importance of effective teamwork and communication in providing safe care. Qual Saf Health Care 2004;13(Suppl 1):i85–90.

121. Kohn L, Corrigan J, Donaldson MS, editors. To err is human: building a safer health care system. Washington (DC): National Academy Press; 1999.

122. Baker DP, Gustafson S, Beaublen J, Salas E, Barach P. Medical teamwork and patient safety: the evidence-based relation. Rockville (MD): Agency for Healthcare Research and Quality; 2005. (AHRQ Publication No. 05-0053.)

123. Shen H, Chiu H, Lee P, Hu Y, Chang W. Hospital environment, nurse-physician relationships and quality of care: questionnaire survey. J Adv Nurs 2011;67(2):349–58.

124. Tschannen D, Kalisch B. The impact of nurse/physician collaboration on patient length of stay. J Nurs Manag 2009;17(7):796–803.

125. Pannick S, Davis R, Ashrafian H, Byrne BE, Beveridge I, Athanasiou T, et al. Effects of interdisciplinary team care interventions on general medical wards: a systematic review. JAMA Intern Med 2015;175(8):1288–98.

126. Zwarenstein M, Rice K, Gotlib-Conn L, Kenaszchuk C, Reeves S. Disengaged: a qualitative study of communication and collaboration between physicians and other professions on general internal medicine wards. BMC Health Serv Res 2013;13:494.

127. Buljac-Samardzic M, Dekker-van Doorn C, van Wijngaarden J, van Wijk K. Interventions to improve team effectiveness: a systematic review. Health Policy 2010;94(3):183–95.

128. Körner M, Bütof S, Müller C, Zimmermann L, Becker S, Bengel J. Interprofessional teamwork and team interventions in chronic care: a systematic review. J Interprof Care 2016;30(1):15–28.

129. Morrow EM, Nicholson C. Carer engagement in the hospital care of older people: an integrative literature review. Int J Older People Nurs 2016;11(4):298–314.

130. Coulter A, Collins A. Making shared decision-making a reality: no decision about me, without me. London: The King's Fund; 2011.

131. Hoffman T, Legare F, Simmons M, McNamara K, McCaffery K, Trevena L, et al. Shared decision making: what do clinicians need to know and why should they bother? Med J Aust 2014;201(1):35–9.

132. Irwig L, Irwig J, Trevena L, Sweet M. Smart health choices. London: Hammersmith Press; 2008.

133. World Health Organization. World Health Organization framework for action on interprofessional education and collaborative practice. Geneva: WHO; 2010.

134. Salas E, King HB, Rosen MA. Improving teamwork and safety: toward a practical systems approach, a commentary on Deneckere et al. Soc Sci Med 2012;75(6):986–9.

135. Oh H. Hospital consultations and jurisdiction over patients: consequences for the medical profession. Sociol Health Illn 2014;36(4):580–95.

136. Gillespie BM, Withers TK, Lavin J, Gardiner T, Marshall AP. Factors that drive team participation in surgical safety checks: a prospective study. Patient Saf Surg 2016;10:3.

137. Holton R, Patel R, Eggebrecht M, Von Hoff B, Garrison O, McHale S, et al. Rounding on rounds: creating a checklist for patient- and family-centered rounds. Am J Med Qual 2015;30(5):493.

138. Tang CJ, Chan SW, Zhou WT, Liaw SY. Collaboration between hospital physicians and nurses: an integrated literature review. Int Nurs Rev 2013;60(3):291–302.

139. Siedlecki SL, Hixson ED. Relationships between nurses and physicians matter. Online J Issues Nurs 2015;20(3):6.

140. Expert Advisory Group. Expert Advisory Group on Discrimination, Bullying and Sexual Harassment: report to the Royal Australasian College of Surgeons. Melbourne: Royal Australasian College of Surgeons; 2015.

141. Sharma U, Klocke D. Attitudes of nursing staff toward interprofessional in-patient-centred rounding. J Interprof Care 2014;28(5):475–7.

142. Kara A, Johnson C, Nicley A, Niemeier M, Hui S. Redesigning inpatient care: testing the effectiveness of an accountable care team model. J Hosp Med 2015;10(12):773–9.

143. Redley B. Risk screening and assessment for avoiding preventable harm to older people in hospitals. Melbourne: Centre for Quality and Patient Safety Research, Deakin University; 2016.

144. Australian Commission on Safety and Quality in Health Care. A better way to care: safe and high-quality care for patients with cognitive impairment (dementia and delirium) in hospital. Actions for clinicians. Sydney: ACSQHC; 2014.

145. Australian Commission on Safety and Quality in Health Care. National consensus statement: essential elements for safe and high-quality end-of-life care. Sydney: ACSQHC; 2015.

146. van Rosse F, Suurmond J, Wagner C, de Bruijne M, Essink-Bot ML. Role of relatives of ethnic minority patients in patient safety in hospital care: a qualitative study. BMJ Open 2016;6(4):e009052.

147. Royal Australian and New Zealand College of Psychiatrists. Position statement 76. Supporting carers in the mental health system. Melbourne: RANZCP; 2012.

148. Hshieh TT, Yue J, Oh E, Puelle M, Dowal S, Travison T, et al. Effectiveness of multi-component non-pharmacologic delirium interventions: a meta-analysis. JAMA Intern Med 2015;175(4):512–20.

149. Australian Commission on Safety and Quality in Health Care. Preventing falls and harm from falls in older people: best practice guidelines for Australian residential aged care facilities. Sydney: ACSQHC; 2009.

150. Australian Commission on Safety and Quality in Health Care. Preventing falls and harm from falls in older people: best practice guidelines for Australian community care. Sydney: ACSQHC; 2009.

151. Australian Commission on Safety and Quality in Health Care. Preventing falls and harm from falls in older people: best practice guidelines for Australian hospitals. Sydney: ACSQHC; 2009.

152. Australian Commission on Safety and Quality in Health Care. Delirium clinical care standard. Sydney: ACSQHC; 2016.

153. Inouye SK, Robinson T, Blaum C, Busby-Whitehead J, Boustani M, Chalian A, et al. Postoperative delirium in older adults: best practice statement from the American Geriatrics Society. J Am Coll Surg 2015;220(2):136–48.e1.

154. Viswanath O, Kerner B, Jean Y-K, Soto R, Rosen G. Emergence delirium: a narrative review. J Anesthesiol Clin Sci 2015 2015;4(1):2.

155. Australian Government Department of Health and Ageing. Living is for everyone. Fact sheet 12: working together for suicide prevention. Canberra: DoHA; 2007.

156. National Mental Health Working Group. National safety priorities in mental health: a national plan for reducing harm. Canberra: Australian Government Department of Health and Ageing; 2005.

157. Australian Commission on Safety and Quality in Health Care. National consensus statement: essential elements for recognising and responding to deterioration in a person's mental state. Sydney: ACSQHC; 2017.

158. Mitchell P, Wynia M, Golden R, McNellis B, Okun S, Webb CE, et al. Core principles and values of effective team-based health care. Discussion paper. Washington (DC): Institute of Medicine; 2012.

159. National Academies of Sciences Engineering and Medicine. Improving diagnosis in health care. Washington (DC): Institute of Medicine; 2015.

160. Naylor MD. Transitional care of older adults. Ann Rev Nurs Res 2002;20(1):127–47.

161. Vincent C. Patient safety. 2nd ed. Oxford: Wiley-Blackwell (BMJ Books); 2010.

162. Australian Commission on Safety and Quality in Health Care. OSSIE guide to clinical handover improvement. Sydney: ACSQHC; 2010.

163. Jorm CM, White S, Kaneen T. Clinical handover: critical communications. Med J Aust 2009;190(11):108–9.

164. Office of Quality and Patient Safety (US). Sentinel event data: root causes by event type 2004–2015 [Internet]. Oakbrook Terrace (IL): The Joint Commission; 2016. Available from: www.jointcommission.org/assets/1/18/Root_Causes_by_Event_Type_2004-2015.pdf

165. NSW Health Care Complaints Commission. Annual report 2015–16. Sydney: HCCC; 2016.

166. Office of the Health Services Commissioner. Health Services Commissioner annual report 2016. Melbourne: OHSC; 2016.

167. Office of the Health Ombudsman. Annual report 2015–16. Brisbane: OHO; 2016.

168. Australian Commission on Safety and Quality in Health Care. Patient identification [Internet]. Sydney: ACSQHC; 2016 [cited 2016 Mar 2]. Available from: www.safetyandquality.gov.au/our-work/patient-identification

169. Australian Commission on Safety and Quality in Health Care. Implementation toolkit for clinical handover improvement. Sydney: ACSQHC; 2011.

170. Cummings E, Showell C, Roehrer E, Churchill B, Yee KC, Wong MC, et al. Discharge, referral and admission: a structured evidence based literature review. Hobart: University of Tasmania, for the Australian Commission on Safety and Quality in Health Care and the NSW Department of Health; 2010.

171. Australian Commission on Safety and Quality in Health Care. Engaging patients in communication at transitions of care. Sydney: ACSQHC; 2015.

172. Eggins S, Slade D, Geddes F, editors. Effective communication in clinical handover: from research to practice. Berlin: De Gruyter; 2016.

173. Meeks DW, Smith MW, Taylor L, Sittig DF, Scott JM, Singh H. An analysis of electronic health record-related patient safety concerns. J Am Med Inform Assoc 2014;21(6):1053–9.

174. Australian Commission on Safety and Quality in Health Care. Electronic discharge summary systems self-evaluation toolkit. Sydney: ACSQHC; 2011.

175. Australian Commission on Safety and Quality in Health Care. National guidelines for on-screen presentation of discharge summaries. Sydney: ACSQHC; 2017.

176. Davey N, Cole A. Safe communication: design, implement and measure. A guide to improving transfers of care and handover. Southampton (UK): Quality Improvement Clinic; 2015.

177. Karsh BT, Holden RJ, Alper SJ, Or CK. A human factors engineering paradigm for patient safety: designing to support the performance of the healthcare professional. Qual Saf Health Care 2006;15(Suppl 1):i59–65.

178. Gosbee J. Human factors engineering and patient safety. Qual Saf Health Care 2002;11(4):352–4.

179. Thomas MJ, Schultz TJ, Hannaford N, Runciman WB. Failures in transition: learning from incidents relating to clinical handover in acute care. J Healthcare Qual 2013;35(3):49–56.

180. World Alliance for Patient Safety. WHO surgical safety checklist and implementation manual. Geneva: WHO; 2008.

181. Australian Commission on Safety and Quality in Health Care. Ensuring correct patient, correct site, correct procedure protocols [Internet]. Sydney: ACSQHS; 2008 [cited 2016 Mar 10]. Available from: www.safetyandquality.gov.au/our-work/patient-identification/patient-procedure-matching-protocols

182. Wood SD, Bagian JP. A cognitive analysis of color-coded wristband use in health care. Proceedings of the Human Factors and Ergonomics Society Annual Meeting. SAGE Publications; 2011:281–5.

183. Mayo NE, Gloutney L, Levy AR. A randomized trial of identification bracelets to prevent falls among patients in a rehabilitation hospital. Arch Phys Med Rehab 1994;75(12):1302–8.

184. Sehgal NL, Wachter RM. Identification of inpatient DNR status: a safety hazard begging for standardization. J Hosp Med 2007;2(6):366–71.

185. Sevdalis N, Norris B, Ranger C, Bothwell S. Designing evidence-based patient safety interventions: the case of the UK's National Health Service hospital wristbands. J Eval Clin Pract 2009;15(2):316–22.

186. Pennsylvania Patient Safety Authority. Use of color-coded patient wristbands creates unnecessary risk. Patient Saf Advis 2005;2(Suppl 2):1–4.

187. Haynes AB, Weiser TG, Berry WR, Lipsitz SR, Breizat A-HS, Dellinger EP, et al. A surgical safety checklist to reduce morbidity and mortality in a global population. NEJM 2009;360(5):491–9.

188. Bell R, Pontin L. How implementing the surgical safety checklist improved staff teamwork in theatre. Nurs Times 2010;106(12):12.

189. Sutcliffe KM, Lewton E, Rosenthal MM. Communication failures: an insidious contributor to medical mishaps. Acad Med 2004;79(2):186–97.

190. Manias E, Gerdtz M, Williams A, Dooley M. Complexities of medicines safety: communicating about managing medicines at transition points of care across emergency departments and medical wards. J Clin Nurs 2014;24(1–2):69–80.

191. Arora V, Johnson J, Lovinger D, Humphrey HJ, Meltzer DO. Communication failures in patient sign-out and suggestions for improvement: a critical incident analysis. Qual Saf Health Care 2005;14(6):401–7.

192. Siddiqui N, Arzola C, Iqbal M, Sritharan K, Guerina L, Chung F, et al. Deficits in information transfer between anaesthesiologist and postanaesthesia care unit staff: an analysis of patient handover. Eur J Anaesth 2012;29(9):438–45.

193. Manias E, Jorm C, White S, Kaneen T. Handover: how is patient care transferred safely? In: Windows into safety and quality in health care 2008. Canberra: Australian Commission on Safety and Quality in Health Care; 2008:37–48.

194. Manias E, Geddes F, Watson B, Jones D, Della P. Perspectives of clinical handover processes: a multi-site survey across different health professionals. J Clin Nurs 2016;25(1–2):80–91.

195. Coleman EA, Smith JD, Frank JC, Min SJ, Parry C, Kramer AM. Preparing patients and caregivers to participate in care delivered across settings: the care transitions intervention. J Am Geriatr Soc 2004;52(11):1817–25.

196. Weingart SN, Zhu J, Chiappetta L, Stuver SO, Schneider EC, Epstein AM, et al. Hospitalized patients' participation and its impact on quality of care and patient safety. Int J Qual Health Care 2011;23(3):269–77.

197. Australian Commission on Safety and Quality in Health Care. A better way to care: safe and high-quality care for patients with cognitive impairment (dementia and delirium) in hospital. Sydney: ACSQHC; 2014.

198. Russell L, Doggett J, Dawda P, Wells R. Patient safety. Handover of care between primary and acute care: policy review and analysis. Prepared for the National Lead Clinicians Group by the Australian Primary Health Care Research Institute, Australian National University. Canberra: Australian Government Department of Health and Ageing; 2013.

199. NSW Department of Health. Implementation toolkit: standard key principles for clinical handover. Sydney: NSW Department of Health; 2009. https://www.aci.health.nsw.gov.au/resources/acute-care/safe_clinical_handover/implementation-toolkit.pdf (accessed Sep 2017).

200. Cunningham N. Editorial. Clinical Communique 2015;2(1):1–2.

201. WA Department of Health. From death we learn 2014. Perth: WA Department of Health; 2015:7–9.

202. Wu R. Turning the page on hospital communication slowly [editorial]. BMJ Qual Saf 2017;26:4–6.

203. Johnston M, Arora S, King D, Stroman L, Darzi A. Escalation of care and failure to rescue: a multicenter, multiprofessional qualitative study. Surgery 2014;155(6):989–94.

204. Broman KK, Kensinger C, Hart H, Mathisen J, Kripalani S. Closing the loop: a process evaluation of inpatient care team communication. BMJ Qual Saf 2015;26(1):30–2.

205. Bhabra G, Mackeith S, Monteiro P, Pothier DD. An experimental comparison of handover methods. Ann RCSE 2007;89(3):298–300.

206. Pothier D, Monteiro P, Mooktiar M, Shaw A. Pilot study to show the loss of important data in nursing handover. Br J Nurs 2005;14(20):1090–102.

207. NSW Health Nursing and Midwifery. Essentials of care. Working with essentials of care: a resource guide for facilitators. Sydney: NSW Department of Health; 2009:12–3.

208. Manias E, Bucknall T, Hutchinson A, Botti M, Allen J. Improving documentation at transitions of care for complex patients. Sydney: Australian Commission on Safety and Quality in Health Care; 2017.

209. Buist M, Bernard S, Nguyen TV, Moore G, Anderson J. Association between clinical abnormal observations and subsequent in-hospital mortality: a prospective study. Resuscitation 2004;62(2):137–41.

210. Calzavacca P, Licari E, Tee A, Egi M, Downey A, Quach J, et al. The impact of a rapid response system on delayed emergency team activation patient characteristics and outcomes: a follow-up study. Resuscitation 2010;81(1):31–5.

211. Hillman K, Chen J, Cretikos M, Bellomo R, Brown D, Doig G, et al. Introduction of the medical emergency team (MET) system: a cluster-randomised controlled trial. Lancet 2005;365(9477):2091–7.

212. Cioffi J, Salter C, Wilkes L, Vonu-Boriceanu O, Scott J. Clinicians' responses to abnormal vital signs in an emergency department. Aus Crit Care 2006;19(2):66–72.

213. Endacott R, Kidd T, Chaboyer W, Edington J. Recognition and communication of patient deterioration in a regional hospital: a multi-methods study. Aus Crit Care 2007;20(3):100–5.

214. McQuillan P, Pilkington S, Allan A, Taylor B, Short A, Morgan G, et al. Confidential inquiry into quality of care before admission to intensive care. BMJ 1998;316(7148):1853–8.

215. Teodorczuk A, Reynish E, Milisen K. Improving recognition of delirium in clinical practice: a call for action. BMC Geriatr 2012;12:55.

216. Iacono T, Bigby C, Unsworth C, Douglas J, Fitzpatrick P. A systematic review of hospital experiences of people with intellectual disability. BMC Health Serv Res 2014;14:505.

217. Shefer G, Henderson C, Howard LM, Murray J, Thornicroft G. Diagnostic overshadowing and other challenges involved in the diagnostic process of patients with mental illness who present in emergency departments with physical symptoms – a qualitative study. PLoS ONE 2014;9(11):e111682.

218. Australian Commission on Safety and Quality in Health Care. National consensus statement: essential elements for recognising and responding to acute physiological deterioration. Sydney: ACSQHC; 2017.

219. Australian Commission on Safety and Quality in Health Care. National consensus statement: essential elements for recognising and responding to clinical deterioration. Sydney: ACSQHC; 2010.

220. Schein RM, Hazday N, Pena M, Ruben BH, Sprung CL. Clinical antecedents to in-hospital cardiopulmonary arrest. Chest 1990;98(6):1388–92.

221. Kause J, Smith G, Prytherch D, Parr M, Flabouris A, Hillman K, et al. A comparison of antecedents to cardiac arrests, deaths and emergency intensive care admissions in Australia and New Zealand, and the United Kingdom. The ACADEMIA study. Resuscitation 2004;62(3):275–82.

222. Inouye SK, Westendorp RG, Saczynski JS. Delirium in elderly people. Lancet 2014;383(9920):911–22.

223. Van Leuvan CH, Mitchell I. Missed opportunities? An observational study of vital sign measurements. Crit Care Resusc 2008;10(2):111–5.

224. Odell M, Victor C, Oliver D. Nurses' role in detecting deterioration in ward patients: systematic literature review. J Adv Nurs 2009;65(10):1992–2006.

225. Cardona-Morrell M, Prgomet M, Lake R, Nicholson M, Harrison R, Long J, et al. Vital signs monitoring and nurse-patient interaction: a qualitative observational study of hospital practice. Int J Nurs Stud 2016;56:9–16.

226. National Patient Safety Agency (UK). Healthcare risk assessment made easy. London: National Health Service; 2007.

227. Bellomo R, Ackerman M, Bailey M, Beale R, Clancy G, Danesh V, et al. A controlled trial of electronic automated advisory vital signs monitoring in general hospital wards. Crit Care Med 2012 Aug;40(8):2349–61.

228. Yeung MS, Lapinsky SE, Granton JT, Doran DM, Cafazzo JA. Examining nursing vital signs documentation workflow: barriers and opportunities in general internal medicine units. J Clin Nurs 2012;21(7–8):975–82.

229. Fidler R, Bond R, Finlay D, Guldenring D, Gallagher A, Pelter M, et al. Human factors approach to evaluate the user interface of physiologic monitoring. J Electrocardiol 2015;48(6):982–7.

230. Cvach M. Monitor alarm fatigue: an integrative review. Biomed Instrum Technol 2012;46(4):268–77.

231. Horswill M, Preece M, Hill A, Watson M. Detecting abnormal vital signs on six observation charts: an experimental comparison. Sydney: Australian Commission on Safety and Quality in Health Care; 2010.

232. Preece MHW, Horswill MS, Hill A, Karamatic R, Hewett D, Watson MO. Heuristic analysis of 25 Australian and New Zealand adult general observation charts. Sydney: Australian Commission on Safety and Quality in Health Care; 2010.

233. Preece M, Horswill M, Hill A, Watson M. The development of the adult deterioration detection systems (ADDS) chart. Sydney: Australian Commission on Safety and Quality in Health Care; 2010.

234. DeVita MA, Bellomo R, Hillman K, Kellum J, Rotondi A, Teres D, et al. Findings of the First Consensus Conference on Medical Emergency Teams. Crit Care Med 2006;34(9):2463–78.

235. Jones D, Opdam H, Egi M, Goldsmith D, Bates S, Gutteridge G, et al. Long-term effect of a medical emergency team on mortality in a teaching hospital. Resuscitation 2007;74(2):235–41.

236. Chen J, Bellomo R, Flabouris A, Hillman K, Finfer S. The relationship between early emergency team calls and serious adverse events. Crit Care Med 2009;37(1):148–53.

237. Calzavacca P, Licari E, Tee A, Egi M, Haase M, Haase-Fielitz A. A prospective study of factors influencing the outcome of patients after a medical emergency team review. Inten Care Med 2008;34(11):2112–6.

238. Douw G, Schoonhoven L, Holwerda T, Huisman-de Waal G, van Zanten AR, van Achterberg T, et al. Nurses' worry or concern and early recognition of deteriorating patients on general wards in acute care hospitals: a systematic review. Crit Care 2015;19(1):230.

239. Australian Resuscitation Council. The ARC guidelines. Melbourne: Australian Resuscitation Council; 2016. https://resus.org.au/guidelines/ (accessed Sep 2017).

240. Hamilton R. Nurses' knowledge and skill retention following cardiopulmonary resuscitation training: a review of the literature. J Adv Nurs 2005;51(3):288–97.

241. Allen J, Currey J, Considine J. Annual resuscitation competency assessments: a review of the evidence. Aus Crit Care 2013;26(1):12–7.

242. Quach JL, Downey AW, Haase M, Haase-Fielitz A, Jones D, Bellomo R. Characteristics and outcomes of patients receiving a medical emergency team review for respiratory distress. J Crit Care 2008;23(3):325–31.
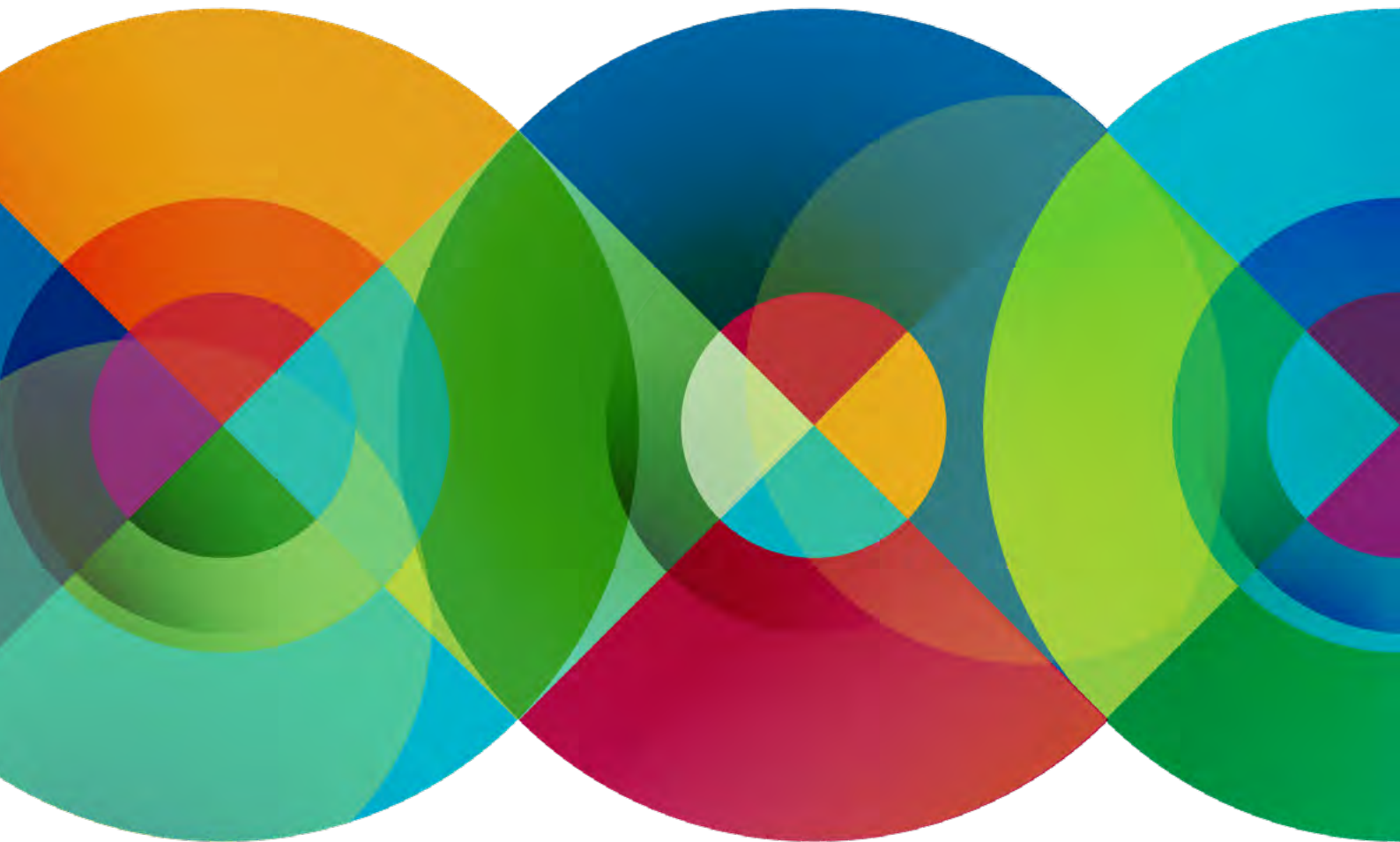
243. Jones D, Bellomo R. Introduction of a rapid response system: why we are glad we MET. Crit Care 2006;10(1):121.

244. Downey AW, Quach JL, Haase M, Haase-Fielitz A, Jones D, Bellomo R. Characteristics and outcomes of patients receiving a medical emergency team review for acute change in conscious state or arrhythmias. Crit Care Med 2008;36(2):477–81.

245. Clinical, Technical and Ethical Principal Committee of the Australian Health Ministers' Advisory Council. A national framework for advance care directives. Canberra: Australian Health Ministers' Advisory Council; 2011. www.coaghealthcouncil.gov.au/Publications/Reports/ArtMID/514/ArticleID/63/National-Framework-for-Advance-Care-Directives (accessed Sep 2017).

246. Australian Commission on Safety and Quality in Health Care. National medication safety and quality scoping study committee report. Sydney: ACSQHC; 2009.

247. Australasian Society of Clinical Immunology and Allergy. What is allergy? [Internet]. Sydney: ASCIA; 2010 [cited 2016 Mar 10]. Available from: www.allergy.org.au/patients/about-allergy/what-is-allergy

248. Department of Health (UK). Comprehensive critical care. London: UK Department of Health; 2002. webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4082872.pdf (accessed Sep 2017).

249. Australian Commission on Safety and Quality in Health Care. Safety and quality improvement guide – Standard 3: preventing and controlling healthcare associated infections. Sydney: ACSQHC; 2012.

250. Australian Commission on Safety and Quality in Health Care. Safety and quality improvement guide – Standard 6: clinical handover. Sydney: ACSQHC; 2012.

251. The High 5s Project. Standard operating protocol. Assuring medication accuracy at transitions of care: medication reconciliation. Geneva: WHO; 2014. www.who.int/patientsafety/implementation/solutions/high5s/h5s-sop.pdf?ua=1 (accessed Sep 2017).

252. Australian Nursing and Midwifery Federation (SA Branch). Best practice guidelines [Internet]. Adelaide: Australian Nursing and Midwifery Federation (SA Branch); 2016 [cited 2016 Apr 17]. Available from: https://www.anmfsa.org.au/professional-practice/best-practice-guidelines/

253. Schrijvers G, van Hoorn A, Huiskes N. The care pathway concept: concepts and theories: an introduction. Int J Integr Care 2012;12:e192.

254. Australian Government. *Carer Recognition Act 2010* (No. 123). Canberra: Australian Government; 2010.

255. Agency for Healthcare Research and Quality (US). Implement teamwork and communication [Internet]. Washington (DC): ARHQ; 2016 [cited 2016 Feb 10]. Available from: www.ahrq.gov/professionals/education/curriculum-tools/cusptoolkit/modules/implement/index.html

256. National Patient Safety Agency (UK). Seven steps to patient safety. London: National Health Service; 2004.

257. Van Der Meijen MJ, Tange HJ, Troost J, Hasman A. Determinants of success of inpatient clinical information systems: a literature review. J Am Med Inform Assoc 2003;10(3):235–43.

258. Consumers Health Forum of Australia. About consumer representation [Internet]. Canberra: CHF; 2016 [cited 2016 Apr 20]. Available from: https://www.chf.org.au/about-consumer-representation.php

259. NSW Nurses' Association. Guidelines on documentation and electronic documentation. Sydney: NSW Nurses' Association; 2010.

260. Australian Commission on Safety and Quality in Health Care. Safety and quality improvement guide – Standard 1: governance for safety and quality in health service organisations Sydney: ACSQHC; 2012.

261. Price O, Baker J. Key components of de-escalation techniques: a thematic synthesis. Int J Ment Health Nurs 2012;21(4):310–9.

262. National Cancer Institute (US). NCI dictionary of cancer terms [Internet]. Bethesda (MD): NCI; 2015 [cited 2015 Jul 10]. Available from: www.cancer.gov/publications/dictionaries/cancer-terms

263. Australian Health Ministers' Advisory Council. Delirium care pathways. Canberra: Australian Government Department of Health and Ageing; 2011.

264. General Medical Council (UK). Treatment and care towards the end of life: good practice in decision making [Internet]. London: General Medical Council; 2010 [cited 2014 Jul 16]. Available from: www.gmc-uk.org/guidance/ ethical_guidance/end_of_life_care.asp

265. Queensland Health. Queensland hospital admitted patient data collection (QHAPDC) manual 2017–2018. Brisbane: Queensland Health; 2017.

266. World Health Organization. Fact sheet no. 344: falls [Internet]. Geneva: WHO; 2010 [cited 2017 Apr 11]. Available from: www.who.int/ mediacentre/factsheets/fs344/en

267. Field MJ, Lohr KN, editors. Guidelines for clinical practice: from development to use. Washington (DC): National Academy Press; 1992.

268. American Medical Association. Opinions on consent, communication & decision making: informed consent [Internet]. Chicago (IL): AMA; 2016 [cited 2017 Oct 23]. Available from: www. ama-assn.org/delivering-care/ama-code-medical-ethics

269. Carey-Hazell K. Improving patient information and decision making. Australian Health Consumer 2005;1(1):2.

270. Runciman WB. Shared meanings: preferred terms and definitions for safety and quality concepts. Med J Aust 2006;184(10 Suppl):S41–3.

271. Australian Government Department of Health. National standards for mental health services. Canberra: DoH; 2010.

272. World Health Organization. Leadership and management. In: Operations manual for delivery of HIV prevention, care and treatment at primary health centres in high-prevalence, resource-constrained settings. Geneva: WHO; 2008:264–81.

273. Health Quality & Safety Commission New Zealand. Serious and sentinel events reported by district health boards: 2006–07 [Internet]. Auckland: Health Quality & Safety Commission New Zealand; 2007 [cited 2008 Mar 7]. Available from: www.hqsc.govt.nz/#dhb

274. Australian Pharmaceutical Advisory Council. Guiding principles for medication management in the community. Canberra: APAC; 2006.

275. Christensen M, Lundh A. Medication review in hospitalised patients to reduce morbidity and mortality. Cochrane Database Syst Rev 2016;(2):CD008986.

276. American Society of Health-System Pharmacists. ASHP guidelines on a standardized method for pharmaceutical care. Am J Health-Sys Pharm 1996;53:1713–6.

277. American Society of Hospital Pharmacists. ASHP statement on pharmaceutical care. Am J Hosp Pharm 1993;50:1720–3.

278. Mitchell GK, Tieman JJ, Shelby-James TM. Multidisciplinary care planning and teamwork in primary care. Med J Aust 2008;188(8 Suppl):S61–4.

279. Discipline. English Oxford living dictionaries [Internet]. Oxford: Oxford University Press; 2015 [cited 2017 Apr 11]. Available from: https:// en.oxforddictionaries.com/definition/discipline

280. Australian Government Department of Health. The personally controlled eHealth record system: glossary [Internet]. Canberra: DoH; 2014 [cited 2015 Jul 13]. Available from: www.ehealth.gov.au/ internet/ehealth/publishing.nsf/Content/glossary

281. Barach P, Small SD. Reporting and preventing medical mishaps: lessons from non-medical near miss reporting systems. BMJ 2000;320(7237):759–63.

282. Australian Commission on Safety and Quality in Health Care. Open disclosure standard Sydney: ACSQHC; 2008. Available from: https:// www.safetyandquality.gov.au/wp-content/ uploads/2012/01/OD-Standards-2008.pdf

283. Institute for Patient- and Family-Centered Care (US). FAQ [Internet]. Bethesda (MD): IPFCC; 2016 [cited 2016 Apr 19]. Available from: www.ipfcc. org/search.html?q=faq

284. Process. English Oxford living dictionaries [Internet]. Oxford: Oxford University Press; 2015 [cited 2017 Apr 11]. Available from: https:// en.oxforddictionaries.com/definition/process

285. Batalden P, Davidoff F. What is 'quality improvement' and how can it transform healthcare? Qual Saf Health Care 2007;16(1):2–3.

286. Australian Institute of Health and Welfare. Mental health services in Australia: key concepts [Internet]. Canberra: AIHW; 2012 [cited 2015 Jun 5]. Available from: mhsa.aihw.gov.au/key-concepts

287. Standards Australia. AS/NZS 4187:2014 – Reprocessing of reusable medical devices in health service organisations. Sydney: Standards Australia; 2014.

288. Institute for Healthcare Improvement (US). Quality improvement and patient safety glossary [Internet]. Cambridge (MA): IHI; 2015 [cited 2015 Jul 9]. Available from: www.ihi.org/education/IHIOpenSchool/resources/Pages/Tools/QualityImprovementAndPatientSafetyGlossary.aspx

289. Australian Wound Management Association. Pan Pacific clinical practice guideline for the prevention and management of pressure injury. Osborne Park (WA): Cambridge Media; 2012.

290. Royal Australian and New Zealand College of Psychiatrists. Self-harm: Australian treatment guide for consumers and carers. Melbourne: RANZCP; 2009.

291. National E-Health Transition Authority. Clinical terminology [Internet]. Canberra: NEHTA; 2016 [cited 2016 Apr 20]. Available from: www.nehta.gov.au/get-started-with-digital-health/what-is-digital-health/clinical-terminology

292. National Transitions of Care Coalition (US). Transitions of care measures; paper by the NTOCC Measures Work Group. Washington (DC): National Transitions of Care Coalition; 2008.