



Implementing the Comprehensive Care Standard

Clinical assessment and diagnosis

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Background

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 service provision. 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.

The second edition of the NSQHS Standards includes eight standards¹:

- Clinical Governance Standard
- Partnering with Consumers Standard
- Preventing and Controlling Healthcare-Associated Infection Standard
- Medication Safety Standard
- Comprehensive Care Standard
- Communicating for Safety Standard
- Blood Management Standard
- Recognising and Responding to Acute Deterioration Standard.

The Comprehensive Care Standard relates to the delivery of comprehensive care for patients within a health service organisation. 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 particular populations.

Comprehensive care requires clinicians to use thorough clinical reasoning and improve diagnostic accuracy² so that the patient's underlying clinical issues are identified and treated, and the best possible outcome is achieved.

One of the steps for delivering comprehensive care is clinical assessment. Clinical assessment should be based on the patient's subjective report of the symptoms and course of the illness or condition, and objective clinical findings to determine provisional and differential diagnoses.²

Diagnostic error has been reported frequently in different types of investigations and research³, and contributes to patient harm.^{3,4} Accurate clinical assessment and diagnosis are crucial to developing a comprehensive care plan that is appropriate, effective, and aligned with a patient's lifestyle and wellbeing.

This paper

This paper is part of a series of resources to support the implementation of the Comprehensive Care Standard. It focuses on clinical assessment and the part it plays in supporting comprehensive care delivery.

Implementation of the Comprehensive Care Standard is supported by six essential elements:

- Element 1: Clinical assessment and diagnosis
- Element 2: Identify goals of care
- Element 3: Risk screening and assessment
- Element 4: Develop a single comprehensive care plan
- Element 5: Deliver comprehensive care
- Element 6: Review and improve comprehensive care delivery.

This paper addresses Element 1: Clinical assessment and diagnosis.

The elements were developed to support practical implementation of the Comprehensive Care Standard. More information about all of the essential elements is available from: *Implementing the Comprehensive Care Standard: Essential elements for delivering comprehensive care.*

This paper has been developed for:

- Clinicians involved in the delivery of care, providers of clinical education and training, research organisations and other health bodies
- Managers and executives responsible for developing, implementing and reviewing processes to support identification of goals
- Planners, program managers and policymakers responsible for developing state and territory government or other strategic programs dealing with the processes associated with providing comprehensive care.



Element 1: Clinical assessment and diagnosis

Purpose

- To evaluate the clinical information and make provisional and possible differential diagnoses
- To determine appropriate investigations and actions required based on the provisional diagnosis
- To prioritise and delegate interventions, timeframes and appropriate escalation processes
- To commence development of an appropriate and effective comprehensive care plan with the patient, families, carers and other support people, and the multidisciplinary team.

Principles

- Communication during clinical assessment and investigations is person-centred and tailored to the recipient
- Patients, families, carers and other support people, as identified by the patient, are involved in clinical assessment processes as appropriate
- Clinicians have the skills and capacity to communicate effectively and discuss patient symptoms and conditions
- Evaluation of a disease or condition incorporates the objective clinical findings and the impact of the patient's experience of symptoms on their lifestyle to inform comprehensive care planning and delivery
- Clinicians, patients, families, carers and other support people have a shared understanding of provisional, differential and final diagnoses, and that they drive comprehensive care planning
- Awareness of the changing information is maintained so that diagnoses are reviewed as appropriate.

Consumer actions

- Patients communicate openly and honestly with their clinician to discuss symptoms and clinical conditions and diseases

- Families, carers and other support people participate in clinical assessment and diagnosis, including discussion of symptoms, when requested by the patient.

Clinician actions

- Clinicians use person-centred approaches to discuss diseases and conditions
- Clinicians consider the patient's level of health literacy and tailor communication styles accordingly
- Clinicians apply processes of clinical reasoning to reach valid, reasoned conclusions about medical treatment
- Clinicians identify who the patient wants involved in discussions about diagnoses, interventions and care planning
- Clinicians use the information about the provisional diagnoses to inform and drive the comprehensive care plan
- Clinicians document and communicate the outcomes of clinical assessment, including provisional, differential and final diagnoses; investigations; and the comprehensive care plan
- Clinicians review information as it becomes available, revise diagnoses and incorporate relevant changes to interventions into the comprehensive care plan.

Organisational actions

- Health service organisations foster a person-centred culture in delivering comprehensive care
- Health service organisations specify and communicate a clear process, and the roles and responsibilities for supervision of clinicians
- Health service organisations provide access to training and education to support clinical assessment activities and diagnostic processes
- Health service organisations provide systems to capture relevant information for comprehensive care delivery, including clinical assessment and diagnosis.



Introduction

Clinical assessment and diagnosis are the identification of a condition, disease, injury or needs of a patient based on clinical information obtained through a process of examination and investigation. Different clinicians may perform different assessments and gather information falling within their scope of practice and skill level. Organisations should have policies and processes in place that support clinicians to perform assessments appropriate to their clinical context and skill level. Clinicians should use clinical reasoning appropriate to their expertise to diagnose conditions and issues, to ensure that the comprehensive care plan is individualised to patient needs and preferences.

Clinical assessment

Different types of clinical assessment may be appropriate for a patient during an episode of care. Assessments will differ for individual patients depending on their reason for admission, the concerns they express and the environment of care. Some examples are:

- **Presentation or initial assessment** – comprehensive assessment by different clinicians that often includes gathering a patient history, noting general appearance, completing a top-to-toe physical examination, obtaining vital signs, reviewing available test results, assessing risks, and ensuring that appropriate additional testing has been organised and reviewed
- **Shift-by-shift or ongoing assessment** – clinical assessment completed at the commencement of each shift, during transition points or if the patient's condition changes at any other time; to aid reliability, shift change assessments could be completed with the clinician from the previous shift to compare and contrast findings
- **Focused assessment** – detailed clinical assessment of a specific body system or multiple systems relating to the presenting problem or any current concern of the patient, family, carer or other support people.

Clinical assessment and diagnostic processes relevant to clinical expertise are outlined during clinicians' training. Further information about performing clinical assessments can be found by referring to relevant texts or attending appropriate training. Organisations should have systems and processes to ensure that clinicians have access to training relevant to their clinical context.

Consideration should be given to ensuring that clinical assessment and diagnosis inform each of the components of the comprehensive care plan. See **Table 1** for some of the potential assessment outcomes for different components of the comprehensive care plan. Not all components of a care plan require review during a clinical assessment.

Table 1: Assessment outcomes and the comprehensive care plan

Care plan component	Examples of assessment outcomes
Personal identifiers and preferences	Establishing or updating: <ul style="list-style-type: none">• Communication requirements• Preferred name• Age• Decision-making capacity/substitute decision-makers/legal status
Clinical assessment and diagnoses	Determining or refining: <ul style="list-style-type: none">• Provisional diagnosis and differential diagnoses• Comorbidities• Reason for admission• Allergies and reactions• History of cognitive impairment, mental illness, frailty, falls, bleeding, infection, absconding, pressure injury, medications, other important information
Goals of care	Establishing or updating: <ul style="list-style-type: none">• Clinical goals• Personal goals• Advance care plans• Preferences for end-of-life care or treatment-limiting orders
Risk screening and assessment	Establishing or updating: <ul style="list-style-type: none">• Identified risks and planned mitigation strategies• Identification of higher-risk patients
Planned or ongoing interventions	Determining or revising: <ul style="list-style-type: none">• Diagnostic tests• Invasive and non-invasive interventions• New, altered or current medications• Indwelling devices
Activities of daily living	Determining or revising: <ul style="list-style-type: none">• Functional status, including assistive devices and processes needed; pressure injury prevention strategies; nutritional needs; hydration and fluid restrictions; elimination, urinary and faecal continence; wounds and dressings; drains; mobility; recreational activities
Monitoring plans	Establishing or modifying: <ul style="list-style-type: none">• Parameters to monitoring• Frequency of monitoring• Escalation plan• Review dates• Additional specialty or problem-specific observations
People involved in care	Identifying or updating: <ul style="list-style-type: none">• Patient's family, carers and other support people the patient has nominated to be involved in care decisions and delivery• Correct contact details, including the order in which to contact people• Team members involved in care decisions and delivery• Clinician with responsibility or accountability for care

Care plan component	Examples of assessment outcomes
Transition of care (discharge plan)	Establishing or updating: <ul style="list-style-type: none"> • Services and resources required after transition from acute care • Potential referrals • Primary care providers, including general practitioner • Discharge instructions • Medication lists

Clinical reasoning and decision-making

Clinical reasoning is often described as a rational cognitive process with two pathways for processing information. The first pathway is described as fast and intuitive, and the second as a slower, analytical, stepwise thinking process.^{5–8} Heuristics (mental shortcuts) are often useful, but there are many cognitive biases that have been linked to clinical reasoning and diagnostic error.⁹ Cognitive bias is the likelihood of making assumptions based on intuitive thinking rather than logic and is a systematic error in cognition.⁵

Recent literature has also implicated emotional experiences of clinicians as important to clinical decision-making.^{10–12} Electronic records^{13,14} and alarm customisation¹⁵ may also influence clinical reasoning and the ability of clinicians to interpret data. Clinicians are required to make decisions within the complex environment of health care, so it is important to examine interventions directed at reducing these kinds of errors.

Diagnosis

Finding out the cause of a health problem requires clinical assessment, testing and clinical reasoning so that an accurate diagnosis can be made and treatment can be tailored to a person's circumstances. Forming, testing, communicating, managing and documenting provisional and differential diagnoses are important aspects of developing the comprehensive care plan. In addition, the plan should include monitoring in line with the Recognising and Responding to Acute Deterioration Standard.

It is important for health service organisations to consider the underlying cognitive, task, environmental, workflow, organisational, cultural or other system factors that are linked to diagnosis, and ensuring that the processes are effective.^{16–18} Monitoring plans often rely on adherence to policy and education to orient staff to what is required to avoid failures that have been associated with human error. System controls to prevent these failures have included good design, user testing and regular clinician training. Diagnostic, management and therapeutic errors in patient care have been shown to be more likely when cognitive bias is evident.⁹

Avoiding diagnostic error

Diagnostic error is a breakdown in the process of identifying a condition, disease or injury. It can occur for many reasons, including errors in clinical reasoning.¹⁹ Potential diagnostic errors are:

- **Missed or delayed diagnosis** – can happen when a condition is not identified in a timely way, or not identified at all, and treatment is delayed or not provided
- **Over-treatment** – can be an issue when there is over-detection or over-definition of a condition that is not causing symptoms for a patient²⁰ but is subsequently treated
- **Wrong diagnosis** – patients may have a condition incorrectly identified and be treated for the incorrect diagnosis; they may also never get treated for the right diagnosis.

When a patient is not responding to treatment, clinicians should also consider 'what else could this be?', particularly when deterioration continues despite treatment. This may require minor or major modifications to the comprehensive care plan.

Errors in diagnosis occur for many reasons.⁷ Standard steps that should be taken when a diagnostic error occurs are outlined in the Australian Open Disclosure Framework.²¹



Strategies for improvement

Improving the process of clinical assessment and diagnosis reduces unwarranted variation in health care, and improves patient experience and outcomes. Assessment leads to more appropriate intervention and risk management responses. There are many ways to improve clinical assessment processes and diagnostic accuracy that align with value-based care.²² Using transparent processes ensures that clinical assessment and diagnosis support safety culture and quality improvement.

A number of interventions to improve clinical assessment skills and diagnostic accuracy have been suggested in the literature. Strategies can be implemented to improve individual clinical decision-making and also have a system-level impact.²³ These interventions may also serve to promote the culture of a learning organisation.

Interventions include:

- Supervision²⁴ and referral
- Reflective reasoning^{9,25}
- Checklists^{26,27}
- Algorithms, protocols, clinical pathways and guidelines²⁸
- Decision support tools²⁹
- Awareness raising³⁰, training and education²⁵
- Direct feedback and supported challenge by other clinicians²⁵
- Improving teamwork, such as through team conferences³¹
- Reducing clinical variation.

Supervision and referral

Supervision takes many forms, both formal and informal. It is usually required in any clinical role and can lead to improved patient care. Supervision can be about good leadership, support and guidance between clinicians in a team, to promote safe and high-quality patient care. In the context of improving clinical assessment and diagnosis, supervision may be a formal process consisting of professional support and learning to enable skill development and competence. Health service organisations should encourage supervision within the culture of the organisation and have processes to support the clinical workforce.

Clinicians may be either supervised or in a supervisory role, or both, depending on the requirements of the health service organisation. Supervision requirements of the clinical workforce may vary with the role undertaken and the time of day or day of the week.

Diagnosis is a collaborative activity. Referrals are the processes, tools and techniques by which a patient (and the provision of all or part of their care) is transferred between clinicians and health provider organisations to facilitate access to services and/or advice that the referring source is unable or unwilling to provide. Clinicians need robust referral systems to support clinical management when expertise or clinical alternatives are required.⁷

The major evidence-based themes identified in the literature³² relating to high-risk scenarios and patient safety around referral processes can be summarised as follows:

- **Delayed and late referrals** have a negative impact on the quality of care; patient risk can be reduced through the development of referral criteria, and ensuring that the timing of the referral is not dependent on the age of the patient or type of disease present
- **Referral failures** are particularly likely for patients during the referral process between general practitioner and hospital outpatient clinic; the impact of minimising delays to appointments, and improved communication between hospitals and other community services allow general practitioners to make appropriate referrals and reduce the risk of missed referrals
- **Communication content** refers to the potential for missing information to result in an increase in adverse events experienced by patients; there is often disagreement between primary and secondary caregivers on what information within the referral letter is essential information
- **Poor quality of referrals** can result in an information gap between clinicians, particularly between services; this can be addressed by allocating a sole point of communication to facilitate the referral and transfer of patients between community and hospital care.

Reflective reasoning

Reflective reasoning is a deliberate process of retracing decisions and exploring alternative thought pathways. This may lead to additional differential diagnoses or changes to the priorities of assessment processes.

The process of reflection may also lead to recognising and correcting any errors, and altering planned care, as appropriate. Reflective reasoning has the advantage of being an independent task that can be done by a clinician at any time by performing a cognitive autopsy.³³

An example of applying reflection is the 'Red team, Blue team' challenge, which is a military strategy that has been applied in some New South Wales health service organisations. Although this strategy is usually undertaken by different members of a team to challenge diagnostic decision-making during a medical round, it could be completed independently using the same principles.³⁴

Checklists

Checklists can be used to reduce complex tasks down to their component parts, with a check box next to each item, so that tasks are performed more consistently and safely, and improve the likelihood of successful task completion correctly. Checklists have been used widely in the healthcare industry since gaining prominence through the Michigan Keystone ICU project³⁵ and Atul Gawande's work in the 2011 book *The Checklist Manifesto*.³⁶

Not all tasks are suitable for a checklist, and use of checklists may drive behaviours that lead to unintended consequences. It is important to consider whether a checklist would help or add unnecessary administrative burden to a task. Checklists are successful in reducing errors through 'slips' such as lapses in concentration, distractions or fatigue.³⁷ Examples are checklists for timeout procedures³⁸, operating theatre check-in, safety equipment checks and transitions of care. Errors in clinical tasks that involve primarily attentional behaviour, such as diagnostic errors, usually require solutions focused on training, supervision and decision support.³⁷

Algorithms, protocols, clinical pathways and guidelines

Algorithms, protocols, clinical pathways and guidelines are widely used as an aid to support clinical decision-making. They are text-based, visual, computerised or paper resources that act as a prompt for planning and determining clinical action. Although these tools may be useful for guiding decisions, they are underpinned by sound critical thinking and assessment skills of the user.

It is important to have formal processes in place during development of these tools to ensure that they cover the evidence base for the components of care, and that they are accurate, current and valid. They should also be developed through a collaborative process that includes consumers. It is important when developing standard approaches at an organisational level that relevant information has been collected and applied. This allows the organisation to tailor outputs to the common diagnoses and risks of the population served, considering the available human and material resources.

Decision support tools

Decision support tools bring together high-quality evidence about particular conditions so that consumers and their clinicians can discuss the risks and benefits of different treatment options, explore the consumer's preferences, and share decisions about care. A recent Cochrane review detailed the benefits and value that decision aids provide for patients.²⁹

Awareness raising, training and education

Awareness-raising campaigns have been a popular form of organised communication to create awareness on particular topics.³⁰ Awareness raising can be a successful strategy when planned and executed using sound project management methodology.³⁰ The right stakeholders could increase visibility and influence regarding particular diagnoses or changes to clinical assessment processes.

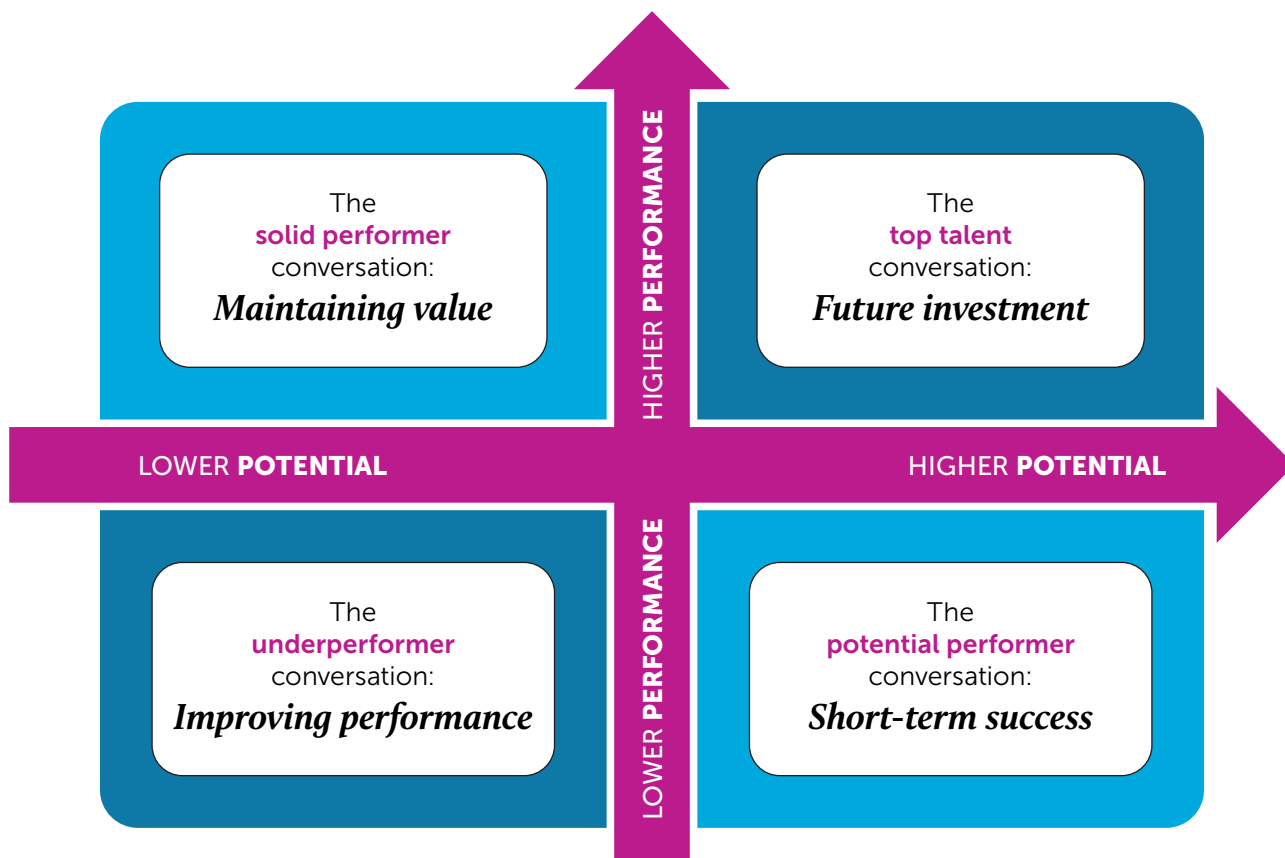
Training and education are an essential component of maintaining clinical currency for individual clinicians. Training can have a positive influence on team behaviours and processes, which affect patient outcomes through improved clinical processes.^{39–42} Training and education to improve clinical assessment and diagnosis should be tailored to the clinical workforce. They should include teamwork and clinical skills training, use of health informatics and current diagnostic testing, best-practice pathways including decision support, and opportunities to obtain feedback and reflect on decision-making.²³

Feedback

Regular feedback is an important aspect of improving performance in all professions.⁴³ Feedback can be provided in many forms⁴⁴ and has generally been reported as more effective when it is provided contemporaneously by leaders.⁴⁵ There are many types of feedback, and it can come from many sources, but the delivery is of particular importance.

There is a place for corrective feedback for novice and new practitioners; however, to influence effective performance in high achievers, facilitating self-reflection in the receiver is important.⁴⁶ Consideration should be given to the type, structure and timing of feedback so that it is directed at optimising and developing talent. The conversation is likely to look different depending on the participants and what is being discussed. Attention to current performance and potential could be one way of guiding interactions. Higher performers will have different conversations from underperformers (see **Figure 1**).

Figure 1: Situation, Behaviour and Impact (SBI) model for effective feedback



Source: Adapted from the Center for Creative Leadership, 2020⁴⁷

In health care, the performance of the team can often have a major impact on patient outcomes. Consideration should therefore be given to frequent evaluation of team performance using evaluation frameworks that support a more agile workforce. This shifts performance review to an ongoing, everyday business model of continuous improvement, instead of the traditional annual process, which individuals will view differently based on their experiences.⁴⁸

Improving teamwork

Teamwork is how teams perform their required tasks together.⁴⁹ Team cohesion and function may be improved by training together regularly.⁵⁰ Every member of the team can contribute to improving diagnostic accuracy, so it is important to foster an organisational culture that supports good teamwork processes. Other teamwork interventions that have been used to improve health care provided to patients include:

- Establishing organisational vision and mission statements
- Ensuring that roles are specified in job descriptions or team procedures
- Holding regular effective meetings
- Ensuring transparent functioning and change processes
- Implementing huddles
- Rounding together.

Reducing clinical variation

Although some variation in care is expected and necessary to meet the individual needs of patients, unwarranted clinical variation can expose patients to harm if they do not receive the care that they need, or receive treatment that is not required and from which they cannot benefit.⁵¹ Action 1.28 of the Clinical Governance Standard is a new action in the NSQHS Standards (2nd ed.) and relates to monitoring, feedback and performance around clinical variation.¹

The Australian Atlas of Healthcare Variation

The Commission has produced a series of resources to map differences in health care according to where people live. The aim of the Atlas series is to provide clinically meaningful information that can be used by health service organisations to investigate and improve appropriateness, effectiveness and efficiency of health care.

Data registries

Clinical quality registries can help with the recognition of clinical inappropriateness.⁵¹ The data collected can be used to identify benchmarks and variation in clinical outcomes, and to provide feedback to clinicians to inform clinical practice and decision-making.

The Commission developed the Framework for Australian Clinical Quality Registries to facilitate efficient development of national clinical quality registry infrastructure and to promote best practice in design, development, operation and security. The framework contains:

- Strategic principles
- National health information arrangements
- A national infrastructure model
- Operating principles
- Technical guidelines
- Prioritisation criteria.

Choosing Wisely

Choosing Wisely Australia® is an initiative that encourages clinicians and patients to discuss what care is needed, and to avoid unnecessary treatment, tests and procedures that can add potential for harm and be emotionally or financially burdensome. The program improves the quality of health care by reducing tests, treatments and procedures that evidence shows provide no benefit or, in some cases, lead to harm.⁵² The program is supported by more than 60 colleges, societies and organisations across Australia.



Conclusion

Clinical assessment and diagnosis are mainstays of ensuring that patients receive appropriate, effective care. Clinical assessment and diagnostic accuracy can be improved in many ways so that care is patient centred and appropriate.

The clinical workforce should have access to:

- Supervision, training and education as required
- Robust referral processes
- Learning through reporting, reflection and feedback
- Processes and tools such as decision support, checklists and data registries.
- Data about the care provided locally.

Making patient outcomes the focus for health system performance facilitates accurate clinical assessment and diagnosis, and improves value and sustainability in the health system. Ensuring efficiency and effectiveness of comprehensive care delivery depends on using evidence to inform clinical practice. Comprehensive care plans developed through methodical clinical assessment processes, with a focus on patient values, lead to better patient experiences and better-value care.

Glossary

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 and 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.⁵³

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 healthcare organisation that systems are in place to deliver safe and high-quality care.

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.

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 patient's health issues on their life and wellbeing, and are clinically appropriate.

comprehensive care plan: a document or electronic view 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, carers and other support people 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.⁵⁴

diagnosis: the identification of a condition, disease or injury, made by evaluating the symptoms and signs presented by a patient.⁵⁵

differential diagnosis: a process of weighing the probability of one disease or condition versus that of others accounting for a patient's clinical features. It includes a prioritised list of potential alternative diagnoses.

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, disability status, religions, beliefs and practices, languages spoken, sexual orientation, gender identity and gender expression, and sex characteristics.

goals of care: clinical and personal 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.

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.²¹

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 health system. It affects the ways in which consumers access, understand, appraise and apply health-related information and services.⁵⁶

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 group 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).

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.⁵⁷

multidisciplinary team: a team including clinicians from 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.⁵⁸ Multidisciplinary care includes interdisciplinary care. (A discipline is a branch of knowledge within the health system.⁵⁹)

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 grounded in mutually beneficial partnerships among clinicians and patients.⁶⁰ 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 family and carers, and access to care.⁶¹ Also known as patient-centred care or consumer-centred care.

policy: a set of principles that reflect the organisation's mission and direction. All procedures and protocols are linked to a policy statement.

procedure: the set of instructions to make policies and protocols operational, which are specific to an organisation.

process: a series of actions or steps taken to achieve a particular goal.⁶²

protocol: an established set of rules used to complete a task or a set of tasks.

provisional diagnosis: a temporary diagnosis that requires further information to confirm or rule out a particular disease or condition. The highest prioritised differential diagnosis.

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.⁶³ Quality improvement activities may be undertaken in sequence, intermittently or on a continuous basis.

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.⁶⁴

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 management: the design and implementation of a program to identify and avoid or minimise risks to patients, employees, volunteers, visitors and the organisation.

risk screening: a short process to identify patients who may be at risk of, or already have, a disease or injury. It is not a diagnostic exercise but rather a trigger for further assessment or action.

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.⁶⁵

screening: a process of identifying patients who are at risk of, or already have, a disease or injury. Screening requires enough knowledge to make a clinical judgement.

training: the development of knowledge and skills.

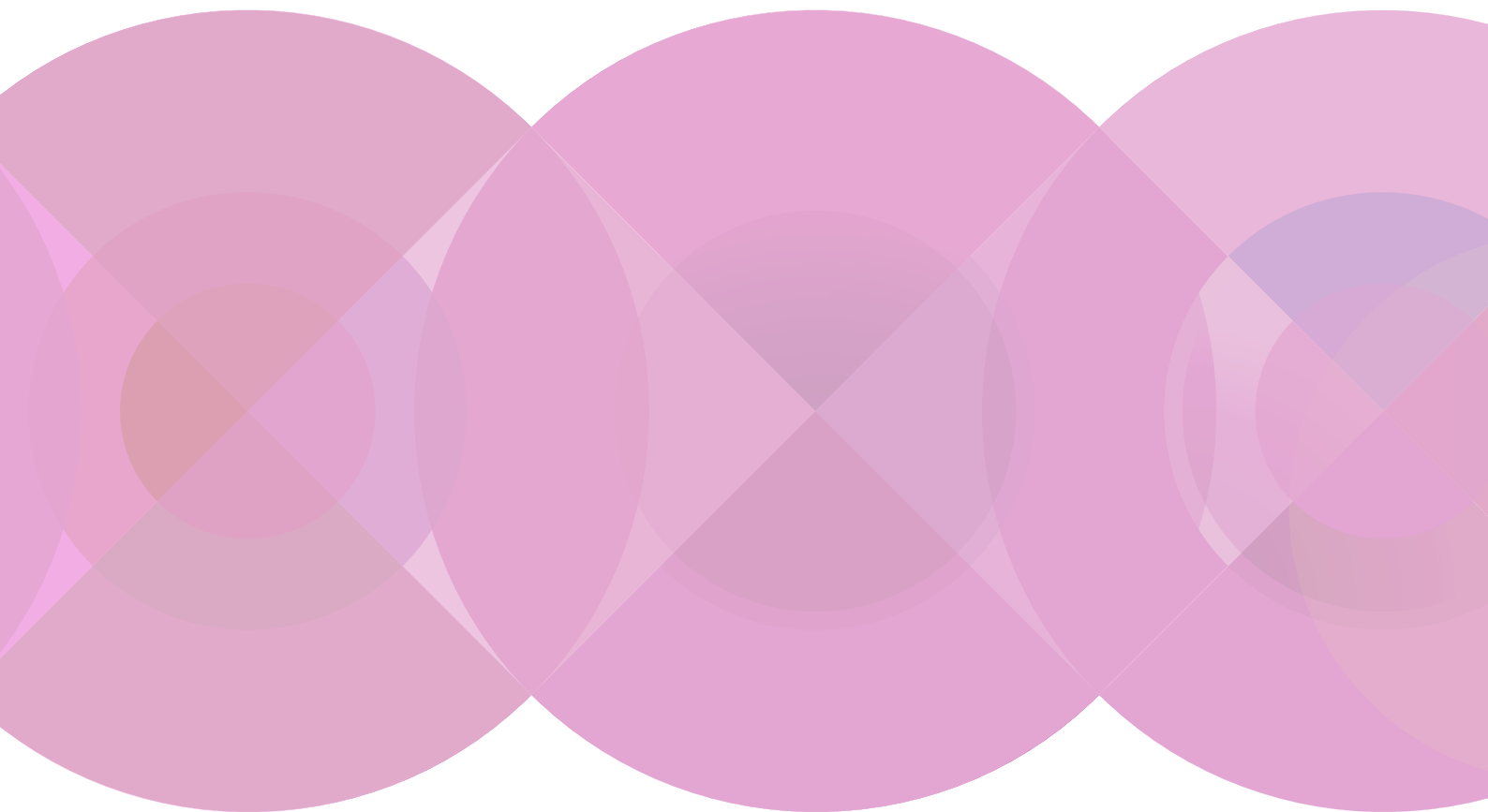
workforce: all people working in a health service organisation, including clinicians and any other employed or contracted, locum, agency, student, volunteer or peer workers. The workforce can be members of the health service organisation or medical company representatives providing technical support who have assigned roles and responsibilities for care of, administration of, support of, or involvement with patients in the health service organisation. *See also* clinician.

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