



Implementing the Comprehensive Care Standard

Deliver comprehensive care

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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.

Patients will require different health care depending on their individual needs, preferences and goals. It is important that care is provided continuously and collaboratively in line with their diagnoses, agreed goals of care and the comprehensive care plan.

The delivery of comprehensive care should aim to address the health issues the patient was admitted with and the risks of harm identified, to achieve the agreed clinical and personal goals of care. The process of delivering comprehensive care should include relevant clinical disciplines working together in a multidisciplinary team to achieve this outcome. Patients, families, carers and other support people are also essential for the delivery of comprehensive care, and strategies need to be in place to ensure that they are supported to be effectively involved.

The principles to ensure delivery of person-centred comprehensive care include a supporting workplace culture, effective communication, collaboration and teamwork, evidence-based practice, and education. The specific processes to deliver comprehensive care will vary depending on the type of health service organisation, the available resources and the population served.

This paper

This paper is part of a series of resources to support the implementation of the Comprehensive Care Standard. It focuses on the delivery of person-centred comprehensive care.

Implementation of the Comprehensive Care Standard is based on 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 5: Deliver comprehensive care.

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 5: Deliver comprehensive care

Purpose

- To ensure that patients receive coordinated delivery of the total health care required or requested
- To ensure that the care provided meets the agreed clinical and personal goals of care as described in the care plan.

Principles

- Communication and delivery of the comprehensive care plan are person-centred and tailored to meet health literacy needs of the recipient
- Delivery of care should align with the comprehensive care plan, and address the identified clinical and personal goals of care, diagnoses and risks
- Comprehensive care delivery should be multidisciplinary, and involve collaboration and effective teamwork
- Comprehensive care delivery needs to be dynamic and responsive to changes in the patient's needs, diagnoses, risks or condition
- Delivery of comprehensive care needs to involve patients, family, carers and other support people in alignment with the wishes of the patient.

Consumer actions

- Patients engage as partners in comprehensive care delivery, to the extent that they wish to and as appropriate
- Families, carers and other support people assist in the care of the patient if they choose to and if it aligns with the wishes of the patient.

Clinician actions

- Clinicians deliver care that is person-centred and appropriate to changes in the patient's diagnoses, condition, experience or expectations
- Clinicians work collaboratively in a multidisciplinary team to achieve the patient's goals of care
- Clinicians care for the patient in a dynamic and individualised way, being responsive and alert to changes in circumstances that require modification to the comprehensive care plan and delivery
- Clinicians involve family, carers and other support people in comprehensive care delivery in alignment with the wishes of the patient.

Organisational actions

- Health service organisations foster a person-centred culture in delivering comprehensive care
- Health service organisations provide access to training and education to support delivery of care that is person-centred and responsive to changes in the patient's needs
- Health service organisations resource services to provide models of care that are person-centred and comprehensive
- Health service organisations provide systems to capture information on comprehensive care delivery, including patient experience of comprehensive care delivery.



Introduction

Delivering comprehensive care requires an understanding of what is important to consumers and the workforce to ensure that care is safe, effective and aligns with patients' needs and preferences and is grounded in the principles of person-centred care. Comprehensive care is delivered when conditions support the healthcare workforce to provide person-centred value based care. To develop this approach, organisations and clinicians need to promote a safety culture, work in partnership with consumers, collaborate in teams, ensure that practice is evidence-based, and access appropriate education and training.

Many patients are cared for each year in acute facilities and are delivered safe health care (see **Table 1**). However, sometimes things go wrong, and data relating to hospital acquired complications and

serious clinical incidents help highlight where care delivery can be improved so that there is better care everywhere.

Table 1: Hospital separations and hospital-acquired complications 2016–2018

Year	Number of hospital separations	Hospital-acquired complications	Serious clinical incidents
2016–2017	11,013,815*	186,397 separations (8.6 million separations in-scope for measure)*	1,236 ²
2017–2018	11,253,275 [†]	185,493 separations (9.6 million separations in-scope for measure) [†]	Not available

* Admitted patient care 2016–17: Australian hospital statistics. Health services series no. 84.

† Admitted patient care 2017–18: Australian hospital statistics. Health services series no. 90.

Person-centred principles for comprehensive care

Person-centred care is health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers. Key dimensions of patient-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.

Delivering comprehensive care that wraps around individual patients starts with the application of person-centred principles, which should form part of the culture of a health service organisation. Ensuring that patients and consumers understand their options, and make decisions that align with their needs and preferences requires good shared decision making and risk communication, with a focus on how to achieve the agreed healthcare goals. The delivery of appropriate care, and robust mechanisms to continuously update and check that the right care is being delivered, is the intention of the Comprehensive Care Standard.

Focusing on appropriateness and value-based care

Appropriateness is a complex issue that defines health care in a construct of ethical and fair allocation that is evidence-based, efficient and consistent with person-centred care.³ The categories common in the literature in relation to appropriateness includes:⁴

- Evidence-based care
- Person-centred care
- Clinical expertise
- Effective use of resources
- Equity.

Value-based health care is about achieving the best care possible for each patient while using resources efficiently.² The focus on people requires thinking about organising health care around patients' values, rather than focusing on volume and throughput. Value-based care is person-centred with similar widely recognised potential benefits. They include²:

- Better patient and community experience
- Better workforce experience and improved wellbeing
- Better clinical outcomes, safety and quality
- Better value care through lower cost of care.



Supporting a safety culture

A strong commitment to safety culture within a health service organisation is an important enabler to improving delivery of comprehensive care, and promotes collaboration and teamwork. The National Model Clinical Governance Framework⁵ sets out the requirements for sustaining a strong safety culture. The list includes⁵:

- Leaders articulating a vision for high-quality, compassionate and safe care, and acting on this vision throughout the organisation
- Translating the vision into clear objectives for safety and quality at all levels of the organisation, and establishing measures to assess progress
- Providing a supportive and positive working environment for the workforce
- Ensuring that members of the workforce are engaged in their work
- Having an organisation that is transparent about performance, open to learning and continually improving
- Supporting multidisciplinary teams to work together effectively.

Safety culture is an element of an organisation's overall culture and is described as the 'shared values, beliefs, norms, and procedures related to patient safety among members of an organisation, unit or team'.⁶ The Commission uses the following definition in the NSQHS Standards:

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 or the organisation to direct resources to deal with safety concerns.¹

Safety culture also incorporates person-centred principles. The following characteristics would be evident in an organisation with a person-centred safety culture⁷:

- Understanding of, and respect for, patients' needs and preferences among the workforce and leaders
- Strong workforce capabilities to deliver person-centred care
- Systematic and informal accountabilities, rewards and incentives for person-centred care
- Support and openness to change, learning and continual improvement
- Commitment to professional values and ethics
- Open and respectful interaction, teamwork and collaboration between the workforce, including between leaders and the workforce
- Sensitivity to non-medical and spiritual dimensions of care
- Respect for equity and diversity among the workforce, and among patients and the community.

Interventions that promote safety culture are generally based on principles of leadership, teamwork, collaboration and behaviour change. They are often presented in the literature as a combined approach that includes several interventions.

Measurement of patient safety culture enables the identification of strengths and areas for improvement. This information can be used to develop appropriate interventions. Patient safety culture measures can also be used to evaluate new safety programs by comparing results before and after implementation.

Patient safety culture can be measured through surveys of hospital staff, qualitative measurement (focus groups, interviews), ethnographic investigation or a combination of these. Surveys of the healthcare workforce are the most common way of measuring patient safety culture. The healthcare workforce is often the first to notice patterns of unsafe practice and the conditions which increase or decrease the likelihood of such practice.



Working in partnership with patients and consumers

Research demonstrates that person-centred care improves patients' care experience and creates public value for services.⁸ When health professionals, managers, patients, families and carers work in partnership, the safety and quality of health care improves, costs decrease, provider satisfaction increases, and patient care experience is enhanced. Efforts at promoting patient engagement and person-centred care through empathic communication are essential to providing comprehensive care and this includes communicating for safety.

Communicating information about care

Clinical communication is the exchange of information about a person's care that occurs between treating clinicians, and patients, carers and families, and other members of a multidisciplinary team. Communication can be formal or informal, and can occur through several different channels, including face-to-face meetings, videoconference, telephone, written notes, digital or other documentation.

Effective communication is two- or multi-way communication that is coordinated and continuous, and results in the timely, accurate and appropriate transfer of information⁹ and is vital for providing compassionate comprehensive care. This can be achieved by actively using empathy during interactions.

Empathic interactions

Empathic engagement is the basis of a trusting relationship and can lead to improved patient outcomes.¹⁰ Evidence also suggests that communication skills training is likely to help healthcare providers empathise more with their patients.¹¹

Empathy is defined as:

a predominantly cognitive ... attribute that involves understanding (rather than feeling) of a patient's concerns, experiences, pain, and suffering combined with a capacity to communicate this understanding and an intention to help.¹⁰

Higher levels of patient satisfaction and trust are reported when empathy and person-centred communication techniques such as the following are used¹²:

- Smiling and maintaining eye contact
- Shaking hands when introductions are made, if appropriate
- Acknowledging any waiting time and apologising for it
- Beginning with an open-ended question such as 'How can I help you?'
- Doing at least one non-medical gesture, such as giving the patient a pillow or offering to help them get comfortable.

Shared decision making

Shared decision making involves integrating a patient's values, goals and concerns with the best available evidence about benefits, risks and uncertainties of treatment, to achieve appropriate healthcare decisions.¹³ It involves clinicians and patients making decisions about the patient's care and treatment together.¹⁴

In partnership with their clinician, patients are encouraged to consider available screening, treatment or management options. They should discuss the likely benefits and risks of each, and communicate their preferences to their clinician. The course of action that best fits with the patient's preferences can then be selected as part of the shared decision making process¹⁵ and incorporated into the comprehensive care plan.

Shared decision making is of increasing interest to policymakers and international researchers.

Research indicates that¹⁶:

- Patients are less informed and involved in making decisions about their health care than they would like to be
- Shared decision making can improve patient and clinician satisfaction with care and leads to better-quality decisions
- Patients using evidence-based decision aids have improved knowledge of their options, have more accurate expectations of possible benefits and potential harms, and feel that they have greater participation in decision-making than people receiving usual care
- Better-informed patients make different, often more conservative, less costly choices about treatment; it is thought that this is because information provides a realistic appreciation of likely benefits and risks of treatment, and enables decisions about the potential outcomes to be made in a more considered way.

The Commission has produced three short videos for clinicians on shared decision making. These provide an [overview of shared decision making](#), [challenge myths about shared decision making in practice](#), and [explain how to use patient decision aids and where to find them](#). They are useful videos for developing an understanding of how to apply this approach when delivering comprehensive care.

Communicating risk

Risk communication is a key part of information sharing to ensure that patients understand the benefits and risks of the treatment choices available to them. To support clinicians develop and refine their skills in communicating effectively, the Commission has developed an e-learning module: [Helping Patients Make Informed Decisions: Communicating risks and benefits](#). Communicating risk is an essential part of supporting shared decision making and is part of developing an appropriate comprehensive care plan and is required to deliver comprehensive care. It is also used when exploring options when preferences and conditions change in the dynamic care environment.

Developing goals for comprehensive care delivery

Goals can be an important motivator for patients, and help give meaning and purpose to activities that form part of the comprehensive care plan. This is important in health care because some activities that are required to support goal attainment may be demanding, unenjoyable or anticipated negatively. Research suggests that, for successful goal attainment, people must be connected to their goals and want to achieve the end point, and there must be parts of the goal that translate into actions.¹⁷ The goal setting process includes components that support goal attainment, components that support multidisciplinary teamwork and collaboration, and components that contribute to both.

Effective goal setting is supported by:

- Dedicated time to set goals
- Writing goals down in words that everyone understands
- Making sure accountability is clear
- Providing timelines
- Chunking larger goals into smaller parts
- Making goals accessible and communicating them to everyone involved
- Measuring and tracking performance.



Encouraging collaboration and teamwork

A strong governance structure that builds positive workplace culture and supports the delivery of multidisciplinary comprehensive care has collaboration at its core.

Multidisciplinary collaboration, which is increasingly referred to as interdisciplinary collaboration in the literature, is defined as:

the process by which different health and social care professional groups work together to positively impact care... [and] involves regular negotiation and interaction between professionals, which values the expertise and contributions that various healthcare professionals bring to patient care.¹⁸

Collaboration strengthens working relationships through mutual respect and trust, and is dependent on the competence, confidence and commitment of all parties.^{19,20} Other factors that contribute to successful collaboration include shared vision; cooperative endeavour; willing participation; non-hierarchical relationships; and shared power, planning, responsibility and decision-making.²⁰

Teamwork relates to the quality of collaboration and communication between members of the healthcare team and is influenced by a number of factors. These include familiarity and trust between team members, the experience of team members, and their professional beliefs and roles in an organisation.^{21,22} High-performing teams share a common vision; have a strong sense of trust and confidence; optimise collaboration, communication and coordination; and understand one another's roles and responsibilities.^{19,20,23,24}

Organisational systems and processes can also influence teamwork and collaboration. These can include governance, infrastructure, resources, availability and quality of workforce training, and quality improvement processes. The extent to which these factors affect the quality of collaboration between team members will vary from setting to setting and over time.²⁵

Teamwork is an essential component of improving the health care provided to patients. Teams will perform differently depending on a number of factors. There are many types of teams that may be composed in variable formats and engage and operate differently. It is often assumed that clinicians will work as a highly functional team even when they may never have worked together before, may not know each other, and may never have been trained to work as a team. It is important to provide appropriate team training to the healthcare workforce.

Characteristics of effective teams

The following characteristics associated with effective multidisciplinary teams have been identified through the literature^{20,26} and agreement through consultation with Commission committees:

- Leadership and management
- Culture and climate (trust)
- Appropriate resources and procedures
- Clarity of vision
- Respect and understanding of roles
- Effective communication
- Appropriate skill mix
- Personal satisfaction, training and development
- Individual characteristics of team members
- Quality and outcomes of care.

The characteristics and relevant actions in the NSQHS Standards (2nd ed.) that support, require or refer to multidisciplinary teamwork and collaboration are shown in **Appendix 1**.

Teams that work effectively have a number of recognised traits, including high levels of trust and shared situational awareness between members.²⁷ High-performing teams are more effective, and members are usually happier within the workplace. A number of models have been suggested to optimise teamwork (see **Table 2**).

Table 2: Models to support team effectiveness

Team model	Year	Model inclusions
Tuckman	1965	Forming, storming, norming, performing, adjourning ²⁸
Katzenbach and Smith – Performance model	1993	Collective work products; performance results; personal growth through commitment, skills and accountability
Lombardo and Eichinger – T7 model	1995	Internal factors (thrust, trust, talent, teaming skills, task skills), external factors (team leader fit, team support from the organisation)
Rubin, Plovnick, and Fry – Team effectiveness model (GRPI)	1997	Goals, roles, procedures, interpersonal relationships
Drexler/Sibbet – Team performance model	1999	Creating (orientation, trust, goal, commitment), sustaining (planning, implementation, reassessment) ²⁸
LaFasto and Larson – Five dynamics of teamwork and collaboration model	2001	Members, relationship, problem solving, leadership, organisational environment
Hackman	2002	Coaching, supporting, enabling, compelling direction, team roles and terms
Lencioni – The five dysfunctions of a team	2005	Improving teams by assessing dysfunction in five areas: absence of trust, fear of conflict, lack of commitment, avoidance of accountability, inattention to results
Google ²⁹ – Project Aristotle model	2015	Psychological safety, dependability, structure and clarity, meaning of work, impact of work

Teamwork and collaboration are also referenced as an element of person-centred care. In a review of the key attributes of high-performing person-centred healthcare organisations⁷, teamwork and collaboration were identified as essential to ensuring a person-centred culture.

Structured communication

Structured communication techniques can be used to standardise communication between two or more people. They help to set expectations within the conversation, and provide specific, relevant and critical informational elements that will be communicated every time a patient is discussed. The ISOBAR tool is often used for structured communication.

Structured and standardised communication at transitions of care has been shown to reduce communication errors between clinicians and improve patient safety, with critical information more likely to be accurately transferred and acted on.³⁰ Structured referral forms have been found to have a positive impact on the communication between general practitioners and emergency departments.³⁰

Escalation and communication of critical information

Critical information is 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.

New critical information can emerge outside formal clinical handover. For timely action to occur, information must be communicated to the right person (that is, a clinician who can make decisions about care) and be documented to ensure patient safety.

Failure to communicate, or poor communication of, critical information can result in failure to rescue³¹, inappropriate treatment, care that does not align with the patient's goals or preferences, and poor coordination of care.³² Further information can be found by referring to the [Communicating for Safety Standard](#) and [Communicating 4 Safety Portal](#).

Situational awareness

Situational awareness is knowing what is going on. The aim is for the care team to maintain an awareness of the 'big picture', and think ahead to plan and discuss contingencies about patient care and responsibilities of the team. This involves an ongoing dialogue, which keeps members of the team up to date with what is happening and how they will respond if a situation changes.

Situational awareness includes a number of domains including perception, comprehension and predicting potential outcomes. Situational awareness should be integrated into risk management strategies, part of organisational training including team training activities and be built into procedures as appropriate. Theatre time outs include situational awareness as part of the process.

Skill mix

Skill mix describes the combination of posts, grades or occupations in a team, ward, organisation or other grouping, and the assortment of activities or skills needed for each job.^{33,34} The term is also often used to describe the proportion of different levels of registered and enrolled nurses in an organisation, or specific ward or unit.

Delivering safe, comprehensive care requires an appropriate skill mix for the organisation. Studies have found that skill mix is a significant predictor of patient outcomes.^{35,36} Research has found a skill mix with a higher proportion of registered nurses in acute facilities resulted in statistically significant lower rates of patient mortality and negative patient outcomes such as pressure injuries, gastrointestinal bleeding, sepsis, shock, physiologic/metabolic derangement, pulmonary failure and failure to rescue.³⁵⁻³⁷

Experts in all clinical disciplines are essential in the clinical skill mix of any organisation. Expertise has been recognised as an important component of appropriateness which is encompassed by best-practice.⁴ Experts provide superior guidance for clinical decision making and are better equipped to tailor treatment to patient needs when outcomes may be uncertain. Experts also contribute to reduced variation and creation and support for clinical guidelines and standards.⁴

Care coordination

Care coordination is a part of delivering safe and high-quality comprehensive care. When patients have multiple morbidities, complex health problems and multiple specialties involved in their care, the risks of errors and failures increase. Having a dedicated person who has responsibility and accountability for coordinating care (administratively and/or clinically) can help reduce risk and provide a more tailored care experience, while improving patient satisfaction and some quality-of-life measures.³⁸

Care coordination can contribute to meeting patient needs and preferences by providing more customised and personalised care. This is particularly important for patients at high risk of harm, patients with complex needs and patients who do not fit specialty models. In a small study, identifying these types of high-risk patients and providing them with specialised care plans was associated with a reduction in adverse events and readmissions.³⁹

Allocating an official care coordinator for every patient may not be feasible. However, it may be useful for a member of the multidisciplinary team to perform the role in an informal capacity, especially when the patient's needs are complex or require input from numerous clinicians. Health service organisations should consider their current approach to care coordination, identifying the types of patients within their service that would most benefit from this approach, and the different types of strategies that could be used to better coordinate care.

Fit

Fit has been described as the compatibility between employees and their workplace. Fit has been linked to employee attitude, performance and turnover.⁴⁰ The premise is that the workforce will have higher levels of job satisfaction and organisational loyalty, and will perform better when their place of employment has similar values to them. Other aspects supporting workforce wellbeing include user-centred design and improving psychological safety in the workplace.⁴¹ Health service organisations should consider how to include 'fit' in recruitment processes.

Enhancing performance of team members

In general, workers who receive regular feedback perform better in the workplace.⁴² Health service organisations should follow principles that provide the workforce with the opportunity to flourish, be happy at work and provide excellent health care to consumers of the service. Recognising and acknowledging talent and expertise within the workforce supports retention in an organisation.

Health service organisations should consider what steps they can take to support all parts of the workforce to perform their job well and retain the workforce to meet the needs of the organisation.

Factors that support the workforce to improve performance include:

- Access to self-care opportunities for the workforce
- Optimised workflows to make the way work is completed as convenient as possible
- Workplace design and physical environment that are comfortable and fit for purpose
- Access to training that supports the workforce to gain competence, grow, develop and advance
- Flexibility in working arrangements
- Clear communication and operating procedures
- Workforce feedback mechanisms that take a strength-based approach
- Opportunities to advance or work in different roles
- Incentives and motivational strategies.

Performance management

Effective performance management is also essential. Health service organisations that have effective systems for performance management are more likely to have better levels of productivity and staff satisfaction. Valid and reliable performance review processes are the focus of Action 1.22 of the Clinical Governance Standard in the NSQHS Standards (2nd ed.).¹

It is vital that problems arising from poor performance are resolved early. If poor performance is not addressed, the problem can amplify because other team members may experience resentment for having to compensate for their colleague. Poor performance can lead to poor morale and unproductive outcomes that can affect the whole team environment.

Examples of underperformance include:

- Unsatisfactory work performance
- Noncompliance with policies and procedures
- Unacceptable behaviour in the workplace
- Disruptive or negative behaviour.

Team members may underperform for many reasons, including⁴³:

- Lack of awareness of expectations – standards and goals are unclear, not set or not explained
- Interpersonal differences
- Mismatch between capability and job requirements
- Lack of feedback on their performance
- Lack of personal motivation, low team morale and poor work environment
- Personal issues
- Cultural misunderstanding
- Workplace bullying.

Most team members want to improve their performance; robust performance management systems can motivate people and provide a framework for development. The aim of performance management is to support employees to flourish and improve so that they are retained in the workforce.

Steps for effective performance management include⁴³:

1. Identify the problem
2. Assess and analyse the problem
3. Meet the team member and discuss the problem
4. Find a solution together
5. Monitor performance.

When performance issues continue, effective strategies may include moving employees to more suitable positions or using redundancy programs. Termination of employment is possible when performance does not improve to an acceptable standard.⁴³

Practicing evidence-based care

Evidence-based practice is a requirement of the Comprehensive Care Standard.⁴⁴ Evidence-based practice is an approach to care that encourages clinicians to use the best available evidence and critically apply it to an individual patient's circumstances and preferences in clinical practice.

There are five steps in the evidence-based practice process (see **Table 3**).

Table 3: Evidence-based practice process⁴⁵

Step	Description
Ask the question	Describe the clinical issue as a question
Acquire the evidence	Search for evidence using standard methodologies
Appraise the evidence	Critically evaluate the evidence using established review frameworks (e.g. PRISMA, CASP)
Apply the evidence	Translate the finding into pragmatic approaches in the workplace
Assess performance and outcomes	Check structures, processes and outcomes to identify sustainable implementation and modifications required

CASP = Critical Appraisals Skills Programme

PRISMA = Preferred Reporting Items for Systematic Reviews and Meta-Analyses

Health service organisations need to ensure that systems are in place to periodically review compliance with, and variations from, evidence-based practice to identify quality improvement opportunities.

Strategies to support clinicians to use the best available evidence and limit unwarranted variations in care include⁴⁶:

- Adopting clinical guidelines, pathways or clinical care standards when appropriate
- Identifying or establishing committees with oversight responsibility for reviewing, approving and implementing best-practice guidelines, pathways, models of care, decision support tools and 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 the clinical care standards being used, and informing clinicians if unwarranted variation occurs.

Support structures for providing care

Good clinical governance promotes clinical practice that is effective and evidence based. Health service organisations need to have current, comprehensive and effective policies, procedures, guidelines and protocols that cover clinical safety and quality risks, and are consistent with the organisation's regulatory obligations.

Action 1.27 of the Clinical Governance Standard requires health service organisations to provide clinicians with ready access to, and support use of, best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice.¹

Clinical care standards support the delivery of appropriate care, reduce unwarranted variation in care, and promote shared decision making between patients, carers and clinicians.⁴⁷ Clinical care standards target specific clinical conditions or treatments, and provide opportunities to better align clinical practice with the best evidence. Refer also to the paper describing Element 1: Clinical assessment and diagnosis.

Models of care

The way health care is delivered in a health service organisation depends on a number of factors but should be based on best-evidence approaches to health and wellbeing. Services should be integrated to ensure that person-centred approaches are strengthened by quality care that is designed according to the differing needs of the population throughout their lives.⁴⁸ Care should be delivered by coordinated multidisciplinary teams, regardless of where a patient presents for treatment. Services should be effectively managed to ensure optimal outcomes and the appropriate use of resources based on the best available evidence, with feedback loops to continuously improve performance.⁴⁸

Health service organisations should have processes in place to ensure that the service is meeting the needs of the patient population, the profile of the clinical workforce, and available resources, including people, equipment and the physical environment. The model of care can be enhanced by improvement activities that engage the workforce and consumers in identifying gaps in care, and reduce waste, minimise inefficiencies and duplication to promote seamless transitions of care.

Resources and equipment

To ensure smooth delivery of comprehensive care, health service organisations need to make resources available to clinicians to implement clinical guidelines, pathways or clinical care standards.

Each clinical area should do a stocktake of equipment so that health service organisations can use the information to ensure best use of current stocks and develop a business plan for the purchase of any new items that may be required. During the stocktake, all equipment should be checked to ensure that it is in good working order. Repair and replacement of broken or obsolete equipment should be included in the service business plan.

Health service organisations need to develop policies that describe maintenance strategies, including a schedule of review to ensure that equipment is fit for purpose, safe and in good working order at all times. These policies must reflect Australian standards for devices and equipment. Faulty devices may be required to be reported to the Therapeutic Goods Administration.



Providing education, training and development

Maintaining a competent and proficient workforce requires education and training. All health service organisations have a responsibility to provide access to ongoing education and training for their workforce, as outlined in [Action 1.20](#) of the Clinical Governance Standard in the NSQHS Standards (2nd ed.).¹

Workforce

Risk management and needs assessment should inform the education schedule in a health service organisation. Comprehensive care may require many different types of training, depending on the specialty needs of a service. Some examples of training requirements include:

- Risk screening and assessment processes
- Clinical communication
- Comprehensive care planning
- End-of-life care
- Difficult conversations
- Conflict management and de-escalation techniques
- Documentation
- Specialty care requirements
- Advanced clinical assessment strategies, techniques and interventions
- As part of policy, guidelines or standards implementation.

Teamwork, collaboration and clinical communication training is important for all levels of the health service organisation and is vital for the delivery of comprehensive care. It is necessary to provide appropriate training to all clinicians involved in patient care. This includes doctors and nurses at all levels and in all specialties at the health service organisation.

Education programs about new or updated policies, procedures and other relevant comprehensive care work practices should include:

- Brief background information about the topic and why it's important for delivering comprehensive care
- Appropriate use of blended learning methods depending on the topic
- Monitoring and evaluation processes.

Changing practices is resource intensive and time consuming. Many organisations find that staged implementation is useful to ensure that adequate training can be provided.

Training to work in teams

The literature cites many different types of team training. Common competencies of team training focus on the 'non-technical' team skills of effective communication, leadership, coordination⁶, situational awareness, role clarity and situation monitoring.^{49,50} Studies of the effectiveness of team training in health care vary in quality of evidence, study design and sample size. Most studies have a low quality of evidence and cannot directly associate training interventions with improvements in clinical outcomes. However, some moderate- to high-quality evidence shows that team training can have a positive influence on team behaviours and processes, which affects patient outcomes through improved clinical processes.⁴⁹⁻⁵²

The most robust evidence suggests that a context-specific multimodal approach to team training, which includes learning activities, practice and use of supportive tools, is an effective strategy for improving teamwork.^{6,50,53} The evidence indicates that simulation training, recreating real-life scenarios, and training based on Crew Resource Management (CRM) principles, used in the aviation industry, will likely result in improved team behaviour, attitudes and perception of institutional support.⁴⁹

Although training may improve team functioning and non-technical skills (communication, collaboration, perception of culture), there is no evidence that these training interventions reduce adverse patient outcomes. Outcomes of team training may be more aligned with other indicators of improved safety, such as lower intention to leave, reduced staff turnover, improved workforce wellbeing and satisfaction, and high confidence of consumers who report better patient experiences.

The importance of training programs that are customisable for local implementation has been identified⁵⁰, reflecting the Commission's emphasis on the need for flexible standardisation. There is limited conclusive evidence on the optimum length of training for it to be effective or the frequency of retraining needed to maintain skills.

Individual states and territories, and Local Health Districts have introduced standardised team training programs to encourage a culture of continuous improvement. For example, SA Health has obtained a licence to deliver the Team STEPPS® (Team Strategies and Tools to Enhance Performance and Patient Safety) program for South Australian health service organisations and NSW Health facilitates the Team Stripes framework and In Safe Hands program. There has also been work internationally to improve teamwork and collaboration through the use of multidisciplinary team rounds.⁵⁴

The Commission undertook a scoping study to understand best practice in relation to the acquisition and maintenance of effective clinical communication, collaboration and teamwork skills for health care providers. Further information is available on the website.

Patient, family, carers and other support people

Many actions in the NSQHS Standards require organisations to meet the information needs of patients, families, carers and other support people.¹ Integration of patient education into comprehensive care plans has been found to improve the prospects for optimal patient outcomes and the effectiveness of education by nurses.^{55,56} Patient education should ideally be structured, culturally appropriate, and individually targeted to the patient's needs, preferences and circumstances. It is important to individualise patient education by assessing the patient's learning needs, and tailoring the delivery to their preferences and health literacy. Effective patient education is facilitated by knowing the patient and their goals of care. Awareness of what matters to a patient enables the clinician to use motivational interviewing techniques when providing education.

A number of tools and strategies can be implemented to aid patient education. Computer-assisted technology, videos, audio recordings, written materials and lectures can be effective, demonstrating positive outcomes for patient knowledge, anxiety and satisfaction.⁵⁵ Verbal instruction and discussions are the least effective methods of patient education. Other teaching strategies should be used in conjunction with verbal teaching, such as the use of illustrations or demonstration. Patient education can be evaluated using teach-back techniques to ensure that the patient has a clear understanding of what has been communicated to them.



Conclusion

To ensure that patients receive coordinated delivery of the total health care required or requested, health service organisations need to have systems and processes to ensure that care provided meets the agreed clinical and personal goals of care as described in the comprehensive care plan.

Important features that influence care delivery include:

- Supporting safety culture
- Encouraging communication, collaboration and teamwork
- Practicing evidence-based care
- Providing education, training and development.

Health service organisations should consider reviewing where gaps in these features are evident and employ quality improvement processes to successfully deliver comprehensive care.

Appendix 1: Characteristics of effective multidisciplinary teams linked with relevant actions in the National Safety and Quality Health Service (NSQHS) Standards (second edition)

Characteristic	Description	Relevant actions in the NSQHS Standards (2nd ed.)
Leadership and management	Having a clear leader of the team, with clear direction and management; democratic; shared power; support/supervision; personal development aligned with line management; leader who acts and listens	1.1, 1.2, 1.3, 1.4, 1.5, 1.6
Culture and climate (and trust)	Team culture of trust and respect, valuing contributions, nurturing consensus, reciprocity; need to create a multidisciplinary atmosphere. Also encompasses respect for the person receiving care, including their goals, preferences and cultural beliefs	1.1, 1.2, 1.33, 2.3, 2.4, 2.5, 2.6, 2.7
Appropriate resources and procedures	Structures (e.g. team meetings, organisational factors, team members working from the same location); ensuring that appropriate procedures are in place to uphold the vision of the service (e.g. communication systems, appropriate referral criteria)	1.7, 5.4, 5.5, 5.6, 6.1, 6.4, 8.6, 8.7, 8.8, 8.9, 8.11, 8.12, 8.13
Clarity of vision	Having a clear set of values that drive the direction of the service and the care provided. Portraying a uniform and consistent external image	2.6, 2.7, 5.13, 5.30
Respecting and understanding roles	Understanding who is part of the team; clear roles, responsibilities and accountabilities; sharing power; joint working; autonomy and flexibility	1.6, 1.25, 1.26, 5.5, 5.6
Effective communication	Individuals with effective communication skills; ensuring that there are appropriate systems to promote communication within and between teams. This can include consistent communication channels for candid and complete communication, which is accessed by all team members across settings	2.8, 2.9, 2.10, 4.12, 5.4, 5.17, 5.32, 6.4, 6.7, 6.8, 6.9, 6.10, 6.11, 7.5, 8.5, 8.6, 8.7, 8.8, 8.9
Appropriate skill mix	Sufficient and appropriate skills, competencies, practitioner mix, balance of personalities; ability to make the most of other team members' backgrounds; having a full complement of staff and timely replacement/cover for empty or absent posts	1.15, 1.23, 1.24, 4.4, 5.16, 8.10

Characteristic	Description	Relevant actions in the NSQHS Standards (2nd ed.)
Personal satisfaction, training and development	Learning; training and development; training and career development opportunities; incorporates individual rewards and opportunity; morale and motivation	1.19, 1.20, 1.21, 2.14, 5.18
Individual characteristics	Knowledge, experience, initiative, knowing strengths and weaknesses; listening skills; reflexive practice; desire to work on the same/shared goals	1.22
Quality and outcomes of care	Patient-centred focus; improved outcomes and satisfaction; encouraging feedback; capturing and recording evidence of the effectiveness of care and using that as part of a feedback and quality improvement cycle to improve care	1.8, 1.9, 1.13, 1.14, 2.11, 2.13, 5.19

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.⁵⁷

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.⁵⁸

diagnosis: the identification by a medical provider of a condition, disease or injury, made by evaluating the symptoms and signs presented by a patient.⁵⁹

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 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.

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.⁶⁰

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.⁶¹

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.

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.⁶²

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.⁶³ Multidisciplinary care includes interdisciplinary care. (A discipline is a branch of knowledge within the health system.⁶⁴)

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.⁶⁵ 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.⁶⁶ 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.⁶⁷

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

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.⁶⁸ Quality improvement activities may be undertaken in sequence, intermittently or on a continuous basis.

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.⁶⁹

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.

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.⁷⁰

training: the development of knowledge and skills.

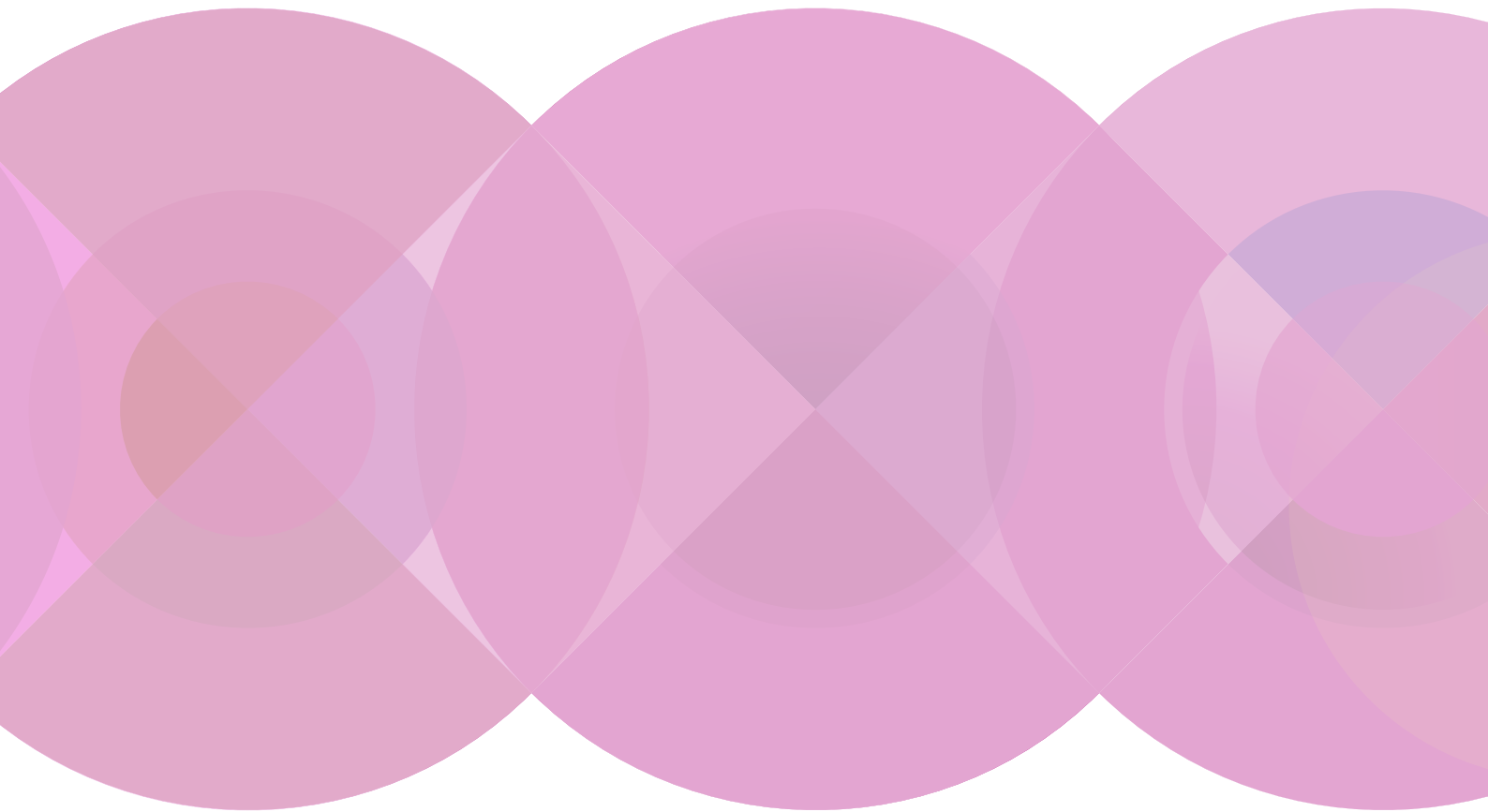
workforce: all people working in a health service organisation, including clinicians and any other employed or contracted, locum, agency, student, volunteer or peer workers. The workforce can be members of the health service organisation or medical company representatives providing technical support 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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