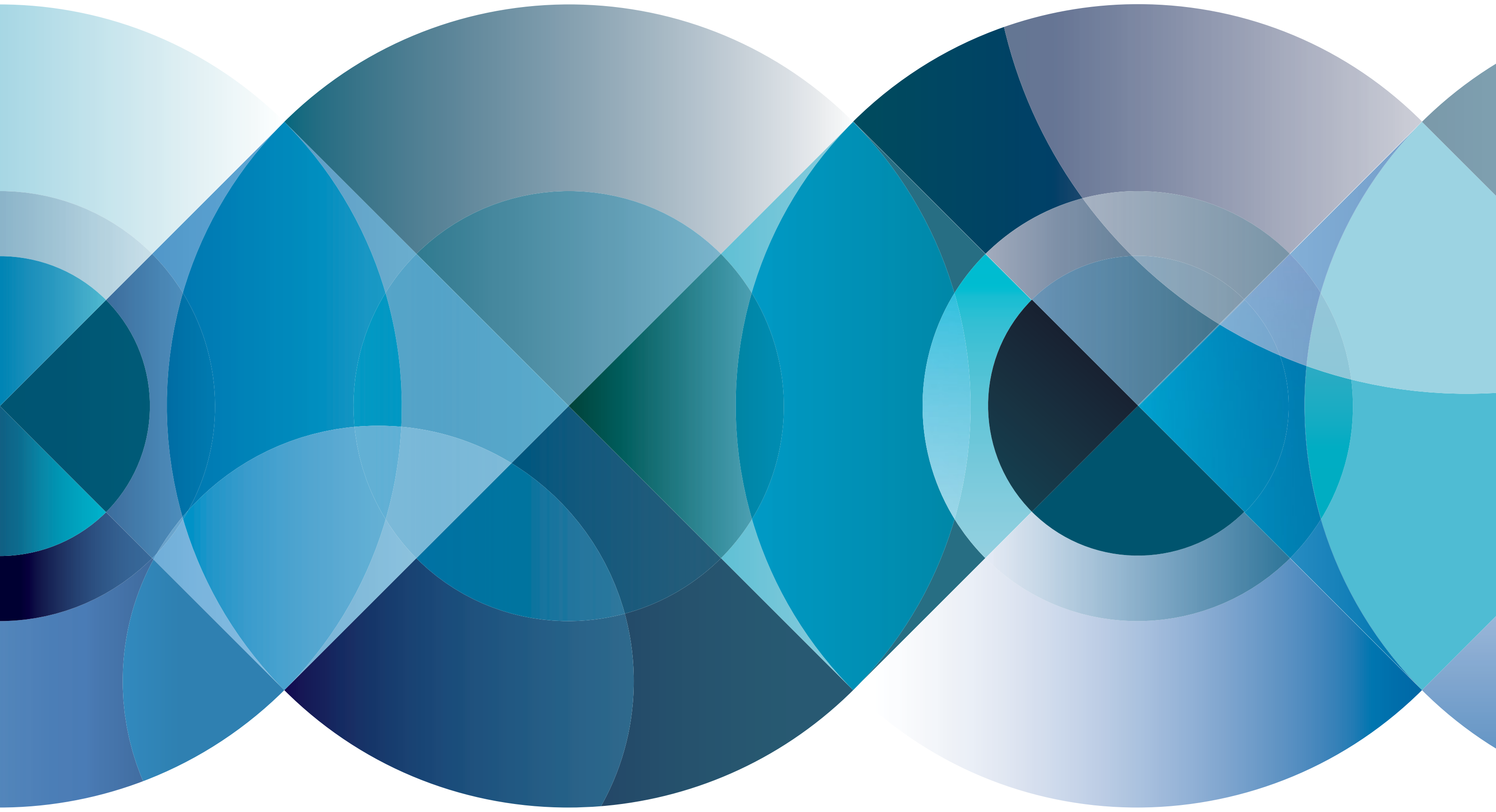
AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

National Safety and Quality
**Primary and Community**
**Healthcare Standards**



## National Safety and Quality Primary and Community Healthcare Standards

# Guide for Healthcare Services

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Level 5, 255 Elizabeth Street, Sydney NSW 2000 Australia
Phone: +61 2 9126 3600
Email: **mail@safetyandquality.gov.au**
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# About the Commission

The Australian Commission on Safety and Quality in Health Care (the Commission) leads and coordinates national improvements in the safety and quality of health care. The Commission works in partnership with the Australian Government, state and territory governments and the private sector to achieve a safe, high-quality and sustainable health system. In doing so, the Commission also works closely with patients, carers, clinicians, managers, policymakers and healthcare organisations.

Key functions of the Commission include:

- Developing **national safety and quality standards**
- Developing **clinical care standards** to improve the implementation of evidence-based healthcare
- Coordinating work in specific areas to improve outcomes for patients
- Providing information, **publications and resources** about safety and quality.

The Commission works in four priority areas:

- Safe delivery of health care
- Partnering with consumers
- Partnering with healthcare professionals
- Quality, value and outcomes.

# Introduction

The **National Safety and Quality Primary and Community Healthcare Standards** (Primary and Community Healthcare Standards) were launched in October 2021. They aim to protect the public from harm and improve the quality of health care delivered through a nationally consistent framework, which all primary and community healthcare services can apply when delivering health care. They describe elements shared by all safe, high-quality healthcare services.

There are three Primary and Community Healthcare Standards that cover clinical governance, partnering with consumers and clinical safety.

**Clinical Governance Standard**, where clinical governance is the set of relationships and responsibilities established by a healthcare service to ensure good clinical outcomes. It ensures that the community and healthcare services can be confident that systems are in place to deliver safe and high-quality health care, and continuously improve services.

**Partnering with Consumers Standard**, which describes the systems and strategies to create a person-centred healthcare service in which patients and consumers are:

- Included in shared decision making
- Partners in their own health care
- Involved in the development and design of quality healthcare services.

**Clinical Safety Standard**, which considers specific high-risk areas of health care commonly encountered that need to be addressed and mitigated.

The Clinical Governance Standard and the Partnering with Consumers Standard set the overarching requirements, or clinical governance framework, for the effective implementation of the third Clinical Safety Standard.

## Where do the Standards apply?

The Primary and Community Healthcare Standards apply to services that deliver health care in a primary and/or community setting. These services address the prevention, treatment and management of illness and injury, and the preservation of physical and mental wellbeing. They vary in size and modes of delivery and are carried out by a diverse range of healthcare providers.

Healthcare services directly involved in patient care are strongly encouraged to implement the Primary and Community Healthcare Standards.

Accreditation, where independent assessment of implementation occurs, is voluntary unless required to satisfy regulatory or contractual obligations. Accredited healthcare services will be able to display a certificate of accreditation and accreditation badge, which will be identifiable to the public.

If your healthcare service is accredited to a profession-specific standard, such as general practice and community pharmacy, these should align with the Primary and Community Healthcare Standards. This will ensure a nationally consistent approach and give patients and consumers confidence they are accessing safe and high-quality health care, wherever health care is delivered.

For more information and resources about the Primary and Community Healthcare Standards, including assessment and accreditation, visit the **Commission's website**.

# About this Guide

The Commission has developed the National Safety and Quality Primary and Community Healthcare Standards Guide for Healthcare Services (the Guide) to provide support for healthcare services implementing the Primary and Community Healthcare Standards. It includes practical guidance and examples of evidence that can be used to implement the actions in a way that is appropriate to the healthcare service.

The Commission may develop context-specific user guides where additional guidance is required due to the specific context of some healthcare services (for example, for healthcare services located in rural or remote areas or healthcare services providing disability services). The user guides may assist healthcare services to improve the safety and quality of care they provide by using the Primary and Community Healthcare Standards as a framework for improvement.

The Guide is general in nature and is not intended as a profession-specific resource. Additional resources and supports may also be available from your local Primary Health Network, consumer groups or professional organisations such as the Australian Dental Association.

# How to use this Guide

Every effort has been made to ensure this Guide is relevant to the broad range of primary and community healthcare services operating in Australia.

**The suggested key tasks and examples of evidence are not mandatory or exhaustive**. Healthcare services will need to select and adapt strategies to suit their individual contexts. A healthcare service can implement alternative strategies specific to its scope of services, location, consumer needs, the risk profile of its patient population and its priorities for improvement.

The type and comprehensiveness of evidence used is dependent on each healthcare service context and the content and complexity of the policies and processes will likely depend on the size of the healthcare service. For example, a sole provider may have a simple document to describe its processes whereas a large healthcare service may require a more comprehensive documentation of protocols or processes.

**DISCLAIMER**: A controlled version of the Guide is available online as a **web document**. Downloaded and hardcopies are uncontrolled. Please check the Commission's **website** regularly for updates to content and resources.

# Terminology

The following terminology has been adopted for clarity of purpose within the Primary and Community Healthcare Standards and the Guide. **A full list of glossary definitions can be found at the end of the Guide**.

### 'Patient', 'client', 'person' or 'consumer'

The Primary and Community Healthcare Standards use the term 'patient' to refer to a person or group receiving healthcare services and the term 'consumer' to refer to a person who has used or may use a healthcare service, or a consumer representative or advocate. The term 'patient' encompasses all other relevant terms that may be used in primary and community health care including 'client', 'person', and 'people with lived experience of specific areas of ill health'.

### 'Healthcare provider', 'health practitioner' or 'clinician'

The Primary and Community Healthcare Standards use the term 'healthcare provider' to describe trained individuals who are involved in the provision of health care in a primary and/or community healthcare setting. Healthcare providers may also be referred to as 'health practitioners' or 'clinicians', or by a profession-specific description, for example, 'dental practitioner' or 'speech pathologist'.

**‘Healthcare service’**

The Primary and Community Healthcare Standards use the term ‘healthcare service’ to describe primary and community healthcare services, as well as other services involved in the delivery of health care to patients and consumers.

Healthcare services are delivered in a wide range of settings and vary in size and organisational structure. These range from owner-operated services – where a single healthcare provider is also responsible for administrative and management operations – to complex organisations comprising of many healthcare providers, a supporting workforce, management and an overarching governing body. Where the term ‘healthcare service’ is used in the actions, this refers to those responsible for leading and governing the service.

**‘Healthcare’ versus ‘health care’ versus ‘care’**

Throughout this document, the Commission has used the words ‘health care’ when referring to a noun (for example, ‘the state of health care in Australia’) and ‘healthcare’ when referring to an adjective (for example, the ‘healthcare system’ or ‘healthcare services’). Where the word ‘care’ is used and is not preceded by a qualifying word (for example, episode of care, comprehensive care), this encompasses broader elements of care (for example, personal or social care).

**‘Systems’**

The Primary and Community Healthcare Standards rely on healthcare services establishing safety and quality systems. A system includes the resources, policies, processes and procedures that are organised, integrated, regulated and administered to accomplish a stated goal. Safety and quality systems will vary depending on the size of the healthcare service and the risks associated with the services being delivered.

# Resources

The resources listed in the Guide under ‘Where to go for more information’ are not exhaustive. The inclusion of a resource in this guide should not be taken as endorsement by the Commission.

Many Commission resources were developed prior to the release of the Primary and Community Healthcare Standards and are based on National Safety and Quality Health Service (NSQHS) Standards. Both standards are aligned in structure and intent, and the principles and strategies outlined are broadly applicable. Over time, resources may be updated.

# Find out more

For more information or to access the online version of the Guide, visit safetyandquality.gov.au/pchs or contact the Safety and Quality Advice Centre

**Email**: AdviceCentre@safetyandquality.gov.au

**Telephone**: 1800 304 056

# Clinical Governance Standard

Healthcare services have a responsibility to the community for continuous improvement of the safety and quality of their services, and ensuring they are person-centred, safe and effective.

## Consumer outcome

*I am confident the healthcare service is well run and that I will receive safe, high-quality health care.*

## Intention of this standard

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

# Governance, leadership and culture

## Consumer outcome

*The healthcare service is high quality and continuously makes improvements.*

### Intention of this standard

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

## Governance, leadership and culture

### Action 1.01

The healthcare service:

a. Has a culture of safety and quality improvement
b. Partners with patients, carers and consumers
c. Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce
d. Establishes and maintains a clinical governance framework
e. Clearly defines the safety and quality roles, responsibilities and accountabilities of those governing the healthcare service, management and the workforce
f. Monitors and reviews the safety and quality performance of the healthcare service
g. Considers the safety and quality of health care for patients in its business decision-making
h. Establishes and maintains systems for integrating care with other service providers involved in a patient's care.

## Explanatory notes

Clinical governance is fundamental to ensuring your healthcare service delivers safe, high-quality health care to patients. It involves your healthcare service establishing, using and continuously improving the quality of their services and minimising risks to patient safety.[1]

Clinical governance is the set of relationships and responsibilities established by a healthcare service between regulators and funders, owners and managers, healthcare providers, patients, consumers and other stakeholders to ensure good clinical outcomes. It ensures:

- The community can be confident systems are in place to deliver safe and high-quality health care
- There is a commitment to continuously improve services
- The healthcare service and its workforce are accountable to patients and the community for ensuring the delivery of safe, effective and high-quality health care.

### Clinical governance framework

Your healthcare service's clinical governance framework describes the safety and quality systems and processes, which, when they are in place, ensure the delivery of safe, high-quality health care.

By implementing the actions in the Clinical Governance Standard and the Partnering with Consumers Standard, your healthcare service will develop its own clinical governance framework. Clinical governance consists of five key components:

- A culture of safety and quality
- Safety and quality improvement systems
- Clinical performance and effectiveness; from a workforce with the right skills and qualifications to deliver high-quality patient care
- Safe environment for the delivery of health care
- Partnering with patients and consumers.

A 'system' is a way of describing all the components that together make up an approach to managing an issue. A system includes resources, policies, processes and procedures that are organised, integrated, regulated and administered to achieve an outcome.

### Governance, leadership and culture

Governance, leadership and culture form a central driver of clinical governance. Healthcare services that demonstrate a culture of safety and quality improvement have strong leadership that prioritises safety and quality. Commitment from leaders is key; their actions and attitudes influence the perceptions, attitudes and behaviours of everyone in the healthcare service. Other important aspects include:

- Shared perceptions of the importance of safety
- Accountability
- Constructive communication
- Mutual trust
- A workforce that is engaged and always aware that things can go wrong
- Acknowledgement at all levels that mistakes can occur
- Ability to recognise, respond to, give feedback about and learn from adverse events, compliments, complaints, data and new models of care.[2]

## Reflective questions

- How are continuous improvement opportunities identified, prioritised, reported and actioned?
- How do you involve the workforce in your healthcare service's safety and quality improvement processes?

## Key tasks

- By understanding the safety and quality risks and performance of your healthcare service, identify the priority areas for safety and quality and the time required for the change to occur. Communicate these priorities to others in your healthcare service.
- Establish mechanisms for incorporating safety and quality of health care into the healthcare service's business decision-making.
- For the people in your healthcare service, describe their safety and quality roles and responsibilities.

Note: the way responsibilities are assigned depends on the size of your healthcare service, whether your healthcare service is in a rural or remote area and the safety and quality risks involved.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Description of safety and quality roles and responsibilities of members of the workforce in your healthcare service
- Summary of safety and quality improvement priorities
- Communications with your workforce about safety and quality priorities, such as emails, entries in a staff communications book, pin-board notice
- Position descriptions describing the safety and quality roles and responsibilities for each member of the workforce
- Policies, protocols or documented process that detail how healthcare providers work together in a patient's care, within or between another service
- Minutes of meetings, notes on business decisions that consider where patient safety and quality can be improved
- Documented clinical governance framework
- Demonstration of shared leadership and collaborative teamwork in multidisciplinary healthcare teams in rural and remote settings
- Annual declaration confirming compliance to the Primary and Community Healthcare Standards.

## Where to go for more information

### Commission resource

- **National Model Clinical Governance Framework** provides guidance on roles and responsibilities, based on the NSQHS Standards. The principles and strategies outlined are broadly applicable.

### Other resource

- BMC Primary care: ***Patient safety and safety culture in primary health care: a systematic review*** – a study reviewing the literature on the safety culture and patient safety measures used globally to inform the development of safety culture among health care workers in primary care.

# Patient safety and quality systems

## Consumer outcome

*I know the health care I receive is well organised and my feedback will be heard and dealt with.*

### Intention of this standard

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

## Policies and procedures

### Action 1.02

The healthcare service uses a risk management approach to:

a. Establish and maintain policies, procedures and protocols
b. Make policies, procedures and protocols easily available to the workforce
c. Monitor and take action to improve adherence to policies, procedures and protocols
d. Ensure compliance with relevant safety and quality legislation, regulation and jurisdictional requirements.

### Explanatory notes

Policies, procedures and protocols are important tools to describe a healthcare service's agreed ways of working. They form an integral part of its clinical governance framework. They should:

- Address how safety and quality risks are identified, prioritised, minimised or eliminated
- Support compliance with safety and quality legislation, regulation and jurisdictional requirements
- Be based on evidence and best practice
- Be implemented consistently throughout the healthcare service, with implementation monitored
- Be regularly reviewed to identify whether there are areas for improvements
- Be updated when improvements are identified and improvements implemented.

Policies, procedures and protocols relating to safety and quality may also be relevant to your healthcare service's legal, jurisdictional and business obligations. For certain healthcare services, integrating these systems may be appropriate. At all times, your healthcare service must adhere to regulatory requirements as prescribed in relevant Commonwealth, state and territory legislation, such as work health and safety obligations.

The content and complexity of the policies, procedures and protocols will vary depending on the size of healthcare services. Sole providers may describe their safety and quality policies, procedure and protocols in a simple format whereas large healthcare services may require more comprehensive documentation.

## Reflective questions

- What policies, procedures and protocols are available in your healthcare service? What safety and quality risks do they seek to reduce or eliminate?
- How does the workforce access and use policies, procedures and protocols?
- How is the implementation of policies, procedures and protocols monitored and reviewed to identify areas of improvement?

## Key tasks

- Develop safety and quality policies, procedures and protocols relevant to reducing or eliminating safety and quality risks in the healthcare service.
- Support the workforce to implement policies, procedures and protocols, including making them easily accessible.
- Implement a schedule to monitor, review and update policies and procedures using a risk management approach.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Policies, procedures and protocols that aim to reduce or eliminate safety and quality risks
- Observation that demonstrates policies and procedures are easily accessible by the workforce and used in everyday practice
- Documented changes to policies, procedures and protocols implemented following the monitoring and review of implementation and identification of improvements.

## Where to go for more information

### Commission resource

- **National Model Clinical Governance Framework** – provides guidance on policies, procedures and protocols, based on the NSQHS Standards. The principles and strategies outlined are broadly applicable.

# Measurement and quality improvement

## Action 1.03

The healthcare service uses a range of data to:

a. Identify priorities for safety and quality improvement
b. Implement and monitor safety and quality improvement activities
c. Measure changes in safety and quality outcomes
d. Provide timely information on safety and quality performance to patients, carers and families and the workforce.

## Explanatory notes

### Data to support safety and quality improvement

Measurement and feedback are key to quality improvement. Data are fundamental to measurement and can be used to identify areas where a healthcare service is doing well and areas where improvement is required. At a healthcare service level, data that can be used to inform measurement for quality improvement may include:

- Data relating to types of services provided
- Patient information, such as the number of appointments over a period of time, reasons for seeking advice/treatment, improvements in health outcomes over time
- Feedback from patients including experiences, compliments and complaints
- Information collected from the workforce about their experiences
- Incidents, near misses and adverse events
- Attendance and appointment data, patient enquiries or community demographics, or other data that is relevant to the healthcare service. Some healthcare services may be required to collect data as part of a contract or agreement, which may also be used to identify safety and quality improvement priorities.

Relevant data will differ between healthcare services and will depend on the safety and quality priorities identified. No single measure should be used in isolation to assess the safety and quality of a healthcare service. Instead, a comprehensive measurement and improvement system should be adopted.

### Validated indicators, measurement and reporting tools

The Commission undertakes a range of projects to support the meaningful use of data to improve patient care and is working to develop tools and resources that support healthcare services to use data for quality improvement.

### National Primary Healthcare Data

The Australian Institute for Health and Welfare (AIHW) is leading the development of a Primary Health Care Information System, including the development of a National Primary Health Care Data Asset, to gain a better understanding of a patient's journey and experiences within the primary healthcare system.[3,4] This work will help fill existing aggregate primary healthcare data gaps at regional and national levels, to enable identification of trends and priorities for safety and quality improvement.

In addition, data provided to Primary Health Networks can be used to inform service and system planning at local and regional levels.

## Reflective questions

- What data does your healthcare service use to identify areas for improvement?
- What changes have been made in your healthcare service as a result of the review of data?
- What impact, if any, have changes that have been implemented made? How was this impact measured?
- How is information about your service's safety and quality performance communicated to patients, carers and families and the workforce?

## Key tasks

- Identify and collect data within your healthcare service that can be used to inform the safety and quality improvement priorities for the service.
- Routinely review data collected to identify areas for improvement and take action to make continuous improvements.
- Measure changes in safety and quality outcomes as a result of improvements implemented.
- Communicate information of the service's safety and quality to patients, carers and families and the workforce.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context, but could include:

- Data collected and reviewed to identify safety and quality improvements
- Examples of changes made within the healthcare service as a result of the review of data and improvements made
- Examples of how information about your service's safety and quality is communicated to patients, carers and families and the workforce, for example
  - certificates of safety and quality performance displayed in common service areas
  - information on notice board in workforce areas
  - communication books or meeting records.

## Where to go for more information

### Commission resource

- **Clinical Care Standards** – recommended indicators and data sets within relevant clinical care standards, which aim to support implementation of quality standards for specific clinical conditions.

### Other resources

- Australian Institute of Health and Welfare: **Primary health care data development** – information about the AIHW's project that will encompass the governance, standards, infrastructure, collection, analysis and reporting of primary health care data within Australia.
- BMJ Journals, quality and care: ***How safe is primary care? A systematic review*** – the review investigated how often patient safety incidents occur in primary care and how often these were associated with patient harm.
- Institute for Healthcare Improvement: **Plan, Do, Study, Action (PDSA) Worksheet** – a useful tool for documenting a test of change.
- Pride in Health + Wellbeing: **Getting Better Audit tool** – a free tool to measure your healthcare service's LGBTQI+ inclusion.

- South Eastern Melbourne Primary Health Network: **Quality Improvement** – an overview of key requirements and resources to support quality improvement
- World Health Organization: **Primary health care measurement framework and indicators: monitoring health systems through a primary health care lens** – a conceptual framework for measuring primary health care performance at a health system level, including a menu of indicators to track and monitor progress, and identify gaps and areas for improvement.

## Risk management

### Action 1.04

The healthcare service:

a. Supports the workforce to identify, mitigate and manage safety and quality risks
b. Documents and routinely monitors safety and quality risks
c. Plans for, and manages, ongoing service provision during internal and external emergencies and disasters.

## Explanatory notes

### Risk management

Risk management helps healthcare services make decisions to avoid or mitigate adverse events and outcomes. It involves implementing a continuous process to identify, mitigate and manage safety and quality risks.

Risks will differ between services and are dependent on the complexity associated with the services it delivers, as well as the size and scope of the healthcare service.

Examples of risks include:

- Cold chain failures in the storage of temperature-sensitive medicines
- Lack of privacy controls to protect patient healthcare records
- Loss of key utilities such as electricity.

### Access to technology such as electronic medical records

By using a risk management approach, healthcare services will identify, analyse, evaluate and treat risks to safety and quality in the service. By determining the best course of action to mitigate and manage safety and quality risks, healthcare services can use a general risk analysis matrix, such as the one in **Table 1**: Healthcare service risk analysis matrix.

**Table 1**: Healthcare service risk analysis matrix

| Likelihood | Consequences | | | | |
|---|---|---|---|---|---|
| | **Insignificant** | **Minor** | **Moderate** | **Major** | **Catastrophic** |
| Almost certain | Medium | High | High | Extreme | Extreme |
| Likely | Medium | Medium | High | High | Extreme |
| Possible | Low | Medium | Medium | High | High |
| Unlikely | Low | Low | Medium | Medium | High |
| Rare | Low | Low | Low | Medium | Medium |

| | |
|---|---|
| Low risk | Manage by routine procedures. |
| Medium risk | Manage by specific monitoring or audit procedures. |
| High risk | This is serious and must be addressed immediately. |
| Extreme risk | The magnitude of the consequences of an event, should it occur, and the likelihood of that event occurring, are assessed in the context of the effectiveness of existing strategies and controls. |

### Planning for emergencies and disasters

A risk management approach should be applied when planning for emergencies and disasters, for example, floods, fires and pandemics. Consider possible scenarios where disruption to service provision may occur and determine how these will be managed to ensure continuity of care for patients.

Links to Action 1.17 Safety and quality roles and responsibilities

## Reflective questions

- How do you identify the safety and quality risks in your healthcare service?
- How are these risks mitigated or managed, and documented?
- How do you prioritise risks?
- How will continuity of care for patients be managed in the event of an emergency or disaster?

## Key tasks

- Develop and implement a risk-management process to identify, manage and mitigate safety and quality risks.
- Identify risks to the service and document them in a central location accessible to the workforce.
- Support the workforce to understand, document and participate in managing risks using the service's orientation system, education, or other existing strategies.
- Maintain a risk register and regularly monitor risks and the strategies or activities that have been put in place to mitigate them.
- Clearly articulate the roles and responsibilities for identifying and managing risks and ensure those with responsibilities for taking action on risks have the training, knowledge and resources required to fulfil their responsibilities.
- Identify and plan for emergency or disasters scenarios and the risks that may be associated with these situations to ensure safety and high-quality care.

For certain healthcare services, it may be appropriate to integrate risk-management systems with other systems to meet safety and quality requirements, and legal and business obligations.

### Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of policies and processes will likely depend on the size of the healthcare service, but could include:

- Documented processes that describe how safety and quality risks are identified, managed, documented and monitored
- Risk register implemented and utilised by the workforce
- Training documents (for example, syllabus, attendance records, competency assessments) relating to risk management
- Emergency and disaster plans
- Business continuity plans.

### Where to go for more information

#### Commission resource

- Risk Management Approach – provides a framework to assess and address risks identified in the organisation.

#### Other resources

- Australian Government Business: ***Assess and manage risk*** – learn how to develop a risk management plan to prepare and protect your business.
- ISO Standards: ***31000:2018 Risk management – Guidelines*** – for use by people who create and protect value in organisations by managing risks, making decisions, setting and achieving objectives and improving performance.
- The New England Journal of Medicine Catalyst: ***What Is Risk Management in Healthcare?*** – looks at the systems and processes employed to uncover, mitigate and prevent risks in healthcare institutions.
- Your local Primary Health Network – may have guidelines, tools and resources to support your healthcare service prepare for emergencies and disasters, specific to your local area.

## Incident management and open disclosure

### Action 1.05

The healthcare service has an incident management system that:

a. Supports the workforce to recognise and report incidents
b. Supports patients, carers and families to communicate concerns or report incidents
c. Involves the workforce in the review of incidents
d. Provides timely feedback on the analysis of incidents to the workforce and patients, carers and families who have communicated concerns or incidents
e. Uses the information from the analysis of incidents to improve safety and quality
f. Incorporates risks identified in the analysis of incidents into the risk management system
g. Regularly reviews and acts to improve the effectiveness of the incident management and investigation systems.

## Explanatory notes

An incident management system is the way a healthcare service records and learns from safety and quality incidents, near misses and adverse events. It relies on a culture of reporting and review, so individuals and services can learn from previous adverse events and change their processes and systems to reduce the risk of them happening again.

The incident management system should include:

- A paper-based or electronic register where incidents can be recorded and tracked
- Training and support for the workforce to recognise, respond to and report incidents
- Support for patients, carers and families to communicate concerns or report incidents
- A process for responding to and reviewing incidents that involves relevant members of the workforce and provides timely feedback to the workforce, patients, carers and families who have communicated concerns or incidents
- A process for regular analysis of incidents recorded to inform safety and quality improvement priorities and risks, and used to monitor and measure the healthcare service's performance
- A process to regularly review and improve the incident management system.

An incident register collects data that includes:

- Date of the incident
- A description of the incident, including timelines, where relevant
- Information on who was involved in the incident (including all workforce, patients, carers, family or visitors to the service such as contractors)
- A description of the harm, if any, the person experienced because of the incident, if known
- Action taken immediately following the incident to ensure the safety of staff, patients and the community (for example, an ambulance was called or urgent repairs to premises occurred)
- Details of open disclosure that occurred at the time of the incident, where applicable
- A statement about to whom the incident was reported, where applicable
- Name (and contact details, if needed) of the person who reported the incident – this may be a member of the workforce, patients, carers, family or visitors
- Name (and contact details, if needed) of the person who documented the incident.

When reviewing incidents, for safety and quality improvements, healthcare services should consider what changes or additional actions could be introduced to prevent the incident occurring again.

**Links to Actions 1.04 Risk management and 1.02 Policies and procedures**

## Reflective questions

- How does your healthcare service identify, report, document and manage incidents?
- How are patients, carers and families supported to communicate concerns or report incidents?
- How could the incident management system be improved?

## Key tasks

- Implement an incident management system.
- Train the workforce to use the incident management system, including types of incidents, risks and near misses that must be reported.
- Inform patients about how they can report risks, incidents or concerns.
- Regularly review incident data, and identify learnings from incidents that could be implemented to drive improvements in safety and quality.
- Periodically review the incident management system to identify areas of improvement.

For certain healthcare services, it may be appropriate to integrate incident management systems with other systems to meet safety and quality requirements, and legal and business obligations.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context, but could include:

- Description of how your service identifies, reports, documents and investigates incidents, near misses and adverse events
- Examples of reports on incidents, near misses and adverse events identified in the service, and the actions taken to manage identified risks
- Training documents (for example, syllabus, attendance records and competency assessments) relating to recognising, reporting, investigating, recording and analysing incidents, near misses and adverse events
- Meetings or communication records where discussion occurred about incidents and the strategies and actions taken to address identified risks
- Information and resources, including incident reporting forms and tools, that are accessible to the workforce and patients
- Records of improvements made from incidents
- Records of risks identified from the analysis of incidents
- Evidence of incident management reviews.

## Where to go for more information

### Commission resource

- ***Incident management guide*** – provides a concise overview of the incident management process and its underlying principles.

### Other resource

- Allied Health Professions Australia: **Incident Management (Allied Health National Insurance Disability Scheme [NDIS] Support)** – provides resources to support healthcare providers establish incident management systems under the National Disability Insurance Scheme. Can be used as example policies and forms.

## Action 1.06

The healthcare service uses the Australian Open Disclosure Framework when a patient is harmed through the delivery of health care.

## Explanatory notes

Healthcare service providers should use the Australian Open Disclosure Framework whenever patients are harmed during the delivery of health care. 'Open disclosure' describes the process of the healthcare provider having an open discussion with the patient, carers and the patient's family about adverse events that resulted in harm to the patient while receiving health care. Further information on open disclosure, including applicability for sole practitioners and small practices is available on the **Commission's website**.

Elements of open disclosure in the framework are:

- An apology or expression of regret, which should include the words 'I am sorry' or 'we are sorry'
- A factual explanation of what happened
- An opportunity for the patient who has experienced harm or an unexpected event, and/or their carers and family to relate their experience
- A discussion of the potential consequences of the adverse event
- An explanation of the steps being taken to manage the adverse event and prevent recurrence.

In using the framework, healthcare services should:

- Foster a culture that supports and prioritises open disclosure processes as part of good clinical care
- Determine how open disclosure processes are implemented in the healthcare service, taking into consideration the principles and elements of the framework
- Support and provide open disclosure training, peer support and mentorship, including communications skills training that supports empathetic and respectful communication
- Ensure there is access to appropriate support for the workforce, people who have experienced harm and their support people
- Conduct continuous evaluation of open disclosure processes and feedback of results to the workforce, patients who have experienced harm and their support people for quality improvement
- Try to communicate lessons learned throughout the broader health system through existing mechanisms and relevant authorities, such as conferences or professional networks.

**Links to Actions 1.05 Incident management and 2.07 Accessing healthcare service information**

## Reflective questions

- Who is responsible for taking action when a patient is harmed during care in your service?
- How are the workforce trained and supported to implement open disclosure?

## Key tasks

- Adopt and implement the **Australian Open Disclosure Framework** when a patient is harmed in the delivery of care.
- Ensure that members of the workforce who will be involved in open disclosure are appropriately trained.
- Regularly review incidents, recorded in the incident management system against the healthcare service's processes and consistency with the Australian Open Disclosure Framework.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Policy documents that are consistent with the principles and processes outlined in the **Australian Open Disclosure Framework**, and which have been adopted and implemented in a way that reflects the context of service provision
- Meeting, communication records or records of an open disclosure
- Training documents (for example, syllabus, attendance records, competency assessments or role-play scenarios where open disclosure is required) relating to the open disclosure program.

## Where to go for more information

### Commission resources

- **Australian Open Disclosure Framework – Better communication, a better way to care** – the framework is designed to enable healthcare services and healthcare providers to communicate openly when health care does not go to plan.
- **Implementing the Australian Open Disclosure Framework in Small Practices** – a resource to assist sole healthcare providers and those working in small practices implement and practice open disclosure in accordance with the Australian Open Disclosure Framework.
- **Preparing and participating in open disclosure discussions** – a fact sheet for consumers and carers.
- **Open disclosure – what to expect if you experience harm during health care?** – a fact sheet for consumers and carers.

# Feedback and complaints management

## Action 1.07

The healthcare service:

a. Seeks feedback from patients, carers and families about their experiences and outcomes of health care
b. Has processes to regularly seek feedback from the workforce on their understanding and use of the safety and quality system
c. Uses feedback to improve safety and quality.

## Explanatory notes

Regular collection of patient feedback to inform safety and quality priorities is an important element of measuring the quality of care. This can be done using feedback forms, informal conversations with patients or follow-up telephone calls. Patient feedback can often be referred to as 'Patient-reported experience measures' (PREMs). These are derived from patients' responses to survey or interview questions about their recent experiences of services received at a healthcare service.

Similarly, feedback from the workforce about their understanding and use of safety and quality systems indicates a healthcare service's safety and quality culture and can be used to identify opportunities for improvement. Feedback may be sought through informal conversations, meetings or emails, surveys, performance discussions and information used to identify safety and quality training and development needs.

**Links to Actions 1.03 Measurement and quality improvement and 2.08 Partnerships in the planning, design, monitoring and evaluation of services**

## Reflective questions

- How and when is feedback sought from patients about their care?
- How and when is feedback sought from the workforce about their understanding and use of safety and quality systems?
- How has the feedback been used to improve care?

## Key tasks

- Regularly seek feedback from patients and the workforce and use this feedback to identify areas for safety and quality improvements.
- Implement changes to address improvement opportunities.

For certain healthcare services, it may be appropriate to integrate systems to seek and record feedback with other systems to meet safety and quality requirements, legal and business obligations.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context, but could include:

- Records of feedback, for example, survey responses and reports, notes from discussions with patients or the workforce, meeting or communication records, training and development plans
- Examples of safety and quality improvements made as a result of patient and/or workforce feedback.

## Where to go for more information

### Commission resource

- ***Australian Hospital Patient Experience Question Set*** – this is available in 20 languages, easy English, large print and braille. While originally designed for the hospital setting, the types of questions that could be used to collect patient feedback are broadly applicable.

### Other resources

- AIHW: ***Patient experiences in Australia by Primary Health Network (PHN)*** – a report providing national and primary health network level information on Australian adults' experiences with the health care system.
- Royal Australian College of General Practitioners (RACGP): ***Develop your own patient feedback methods and templates*** – a resource to support general practices implementing the *Standards for general practices 5th edition*. The methods and examples are broadly applicable.

Your profession-specific representative organisation may implement surveys for healthcare services to use in collecting feedback from patients.

## Action 1.08

The healthcare service:

a. Provides opportunities for its patients to report complaints
b. Has processes to address complaints in a timely way
c. Uses information from the analysis of complaints to improve safety and quality.

## Explanatory notes

Complaints from patients provide a unique opportunity to discuss with patients the care they have received, address any gaps in service delivery, and make improvements.

A well-designed complaints management system includes:

- A clear description of how patients can report complaints
- Opportunities for patients to submit complaints
- A process on complaints reporting, investigation and actions taken
- Description of the roles, responsibilities and accountabilities of the workforce in complaints management
- Processes for compliance with relevant state and territory mandatory reporting requirements
- Information on how complaints and complaints resolution are communicated to patients
- A process to analyse complaints in a timely way and improve safety and quality of care

- Mechanisms that link complaints management with other organisational processes and systems, including measurement and quality improvement, incident management system, open disclosure, risk management and policy development.

**Links to Actions 1.02 Policies and procedures; 1.03 Measurement and quality improvement; 1.04 Risk management; 1.05 and 1.06 Incident management and open disclosure; and 2.07 Accessing healthcare service information**

## Reflective questions

- How can patients, carers and families make a complaint in your service?
- How are complaints resolved in a timely manner?
- How are relevant members of the workforce, patients, carers and families involved in the review of complaints?
- How has your service learnt from the analysis of and action following complaints?

## Key tasks

- Implement a process for
  - patients to report complaints
  - your healthcare service to resolve complaints in a timely way
  - your healthcare service to analyse complaints to identify opportunities for improvement.

For certain healthcare services, it may be appropriate to integrate systems to report and manage complaints with other systems to meet safety and quality requirements, legal and business obligations.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Information on how patients may make complaints
- Complaints register that includes detail on the issues identified, people involved and actions taken to resolve complaints
- Policy documents that describe the processes for reporting, investigating and analysing complaints
- Examples of improvement activities that have been implemented in response to complaints.

## Where to go for more information

### Commission resources

- **Australian Charter of Healthcare Rights (second edition)** – describes the rights that people can expect when receiving health care. A range of resources are available to support the use of the Charter by healthcare services.
- **Your healthcare rights – Key contacts** – lists several organisations who may be able to advise or support you if you have a question about healthcare rights.

### Other resource

- Australian Health Practitioners Regulation Agency: **Concerns about practitioners** – information and resources for consumers, registered health practitioners, employers and health education providers.

## Patient populations and social determinants of health

### Action 1.09

The healthcare service identifies patient populations using its service at greater risk of avoidable differences in health outcomes, including:

a. People of Aboriginal and Torres Strait Islander origin
b. People with disability
c. People with diverse backgrounds.

### Explanatory notes

Understanding your patient population, inequities and the challenges these can cause is an important step in providing safe, high-quality health care that is appropriate for your local community.

Health inequities are systematic differences in the health status or in the distribution of health resources between different population groups. This arises from social conditions in which people are born, grow, live, work and age and can lead to further differences in health outcomes.[5,6] Examples of population groups that experience inequities include:

- People of Aboriginal and Torres Strait Islander origin
- People with disability – noting that intersectional needs and experiences may be due to a variety of factors
- People with diverse backgrounds – that is social, economic and geographic circumstances as well as their cultural backgrounds, religions, beliefs and practices, languages spoken, sexual orientation, gender identity and gender expression, and sex characteristics.

People can belong to multiple population groups, and there are intersections and tensions that must be considered.

Considering the trends of population groups accessing the service can inform the planning and delivery of health care for patients in a way that maximises access and seeks to overcome these challenges. In turn, this reduces the risk of avoidable differences in health outcomes.

**Links to Actions 1.10 Patient populations and social determinants of health; and 1.24 and 1.25 Safe environment**

## Reflective questions

- What are the local patient populations that access your healthcare service?
- What potential challenges do these population groups face that could have an impact on their health outcomes?

## Key task

- Identify patients in your healthcare service that are at risk of avoidable differences in health outcomes. This can be done via review of healthcare records and observation within the healthcare service, or by supporting patients to self-identify.

## Example of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context, but could include:

- A list of patient populations where health inequities exist and the potential challenges these population groups face that could have an impact on their health outcomes.

## Where to go for more information

### Resources

- Australian Bureau of Statistics Census data: **QuickStats and Community Profiles – search Census data** – useful resources including an interactive map to assist with search options.
- Australian Government Department of Health and Aged Care: **Your local Primary Health Network** – information about the population profile and location of your local Primary Health Network (PHN), plus links to tools.
- Pride in Health + Wellbeing: **Statistics** – provides the latest LGBTQI+ health statistics from research in the previous 12 months.

## Action 1.10

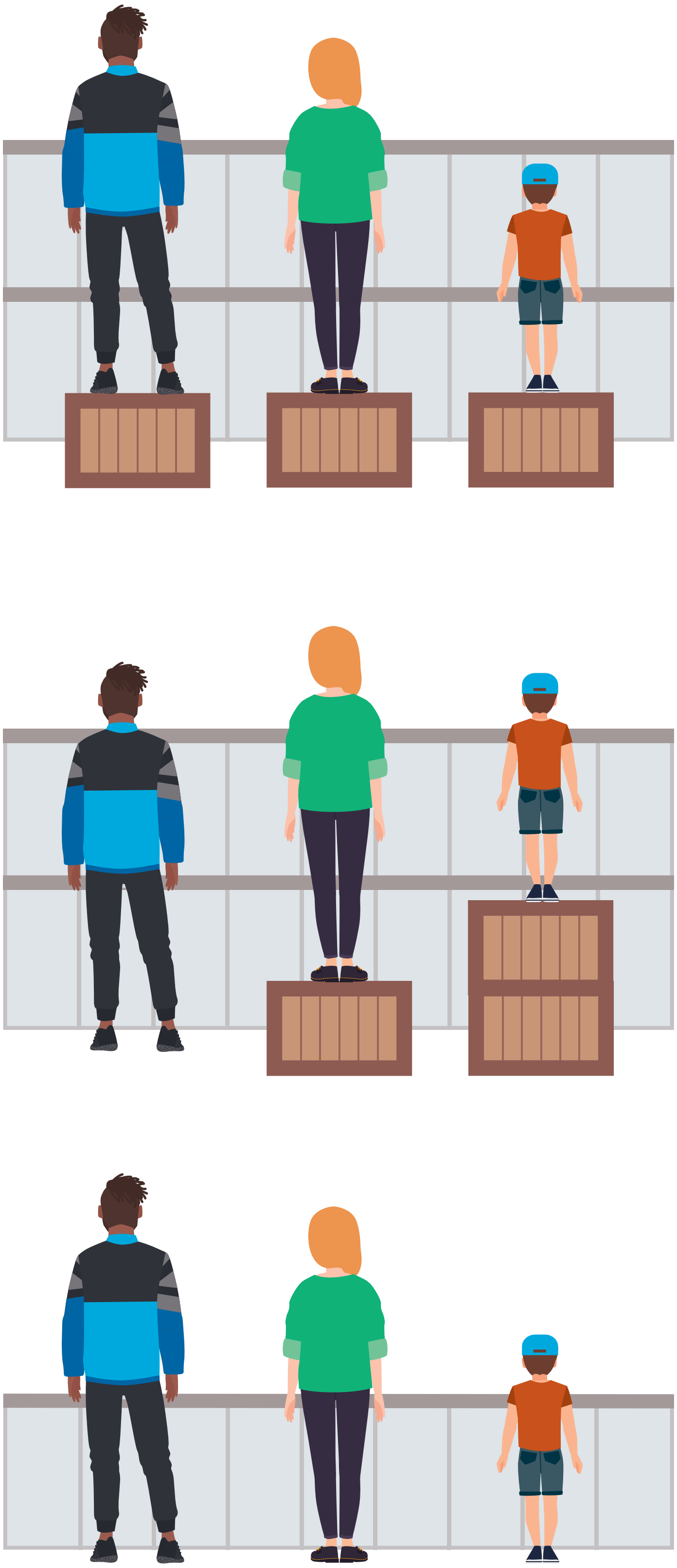
The healthcare service uses information on its patient populations to inform planning and delivery of health care for patients.

## Explanatory notes

Health inequities are systematic differences in the health status or in the distribution of health resources between different population groups, arising from social conditions in which people are born, grow, live, work and age. This can lead to further differences in health outcomes.[5,6]

Healthcare services have an important role to play in ensuring that healthcare providers consider information on population groups, and tailor care to achieve better health outcomes. **Figure 1** describes the impact of equality, equity and justice. In a healthcare setting, information on your patient populations and the inequities that exist can inform planning and delivery of health care to achieve better outcomes.

**Figure 1**: Demonstration of the differences between equality, equity and justice



**Equality**

The assumption is that **everyone benefits from the same supports.** This is equal treatment.

**Equity**

**Everyone gets the support they need** (this is the concept of ‘affirmative action’), thus producing equity.

**Justice**

All three can see over the fence without supports or accomodations because **the cause(s) of the inequity was addressed.** The systemic barrier has been removed.

Source: Assessing the Aboriginal and Torres Strait Islander actions in national safety and quality standards: Learner’s Guide (ACSQHC, 2022, unpublished)

Care should be planned and delivered that is tailored to meet patients' needs and preferences and ensure the principles of the *Australian Charter of Healthcare Rights (second edition)*[7] are applied.

## Reflective question

- How does your healthcare service tailor its care to meet the different needs of its patient population groups?

## Key tasks

- Use information on patient groups to identify challenges and barriers to health care and inform the planning and delivery of health.
- Provide access to training and or support for the workforce to improve awareness and understanding of patient population groups using your healthcare service.

**Links to Actions 1.09 Patient populations and social determinants of health; 1.24 Safe environment; 2.02 Healthcare rights and informed consent; and 2.06 Communication that supports effective partnerships**

## Examples of evidence

Examples of evidence will be dependent on patient populations identified in your healthcare service's locality, but could include:

- Amended processes or protocols
- Accessing resources or information packs in different languages
- Using an appropriately trained and credentialed interpreter. Interpreters may be required in Auslan, First Nations sign languages or spoken languages other than English
- Examples of referring a patient on to other service providers if health issues are identified that impact on the care your healthcare service is providing
- Hiring a workforce that speaks languages other than English to support communication with local community members
- Participation in programs to support services improve their inclusive care
- Adjustments to premises to support disability access including appropriate adaptations and remedial action to existing infrastructure.

## Where to go for more information

### Commission resources

The principles and strategies outlined in these resources are broadly applicable:

- **NSQHS Standards User Guide for Health Service Organisations Providing Care for Patients from Migrant and Refugee Backgrounds** – provides practical support for healthcare services where specific efforts or additional attention is required to meet the health needs of this patient population, based on the NSQHS Standards.
- **NSQHS Standards User guide for Aboriginal and Torres Strait Islander health** – provides practical support for the implementation of the Aboriginal and Torres Strait Islander-specific actions in the NSQHS Standards.

- **NSQHS Standards User Guide for health service organisations providing care for patients with cognitive impairment or at risk of delirium** – provides practical support for healthcare services where specific efforts or additional attention is required to meet the health needs of this patient population, based on the NSQHS Standards.
- **NSQHS Standards User Guide for health services providing care for people with mental health issues** – provides practical support for healthcare services where specific efforts or additional attention is required to meet the health needs of this patient population, based on the NSQHS Standards.
- **NSQHS Standards User Guide for acute and community health service organisations that provide care for children** – provides practical support for healthcare services where specific efforts or additional attention is required to meet the health needs of this patient population, based on the NSQHS Standards.

## Other resources

- Australian Federation of Disability Organisations: ***How to be Disability Inclusive*** – provides tips and examples for disability inclusion.
- Australian Government Department of Health: **National Roadmap for Improving the Health of People with Intellectual Disability** – aims to address serious health inequities faced by people with intellectual disability. It outlines how we can create a health system where people with intellectual disability are valued, respected and have access to high-quality, timely and comprehensive health care.
- Council for Intellectual Disability: **Resources for health practitioners** – resources for healthcare providers to support better appointments when working with people with intellectual disability.
- Dementia Australia: **Dementia-Friendly Communities** – ensures that people living with dementia are welcome, included and valued.
- Developmental Disability WA: **Resources** – provides current resources for people with disability, including online courses.
- NSW Government Agency for Clinical Innovation: **Intellectual Disability Network Resources** – relates to the care and health of people with intellectual disability across all ages, including acquired brain injuries by enhancing the capacity of primary and secondary health services.
- NSW Government Agency for Clinical Innovation: **Brain Injury Rehabilitation Network Resources** – relates to rehabilitation outcomes for adults, young people and children following traumatic brain injury.
- **Pride in Health + Wellbeing** – a national membership program that supports organisations within the Health, Wellbeing and Humans services sector to improve their LGBTQI+ inclusive care, remove systematic barriers to accessing care and thereby reduce health disparities faced by LGBTQI+ communities.
- CheckUP Australia: **Access for All** – a free online course funded by the National Disability Insurance Agency that aims to improve disability awareness among healthcare providers, and increase understanding about the barriers people with disability experience when accessing health care.
- Queensland Centre for Intellectual and Developmental Disability (QCIDD): **Resources** – provides current resources for people with intellectual disabilities and their support people.

# Healthcare records

## Action 1.11

The healthcare service has a healthcare record system that:

a. Makes the healthcare record available to healthcare providers at the point of care
b. Supports healthcare providers to maintain accurate and complete healthcare records
c. Complies with privacy and security regulations
d. Supports audits of healthcare records
e. Facilitates a patient's access to their healthcare record.

## Explanatory notes

Healthcare records provide one of the most important information sources available to healthcare providers. Undocumented or poorly documented information relies on an individual healthcare provider's memory and is less likely to be communicated and retained. This can lead to a loss of information, which can result in misdiagnosis, and inadequate or inappropriate treatment and harm.

Healthcare records can be paper-based, electronic or a mix of both. Irrespective of the form, an effective healthcare record system must be applied consistently. This includes:

- When creating, maintaining and using patient healthcare records
- Recording patient notes and relevant communications between healthcare providers
- Complying with relevant privacy and security regulations.

The records should be designed so they can be audited for clinical review and improvement. Healthcare services should have a process for patients to access their healthcare records.

For detailed information about what should be included in a patient's healthcare record, refer to the Explanatory notes in Action 3.26.

**Links to Actions 1.12, 1.13 and 1.14 Healthcare records and 3.26 Processes for effective communication**

## Reflective questions

- How do healthcare providers access healthcare records at the point of patient care?
- How are healthcare providers supported to record patient notes, file relevant communications with other healthcare providers and ensure healthcare records are complete, current and up to date?
- How are healthcare records stored securely?
- What processes are in place for auditing healthcare records?
- How can patients access their healthcare records?

## Key tasks

- Implement a process to create, maintain and use healthcare records that
  - makes healthcare records available to healthcare providers at the point of care
  - supports healthcare providers to maintain accurate and complete healthcare records
  - complies with privacy and security regulations.
- Conduct regular audits of healthcare records to identify areas for safety and quality improvement.
- Implement a process to facilitate a patient's access to their healthcare record when required or requested.
- Provide training to healthcare providers about the healthcare record system during orientation and refresher training as required.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Policy documents on healthcare record management, including access, storage, security, consent and sharing patient information
- Audit templates or reports on results of healthcare records for compliance with policies or procedures
- Demonstration or observation of how healthcare records are accessible at the point of patient care
- Training (for example, syllabus, attendance records, competency assessments) relating to the healthcare records system
- Documented information system management, data security and data breach protocols
- Observation of safe and secure storage systems for healthcare records, including evidence of fire protection and pest control strategies.

## Where to go for more information

### Resources

- Office of the Australian Information Commissioner: **Privacy in your state** – looks at what privacy laws apply in each state and territory and for private sector health service providers.
- Office of the Australian Information Commissioner: **Privacy for health service providers** – provides additional information about healthcare provider obligations.
- **Open Notes website**: information about an international movement advocating for improving how medical information is shared with patients and their care partners.
- The ***Privacy Act 1988*** (the Privacy Act) – outlines the privacy responsibilities that most healthcare providers have to comply with in managing health and personal information. The key requirements are contained in the **Australian Privacy Principles** (APPs).

## Action 1.12

The healthcare service has processes to:

a. Receive and review reports on patients
b. Recall patients and communicate about reports and health care options
c. Take action on reports in a timely manner
d. Document reports in a patient's healthcare record.

## Explanatory notes

Reports from other healthcare providers, such as patient referrals, medication reviews, pathology or diagnostic imaging results can be a critical component in determining the course of action in a patient's health care.

Ensuring a healthcare service has established processes to receive, review, act on and document reports on patients will minimise the risk of loss of information, which can result in misdiagnosis and harm. This should include processes for receiving and actioning urgent reports when a patient's healthcare provider is unavailable, or reports are received out of hours.

**Links to Actions 1.11, 1.13 and 1.14 Healthcare records and 3.26 Processes for effective communication**

## Reflective questions

- How are patient reports received, reviewed, actioned and documented in your healthcare service?
- What processes are in place to recall patients when needed to discuss patient reports, identified risks and subsequent health care options?

## Key tasks

- Implement a process to consistently
  - receive reports on patients and have reports reviewed by relevant healthcare providers and take action on reports in a timely manner
  - recall patients when required to discuss reports and subsequent health care options and risks
  - document reports in a patient's healthcare record.
- During orientation and/or when needed, explain to healthcare providers about processes to receive, action and record patients' reports.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Policies, procedures and protocols that describe
  - how patient reports are received, reviewed, actioned and documented in a timely manner
  - how patient recalls are managed
  - processes to communicate about patient reports and health care options
- Example of patient reports that have been received, reviewed, actioned and documented in a patient's healthcare record.

## Where to go for more information

Resources relating to this Action may be added as they become available.

# Action 1.13

The healthcare service using My Health Record has processes to:

a. Use national healthcare identifiers for patients and healthcare providers
b. Use standard national terminologies
c. Support healthcare providers to use My Health Record to optimise the safety and quality of health care for patients.

## Explanatory notes

**Note:** This action is only applicable if your healthcare service uses My Health Record.

My Health Record is a secure online summary of a patient's key health information and is available to all Australians.[8] Healthcare providers registered with My Health Record can upload and view patient information. This may include information uploaded by your patient's other healthcare providers, and this information can be used for planning and delivery of health care. Information available through My Health Record can include a patient's health summary, medication prescribing and dispensing history, pathology reports, diagnostic imaging reports and discharge summaries.[8]

Healthcare identifiers are unique numbers. They are used in health-related information to clearly identify the patient, the treating professional and the organisation where healthcare is provided. They reduce the potential for errors with healthcare related information and communication. In Australia, the **Healthcare Identifiers (HI) Service** is a national system for uniquely identifying, healthcare providers, healthcare organisations and individuals receiving healthcare. These include:

- Individual Healthcare Identifier (IHI) – identifies a patient (individual) receiving healthcare. An IHI uniquely identifies individuals who receive healthcare, including Australian citizens, permanent residents and visitors to Australia

- Healthcare Provider Identifier – Individual (HPI-I) – identifies an individual healthcare provider who provides healthcare, such as general practitioners and rural generalists, allied health professionals, specialists, nurses, dentists and pharmacists, among others
- Healthcare Provider Identifier – Organisation (HPI-O) – identifies the healthcare provider organisation where healthcare is provided, such as hospitals, medical practices, pathology or radiology laboratories and pharmacies. Healthcare providers must be registered with the HI Service and assigned healthcare identifiers to access a patient's My Health Record.

Standard national terminologies are structured vocabularies used in clinical practice to accurately describe the care and treatment of patients. Healthcare providers around the world use specialised vocabulary to describe diseases, operations, clinical procedures, findings, treatments and medicines. In Australia, terminologies include **SNOMED CT-AU and Australian Medicines Terminology (AMT)**.

Healthcare services that use My Health Record system must have processes to:

- Use national healthcare identifiers for patients and healthcare providers
- Use standard national terminologies when uploading patient reports and information
- Support healthcare providers to use My Health Record to optimise safe, high-quality health care.

**Links to Actions 1.11, 1.12 and 1.14 Healthcare records and 3.26 Processes for effective communication**

## Reflective questions

- How does using My Health Record in your healthcare service benefit patients?
- How is your service using national healthcare identifiers and standard national terminologies?
- How is the workforce supported to use My Health Record?

## Key tasks

- Develop and implement a process for the use of My Health Record that includes using unique national identifiers for patients, healthcare providers and healthcare service organisations in local information systems and in clinical documents loaded into the My Health Record system.
- Implement standard national terminologies such as AMT in healthcare records and clinical documents loaded to My Health Record.
- Support the workforce to use standard national terminologies when uploading to My Health Record by facilitating access, providing training and making resources available.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context, but could include:

- Evidence of registration with and contributions to My Health Record
- Documented processes for accessing and contributing to My Health Record using national healthcare identifiers and standard national terminologies
- Example of an entry by the healthcare service in My Health Record
- Training records relating to My Health Record (for example, syllabus, attendance records, competency assessments).

## Where to go for more information

### Resources

- Australian Digital Health Agency: **My Health Record** – provides a suite of training, resources and guides.
- National Clinical Terminologies Service: **What is clinical terminology?** – the service is operated by the Australian Digital Health Agency, and is responsible for managing, developing and distributing national clinical terminologies and related tools and services.
- Office of the Australian Information Commissioner: **Healthcare identifiers** – the OAIC is the independent regulator of the privacy aspects of the ***Healthcare Identifiers Act 2010*** (HI Act) and the **Healthcare Identifiers Regulations 2010** (HI Regulations).

## Action 1.14

The healthcare service providing clinical information to the My Health Record system has processes to:

a. Comply with legislative requirements
b. Ensure the accuracy and completeness of information uploaded.

## Explanatory notes

**Note:** This action is only applicable if your healthcare service uses My Health Record.

My Health Record is a secure online summary of a patient's key health information and is available to all Australians.[8] Healthcare providers registered with My Health Record can upload and view patient information, including information uploaded by other healthcare providers. This information can be used in the planning and delivery of health care. Information available through My Health Record can include a patient's health summary, medication prescribing and dispensing history, pathology reports, diagnostic imaging reports and discharge summaries.[8]

Healthcare services providing clinical information to My Health Record are required to comply with a range of legislative requirements, including:

- *My Health Records Act 2012*
- My Health Records Rule
- My Health Records (Assisted Registration) Regulation.[9]

More detailed information about these obligations is available on the **My Health Record** website.

As part of these obligations, your healthcare service must ensure clinical information uploaded is accurate and complete. Undocumented or poorly documented records can lead to a loss of information, which can result in misdiagnosis and harm.

Links to Actions 1.11, 1.12 and 1.13 Healthcare records and 3.26 Processes for effective communication

## Reflective questions

- How is information uploaded to My Health Record in your healthcare service?
- How is clinical information reviewed for accuracy and completeness before uploading to My Health Record?

## Key tasks

- Implement a process that can be used to upload relevant clinical information to My Health Record using compliant clinical software, ensuring information uploaded is accurate and complete.
- Provide training to healthcare providers on how to upload information to My Health Record.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Process for uploading clinical information to My Health Record, including steps to ensure accuracy and completeness of information uploaded
- Training documents (for example, syllabus, attendance records and competency assessments) on how to access and contribute to patient information in the My Health Record system
- Examples of clinical information uploaded by the healthcare service in My Health Record.

## Where to go for more information

### Resources

- Australian Digital Health Agency: **My Health Record** website – provides a suite of information and resources regarding viewing and uploading clinical information.

# Clinical performance and effectiveness

## Consumer outcome

*I get the healthcare services that I need from people who are qualified to provide my health care.*

### Intention of this standard

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

## Safety and quality training

### Action 1.15

The healthcare service:

a. Provides its workforce with orientation and training to their safety and quality roles on commencement with the service, when safety and quality responsibilities change and when new healthcare services are introduced
b. Identifies the training needs of its workforce to meet the requirements of these standards
c. Ensures its workforce completes training to meet its safety and quality training needs.

### Explanatory notes

Ensuring your workforce have (and keep updated) the right qualifications, knowledge and skills is core to the delivery of safe, high-quality health care. For all healthcare providers, formal education requirements and maintenance of profession-specific registration requirements will make up the majority of safety and quality training.

Although the safety and quality of health care provided to each patient is highly dependent on the skills and performance of individual healthcare providers, it is also a healthcare service's responsibility.[10]

The safety and quality roles within your healthcare service must be defined and relevant roles and responsibilities allocated.

**Links to Action 1.17 Safety and quality roles and responsibilities**

All people who form part of your healthcare service's workforce must understand their safety and quality roles in the context of your healthcare service. Orientation and access to training should occur on commencement to the service, whenever responsibilities change and when new services are introduced.

The safety and quality training needs for your workforce need to be regularly reviewed in light of the services provided, the health outcome achieved and the risks facing patients in the service.

Records of content and participation in orientation and training should be maintained to support review and future identification of training needs.

## Reflective questions

- What orientation and training do new members of your service's workforce undertake?
- How are ongoing training needs identified?
- How does your workforce ensure relevant training is completed?

## Key tasks

- Implement and document the minimum orientation and training your workforce must complete on commencement at your healthcare service.
- Provide ongoing education and training on relevant aspects of safety and quality for all members of the workforce, when change occurs in the service or when new services are introduced.
- Ensure that staff who have additional safety and quality responsibilities are provided with additional training to meet the requirements of their role.
- Maintain training records and a training schedule for staff to ensure that safety and quality training is provided in a timely manner, as required.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context, but could include:

- Orientation and training documents that detail content and participation by the workforce
- Training plans and records for members of the workforce that include the requirements of the Standards
- Description of how training needs of the workforce are identified.

## Where to go for more information

Resources relating to this Action may be added as they become available.

## Action 1.16

The healthcare service supports its workforce to provide culturally safe services to meet the needs of its Aboriginal and Torres Strait Islander patients.

### Explanatory notes

Culturally safe services improve Aboriginal and Torres Strait Islander peoples' experiences of, and access to, health care. Embedding cultural safety in our health system will improve health outcomes and address widening gaps in health and wellbeing between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians.

The Commission defines 'cultural safety' in accordance with the Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health.[11] Cultural safety identifies that health consumers are safest when health professionals have considered power relations, cultural differences and patients' rights. Part of this process requires health professionals to examine their own realities, beliefs and attitudes.

The essential features of cultural safety are:

- Understanding your own culture and cultural bias
- Acknowledging difference, requiring that caregivers are actively mindful and respectful of difference(s)
- Being informed by the theory of power relations; any attempt to depoliticise cultural safety is to miss the point
- Appreciating the historical context of colonisation, the practices of racism at individual and institutional levels and their impact on First Nations peoples' living and wellbeing, both in the present and past
- Its presence or absence is determined by the experience of the recipient of care and not defined by the caregiver.[12]

Australian Health Practitioner Regulation Agency's **Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025** focuses on achieving patient safety for Aboriginal and Torres Islander peoples in Australia's health system and recognises the linked elements of clinical and cultural safety in patient safety.

When providing care to Aboriginal and Torres Strait Islander patients, the workforce should acknowledge and be respectful of the cultural factors and complex kinship relationships that exist in the local community. Currently, the Australian health system does not always meet the needs of Aboriginal and Torres Strait Islander peoples. Aboriginal and Torres Strait Islander peoples may experience:

- Language barriers in understanding health messages and difficulty in informing members of the workforce of their needs
- Financial difficulties in gaining access to treatments and funding the costs of treatment
- Perception of inferior treatment.

Embedding cultural safety is an ongoing process, and something that the workforce must be supported in doing, in partnership with Aboriginal and Torres Strait Islander peoples. **Table 2** compares actions and practices that improve the delivery of culturally safe care versus actions and practices that lack cultural safety. If your healthcare service implements these practices, the likelihood of an individual feeling safe when accessing health care will improve.

**Links to Actions 1.09 and 1.10 Patient populations and social determinants of health and 1.24 and 1.25 Safe environment**

**Table 2**: Practices and actions that improve the delivery of culturally safe care compared to those that lack cultural safety

| Practices and actions undertaken by the healthcare workforce that embed cultural safety | Practices and actions that create a lack of cultural safety |
|---|---|
| Have an awareness of their own culture, cultural practices and assumptions | Are unaware of their own culture, cultural practices and assumptions |
| Have an awareness of how their own cultural practices and assumptions may be different from those of other cultural groups | Focus on understanding other cultures. This assumes that people can be understood by studying their culture. This approach can promote the 'othering' of consumers and 'cultural voyeurism'. It can reinforce stereotypes by not exploring social, historical, economic, class and occupational diversity |
| Use personal reflection to become aware of stereotypes and act to counter stereotypes | Are unaware of their own stereotypes |
| Have an awareness of how cultural diversity may impact relationships with consumers from other cultures | Apply cultural group stereotypes to individuals |
| Include the world view and life experience of the person receiving care | Focus on lifestyles without considering the world view and life experience of the person receiving care |
| Know that healthcare services may be unfamiliar to some people | Assume that healthcare providers and the culture of healthcare services are the norm |
| Give the power of defining 'health' to the person receiving care | Retain the power to define norms for the person receiving care |
| Are aware of power dynamics in relationships with people receiving care | Are unaware of power dynamics in relationship with people receiving care |
| Accept that power imbalances can be negotiated/ changed | Retain power |
| Are aware of the strengths, resilience and resistance of Aboriginal and Torres Strait Islander peoples | Unaware of the strength, resilience, and resistance of Aboriginal and Torres Strait Islander peoples |
| Consider identity as a resource that can support wellbeing and social connectedness during times of illness and stress | May consider identity a burden or a problem related to poor health outcomes |
| Are aware of the importance of developing trust in the relationship | May assume trust because of profession |
| Engage in a two-way dialogue where knowledge is shared | Uses one-way dialogue |
| Understand how past events can impact the health of Aboriginal and Torres Strait Islander peoples | Unaware of history of Aboriginal and Torres Strait Islander peoples and current impacts |
| Understand that culture shock may be present | Unaware of potential for culture shock |

Source: Adapted from Assessing the Aboriginal and Torres Strait Islander actions in national safety and quality standards: Pre-reading workshop readings and activity (ACSQHC, 2022, unpublished).

## Reflective questions

- What cultural safety training has your workforce undertaken?
- How does your healthcare service support the workforce to provide culturally safe services?

## Key tasks

- Facilitating ongoing access to cultural safety training for all members of your workforce, that is tailored to your Aboriginal and Torres Strait Islander patients
- Participating in and celebrating events of significance to Aboriginal and Torres Strait Islander communities, for example, National Sorry Day, National Reconciliation Week, NAIDOC week
- Recruiting more Aboriginal and Torres Strait Islander peoples to be part of your healthcare service's workforce where possible
- Considering the establishment of a **Reconciliation Action Plan** for your healthcare service
- Developing an understanding and appreciation of your specific community context, particularly in rural and remote settings.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context, but could include:

- Training documents that are specific to Aboriginal and Torres Strait Islander cultural safety and are tailored to the needs of the service's patient population
- Evidence of participation in events of significance to Aboriginal and Torres Strait Islander communities, for example, National Sorry Day, National Reconciliation Week
- Evidence of recruitment of Aboriginal and/or Torres Strait Islander peoples to the workforce
- A Reconciliation Action Plan
- Evidence of cultural orientation to a community.

## Where to go for more information

### Commission resource

- **NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health** – provides practical support for the implementation of the Aboriginal and Torres Strait Islander-specific actions in the NSQHS Standards. The principles and strategies outlined are broadly applicable.

### Other resources

- Australian Health Ministers' Advisory Council: **Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health** – use to develop, implement and evaluate cultural awareness and cultural competency strategies.
- **Australian Indigenous HealthInfoNet website**, including **Cultural Safety for Health Professionals** – access to resources, courses, information and literature on Aboriginal and Torres Strait Islander Health and cultural safety training.
- Australian Institute of Health and Wellbeing's **Cultural safety in health care for Indigenous Australians: monitoring framework**.
- Department of Health and Human Services Victoria: ***Improving Care for Aboriginal and Torres Strait Islander Patients Resource Kit*** – for people who are working together to realise the goals established by the Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) reform.
- Department of Health, Western Australia: **Journey of health and wellbeing** – a short video intended to raise awareness of Aboriginal people's journey of health and wellbeing. Developed by Tim Muirhead and Danny Ford.

- Indigenous Allied Health Australia: **Cultural responsiveness training** – delivers cultural safety training using our evidence-based Cultural Responsiveness Framework.
- Murra Mullangari: **Introduction to Cultural Safety and Cultural Humility** – delivers information and a short video about cultural safety in the professional roles of Nurses and Midwives.
- National Aboriginal and Torres Strait Islander Health Workers Network: ***Cultural Safety Framework*** – the framework is a companion document to both the Aboriginal and Torres Strait Islander Health Worker Professional Practice Framework (2012) and the Growing Our Futures report by Health Workforce Australia.
- Pharmaceutical Society of Australia: ***Guidelines for pharmacists supporting Aboriginal and Torres Strait Islander peoples with Medicines Management*** – supports you to reflect on your personal and professional connections with Aboriginal and Torres Strait Islander peoples, culture and practices.
- Reconciliation Australia: **Reconciliation action plans** – assists businesses to embed the principles and purpose of reconciliation.
- Reconciliation Australia: **Share our Pride** – provides a glimpse of how life looks from an Aboriginal and Torres Strait Islander perspective.
- The National Registration and Accreditation Scheme: **Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025** and other work led by the **Aboriginal and Torres Strait Health Strategy Group**, established by Australian Health Practitioner Regulation Agency (Ahpra) and the National Health Practitioner Boards.
- Western Sydney University: ***Dalarinji – 'Your Story': Community Roadmaps*** – findings from a project investigating the social, emotional and cultural wellbeing of Indigenous LGBTQI+ people in NSW.

## Safety and quality roles and responsibilities

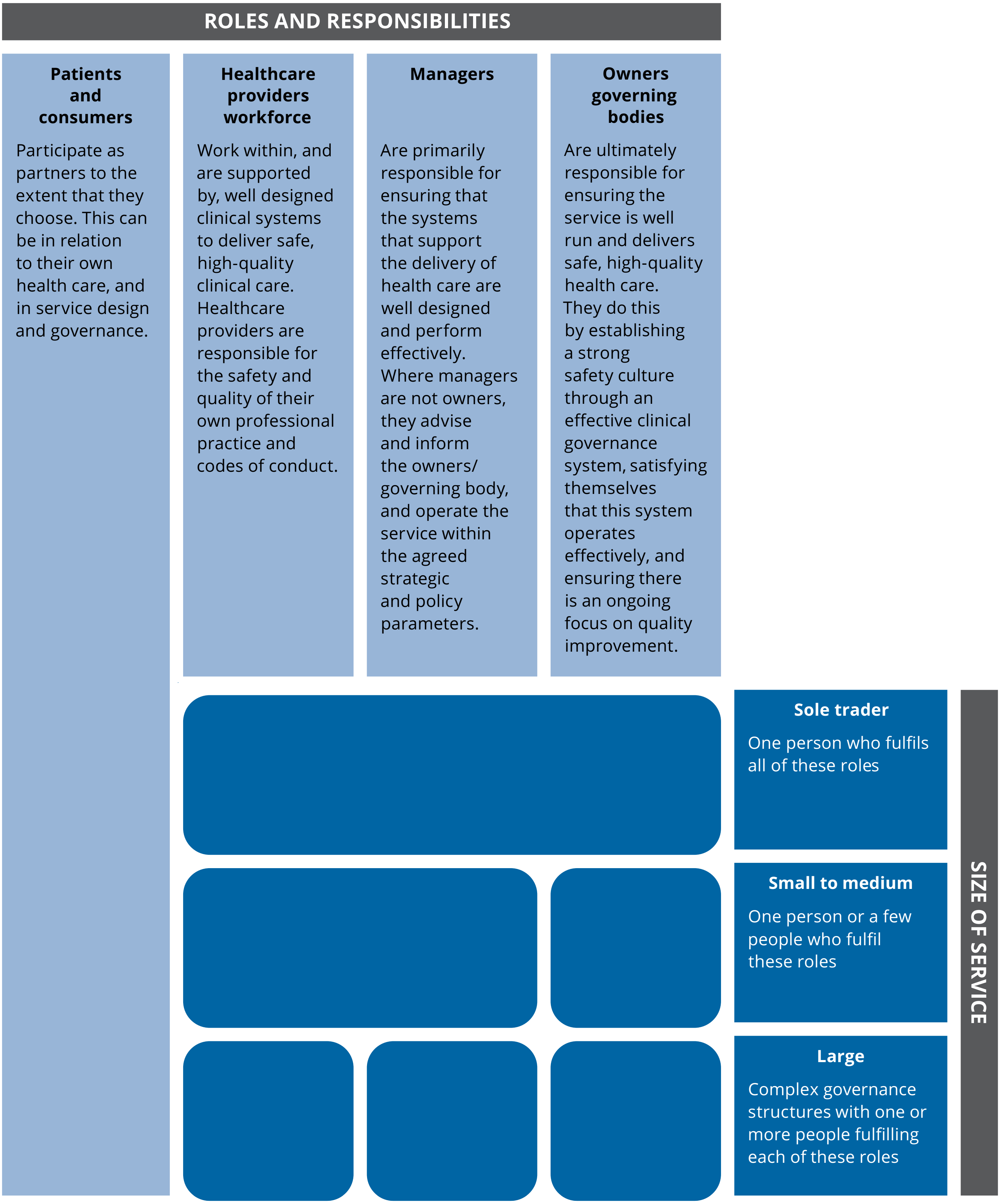
### Action 1.17

The healthcare service has processes to support its workforce to understand and fulfil their assigned safety and quality roles and responsibilities.

### Explanatory notes

Safety and quality are everybody's responsibility. Having a culture of safety and quality improvement requires a clear understanding of who is accountable for what. **Figure 2** outlines the key safety and quality roles and responsibilities and how these might be assigned, depending on the size of the healthcare service.

**Figure 2:** Roles and responsibilities for clinical governance in different service sizes



**ROLES AND RESPONSIBILITIES**

**Patients and consumers**

Participate as partners to the extent that they choose. This can be in relation to their own health care, and in service design and governance.

**Healthcare providers workforce**

Work within, and are supported by, well designed clinical systems to deliver safe, high-quality clinical care. Healthcare providers are responsible for the safety and quality of their own professional practice and codes of conduct.

**Managers**

Are primarily responsible for ensuring that the systems that support the delivery of health care are well designed and perform effectively. Where managers are not owners, they advise and inform the owners/governing body, and operate the service within the agreed strategic and policy parameters.

**Owners governing bodies**

Are ultimately responsible for ensuring the service is well run and delivers safe, high-quality health care. They do this by establishing a strong safety culture through an effective clinical governance system, satisfying themselves that this system operates effectively, and ensuring there is an ongoing focus on quality improvement.

**SIZE OF SERVICE**

**Sole trader**

One person who fulfils all of these roles

**Small to medium**

One person or a few people who fulfil these roles

**Large**

Complex governance structures with one or more people fulfilling each of these roles

Source: National Safety and Quality Primary and Community Healthcare Standards (ACSQHC, 2021).

Supporting your workforce to understand and fulfil their assigned safety and quality responsibilities can be carried out in a variety of ways and may be dependent on the size and complexity of your healthcare service. In some circumstances, a shared understanding of different people's safety and quality roles may help contextualise an individual's understanding of and ability to carry out assigned responsibilities.

**Links to Actions 1.01 Governance, leadership and culture and 1.15 Safety and quality training**

## Reflective question

- How is your workforce supported to understand and fulfil their safety and quality roles and responsibilities?

## Key tasks

- Ensure that safety and quality roles and responsibilities are clearly defined and described in your healthcare service's clinical governance framework.
- Support the workforce to understand and fulfil their assigned safety and quality roles and responsibilities through position descriptions, orientation and training, ongoing communications, performance review processes (if applicable).

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Policy documents or position descriptions that outline or describe the safety and quality roles and responsibilities of the workforce
- Training and orientation documents about the safety and quality roles and responsibilities of the workforce
- In larger healthcare services, an organisational chart and delegation policy that demonstrates clinical governance reporting lines and relationships, where applicable.

## Where to go for more information

### Commission resource

- **National Model Clinical Governance Framework** – provides practical guidance on clinical governance roles and responsibilities, based on the NSQHS Standards. The principles of clinical governance and roles and responsibilities outlined are broadly applicable.

# Evaluating performance

## Action 1.18

The healthcare service has valid and reliable review processes for the workforce that:

a. Are used to regularly review their performance
b. Identify needs for training and development of safety and quality.

### Explanatory notes

Regular evaluation of performance is an important tool to identify gaps in skills and understanding and training and development needs. The ways your service evaluates performance will depend on its structure and size, as well as the roles and responsibilities of people working in the healthcare service.

For healthcare providers, evaluation of performance may include continuing professional development activities, self-reflection and peer evaluation linked to maintenance of professional registration requirements. Other mechanisms include regular discussions about performance or that performance forms part of prescribed professional development processes. However they are conducted, outcomes of performance evaluations provide opportunities to set goals and plan for skills and knowledge development and should be linked to the overall goals of the healthcare service, including delivering safe and high-quality care.

**Links to Actions 1.15 Safety and quality training, 1.17 Safety and quality roles and responsibilities**

### Reflective questions

- How does the performance review process ensure that safety and quality training and development needs are identified?
- How is the safety and quality performance of non-clinical members of the workforce evaluated?

### Key tasks

- Establish processes to review and evaluate the safety and quality performance of the workforce and identify their training and development needs.
- Identify the training needs that support the implementation of these standards.

### Examples of evidence

The type and comprehensiveness of the evidence used is dependent on each healthcare service context, but could include:

- Professional development plans or portfolios for healthcare providers registered with a national board under the National Registration and Accreditation Scheme, or that are self-regulated
- Documentation of discussions about workforce performance and identified training needs
- Schedule of training and workforce participation.

## Where to go for more information

### Commission resources

- **National Model Clinical Governance Framework** – provides practical guidance on clinical governance roles and responsibilities, based on the NSQHS Standards. The principles of clinical governance and roles and responsibilities outlined are broadly applicable and can be considered when evaluating performance.
- ***Review by peers: A guide for professional, clinical and administrative processes*** – a tool to support healthcare services implementing processes for the review of professional practice.

### Other resource

- Australian Health Practitioner Regulation Agency: **Continuing Professional Development (CPD)** – links to CPD requirements, codes and guidelines for each national board.

# Scope of clinical practice

## Action 1.19

The healthcare service has processes to ensure that healthcare providers have the qualifications, knowledge and skills required to perform their role by:

a. Describing the scope of clinical practice for healthcare providers practising in the healthcare service
b. Monitoring healthcare providers' practices to ensure they are operating within their designated scope of clinical practice
c. Reviewing healthcare providers' scope of clinical practice when a clinical service, procedure or technology is introduced or substantially altered.

## Explanatory notes

All healthcare providers in your healthcare service must practice within a designated scope of clinical practice. Describing a scope of clinical practice for each healthcare provider, monitoring their practices and reviewing the scope of clinical practice when there are substantial changes will all support the delivery of safe, high-quality health care.

The scope of clinical practice is specific to a role and describes the extent a healthcare provider's clinical skills, knowledge, professional registration (where applicable), performance and professional suitability are used in a healthcare service.

This is distinct from a healthcare provider's scope of practice. The National Boards, under the **National Registration and Accreditation Scheme** for health practitioners, expect all registered healthcare providers to practise within their individual scope of practice and the relevant National Boards standards, codes and guidelines of their respective profession, and are reinforced through profession-specific documents such as codes of conduct or equivalent.[13]

Healthcare providers based in rural and remote areas often practice to their full scope with greater autonomy to meet diverse population and consumer needs. This is due to the unique circumstances in which they work, including resource limitations, distance from support and collaboration with medical retrieval services.[14]

For example, a healthcare provider practising within their individual scope of practice may be qualified to provide services A, B and C. However, the healthcare service they are working within does not have the appropriate equipment or community demand for service C. While the healthcare provider is working in that particular healthcare service, their scope of clinical practice would only encompass the provision of services A and B.

The description of a healthcare provider's scope of clinical practice could be a stand-alone document or included in a position description or contract of services. It should include:

- Types of services the healthcare provider is expected to deliver within the healthcare service
- Minimum requirements for professional registration or self-regulation
- Minimum requirements for working with specific population groups, for example, Working With Children Checks when providing care to children
- Additional training or qualifications required if applicable
- Any supervision or continuing professional development requirements.

## Reflective questions

- Where is a healthcare provider's scope of clinical practice described?
- What processes are in place to ensure a healthcare provider works within their scope of clinical practice in your healthcare service?
- How is a healthcare provider's scope of clinical practice reviewed when a clinical service, procedure or technology is introduced or substantially altered?

## Key tasks

- Record the scope of clinical practice for healthcare providers within your healthcare service, either in a stand-alone document, position description or contract for services.
- Incorporate a periodic review of a healthcare provider's scope of clinical practice when a clinical service, procedure or technology is introduced or substantially altered.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context, but could include:

- Documented scope of clinical practice described in position descriptions, contract for services or standalone document
- Review of services provided against the described scope of clinical practice, or records of performance reviews or communication that demonstrate monitoring
- Planning documents to introduce new services (including workforce, equipment, procedures and the scope of clinical practice amendments required)
- Evidence of a regular review of the described scope of clinical practice, position descriptions or contract for services and any changes made.

## Where to go for more information

### Resource

Office of the National Rural Health Commissioner: **National Rural and Remote Nursing Generalist Framework 2023–2027**.

# Evidence-based care

## Action 1.20

The healthcare service:

a. Provides its healthcare providers with ready access to best-practice guidelines and available evidence, clinical care standards developed by the Commission and decision support tools relevant to their clinical practice
b. Supports its healthcare providers to use best-practice guidelines and available evidence, clinical care standards developed by the Commission and decision support tools relevant to their clinical practice to deliver best-practice care.

## Explanatory notes

The delivery of safe, high-quality health care must be underpinned by up-to-date evidence-based practice, taking into consideration clinical judgement, the patient's needs and their preferences for health care.[15]

Your healthcare service has an important role in facilitating the use of evidence-based care in practice. This means giving healthcare providers ready access to, and supporting their use of, best-practice guidelines, available evidence, relevant **clinical care standards** developed by the Commission and decision support tools[4] relevant to their clinical practice. These resources may be profession specific, or multidisciplinary, for example, integrated clinical pathways. They may be national or international best-practice guidelines, or locally adapted guidelines.

## Reflective questions

- Which best-practice guidelines, clinical care standards developed by the Commission and decision support tools are available to healthcare providers in your service?
- How are your healthcare providers supported to use best-practice guidelines, clinical care standards and decision support tools in the delivery of health care?

## Key tasks

- Provide healthcare providers with access to best-practice guidelines and available evidence, clinical care standards developed by the Commission and decision support tools relevant to their clinical practice.
- Support healthcare providers to use relevant best-practice guidelines, available evidence and clinical care standards developed by the Commission.
- Support healthcare providers to use decision support tools relevant to their clinical practice in their delivery of health care to patients.
- Support healthcare providers to participate in continuing professional development activities, and facilitate a culture of peer sharing and learning from patient case studies within the healthcare service (where possible).

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context, but could include:

- Evidence of the best-practice guidelines, clinical care standards developed by the Commission and decision support tools that are available to healthcare providers
- Description of how healthcare providers access and use best-practice guidelines, pathways, decision support tools and clinical care standards that reflect best available evidence
- Training documents (for example, continuing professional development records) relating to clinical updates.

## Where to go for more information

### Commission resource

- **Clinical Care Standards** – contain a small number of quality statements that describe the care patients should be offered by healthcare providers and healthcare services for a specific clinical condition or defined clinical pathway in line with current best evidence.

### Other resources

- Primary Health Network: HealthPathways – most **Primary Health Networks (PHNs)** provide access to HealthPathways, an online health information portal for healthcare providers to be used at the point of care. It provides localised information on how to assess and manage medical conditions and how to refer patients to local specialists and services in the most timely manner.[16]
- Queensland Health: ***Primary Clinical Care Manual*** – provides a clinical reference for health professionals working in rural, remote and isolated healthcare settings.
- **Therapeutic guidelines**: a leading source of independent, evidence-based, practical treatment advice to assist practitioners with decision-making at the point of care.

# Variation in care delivered and health outcomes

## Action 1.21

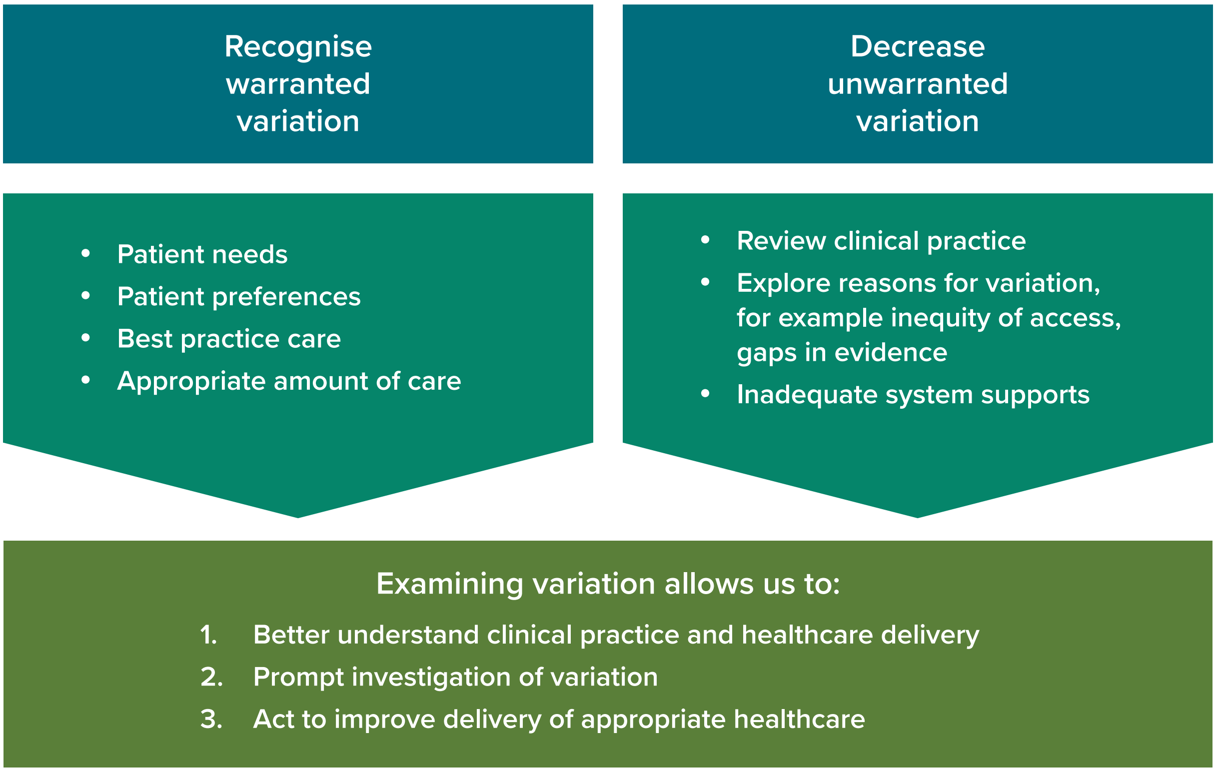
The healthcare service supports its healthcare providers to:

a. Monitor and review care delivered against relevant best-practice care
b. Explores reasons for variation of health care from best practice
c. Uses information on unwarranted variation from best practice to improve health care.

## Explanatory notes

Appropriate care means that patients are receiving the right health care, at the right time, from the right healthcare provider. The health care offered should also be informed by the best available evidence. However, healthcare interventions and outcomes vary between populations and across geographic areas, services and healthcare providers. Understanding this variation is critical to improving the quality and appropriateness of health care. Some variation is desirable and warranted, as it reflects differences in people's healthcare needs and preferences. If variation is unwarranted, it signals that people are not getting appropriate care and presents an opportunity for changes and improvements. **Figure 3** describes this concept in more detail.

**Figure 3**: Understanding healthcare variation



Healthcare providers have a professional responsibility to review the care they provide and to participate in efforts to address unwarranted clinical variation to improve the quality of care.

## Reflective questions

- What areas of clinical practice has your healthcare service reviewed for variations in health care?
- What reasons, if any, were identified for variation?
- Was the variation warranted or unwarranted?
- What improvements were identified and how were these improvements implemented?
- What checks and balances are in place to ensure that patients are receiving the right care, and the right amount of care according to their needs and preferences, at the right time?

## Key tasks

- Identify the areas of clinical practice to review the care delivered against relevant best practice. This may be based on the population served, the common services provided or high-risk services.
- Discuss or review how services are delivered against best-practice care. This could be done via continuing professional development and documented self-reflection, peer evaluation or group evaluation within a large healthcare service.
- Where clinical variation is identified, explore the reasons for variation, determine if the variation is warranted or unwarranted and identify areas for improvement.

- Act to improve the appropriateness of care

  - specify the desired goal for improvement
  - explore the reasons for current practice
  - identify the barriers or enablers for any desired change in practice
  - make changes to healthcare processes
  - monitor progress and make further changes as necessary.
- Maintain records of reviews and actions taken as a result of examining the variation and the appropriateness of care.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context, but could include:

- Records of continuing professional development and self-reflection
- Records of clinical practice audits where service delivery was compared against best-practice guidelines and opportunities for improvement identified
- Reports that compare clinical practice using external sources such as the **Australian Atlas of Healthcare Variation**, or data provided by or shared with external organisations such as Primary Health Networks or professional organisations
- Examples of improvement activities that have been implemented and reviewed to reduce unwarranted variation, including relevant clinical care standards.

## Where to go for more information

### Commission resources

- **User Guide for the Review of Clinical Variation in Health Care** – provides practical guidance, including clinical case studies, on how health services can review clinical practice and address unwarranted variation, based on the NSQHS Standards. The principles and strategies are broadly applicable.
- **Better Care Everywhere program series** – explores why healthcare variation happens and what can be done about it.
- **Australian Atlas of Healthcare Variation series** – presents maps of variation in care, derived from information routinely gathered by the health system, which show how healthcare use differs across the country.

### Other resource

- NPS MedicineWise: **Clinical case studies** – supports reflective learning to inform clinical decision-making.

# Safe environment for the delivery of care

## Consumer outcome

*I feel safe and comfortable accessing health care.*

## Intention of this standard

The environment in which services are delivered enables safe and high-quality health care for patients.

## Safe environment

## Action 1.22

The healthcare service maximises safety and quality of health care:

a. Through the design of the environment and management of the location where health care is provided
b. By providing access to an environment, devices and equipment that are fit for purpose and well maintained
c. By ensuring patient privacy when health care is provided.

## Explanatory notes

Your healthcare service's environment can support the delivery of safe, high-quality health care for patients. Good design can also reduce the potential for adverse events and incidents, reduce infections associated with heath care, ensure privacy is maintained and improve patient and workforce satisfaction.

Regardless of the location or mechanism used to deliver service, the equipment and devices used should be fit for purpose and well maintained.

Where healthcare services are delivered from a fixed location or mobile outreach service, the spaces used in the delivery of health care should be clean, designed to minimise harm and well maintained. Where telehealth or virtual care forms part of service delivery, the information and communications technologies (ICT) should be included in the equipment used, and devices should use programs that are accessible to patients.

Healthcare services providing home-based care must take a risk management approach in determining the most appropriate space to use when attending to a patient in their home and in circumstances where home-based care is not appropriate.

## Reflective questions

- How often is your healthcare service's environment reviewed? What improvements have been made to ensure it is fit for purpose, well maintained and privacy is provided to patients?
- What equipment does your service use to deliver health care? How often are maintenance checks conducted on equipment?
- What are key considerations for healthcare providers visiting a patient's home when determining the most appropriate space to deliver health care?

## Key tasks

- Implement a schedule and process to regularly review the spaces where healthcare services are delivered. Action any required improvements to ensure spaces are fit for purpose and well maintained, and that there is space for the patient's privacy when health care is provided.
- Implement a schedule and process to conduct maintenance checks on equipment used by the healthcare service. Action any required repairs or replacement equipment to ensure they are fit for purpose, safe and in good working order at all times.
- For healthcare services providing home-based care, implement a process for a risk management approach to determining the most appropriate space in a patient's home for the provision of health care.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on the context of each healthcare service, but could include:

- Maintenance schedule for healthcare service premises, mobile vehicles and equipment
- Completed risk assessments for care provided in patient's homes or other locations, and any actions taken to address the risks
- Register of equipment that includes details of their maintenance schedule and completed repairs or replacements
- Observation of design and use of the environment that supports safe, high-quality care, including supporting patient privacy
- Checklists of actions to be completed or equipment required to safely deliver care outside the healthcare service's environment.

## Where to go for more information

### Resources

- Office of Industrial Relations Workplace Health and Safety Queensland: ***A guide to working safely in people's homes*** – is an easy-to-read guide providing practical advice about how to manage work health and safety for community workers working in people's homes.
- World Health Organization: ***Medical equipment maintenance programme overview*** – describes the key elements of a maintenance strategy for medical equipment.

# Action 1.23

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

## Explanatory notes

Within any health setting, there are spaces where there is a higher potential for stress and conflict. These include busy, high-traffic areas, and the stress they may cause can be exacerbated when people are uncertain about what care will be provided and whether there are actual or perceived delays in accessing treatment.

People respond to stress in different ways and have different needs in terms of environmental response. A calm and quiet environment is clinically appropriate for a person experiencing agitation and aggressive feelings, and this minimises risks of them harming themselves and others.[17]

Children can experience fear when exposed to new surroundings. In some instances, providing a separate safe space that is age-appropriate, with access to play equipment, books or toys in good working order, where the child can be supervised by their accompanying adult may support their unique needs and minimise risks of disruption and/or harm.[18]

Supporting health providers by providing training or orientation about managing unexpected behaviour in the healthcare service's environment will also help minimise risks.

Healthcare services providing home-based care must identify areas that have a high risk of unpredictable behaviours. This forms part of their risk management approach in determining the most appropriate space when attending to a patient in their home, and circumstances where home-based care is not appropriate.

**Links to Actions 1.04 Risk management and 3.32 Planning for safety**

## Reflective questions

- Which spaces in your healthcare service have a higher risk of causing people to feel stressed?
- How are people who are behaving unpredictably supported in a way that minimises risks of harm to others in your healthcare service?
- How do healthcare providers delivering home-based care identify areas where a patient may behave unpredictably? How do they use this information to determine the most appropriate space in a patient's home for the provision of health care, and circumstances where home-based care is not appropriate?

## Key tasks

- Identify any spaces in the healthcare service that have a high risk of potentially causing stress leading to people behaving unpredictably.
- Develop and implement strategies that can be used in instances where unpredictable behaviour occurs to minimise the risk of harm to others in the healthcare service.

- For healthcare services providing home-based care, incorporate the identification of areas that have a high risk of unpredictable behaviours into the process for a risk management approach. This helps to determine the most appropriate space in a patient's home for the provision of health care, and circumstances where home-based care is not appropriate.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Observation of flexible use of spaces to minimise the risk of harm to others when there is a high risk of unpredictable behaviours
- Examples of risk management approaches used during home visits
- Training and orientation documents about safe work practices and emergency situations
- Evidence of policies, processes and training used to support workforce to implement strategies
- Entries into risk register documenting responses to unpredictable behaviour.

## Where to go for more information

### Resource

- National Institute for Health and Care Excellence: ***Violence and aggression: short-term management in mental health, health and community settings*** – aims to safeguard both staff and people who use services by helping to prevent violent situations and providing guidance to manage them safely when they occur.

## Action 1.24

The healthcare service supports patients to access health care, including patients from diverse backgrounds and patients with disability.

## Explanatory notes

Supporting patients to access your healthcare service is fundamental to the delivery of safe, high-quality health care. Support should consider relevant feedback from patients as well as consideration for patient populations that have historically faced barriers to accessing health care.

### People with diverse backgrounds

Diverse backgrounds are the varying social, economic and geographical circumstances of consumers who access, or may access, the services of a healthcare service.[19] The intersectional needs and experiences of people may be due to a variety of factors. They also encompass the cultural backgrounds, disability status, religions, beliefs and practices, languages spoken, sexual orientation, gender identity and gender expression, and sex characteristics.[19] While barriers faced may vary, they can include the communication, cultural experience or attitude of healthcare providers.

### People with disability

There is a complex relationship between disability and health; disability can contribute to health issues and long-term health conditions can cause disability.[20] Some people with disability experience barriers to accessing health care, such as unacceptable or lengthy waiting times, cost, inaccessibility of buildings and discrimination by health professionals, as well as issues caused by lack of communication between the different health professionals who treat them.[20] These barriers are often compounded by the intersectional needs and experiences of the person with disability.

## Supporting access to health care

Your healthcare service can support patients to access health care by understanding the barriers and challenges faced by patient populations and making changes to mitigate the barriers identified. The specific circumstances of population groups should be considered in determining how access for patients may be supported. They may include but not limited to:

- Being aware of and understanding the health needs and sensitivities of patient populations
- Providing relevant information in a language which is accessible to the local population
- Adjusting the physical environment to support wheelchair access
- Including artwork and signage that demonstrates a welcoming environment to patient populations
- Ensuring that spaces for children are age-appropriate, and provide enough space for accompanying adults
- Having a mix of experience, skill sets, genders and cultures in the workforce to cater to patient populations
- Providing inclusivity and culturally responsive training for the workforce to increase their confidence, knowledge and skills when working with diverse communities
- Provide access to services such as the **Translating and Interpreting Service** (TIS National) which provides access to phone and on-site interpreting services in over 150 languages
- Supporting patients to communicate with the assistance of the **National Relay Service**
- Providing telehealth or virtual care options for patients to access health services, particularly in rural and remote locations.

Where access to appropriate health care cannot be provided, your healthcare service should facilitate the referral of patients to alternative, accessible services.

**Links to Actions 1.09 and 1.10 Patient populations and social determinants of health; 2.06 Communication that supports effective partnerships and 2.07 Accessing healthcare service information**

## Reflective questions

- How is patient population information used to plan service delivery and manage the inherent barriers that exist to care for patients?
- What adjustments have been made to decrease the barriers to allow equal access for patients?

## Key tasks

- Implement strategies to support patients to access your healthcare service, with particular consideration for barriers to health care faced by patients from diverse communities and patients with disability, including barriers compounded by a person’s combination of needs and experiences.
- Ensure the telehealth and/or virtual care infrastructure is available for patients.
- Foster multidisciplinary healthcare teams to meet consumer healthcare needs.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Examples of how demographic data and characteristics of the local community or patient population have been used to plan for or improve access to services
- Processes that enable access to the service for people with a disability, such as providing outreach or flexible appointment times
- Observation of the written health information about accessing the healthcare service in a range of formats tailored to the local community and patient populations
- Observation of the healthcare service's physical environment and the equipment that supports access for patients with low mobility
- Observation of non-verbal demonstrations of inclusion in environment, for example, non-gendered bathrooms, display of rainbow flag
- Observation of infrastructure that supports telehealth and/or virtual care practices
- Evidence of culturally informed comprehensive care planning
- Examples of resources or partner organisations that the healthcare service uses to enable people from diverse backgrounds to access the healthcare service
- Records of training or professional development undertaken by the workforce to meet the needs of people from diverse populations.

## Where to go for more information

### Commission resources

- ***Cognitive impairment fact sheet: Clinicians can take action to reduce the risk of harm*** – a fact sheet listing the steps and details a quality and safety pathway.
- **Cognitive impairment resources** – to help improve the safety and quality of health care for people with cognitive impairment or at risk of delirium.
- **NSQHS Standards User Guide for health service organisations providing care for patients with cognitive impairment or at risk of delirium** – provides practical support for healthcare services where specific efforts or additional attention is required to meet the health needs of this patient population, based on the NSQHS Standards. The principles and strategies outlined in this resource are broadly applicable.
- **NSQHS Standards User Guide for health services providing care for people with mental health issues** – provides practical support for healthcare services where specific efforts or additional attention is required to meet the health needs of this patient population, based on the NSQHS Standards. The principles and strategies outlined in this resource are broadly applicable.

### Other resources

- Australian Human Rights Commission: ***Access for all: Improving accessibility for consumers with disability*** – provides practical tips for businesses on improving access to goods, services, facilities, premises and information for consumers with disability.
- Australian Human Rights Commission: **Disability Rights** – promoting the rights of people with disabilities and building a more accessible, more inclusive community.
- Australian Government: **Translating and Interpreting Service (TIS)** – a free interpreting service which aims to provide equitable access to key services for people with limited or no English language proficiency.
- Australian Government: **National Relay Service** – for people who are deaf and/or find it hard hearing or speaking with people who use a phone.

- Council for Intellectual Disability: **Resources for health practitioners** – resources for healthcare providers to support better appointments when working with people with intellectual disability.
- **Diversity Council of Australia: Leading Diversity and Inclusion in the Workplace** – the website includes comprehensive directory of diversity and inclusion service providers in Australia.
- People with Disability Australia: ***Language Guide*** – best-practice advice to assist developing policies and information that has inclusive and respectful language around disability.
- Pride in Health + Wellbeing: **About The HWEI Benchmarking Index** – the annual Health + Wellbeing Equality Index (HWEI) has been designed as a free tool to assess and benchmark LGBTQI+ service provision among health, wellbeing and human service providers.

## Action 1.25

The healthcare service provides a culturally safe environment that recognises the importance of the cultural beliefs and practices of Aboriginal and Torres Strait Islander peoples.

## Explanatory notes

Some Aboriginal and Torres Strait Islander peoples do not access primary healthcare services due to barriers such as cost, long wait times, lack of service availability, dislike of the service, embarrassment or feeling afraid or uninformed, experiences of discrimination and racism, and poor communication with healthcare providers.[21,22] In 2018–19, about one in eight Aboriginal and Torres Strait Islander people reported they did not go to the doctor when they needed to, and about one in five did not go to the dentist when they needed to.[22]

Providing a culturally safe environment is an important element of providing culturally safe care. Culturally safe services improve Aboriginal and Torres Strait Islander peoples' experiences of, and access to, health care.

The Commission defines 'cultural safety' in accordance with the Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health.[11] Cultural safety identifies that health consumers are safest when health professionals have considered power relations, cultural differences and patients' rights. Part of this process requires health professionals to examine their own realities, beliefs and attitudes.

The essential features of cultural safety are:

- Understanding one's culture
- Acknowledging difference, so that caregivers are actively mindful and respectful of difference(s)
- Being informed by the theory of power relations; any attempt to depoliticise cultural safety is to miss the point
- Appreciating the historical context of colonisation, the practices of racism at individual and institutional levels and their impact on Aboriginal and Torres Strait Islander peoples living and wellbeing, both in the present and past
- Its presence or absence is determined by the experience of the recipient of care and not defined by the caregiver.[12]

Providing a culturally safe environment in your healthcare service is about creating a place where Aboriginal and Torres Strait Islander peoples feel safe, comfortable, accepted and confident that they will be respected, will be listened to and will receive high-quality care. Healthcare services should recognise the importance of cultural beliefs and practices of Aboriginal and Torres Strait Islander peoples. Cultural determinants of health are anchored in Aboriginal and Torres Strait Islander ways of knowing, being and doing that encompass a holistic understanding of health and wellbeing.

The physical, emotional and relational aspects of spaces are all critical components of creating culturally safe environments:

- Physical – design, layout and appearance
- Emotional – the feeling of being supported and cared for within the healthcare service
- Relational – the quality of relationships developed with the workforce and other consumers.

Ways that your healthcare service can create culturally safe environments are interrelated with improving cultural safety. They may include:

- Where there is a significant Aboriginal or Torres Strait Islander patient cohort, consult with your Aboriginal and Torres Strait Islander patients and local Aboriginal Community Controlled services to review the design, use and layout of the healthcare service, and to maximise privacy and minimise distress in clinical spaces
- Providing access to training and scope for reflective practice, to enable healthcare providers deliver culturally safe care.

**Links to Actions 1.09 and 1.10 Patient populations and social determinants of health and 1.16 Safety and quality training**

## Reflective question

- How does your healthcare service provide a culturally safe environment for Aboriginal and Torres Strait Islander peoples?
- How does your healthcare service recognise cultural beliefs and practices of Aboriginal and Torres Strait Islander peoples?

## Key task

- Identify and implement ways to improve the physical, emotional and relational environment for local Aboriginal and Torres Strait Islander communities in partnership with local communities where possible.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on the context of each healthcare service, but could include:

- Physical space that reflects the cultural identity of Aboriginal and Torres Strait Islander peoples
- Implementation of culturally appropriate programs (for example, incorporating traditional healing practices)
- Evidence of cultural competency training
- Resources tailored to the needs of Aboriginal and Torres Strait patients such as use of visual aids or posters with culturally relevant information

- Evidence of working in partnership with Aboriginal and Torres Strait Islander patients and local Aboriginal Community Controlled services where there is a significant Aboriginal or Torres Strait Islander patient cohort when carrying out a review of the design, use and layout healthcare service.

## Where to go for more information

### Commission resource

- **NSQHS Standards User guide for Aboriginal and Torres Strait Islander health** – provides practical support for the implementation of the Aboriginal and Torres Strait Islander-specific actions in the NSQHS Standards. The principles and strategies outlined in this resource are broadly applicable.

# Partnering with Consumers Standard

Healthcare services develop, implement and maintain systems to partner with consumers in their own health care.

### Consumer outcome

*I am a partner in my own health care and my opinion is valued in designing and delivering health care.*

## Intention of this standard

The Partnering with Consumers Standard recognises the importance of working with consumers in the planning and delivery of their own health care and providing clear communication to minimise risks of harm. This standard, together with the Clinical Governance Standard, form a comprehensive clinical governance framework.

# Clinical governance and quality improvement systems to support partnering with consumers

## Consumer outcome

*I am supported to be a partner in my own health care.*

## Intention of this standard

Systems are designed and used to support patients, carers, families and consumers to be partners in health care.

## Integrating clinical governance

### Action 2.01

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

a. Implementing policies and procedures for partnering with consumers
b. Managing risks associated with partnering with consumers
c. Monitoring processes for partnering with consumers.

### Explanatory notes

After more than 40 years of growing recognition and acceptance, patient partnerships in health care are now viewed as integral to improving outcomes for patients. Patient partnerships are also a pillar of person-centred care – that is, care that is respectful of, and responsive to, the preferences, needs and values of the individual patient.

There is growing acceptance that practices that support partnerships at the level of the individual – from communication and structured listening, through to shared decision making, self-management support and care planning – can improve the safety and quality of health care, improve patient outcomes and experience, and improve the performance of healthcare services.[23]

As with any other quality improvement process, patient partnerships should be monitored and their impact evaluated and refined.

This action requires healthcare services to use the systems established in the Clinical Governance Standard to partner with consumers.

**Links to Actions 1.02 Policies and procedures, 1.03 Measurement and quality improvement and 1.04 Risk management**

## Reflective questions

- How does your healthcare service partner with consumers?
- What policies and procedures exist and how are they used to support partnering with consumers?
- How are risks associated with partnering with consumers identified and managed?
- What training has been provided to the workforce to support partnering with consumers?

## Key tasks

- Set up and implement structures to enable partnering with consumers.
- Identify key principles or documents that underpin how the healthcare service partners with consumers.
- Use risk management systems to identify, monitor, manage and review risks associated with partnering with consumers.
- Deliver or provide access to training on partnering with consumers based on the specific needs of the workforce.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Policies and procedures that are implemented and cover
  - healthcare rights
  - informed consent
  - shared decision making and planning care
  - health literacy and effective communication with patients, carers, families and consumers
  - partnering with consumers in service design
- Feedback sought through surveys, verbally or through the healthcare service's website
- Resources available to support consumer participation
- Observation of the workforce using the processes for partnering with consumers
- Evidence of the assessment of workforce needs for education and training in relation to partnering with consumers
- Feedback from the workforce about their training needs to support partnering with consumers
- Schedule of workforce education and training that includes partnering with consumers
- Documentation or examples of how consumer feedback, including complaints, has been used to inform workforce training and changes in systems and processes
- Feedback from consumers, consumer representatives, consumer organisations and carers on their experience of engaging with the healthcare service
- Examples of any risks the service may have identified that prevents consumers from engaging with the service and the actions taken.

## Where to go for more information

### Commission resource

- Partnering with Consumers – partnering with consumers is about actively working with people who use the healthcare system to ensure that care is safe, high-quality and meets their needs.

# Partnering with patients in their own care

## Consumer outcome

*I can choose how I partner in my health care.*

## Intention of this standard

Partnering with patients underpins the delivery of care. Patients are partners in their own health care to the extent that they choose.

## Healthcare rights and informed consent

## Action 2.02

The healthcare service:

a. Uses a charter of rights consistent with the *Australian Charter of Healthcare Rights (second edition)*
b. Has processes to support the workforce to apply the principles of the charter of rights in the planning and delivery of health care
c. Makes the charter of rights easily accessible for patients, carers, families and consumers
d. Ensures its informed consent processes comply with legislation and best practice.

## Explanatory notes

### Charter of rights

A healthcare service's charter of rights describes the rights that consumers, or someone they care for, can expect when receiving health care. The healthcare service's charter of rights should be consistent with the *Australian Charter of Healthcare Rights (second edition)*, as illustrated in **Figure 4**.

In using a charter of rights, your healthcare service ensures that the seven healthcare rights described are upheld in the planning and delivery of health care. This includes informed consent, which is a person's voluntary decision about their health care that is made with knowledge and understanding of the benefits and risks involved.

**Figure 4**: Australian Charter of Healthcare Rights (second edition)

# My healthcare rights

This is the second edition of the **Australian Charter of Healthcare Rights.**

These rights apply to all people in all places where health care is provided in Australia.

The Charter describes what you, or someone you care for, can expect when receiving health care.

## I have a right to:

### Access

- Healthcare services and treatment that meets my needs

### Safety

- Receive safe and high quality health care that meets national standards
- Be cared for in an environment that is safe and makes me feel safe

### Respect

- Be treated as an individual, and with dignity and respect
- Have my culture, identity, beliefs and choices recognised and respected

### Partnership

- Ask questions and be involved in open and honest communication
- Make decisions with my healthcare provider, to the extent that I choose and am able to
- Include the people that I want in planning and decision-making

### Information

- Clear information about my condition, the possible benefits and risks of different tests and treatments, so I can give my informed consent
- Receive information about services, waiting times and costs
- Be given assistance, when I need it, to help me to understand and use health information
- Access my health information
- Be told if something has gone wrong during my health care, how it happened, how it may affect me and what is being done to make care safe

### Privacy

- Have my personal privacy respected
- Have information about me and my health kept secure and confidential

### Give feedback

- Provide feedback or make a complaint without it affecting the way that I am treated
- Have my concerns addressed in a transparent and timely way
- Share my experience and participate to improve the quality of care and health services

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AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

**For more information**
**ask a member of staff or visit**
**safetyandquality.gov.au/your-rights**

### Informed consent

Informed consent is a person's decision, given voluntarily, to agree to a healthcare treatment, procedure or other intervention that is made:

- Following the provision of accurate and relevant information about the healthcare intervention and alternative options available
- With adequate knowledge and understanding of the benefits and material risks of the proposed intervention relevant to the person who would be having the treatment, procedure or other intervention.

For there to be valid informed consent, the person consenting must:

- Have the legal capacity to consent
- Give their consent voluntarily
- Give their consent to the specific treatment, procedure or other intervention being discussed
- Have enough information about their condition and treatment options, the benefits and risks relevant to them, and alternative options for them to make an informed decision to consent. This includes the opportunity to ask questions and discuss concerns.

**Links to Actions 2.03 Healthcare rights and informed consent**

## Reflective questions

- Does your healthcare service use a charter of rights? Is it consistent with the *Australian Charter of Healthcare Rights (second edition)* in that it addresses access, safety, respect, partnership, information, privacy and feedback?
- How is this information about healthcare rights communicated to consumers?
- How do people who use your service know what their healthcare rights are?
- How does the workforce use the charter of rights in the delivery of health care?
- Does your informed consent policy comply with legislation and best practice?
- How does your healthcare service monitor compliance with informed consent processes?

## Key tasks

### Healthcare rights

- Adopt the Australian Charter of Healthcare Rights (second edition) (with or without amendments).
- Provide ready access to copies of the **charter, in appropriate languages or formats**, to all patients, and their carers and families.
- Inform patients, carers, and families about the charter, and make sure that they can find it easily.
- Support the workforce to apply the principles of the healthcare service's charter in the planning and delivery of care. This includes
  - allocating responsibility for implementing and reviewing the charter to a manager with decision-making authority
  - including information about the charter during orientation for new members of the workforce
  - holding, or providing access to, regular education and training sessions for the workforce on their responsibilities for implementing the charter; this includes all members of the workforce, and, if relevant, volunteers
  - building the charter into organisational processes, and staff codes of conduct
  - documents that outline how the rights will be achieved.

### Informed consent

Develop or adopt a process for informed consent by patients. This should include how the healthcare service:

- Informs patients (and, if applicable, their carers and substitute decision-makers) about the risks, benefits and alternatives of a treatment, including any fees and charges associated with treatment and referrals
- Determines patient preferences for treatment
- Documents patient consent to treatment
- Supports the healthcare providers workforce to meet legal and ethical requirements.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- The healthcare service has adopted the **Australian Charter of Healthcare Rights (second edition)** in different languages and formats consistent with the community profile
- Charter of rights is displayed in areas that are accessible to the public
- Material showing that patients and carers received information about their healthcare rights
- Feedback from patients and consumers about awareness of the charter of rights
- Feedback from patients about the health care they receive that demonstrates the workforce is applying the charter of healthcare rights in the planning and delivery of care
- Policy documents for informed consent that reference relevant legislation and best practice and consider issues, such as
  - circumstances where consent should be obtained and when it is not required
  - circumstances in which verbal consent is acceptable and when written consent is required
  - requirements for consent to be valid
  - processes for when consent is not provided, or treatment is refused
  - obtaining consent from patients from culturally and linguistically diverse backgrounds
  - the age at which patients can provide consent and consent for minors
- Consent forms that are currently in use or documentation of the patient's verbal consent where appropriate
- Audit results of patient healthcare records documenting informed consent
- Training documents on informed consent processes.

## Where to go for more information

### Commission resources

- ***Australian Charter of Healthcare Rights* – Using the charter in your health service** – outlines ways in which healthcare services can provide information about health rights and incorporate a charter in their systems. Resources to assist with the adoption of the Australian Charter of Healthcare Rights are available for download including versions translated to other languages.
- ***Australian Charter of Health Care Rights* – LGBTQI+** – the LGBTQI+ version of the charter of rights can be used by health services to promote diversity and inclusion.
- **Informed consent** – access fact sheets for healthcare providers and useful links.

# Action 2.03

The healthcare service has processes to identify:

a. The capacity of a patient to make decisions about their own health care
b. A substitute decision-maker if a patient does not have the capacity to make decisions for themselves.

## Explanatory notes

According to the legislation of every Australian jurisdiction, all adults are presumed to have the capacity to make decisions about their care.

A policy on identifying substitute decision-makers is required for patients whose decision-making capacity is limited or fluctuates. Substitute decision-makers are involved in decisions about a patient's care.

If a patient does not have the capacity to make decisions about their own care, a substitute decision-maker may be nominated. Examples of substitute decision-makers are a nominated carer, a health attorney or a person nominated under an enduring power of attorney or guardianship arrangement.

A person has capacity to make a decision about their care if they can:

- Understand and retain the information needed to make a decision
- Use the information to make a judgement about the decision
- Communicate the decision in some way, including by speech, gestures or other means
- Decision-making capacity can be decision- and situation-specific.[24]

This means that a person's capacity can vary at different times, in different circumstances and between different types of decisions. The healthcare service should identify patients who do not have the capacity to make decisions about their own care and should implement a system to identify:

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

## Reflective questions

- What processes are in place to support the workforce to identify a patient's capacity to make decisions about their own care?
- How are the workforce supported to identify and document a substitute decision-maker?

## Key tasks

- Develop or adopt a policy or procedure for assessing the capacity of patients to make decisions about their own health care and identifying a substitute decision-maker where needed. It should
  - outline the identification process and requirements of the workforce assessing patients
  - outline the appointment process, where applicable
  - comply with relevant state or territory legislation
  - include a list of appropriate decision-makers that is consistent with relevant state and territory legislation and best-practice guidelines.

- The policy or procedure should be developed in consultation with the workforce responsible for assessing patient's capacity to provide consent.
- The workforce must be trained in the healthcare service's policies, procedures and protocols for assessing a person's capacity to make decisions about their care and engaging substitute decision-makers.
- A periodic review of the policy/procedure should be scheduled, to consider the effectiveness and outcomes of the policy.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context, but could include:

- Observation or documented examples of
  - identifying a patient's capacity for making decisions about their care
  - identifying a substitute decision-maker, if a patient does not have the capacity to make decisions about their care
  - documenting substitute decision-makers such as next of kin, advocates, people with power of attorney and legal guardians
- Screening and assessment tools, or processes used to identify the patient's capacity for decision-making
- Audit results of patient healthcare records that identify the patient's capacity to make decisions, and confirm the identity of the substitute decision-maker, if required
- Audit results of patient healthcare records for compliance with policies, procedures or protocols for determining a patient's capacity and determining a substitute decision-maker, if required
- Information packages or links to resources about advocacy, power of attorney and legal guardianship that are available for consumers in different formats and languages, consistent with diversity of the patient population and local community.

## Where to go for more information

### Commission resources

The principles and strategies outlined in these resources are broadly applicable.

- **NSQHS Standards User Guide for health service organisations providing care for patients with cognitive impairment or at risk of delirium** – provides practical support for healthcare services where specific efforts or additional attention is required to meet the health needs of this patient population, based on the NSQHS Standards.
- **NSQHS Standards User Guide for health services providing care for people with mental health issues** – provides practical support for healthcare services where specific efforts or additional attention is required to meet the health needs of this patient population, based on the NSQHS Standards.

### Other resource

- **Capacity Australia**: access to resources, tools and training for resources and tools available to assist the workforce assess and support a person's capacity to make decisions.

# Shared decisions and planning care

## Action 2.04

The healthcare service has processes for healthcare providers to partner with patients and/or their substitute decision-maker to plan, communicate, set and review goals, make decisions and document their preferences about their current and future health care.

## Explanatory notes

Shared decision making is a process in which the healthcare provider and patient jointly participate in making a health decision, having discussed the options and their potential benefits and risks, and having considered the patient's values, preferences and circumstances. Where possible, supported decision-making enables a patient to remain involved. Substitute decision-making should be used as a last resort for the shortest possible time and reviewed regularly. It should not be a substitute to appropriate support for the patient making decisions about their own care.[24]

**Links to Action 2.05 Shared decisions and planning care**

## Reflective questions

- How is the workforce supported to partner with a patient or their substitute decision-maker to plan, communicate, set goals and makes decisions about current and future care?
- How does the healthcare service review the use and outcomes of systems and processes for partnering with a patient or their substitute decision-maker?
- How does the healthcare service demonstrate that patient are supported to be actively involved in their own care?

## Key tasks

- Develop processes to involve a patient or their substitute decision-maker in planning, communication, goal setting and decision-making for their current and future care, and review workforce compliance with these processes.
- Identify any communication barriers and areas for improvement and implement solutions to overcome these. Consider engaging consumers in this review process by establishing a focus group or seeking feedback from patients.
- Encourage healthcare providers to create an environment in which patients feel confident asking questions and healthcare providers respond positively to patient needs; this may involve speaking with patients in a neutral environment, away from the clinical setting.
- During the delivery of health care, provide consumers with access to information and resources in a format that meets their needs; this may include
  - general information about their health, condition and healthcare arrangements
  - information about how they can be involved in their own care

  - information that has been developed specifically for them regarding tests and treatment options
  - provide patients with timely and open access to their healthcare record, test results and other clinical information relevant to their care.
- Implement ways to support patients self-manage their health care.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- A documented process, templates or other tools to support shared decision making, care planning and the development of goals of care, including supporting communication and interpersonal skills, shared decision making, and planning current and future care as well as advance care planning, where required
- Documentation in patient healthcare records, or observation that demonstrates
  - information was provided to patients and carers about care options
  - patients and carers, or substitute decision-makers, were involved in screening and assessment processes, decision-making, developing goals of care and given information about the treatment to be provided
  - a plan for care was developed with patients and the workforce, and provided to patients to review and retain a copy
- Patient information packages or resources about care options are provided to patients in different languages and formats consistent with the diversity of the consumer population and local community
- De-identified examples of patient notes and electronic healthcare record entries that demonstrate the engagement and discussions regarding planning and involvement in care
- Results of patient and carer experience surveys about involvement in shared decision making, care planning and actions taken to deal with the issues identified
- Use of technology such as mobile and tablet apps to interact and share information with patients before, during and after their care.

## Where to go for more information

### Commission resources

- **Identifying goals of care** – access to a number of resources describing different approaches to identifying goals of care.
- **NSQHS Standards User Guide for health service organisations providing care for patients with cognitive impairment or at risk of delirium** – provides practical support for healthcare services where specific efforts or additional attention is required to meet the health needs of this patient population, based on the NSQHS Standards. The principles and strategies outlined in this resource are broadly applicable.
- **NSQHS Standards User Guide for health services providing care for people with mental health issues** – provides practical support for healthcare services where specific efforts or additional attention is required to meet the health needs of this patient population, based on the NSQHS Standards. The principles and strategies outlined in this resource are broadly applicable.
- **Top Tips for Safe Health Care** – this can help consumers, families, carers and other support people get the most out of their health care.

### Other resources

- The Commission and Healthdirect Australia: **Question Builder** – a free web-based tool to help consumers prepare for a visit to the doctor.
- La Trobe Support for **Decision Making Practice Framework** – a resource to guide healthcare services through the process of supporting people with cognitive disabilities to make decisions.

## Action 2.05

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

## Explanatory notes

Good interpersonal and communication skills are critical for healthcare providers to partner effectively with patients in their care. It is important the healthcare service provides the relevant opportunities for the healthcare provider to improve their skills so they feel confident about approaching consumer partnerships.

## Reflective question

- How does your healthcare service support the workforce to form partnerships with patients so that patients can be actively involved in their own care?

## Key tasks

- Engage senior members of the workforce to act as champions for partnerships between healthcare providers and patients
- Provide enough resources to support healthcare providers to partner with patients in their health care
- Provide access to education and training to equip the workforce to partner with patients in their care. Education and training which develops the workforce’s skills to partner with consumers may include
  - communication and interpersonal skills
  - techniques for shared decision making
  - awareness of individual health literacy and the health literacy environment.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Processes or resources to support the workforce to partner with consumers in their care, such as policies for education and training on communication, interpersonal skills, shared decision making, health literacy and ways to actively involve the patient in their own care
- Schedule of workforce education and training that includes communication and interpersonal skills, shared decision making and health literacy
- Training documents (for example, syllabus, attendance records and competency assessments) about partnering with consumers in their care

- Audit results of the proportion of the workforce who have completed education and training on partnering with consumers
- Feedback from the workforce about their training needs
- Reviews and evaluation reports of education and training programs.

## Where to go for more information

### Resources

- The **Health Issues Centre** and other state-based health consumer organisations that provide consumer engagement training for the health workforce.
- Point of Care Foundation: ***Patient and Family-Centred Care toolkit*** – provides a step-by-step method to help the workforce understand the importance of partnering with consumers.

# Health literacy

## Consumer outcome

*I am given the information I need, in a way I can understand, to support me in making decisions about my health care.*

## Intention of this standard

Healthcare services communicate with consumers in a way that supports effective partnerships.

## Communication that supports effective partnerships

### Action 2.06

The workforce communicates with patients, carers, families and consumers about health and health care in a way that:

a. Is tailored to the patient's needs and preferences
b. Is easily understood
c. Addresses the need for ongoing health care.

### Explanatory notes

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

Health literacy is important for:

- Consumers, because it affects their capacity to make informed decisions and take action to manage their health
- Healthcare providers, because it affects the way they manage their communication and partnerships with consumers and deliver care.

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

Processes to support the workforce to communicate effectively with patients and their carers about all aspects of their care involve obtaining informed consent and determining a patient's treatment preferences and goals of care.

When tailoring information, consider the diversity of people who use the service and, where relevant, the cultural diversity of the local community. Visual diagrams, decision aids, cue cards and interpreters may be useful when communicating with patients who have low health literacy or have difficulty understanding English.

**Links to Actions 1.09 and 1.10 Patient populations and social determinants of health; and 3.23 Planning and delivering comprehensive care**

## Reflective questions

- How does your healthcare service provide information about the services it provides?
- What processes are used to ensure the information provided by the workforce to patients meets the patient's needs?
- How are the workforce supported to meet the information needs of patients for ongoing care and self-management?

## Key tasks

- Set up processes to support the workforce to communicate effectively with patients about their health and healthcare needs.
- Ensure that the healthcare environment supports open, clear and effective communication between the patients and the workforce. This could be achieved by
  - regularly observing the healthcare service's environment to ensure the information consumer require is readily available
  - implementing a plain-language policy that makes written information easier to understand
  - providing the workforce with access to training on health literacy and communications skills.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Observation that the workforce, patients and carers have access to information about the healthcare service, the services it provides and common health conditions
- Evidence of a process for identifying and selecting consumer information materials and resources, for example, a needs assessment of patient information needs
- Examples of information materials and resources provided to patients and carers that are in plain language, and available in different languages and formats
- Access to the Translating and Interpreting Service (TIS National)
- Feedback received from patients and carers, including results of patient and carer experience surveys regarding the information provided about their care
- Training documents (for example, syllabus, attendance records, competency assessments) and records of workforce attendance at training programs on health literacy and communication skills.

## Where to go for more information

### Commission resources

- **Supportive resources on health literacy** – resources to support improvements in health literacy.
- **Finding good health information online** – resources to help find reliable information from trusted sources.
- ***Resources for the Australian Charter of Healthcare Rights (second edition)*** – resources in easy English, translated versions, Auslan and multimedia recording are available on the Commission's website.

- ***My Healthcare Rights – A guide for people with cognitive impairment*** – provides healthcare information for people with cognitive impairment, their carers and family members.
- **NSQHS Standards User Guide for Health Service Organisations Providing Care for Patients from Migrant and Refugee Backgrounds** – provides practical support for healthcare services where specific efforts or additional attention is required to meet the health needs of this patient population, based on the NSQHS Standards. The principles and strategies outlined in this resource are broadly applicable.

### Other resources

- **Better Health Channel** – provides a range of easy to understand resources on health information.
- Council for Intellectual Disability: **Resources for health practitioners** – resources for healthcare providers to support better appointments when working with people with intellectual disability.
- Council for Intellectual Disability: **Easy Read resources for people with intellectual disability** – a collection of health fact sheets in Easy Read format for people with intellectual disability, their families and carers.
- Department of Health and Social Services (United States of America) **Agency for Healthcare Research and Quality: Health Literacy Universal Precautions Toolkit (2nd ed.)** – offers evidence-based guidance to help healthcare providers make health information easier to understand and act on, make healthcare easier to navigate, and increase support for patients of all health literacy levels.
- Eastern Health: **Cue Cards in Community Languages** – cue cards to custom-make communication boards for individual client need.
- NSW Health: Health Education and Training – **Health Literacy and Teach-back** – a podcast series, which emphasises the importance of health literacy in providing health care that is safe and supports improved patient outcomes.
- SA Health: **Guide for Engaging with Consumers and the Community, Tool 3** – Tips for communicating clearly.
- **UNSW: Department of Developmental Disability Neuropsychiatry (3DN)** – provides resources for professionals and consumers.
- Victorian Government: **Health Translations – translated information about health and wellbeing** – a free online library of high-quality translated Australian health and wellbeing information.

## Accessing healthcare service information

### Action 2.07

The healthcare service makes information available to consumers on:

a. The services available
b. The opening hours and how to access health care
c. Who can access the services
d. Estimated service costs
e. Alternative health care when the service is closed, after-hours and in an emergency
f. Service location(s) and access details
g. Mechanisms for providing feedback and contact details for the appropriate healthcare complaints authority.

## Explanatory notes

Providing access to information about your service will help consumers decide when, how and whether to use the service. Access details can refer to physical access or remote access where telehealth is used. Where the same service is provided from multiple sites, access details for each site should be provided. Where services are provided in a patient's home, access details are not required.

Ideally, consider involving consumers in the development of information about your healthcare service. It can be useful to ask questions about what information they need, when they need it (whether on the organisation's website, when making an appointment or in the waiting room) and what format will work best for them. Testing the final resource with consumers can tell you whether the information meets their needs.

## Reflective questions

- How can people find information about your healthcare service?
- How can consumers provide feedback about your service's accessibility?
- How is information regarding costs made readily available to consumers in an accessible manner?
- Where would consumers find information about who they can contact in an emergency when your healthcare service is not available?

## Key tasks

- Consider a resource that provides details about
  - the services available
  - the opening hours and how to access health care, including accessibility
  - who can access the service and contact for special requirements
  - estimated service costs
  - alternative health care when the service is closed, after-hours and in an emergency
  - service location(s) and access details, including parking and public transport
  - how to provide feedback or make a complaint and contact details for the appropriate healthcare complaints authority.
- Take into account that a resource may be a web page, fact sheet, poster display or a frequently asked questions sheet for the workforce.
- Ensure your resource is freely available and displayed in a prominent place, on your website (if relevant), and available to the workforce to answer queries from consumers.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context, but could include:

- Healthcare service website that includes details of the services provided, how consumers can access those services, opening hours, costs, the service's physical location, if applicable and contact details such as phone and email information
- Brochures, links to or information about options for emergency care providers when the healthcare service is not open or not able to provide urgent care or for additional support.

## Where to go for more information

### Commission resource

- Fact sheet 4 – ***Writing health information for consumers*** – describes how you can review and improve the content and format of your organisation's written information. Making your written information easier to understand will improve your health literacy environment and help you meet some of the requirements of the NSQHS Standards.

### Other resource

- Healthdirect: **After-hours general practitioner (GP) helpline** – a safety-net health service that helps people in rural and remote areas obtain the services of a GP and provides an alternative to visiting a hospital emergency department.

# Partnering with consumers in service design

## Consumer outcome

*My opinion matters in the development, delivery and review of healthcare services.*

### Intention of this standard

Consumers are partners in the planning, design, monitoring and evaluation of services.

## Partnerships in the planning, design, monitoring and evaluation of services

## Action 2.08

The healthcare service works in partnership with patients, carers, families and consumers to seek and incorporate their views and experiences into the planning, design, monitoring and evaluation of services.

### Explanatory notes

Consumers can make effective and meaningful contributions to healthcare service planning, design, monitoring and evaluation. Consumers and carers can provide unique insights into safety and quality issues and risks, including with prioritising issues and which solutions are acceptable. Engaging consumers, carers, families, and support people in measuring and evaluating the safety and quality of the healthcare service can occur in many ways, including in evaluating feedback.

Consumer involvement in the development, implementation and evaluation of health care contributes to:

- Appropriately targeted initiatives
- Efficient use of resources
- Improvement in patient experience and the quality of care provided by a healthcare service.[25]

Different types of partnerships with patients and consumers exist within the healthcare system.

Methods of partnership range from informal, one-off events or feedback through social media to formal participation in design processes and ongoing participation on boards and committees.

Engagement may be as an individual, or in small or large groups, and should be guided by the size and capacity of the healthcare service, the type of feedback required, and the diversity of the local population. An example of this type of larger engagement could involve seeking feedback from patients and consumers, including local Aboriginal and Torres Strait Islander peoples and culturally and linguistically diverse communities when redesigning the physical environment or when planning to offer a new type of service.

There are multiple successful approaches to partnering with consumers.[26] Different healthcare services have different contexts and resources available to embed consumer partnerships. Although capacity and resource limitations may appear to pose a barrier to forming consumer partnerships, a simple approach to partnering can often be the most effective.

**Links to Action 1.07 Feedback and complaints management**

## Reflective questions

- How are consumers involved in the planning, design, monitoring and evaluation of care provided by the healthcare service?
- How does the healthcare service ensure that the diversity of consumers and local communities who use the service are reflected in these partnerships?

## Key tasks

- Identify the diversity of consumers who use the services and who are part of the local community and ensure these groups are captured in any partnership activities.
- Identify opportunities to partner with consumers in the design, monitoring and evaluation of the healthcare service. Examples include when
  - redesigning or refitting the service’s premises
  - reviewing the services available and their opening hours
  - considering introducing new services, or an additional healthcare provider
  - assessing consumer feedback on the service and designing actions to make improvements
  - assessing performance information on the service and designing actions to improve the consumer experience
  - inviting consumers to be part of ‘waiting room workshops’
  - talking with consumers in waiting rooms or at informal meetings at a time that is convenient to the consumer
  - using data about consumer experiences (such as patient experience surveys) to help identify key issues and opportunities for improvement
  - meeting with community and consumer organisations to identify key issues and opportunities for improvement
  - inviting consumers to take part in a lunchtime or evening workshop with members of the workforce.
- Ensure that, if feasible, the healthcare service acts on the information provided by consumers and feeds back information on changes that have occurred as a result of consumer suggestions.
- Ensure that information provided by consumers or carers about their experiences is treated sensitively, that privacy and confidentiality are maintained, and that consumers and carers are supported to share their experiences and stories to the extent that they are comfortable.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context, but could include:

- Observations or interviews with consumers that demonstrate how the healthcare service involves consumers in design, measurement and evaluation of the healthcare service's performance and care
- Feedback from consumers engaged in partnerships with the healthcare service about their experience in being a part of the process
- Feedback from consumers that includes options for providing suggestions about ongoing improvement
- Records of actions that have been taken using consumer feedback and advice
- Workshop records (including activities such as 'waiting room workshops' or surveys) to seek feedback from consumers on how the healthcare service operates
- Evidence of informal interviews with consumers who attend the service to seek feedback on design, monitoring and evaluation of care provided by the healthcare service.

## Where to go for more information

### Commission resource

- **NSQHS Standards User guide for Aboriginal and Torres Strait Islander health** – provides practical support for the implementation of the Aboriginal and Torres Strait Islander-specific actions in the NSQHS Standards. The principles and strategies outlined in this resource are broadly applicable.

### Other resources

- Agency for Clinical Innovation: **Co-design toolkit** – provides access to practical information, tools and resources for healthcare services to adopt a co-design approach.
- Cancer Australia: **Consumer Involvement Toolkit** – provides web-based practical tools to assist, **CEOs and Executives**, **Service Managers**, **Health Professionals**, **Researchers**, **Policy Makers** and **Consumers** to actively engage with consumers around a shared focus and vision.
- Health Issues Centre: **Getting started: Toolkit for Health Services** – a series of resources for healthcare providers working with consumer representatives.
- Health Issues centre: ***Consumer Model – Partnering with Healthcare Organisations*** – a model that shows health consumers how they can effectively partner with healthcare services. It highlights opportunities that exist for consumers to contribute, for all experience levels.
- People with Disabilities Western Australia: **Co-design toolkit** – provides guidance on how to successfully engage, connect and co-design with people with disability.
- Queensland Australia: **Health Care Providers' Guide to Engaging Multicultural Communities and Consumers** – aims to assist health care providers to involve people from a culturally and linguistically diverse background in the planning, delivery and evaluation of health services.

# Clinical Safety Standard

Healthcare services implement systems and processes to maximise safe, high-quality care and minimise clinical safety risks.

### Consumer outcome

*The clinical care I receive is safe and of high quality.*

## Intention of this standard

This standard aims to ensure common clinical safety risks in healthcare services are identified and mitigated. The clinical safety risks in this standard include:

- Preventing and controlling infections
- Medication safety
- Comprehensive care
- Communicating for safety
- Recognising and responding to serious deterioration and minimising harm.

# Clinical governance and quality improvement systems to support clinical safety

## Consumer outcome

*The risks I face with accessing health care are known and actively managed.*

## Intention of this standard

The healthcare service uses its clinical governance systems to identify and mitigate clinical safety risks.

## Integrating clinical governance

### Action 3.01

The workforce uses safety and quality systems from the Clinical Governance Standard when:

a. Implementing policies and procedures for clinical safety
b. Managing risks associated with clinical safety
c. Identifying training requirements to support clinical safety.

### Explanatory notes

By implementing the Clinical Governance Standard and the Partnering with Consumers Standard, your healthcare service will establish an individualised clinical governance framework. The systems and processes that form clinical governance framework can be used to implement the Clinical Safety Standard, which addresses risks to safety and quality commonly encountered.

This action requires healthcare services to apply the systems and processes developed when implementing the Clinical Governance Standard to each criterion described in the Clinical Safety Standard. This will ensure a consistent approach to managing safety and quality risks in the healthcare service.

### Implementing policies and procedures for clinical safety

Policies and procedures written to address safety and quality risks should be developed and implemented in a way that is consistent with Action 1.02 Policies and procedures. That is:

- Policies and procedures aim to reduce or eliminate safety and quality risks in the healthcare service
- The workforce is supported to implement policies, procedures and protocols, including making them easily accessible
- A schedule is implemented to monitor, review and update policies and procedures using a risk management approach.

Policies and procedures must address clinical safety risks relevant to your healthcare service. Key clinical safety risks are described in the Clinical Safety Standard and include preventing and controlling infections, medication safety, comprehensive care, communicating for safety and recognising and responding to serious deterioration and harm.

Links to Action 1.02 Policies and procedures to actions in the Clinical Safety Standard

### Managing risks associated with clinical safety

Risk management approaches to identify, analyse, evaluate and mitigate safety and quality risks that have been used to address clinical safety risks relevant to your healthcare service. Key clinical safety risks are described in the Clinical Safety Standard and include preventing and controlling infections, medication safety, comprehensive care, communicating for safety and recognising and responding to serious deterioration and harm.

Links to Action 1.04 Risk management to actions in the Clinical Safety Standard

### Identifying training requirements to support clinical safety

All people who form part of your healthcare service's workforce must understand their safety and quality roles in the context of your healthcare service. Orientation and access to training should occur on commencement to the service, whenever responsibilities change and when new services are introduced. The identification of training requirements should be consistent with Action 1.15 Safety and quality training and address the clinical safety risks relevant to your healthcare service. These include preventing and controlling infections, medication safety, comprehensive care, communicating for safety and recognising and responding to serious deterioration and harm.

Links to Actions 1.09 and 1.10 Patient populations and social determinants of health; 1.15 and 1.16 Safety and quality training; 1.17 Safety and quality roles and responsibilities; and 1.18 Evaluating performance to actions in the Clinical Safety Standard

## Reflective question

- How is your healthcare service's clinical governance framework used to
  - support the implementation of policies and procedures for clinical safety?
  - identify and manage risks associated with clinical safety?
  - identify training requirements for clinical safety?

## Key tasks

- Develop and implement policies and procedures for clinical safety.
- Use risk management processes established in Action 1.04 to identify, monitor, manage and review risks associated with clinical safety.
- Deliver or provide access to training on relevant clinical safety risks based on the patient population and the specific needs of the workforce.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Policies and procedures that provide guidance on relevant clinical safety issues
- Risk register entries relating to clinical safety
- Training documents (for example, orientation training plans and records) for members of the workforce relating to clinical safety.

## Where to go for more information

Resources relating to this Action may be added as they become available.

# Applying quality improvement systems

## Action 3.02

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

a. Monitoring clinical safety risks
b. Implementing strategies to improve clinical safety outcomes and associated processes
c. Reporting on clinical safety.

## Explanatory notes

By implementing the Clinical Governance Standard and the Partnering with Consumers Standard, your healthcare service will establish an individualised clinical governance framework. The systems and processes that make up the clinical governance framework can be used to implement the Clinical Safety Standard, which addresses commonly encountered risks to safety and quality. These include preventing and controlling infections, medication safety, comprehensive care, communicating for safety and recognising and responding to serious deterioration and harm.

This action requires healthcare services to use quality improvement systems for each criterion described in the Clinical Safety Standard to:

- Identify and collect data available within your healthcare service to monitor clinical safety risks
- Act on areas identified for improvement
- Document the clinical safety risks and the action taken.

**Links to Actions 1.03 Measurement and quality improvement and 1.07 Feedback and complaints management to actions in the Clinical Safety Standard**

## Reflective questions

- What data does your healthcare service review to identify clinical safety improvements?
- What clinical safety changes have been made as a result of the data review?
- How is information about your healthcare service's clinical safety performance documented and reported?

## Key tasks

- Identify and collect data within your healthcare service that can be used to inform improvements to clinical safety.
- Take action to address the areas of clinical safety identified for improvement.
- Document clinical safety risks using established processes from Actions 1.03 and 1.05 and action taken.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context, but could include:

- Clinical safety data, for example, from incidents, collected and reviewed to identify safety and quality improvements
- Example of clinical safety changes made within the healthcare service as a result of the review of data and implementations made
- Meetings or communication records where discussion about clinical safety incidents occurred, and the strategies and actions taken to address identified risks
- Reports on clinical safety.

## Where to go for more information

### Resource

- Institute for Healthcare Improvement: **Plan, Do, Study, Action (PDSA) Worksheet** – a useful tool for documenting a test of change.

## Partnering with consumers

### Action 3.03

The workforce uses the healthcare service's processes from the Partnering with Consumers Standard when addressing clinical safety to:

a. Actively involve patients in their own health care
b. Meet the patient's information needs
c. Share decision-making.

### Explanatory notes

Implementing the Partnering with Consumers Standard is fundamental to the delivery of safe, high-quality health care. Implemented together with the Clinical Governance Standard, your healthcare service will establish an individualised clinical governance framework.

This action requires healthcare services to apply principles of partnering with consumers, health literacy and shared decision making, developed when implementing the Partnering with Consumers Standard, to each criterion described in the Clinical Safety Standard. These include preventing and controlling infections, medication safety, comprehensive care, communicating for safety and recognising and responding to serious deterioration and harm.

**Links to Actions 2.02 and 2.03 Healthcare rights and informed consent; 2.04 and 2.05 Shared decisions and planning care; 2.06 Communication that supports effective partnerships; and 2.07 Accessing healthcare service information to actions in the Clinical Safety Standard**

### Reflective questions

- What processes from the Partnering with Consumers Standard do healthcare providers use to involve patients in relevant clinical safety areas?
- How does your healthcare service ensure that information provided to patients regarding clinical safety are tailored to their needs and health literacy?

### Key tasks

- Use processes developed when implementing the Partnering with Consumers Standard to inform implementation of relevant actions in the Clinical Safety Standard.
- Support the workforce to communicate effectively with patients, carers and families about clinical safety tailored to their needs and preferences.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Examples of information material and resources relating to clinical safety displayed or provided to patients, families and carers in plain language, available in different languages and formats
- Documents outlining processes relating to clinical safety that include how patients are supported to be actively involved in their own health care
- Examples of healthcare records that demonstrate healthcare providers have partnered with patients in shared decision making about clinical safety
- Patient feedback regarding areas of clinical safety.

## Where to go for more information

### Commission resource

- **Partnering with Consumers** – information and resources to support healthcare services understand the value of partnerships with consumers, how to engage with consumers and integrate person-centred approaches.

# Preventing and controlling infection

## Consumer outcome

*My risk of getting or spreading an infection is assessed and minimised.*

### Intention of this standard

Evidence-based processes are used to prevent and control infections. Patients presenting with, or with risk factors for, infection or colonisation with an organism of local, national or global significance are identified promptly, and receive the necessary management and treatment. The healthcare service is clean and hygienic.

## Standard and transmission-based precautions

## Action 3.04

The healthcare service has processes to apply standard and transmission-based precautions that are fit for the setting and consistent with the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*, and jurisdictional requirements, and relevant jurisdictional laws and policies, including work health and safety laws.

### Explanatory notes

In all healthcare settings there is a risk of infection. Processes for preventing and controlling infections include ensuring training on how, and when, to apply the various elements of standard and transmission-based precautions relevant to the primary healthcare setting.

***The Australian Guidelines for the Prevention and Control of Infection in Healthcare*** is a key national resource that outlines critical aspects of infection prevention and control, focusing on core principles and priority areas for action. It provides evidence-based recommendations for healthcare workers and healthcare services.

Priority areas in the guideline are standard and transmission-based precautions.

Standard precautions are work practices that provide a first-line approach to infection prevention and control in the healthcare environment and should be adopted by all healthcare workers for all patients, regardless of suspected or confirmed infection status.

Standard precautions include:

- **Hand hygiene**
- The use of appropriate personal protective equipment
- The safe use and disposal of sharps
- Routine **environmental cleaning**
- Cleaning and reprocessing of reusable medical equipment and instruments
- Respiratory hygiene and cough etiquette
- **Aseptic technique**
- Waste management
- Appropriate handling of linen.

**Transmission-based precautions** are applied to patients suspected or confirmed to be infected with agents transmitted by the contact, droplet, or airborne routes (such as the use of contact precautions to mitigate contact transmission of methicillin-resistant *Staphylococcus aureus*). There are three categories of transmission-based precautions:

- **Contact precautions** are used when there is a known or suspected risk of transmission of infectious agents by direct or indirect contact
- **Droplet precautions** are used when there is a known or suspected risk of transmission of infectious agents by respiratory droplets
- **Airborne precautions** are used when there is a known or suspected risk of transmission of infectious agents by the airborne route.

Transmission-based precautions are used to respond to these specific means of transmission. For some infectious agents, a combination of precautions may be required (for example, seasonal influenza requires both contact and droplet precautions).

This action requires healthcare services to describe how the different elements of standard and transmission-based precautions are implemented.

Healthcare services will also be required to adhere to relevant jurisdictional laws and policies relating to infection prevention and control, including work health and safety laws.

## Reflective questions

- How does the workforce in your healthcare service implement standard and transmission-based precautions?
- What jurisdictional laws and policies regarding infection prevention and control are relevant to your healthcare service?

## Key tasks

- Identify infection and prevention control jurisdictional laws and policies relevant to the healthcare service.
- Describe how relevant standard and transmission-based precautions will be implemented in the healthcare service.
- Ensure that the equipment, supplies and products required by the workforce to work safely and minimise the risk of infection transmission are accessible, located where required and appropriate to the risks identified for the context and physical environment of the healthcare service.
- Develop or review signage, alert systems, and information/reminder systems and resources to raise awareness of standard and transmission-based precautions.
- Consider how the need for transmission-based precautions are communicated within the healthcare service and with other healthcare services who are providing care to the patient.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Policies and procedures regarding standard and transmission-based precautions
- Evidence that policies and procedures are easily accessible by the workforce
- Observation of the workforce practising standard and transmission-based precautions
- Training documents (for example, syllabus, attendance records, competency assessments) relating to standard and transmission-based precautions
- Examples of improvement activities that have been implemented and evaluated to raise awareness and improve compliance with standard and transmission-based precautions
- Examples of incidents relating to compliance with standard and transmission-based precautions being documented and discussed with appropriate actions taken to address the identified risks or improve clinical safety
- Observation of standardised signage and other forms of clinical communication informing about the need for standard and transmission-based precautions as part of patient care
- Processes to assess infection risk.

## Where to go for more information

### Commission resources

- **Addendum NSQHS Standards Accreditation Workbook 2021 Infection Prevention and Control Standard** – provides users with updated information on reflective questions and examples of evidence for the 2021 Preventing and Controlling Infections Standard within the NSQHS Standards. Principles and strategies are broadly applicable.
- **Infection Prevention and Control eLearning Modules: Basics of infection prevention and control course** – an online learning module on hand hygiene and infection prevention and control.
- **Infection Prevention and Control eLearning Modules: Principles of infection prevention and control course** – an online learning module on hand hygiene and infection prevention and control.
- **Use of the hierarchy of controls in infection prevention and control** – a factsheet that provides guidance on using the hierarchy of controls, in conjunction with infection prevention and control systems, to identify and manage infection risks.
- **Standard and transmission-based precaution posters** – showing the key steps for standard precautions and when caring for patients who require transmission-based precautions, due to a known or suspected infection.

### Other resource

- National Health and Medical Research Council in collaboration with the Commission: ***Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019)*** – developed to specifically support improved infection prevention and control in acute health settings and provides a risk management framework to ensure that the basic principles of infection prevention and control can be applied to a wide range of healthcare settings.

## Hand hygiene

### Action 3.05

The healthcare service has a hand hygiene process that is incorporated in its overarching infection prevention and control program as part of standard precautions and:

a. Is consistent with the appropriate elements of the National Hand Hygiene Initiative, and jurisdictional requirements
b. Supports the workforce and consumers to practise hand hygiene.

### Explanatory notes

Effective hand hygiene is an evidence-based infection prevention strategy. The **National Hand Hygiene Initiative** uses a multimodal approach to improving hand hygiene and involves strategies such as:

- Promoting the use of alcohol-based hand rub
- Making handwashing facilities available
- Education
- Monitoring and review of hand hygiene compliance and addressing non-compliance.

Note: The **National Hand Hygiene Initiative** does not recommend direct observational auditing of hand hygiene compliance in the non-acute and primary care settings.

### Reflective questions

- What is your healthcare service's process for hand hygiene? Is it consistent with the current **National Hand Hygiene Initiative** and with state or territory requirements?
- How does your healthcare service support the workforce and people who use the service to practise hand hygiene?
- How does your healthcare service promote hand hygiene to the workforce, patients and consumers?

### Key tasks

- Define and implement a process for hand hygiene that is consistent with appropriate elements of the National Hand Hygiene Initiative and relevant state or territory requirements.
- Support the workforce to practise hand hygiene by
  - providing access to training on hand hygiene
  - ensuring the workforce has the necessary consumables and facilities, such as alcohol-based hand rubs, soap products and handwashing basins to comply with hand hygiene processes
  - promoting hand hygiene.
- Display promotional material in the healthcare service to support the workforce and consumers to practise hand hygiene.
- Encourage the workforce to promote hand hygiene to consumers.
- Ensure compliance with the ***Australasian Health Facility Guidelines*** **specifications for hand washing facility design** and other relevant Australian Standards.
- Ensure monitoring and reporting of workforce hand hygiene compliance.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- A demonstrated hand hygiene process that is consistent with the current **National Hand Hygiene Initiative** and state or territory requirements
- Training documents (for example, syllabus, attendance records or competency assessments) relating to the hand hygiene program
- Observation of hand hygiene promotion within the healthcare service.

## Where to go for more information

### Commission resources

- **What is hand hygiene?** – when performed correctly, hand hygiene results in a reduction of microorganisms on hands and contributes to prevention of healthcare-associated infection and improved patient safety.
- **National Hand Hygiene Initiative** – part of a suite of initiatives to prevent and reduce healthcare-associated infections in Australian healthcare settings.
- **Addendum NSQHS Standards Accreditation Workbook 2021 Infection Prevention and Control Standard** – provides users with updated information on reflective questions and examples of evidence for the 2021 Preventing and Controlling Infections Standard within the NSQHS Standards. Principles and strategies are broadly applicable.
- **Infection Prevention and Control eLearning Modules** – for hand hygiene (separate modules for the clinical and non-clinical workforces).
- **Infection prevention and control resources for consumers** – a series of fact sheets for consumers and carers about infection prevention and control, and common and emerging healthcare-associated infections.
- **Audit tools for non-acute settings, including primary care and mental health** – tools to support hand hygiene auditing in acute and non-acute healthcare settings.

# Respiratory hygiene, cough etiquette and physical distancing

## Action 3.06

The healthcare service supports the workforce and consumers to practise respiratory hygiene, cough etiquette and physical distancing where relevant.

## Explanatory notes

Transmission of infections that are spread by droplet and airborne modes, such as influenza and acute respiratory illness/viruses, can be minimised with respiratory hygiene, cough etiquette practices and physical distancing (or social distancing).

Respiratory hygiene and cough etiquette are part of standard precautions and involve covering sneezes and coughs to prevent infected persons from dispersing respiratory secretions into the air. Hand hygiene must be performed after coughing, sneezing, using tissues or after contact with respiratory secretions or objects contaminated by these secretions.

Physical distancing refers to the practice of maintaining distance, usually one to two metres between yourself and others to prevent the transmission of infection.

**Links to Action 1.22 Safe environment**

## Reflective questions

- How does your healthcare service support the workforce to practise respiratory hygiene, cough etiquette and physical distancing?
- How does the environment in your healthcare service promote physical distancing between people moving around the service?
- How does your healthcare service promote key messages regarding respiratory hygiene, cough etiquette and physical distancing to consumers in a way that is easily understood?

## Key tasks

- Support the workforce and consumers to practise respiratory hygiene, cough etiquette and physical distancing by
  - providing the resources and environment to achieve respiratory hygiene, cough etiquette and physical distancing
  - promoting key messages regarding respiratory hygiene and cough etiquette in the healthcare service
  - reviewing and adjusting the environment to maximise distance between people, for example, separating seating and furniture
  - promoting good indoor air quality and effective ventilation to help reduce circulating infectious particles in the air.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on the context of each healthcare service. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Processes or resources that are available to the workforce regarding respiratory hygiene, cough etiquette and physical distancing
- Observation of promotional material such as posters in the healthcare service, for example, in waiting rooms or treatment rooms, audiovisual material or brochures
- Observation of resources made available to the workforce, patients and consumers, for example, such as face masks, tissues and waste receptacles
- Completion of training that supports the workforce to practise respiratory hygiene, cough etiquette and physical distancing and how to perform these actions correctly
- Examples of documentation where respiratory hygiene, cough etiquette and physical distancing has been discussed with patients or their carer
- The design of the healthcare service provides for sufficient space to maximise physical distancing where possible.

## Where to go for more information

### Commission resources

- **Addendum NSQHS Standards Accreditation Workbook 2021 Infection Prevention and Control Standard** – provides users with updated information on reflective questions and examples of evidence for the 2021 Preventing and Controlling Infections Standard within the NSQHS Standards. Principles and strategies are broadly applicable.
- **Infection prevention and control resources for consumers** – fact sheets for consumers and carers about infection prevention and control, and common and emerging healthcare-associated infections.
- **Break The Chain of Infection Poster** – illustrates the chain of transmission of infection, in the context of COVID-19, and highlights measures that can be implemented to interrupt the spread of infection.
- **Hand hygiene and infection prevention and control eLearning modules** – a suite of eLearning modules on hand hygiene and infection prevention and control.
- **COVID-19 Resources** – for Australian health service organisations, healthcare professionals and consumers.

### Other resources

- Australian Government Department of Health: **Coronavirus (COVID-19) information and resources** – information about the coronavirus (COVID-19) pandemic, how to protect yourself and your family, where and when you can get vaccinated, and the current situation in Australia.
- National Health and Medical Research Council in collaboration with the Commission: ***Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019)*** – developed to specifically support improved infection prevention and control in acute health settings and provides a risk management framework to ensure that the basic principles of infection prevention and control can be applied to a wide range of healthcare settings.

# Aseptic technique

## Action 3.07

Where aseptic technique is required as part of the provision of health care, the healthcare service has processes to:

a. Identify procedures where aseptic technique applies
b. Monitor healthcare providers' practices to ensure compliance with the healthcare service's policies and procedures on aseptic technique.

## Explanatory notes

**Note**: This action is only applicable if your healthcare service uses aseptic technique in the provision of health care.

Aseptic technique is a set of practices that protect patients and healthcare providers from healthcare-associated infections and protects healthcare providers from contact with blood and body fluids. It should be used when a procedure or medical device enters one or more of the body's normal defences, such as the skin, mucous membranes or body cavity.

Aseptic technique, when performed correctly will:

- Minimise contamination of key sites
- Protect patients from their own pathogenic microorganisms that may cause infection
- Reduce the transmission of microorganisms
- Maintain the sterility of equipment and key parts used for aseptic procedures.

Aseptic technique is an important patient safety strategy and is an element of standard precautions.

There are five essential principles of aseptic technique:

1. **Sequencing** – ensures that each step in the process is performed in a safe and appropriate order. Sequencing includes assessing for risks to the patient, and healthcare workforce safety and identifying strategies to mitigate these risks prior to starting the procedure
2. **Environmental control** – ensures that factors in the clinical environment that can increase the risk of infection or harm throughout the procedure are assessed and minimised
3. **Hand hygiene** – ensures this is maintained throughout the entire process, including absence of hand and wrist jewellery
4. **Maintenance of aseptic fields** – ensures that the aseptic field and sites are protected throughout the entire process
5. **Personal protective equipment (PPE)** – protects both the clinician and the patient throughout the entire process.

Many of the work practices that form standard precautions are also required for aseptic technique. Examples include hand hygiene and the use of PPE. However, adherence to these practices individually does not constitute aseptic technique.

Prior to commencing any clinical procedure where aseptic technique is required, a risk assessment should be performed and any identified risks should be eliminated or minimised before and during the procedure.

A person who is observing and assessing aseptic technique in the provision of care must also demonstrate that they are competent in aseptic technique prior to assessing other members of the workforce. Theoretical knowledge, or an understanding of aseptic technique alone, are not enough to ensure someone is competent in aseptic technique (see **Table 3**).

**Table 3**: Aseptic technique competency

| Someone who understands aseptic technique should be able to: | Someone who is practically competent in aseptic technique should be able to: |
|---|---|
| • Use the correct terminology to describe concepts used in aseptic technique such as key sites, key parts and aseptic fields<br>• Describe how to assess the risk of infection associated with a particular procedure and how to mitigate those risks<br>• Describe the correct sequence to perform each step in a procedure to maintain asepsis<br>• Describe the correct steps to take if asepsis is breached during a procedure<br>• Describe other factors that may affect asepsis, such as sterile stock storage and handling, environmental and patient factors. | • Demonstrate the correct method and sequence to perform a procedure that requires aseptic technique, consistent with local policy or written procedures<br>• Maintain aseptic technique throughout the procedure<br>• Use standard precautions during the procedure, including performing hand hygiene, use of person protective equipment (PPE), safe handling and disposal of sharps and waste<br>• Demonstrate the correct steps to take if the aseptic field is breached during a procedure. |

Source: Adapted from **NSQHS Standards Implementation guide for Action 3.11 Aseptic Technique** (ACSQHC, 2022).

## Reflective questions

- What procedures are performed in your healthcare service that require aseptic technique?
- Who performs these procedures and what types of training and competency assessment is available to the workforce?
- What processes do the workforce use to support correct aseptic technique?
- How does the healthcare service ensure healthcare providers routinely follow aseptic technique when required?

## Key tasks

- Identify the procedures carried out by the healthcare service for which aseptic technique is required. These include, but are not limited to
  - intravenous or invasive device insertion, access and maintenance
  - wound dressings
  - collection of clinical specimens (blood, swabs or urine)
  - parenteral medication preparation.
- Facilitate access to training to address gaps in compliance. Training programs for aseptic technique may either be specific to individual clinical procedures or may apply to many different procedures. These programs need to incorporate all the principles of aseptic technique.
- Consider the appropriateness of technological advances to improve aseptic technique in practice, such as
  - equipment bundles
  - sterile ‘starter’ packs.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context, but could include:

- List of procedures and activities provided in the healthcare service where aseptic technique is required
- Evidence of the assessment of workforce competence in performing aseptic technique
- Training documents (for example, syllabus, attendance records, competency assessments) relating to aseptic technique, including training to reduce gaps in competence
- Aseptic technique or specific procedure training that includes aseptic technique (such as wound care training), completion certificates or a register of training modules undertaken by the workforce
- Actions taken to reduce identified clinical risks associated with aseptic technique.

## Where to go for more information

### Commission resources

- **Principles for aseptic technique: Information for healthcare workers** – for staff who carry out aseptic technique.
- **Addendum NSQHS Standards Accreditation Workbook 2021 Infection Prevention and Control Standard** – provides users with updated information on reflective questions and examples of evidence for the 2021 Preventing and Controlling Infections Standard within the NSQHS Standards. Principles and strategies are broadly applicable.
- **NSQHS Standards Implementation guide for Action 3.11 Aseptic Technique** – a fact sheet to assist health services to meet the requirements of Action 3.11.
- **Infection Prevention and control eLearning Module** – a course providing the basics of infection prevention and control.
- **Infection Prevention and control eLearning Module** – a course covering the principles of infection prevention and control.
- **Aseptic technique resources** – resources to support implementation of aseptic technique.

### Other resources

- National Health and Medical Research Council in collaboration with the Commission: ***Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019)*: Section 3.1.6 Aseptic Technique** – was developed to specifically support improved infection prevention and control in acute health settings and provides a risk management framework to ensure that the basic principles of infection prevention and control can be applied to a wide range of healthcare settings.

# Invasive medical devices

## Action 3.08

Where invasive medical devices are used, the healthcare service has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*.

## Explanatory notes

**Note**: This action is only applicable if your healthcare service uses invasive medical devices in the provision of health care.

Invasive medical devices are devices inserted through skin, mucosal barrier or internal cavity. Examples of these include intravenous devices, dental implants, catheters, curettes, podiatry forceps or acupuncture needles.

Use of invasive medical devices during the provision of health care increases the risk of infection and provides a route for infectious agents to enter the body. Aseptic insertion and careful maintenance of devices is critical to reducing infection risk.

The current edition of the ***Australian Guidelines for the Prevention and Control of Infection in Healthcare*** recommends processes for invasive medical devices. These include:

- Criteria for the insertion, and selection of the best device for patient indications and purpose
- Indications for the device to be left in place once inserted
- Assessment of aseptic technique used at insertion and for maintenance activities
- Use of evidence-based safety-engineered technology
- Evaluation of how clinicians choose the most appropriate device
- Physical environment issues that affect insertion and maintenance of devices
- Patient monitoring activities to identify infections relating to invasive medical devices
- Patient engagement and education about the use and maintenance of invasive medical devices
- Indication for removal, evidence-based removal procedure and post-removal assessment of possible complications (for example, air emboli, bleeding from removal site).

## Reflective questions

- What procedures are delivered in your healthcare service that require the use of invasive medical devices?
- How does your healthcare service identify risks associated with the different invasive devices?
- What processes does your healthcare service use to ensure appropriate use and management of invasive medical devices, consistent with the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*?
- How is your workforce supported to use and manage invasive medical devices appropriately?

## Key tasks

- Identify procedures where invasive medical devices are used in the provision of health care.
- Develop processes to support the workforce appropriately use and manage invasive medical devices.
- Review incident reports relating to invasive medical devices for appropriateness, infection, referral, inconsistency or noncompliance with organisational policy, equipment failure and other adverse events.
- Provide the workforce with training for the appropriate use and management of invasive medical devices.

### Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context, but could include:

- List of the invasive medical devices in use in the healthcare service and where they are used
- Documents outlining the process for appropriate use and management of invasive medical devices, including the selection, insertion, maintenance and removal of invasive medical devices
- Examples of records in which use of invasive medical devices was discussed
- Observation of use of invasive medical devices as per the healthcare service's processes
- Actions taken to manage identified risks with the selection, insertion, maintenance and removal of invasive medical devices
- Records of workforce training and competency in the insertion/maintenance and removal of invasive devices.

## Where to go for more information

### Commission resources

- **Addendum NSQHS Standards Accreditation Workbook 2021 Infection Prevention and Control Standard** – provides users with updated information on reflective questions and examples of evidence for the 2021 Preventing and Controlling Infections Standard within the NSQHS Standards. Principles and strategies are broadly applicable.
- **Management of Peripheral Intravenous Catheters Clinical Care Standard** – describes best-practice care for using peripheral intravenous catheters (PIVCs) – also known as 'cannulas'.
- **Infection and Prevention Control eLearning Module** – a course covering the basics of infection prevention and control.
- **Infection and Prevention Control eLearning Module** – a course covering the principles of infection prevention and control.

### Other resources

- National Health and Medical Research Council in collaboration with the Commission: ***Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019)*****: Section 3.5.2 Invasive Medical Devices** – developed to specifically support improved infection prevention and control in acute health settings and provides a risk management framework to ensure that the basic principles of infection prevention and control can be applied to a wide range of healthcare settings.

# Clean and safe environment

## Action 3.09

The healthcare service has processes to maintain a clean, safe and hygienic environment – in line with the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*, and jurisdictional requirements to:

a. Respond to environment risks, including novel infections

b. Require cleaning and disinfection using products listed on the Australian Register of Therapeutic Goods consistent with manufacturers' instructions for use and recommended frequencies

c. Provide access to training on cleaning processes for routine and outbreak situations, and novel infections.

## Explanatory notes

Infection risks are minimised when the environment is clean and well maintained. A visually clean and hygienic environment that is well maintained and free of clutter and unnecessary items supports a health consumer's right to access safe and high-quality care in an environment that makes them feel safe.

Essential elements of an environmental cleaning process include developing an environmental cleaning program, which can be a complex process. As a minimum, a successful environmental cleaning program in a small healthcare service should address the following outcomes:

- Relevant environmental risks are identified, assessed and responded to appropriately and as required. This could include increasing the frequency of cleaning in response to changes in rates of communicable diseases within the local community, for example, COVID-19
- As part of a healthcare service's overall infection prevention and control program, staff responsible for environmental cleaning are provided with training on the principles of infection prevention and control. This includes training in
  - the correct use of various cleaning equipment
  - handling and storage of cleaning solutions
  - the appropriate use of personal protective equipment (PPE)
- A detailed cleaning schedule for the entire healthcare service describes recommended cleaning frequencies, cleaning procedures and policies and role responsibilities of all staff. For more information about developing a cleaning schedule refer to the **Environmental cleaning practices in small health service organisations** fact sheet
- Cleaning outcomes are routinely evaluated and monitored by routine auditing and action is taken where issues or risks are identified
- Cleaning equipment and products are assessed for their suitability for environmental cleaning in the facility. This includes using products listed on the **Australian Register of Therapeutic Goods** and consistent with the manufacturer's instructions for use and recommended frequencies.

## Reflective questions

- What processes does your healthcare service use to ensure a clean and hygienic environment?
- What processes are used to evaluate that the environment is clean and hygienic?
- How does your healthcare service ensure the appropriate workforce is trained in cleaning processes for routine and outbreak situations, and novel infections?

## Key tasks

- Identify infection risks associated with the healthcare environment.
- Develop an environmental cleaning process for the healthcare service, addressing the outcomes described above.
- Facilitate training for the workforce on the healthcare service's environmental cleaning process.
- Implement the healthcare service's environmental cleaning process and schedule.
- Evaluate environmental cleaning practices for compliance with policies, procedures and protocols and measure outcomes of cleaning processes.
- Review position descriptions or contract specifications as part of the appraisal or contract review process, and provide feedback to the relevant person or group on achievements or areas for improvement.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Documented cleaning process that includes essential elements
- Cleaning schedule for the healthcare service
- Documented cleaning schedules and evidence of physical observation or audits that indicate that cleaning has been completed
- Evidence that the relevant workforce has undertaken training in infection and prevention control
- Evidence that cleaning equipment and products used are listed on the Australian Register of Therapeutic Goods.

## Where to go for more information

### Commission resources

- **Environmental cleaning and infection prevention and control resources** – environmental cleaning is a critical element of standard precautions and should be a feature of every health service organisation's infection prevention and control program.
- **Addendum NSQHS Standards Accreditation Workbook 2021 Infection Prevention and Control Standard** – provides users with updated information on reflective questions and examples of evidence for the 2021 Preventing and Controlling Infections Standard within the NSQHS Standards. Principles and strategies are broadly applicable.
- **Infection Prevention and Control eLearning Modules: Clean and safe environment course** – an online learning module on hand hygiene and infection prevention and control.
- ***Australian Guidelines for Infection Prevention and Control in Healthcare*** – the guidelines have been developed for use in all healthcare settings, including office-based practices. They contain guidance on personal protective equipment (PPE), standard and transmission-based precautions and outbreak management in section 3.

## Action 3.10

The healthcare service has processes to evaluate and respond to infection risks for:

a. New and existing equipment, devices and products used in the healthcare service
b. Clinical and non-clinical areas, and workplace amenity areas
c. Maintaining, repairing and upgrading buildings, equipment, furnishings and fittings
d. Handling, transporting and storage of linen
e. Novel infections, and risks identified as part of a public health response or pandemic planning.

## Explanatory notes

Infection risks associated with the healthcare environment are minimised when the environment is clean and well maintained. In particular, processes should be in place to minimise infection risks for:

- New and existing equipment, devices and products used in the healthcare service
- Clinical and non-clinical areas, and workplace amenity areas
- Maintaining, repairing and upgrading buildings, equipment, furnishings and fittings

- Handling, transporting and storing linen (if applicable)
- Novel infections, and risks identified as part of a public health response or pandemic planning.

Infection risks to be considered may include:

- Dust
- Aerosols
- Air handling
- Filters and filtration
- Sinks, drains and other plumbing
- Water quality, biofilms and supply
- Sewerage and wastewater
- Infectious agents
- Waste materials
- Disruption of services and utilities
- Patient, carer and workforce safety
- Extra cleaning and reprocessing requirements for critical equipment.

## Reflective questions

- How are infection risks for new and existing equipment, devices and products determined?
- What processes are in place for minimising infection risks associated with maintaining, repairing and upgrading buildings, equipment, furnishings and fittings?
- What processes are in place for minimising infection risks associated with linen?
- What processes are in place for identifying and mitigating risks associated with novel infections, and risks identified as part of a public health response or pandemic planning?

## Key tasks

- Define and implement a process based on a risk assessment of infection risks to evaluate and respond to those risks for
  - new and existing equipment, devices and products used in the healthcare service
  - clinical and non-clinical areas, and workplace amenity areas
  - maintaining, repairing and upgrading buildings, equipment, furnishings and fittings
  - handling, transporting and storage of linen (if applicable)
  - novel infections, and risks identified as part of a public health response or pandemic planning.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context, but could include:

- Risk assessment of infection risks
- Process to evaluate and respond to infection risks for
  - new and existing equipment, devices and products used in the healthcare service
  - clinical and non-clinical areas, and workplace amenity areas
  - maintaining, repairing and upgrading buildings, equipment, furnishings and fittings
  - handling, transporting and storage of linen (if applicable)
  - novel infections, and risks identified as part of a public health response or pandemic planning
- Example of changes made to cleaning processes in response to an identified infection risk.

## Where to go for more information

### Commission resources

- **Processes and product selection for routine environmental cleaning** – flowchart to guide routine environmental cleaning.
- **Infection Prevention and Control eLearning Modules – Clean and safe environment course** – an online learning module on hand hygiene and infection prevention and control.
- **Addendum NSQHS Standards Accreditation Workbook 2021 Infection Prevention and Control Standard** – provides users with updated information on reflective questions and examples of evidence for the 2021 Preventing and Controlling Infections Standard within the NSQHS Standards. Principles and strategies are broadly applicable.
- **Infection Prevention and Control eLearning Modules: Epidemiology and outbreaks course** – an online learning module on hand hygiene and infection prevention and control.
- ***2021 Recommendations for the control of carbapenemase-producing Enterobacterales* (2021 CPE Guide)** – provides updated guidance on recommended strategies to prevent, detect and contain CPE in Australian health service organisations.

# Workforce screening and immunisation

## Action 3.11

The healthcare service has a risk-based workforce vaccine-preventable diseases screening and immunisation process that:

a. Is consistent with the current edition of the *Australian Immunisation Handbook*
b. Is consistent with jurisdictional requirements for vaccine-preventable diseases
c. Identifies and addresses specific risks to the workforce, consumers and patients.

## Explanatory notes

This action protects the workforce from vaccine-preventable infections and minimises the transmission of vaccine-preventable infections in a healthcare service. It requires a documented screening and immunisation process for the workforce, including those who refuse vaccination.

A **Workforce Immunisation Risk Matrix** (see **Table 4)** may be used to support healthcare services identify, evaluate and address risks that are relevant to the scope of the role and function of the members of the workforce. The risks for vaccine-preventable diseases may differ between healthcare services.

**Table 4**: Workforce Immunisation Risk Matrix

| **Risk of disease exposure** | **Workforce immunity/vaccination status and access to workforce screening** | | |
|---|---|---|---|
| | - All members of the workforce have up-to-date records of their immune status/ vaccination history available<br>**AND**<br>- A workforce screening/ vaccination program is in place | - Up-to-date immune status/vaccination records are **NOT** available for all members of the workforce<br>**AND**<br>- A workforce screening/ vaccination program is in place | - Up-to-date immune status/vaccination records are **NOT** available for all members of the workforce<br>**AND**<br>- A workforce screening/ vaccination program is NOT in place |
| No increased risk of exposure to disease or infection associated with working in the health service organisation | Low | Medium | High |
| Members of the workforce have a risk of exposure to vaccine-preventable disease due to the nature of their role | Medium | High | Very high |
| Hospital-based outbreak of vaccine-preventable disease (no evidence of community transmission) | Medium | High | Very high |
| Community-wide outbreak of a vaccine-preventable disease | High | Very high | Very high |
| Disease with no available vaccine | Very high | Very high | Very high |

| | |
|---|---|
| Low risk | Risk is managed by routine procedures. There is minimal risk of harm or injury from the risk. |
| Medium risk | Risk is managed by specific monitoring or audit procedures. There is potential for harm or injury from the risk. |
| High risk | There is a serious risk that must be addressed immediately. Consequences to individuals and the organisation are high due to a high potential for harm or injury. |
| Very high risk | There is a serious risk that must be addressed immediately. The magnitude of the consequences to the individual and organisation of an event, should it occur, are considered very high with potentially significant harm or injury. |

Note: Vaccination programs should include catch-up vaccination, such as annual influenza vaccination.

Source: NSQHS Standards Workforce Immunisation Risk Matrix (ACSQHC, 2021).

## Reflective questions

- What are the recommended and/or mandated vaccinations for the workforce in your healthcare service?
- What additional risk mitigation strategies are implemented when a member of the workforce refuses, or has a medical exemption for, specified vaccinations?
- How is compliance with your healthcare service's recommendations or requirements for immunisation verified?

## Key tasks

- Develop a process to facilitate workforce immunisation for vaccine-preventable diseases. This process should
  - identify specific risks to the workforce, consumers and patients, including prevalence of certain vaccine-preventable diseases and occupational risks
  - specify recommended and/or mandated vaccinations for the workforce based on identified risks. Ensure requirements are consistent with the current edition of the ***Australian Immunisation Handbook*** and state or territory requirements for vaccination
  - specify employer and employee responsibilities regarding immunisation
  - outline additional risk mitigation strategies required where members of the workforce refuse, or have medical exemptions for specified vaccinations
  - ensure employment agreements, policies, procedures or protocols specify recommended and/or mandated vaccinations.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- List of recommended and/or required workforce vaccinations, including the rationale for inclusion
- Evidence of employment agreements, policies, procedures or protocols that outline to both the employer and employee the responsibilities for managing occupational risks for vaccine-preventable diseases or immunisation requirements
- Audit results or records of workforce vaccination compliance
- Evidence of communication with prospective employees or the existing workforce about vaccination requirements
- Workforce vaccination records.

## Where to go for more information

### Commission resources

- **NSQHS Standards Workforce Immunisation Risk Matrix** – used by healthcare service organisations to assess their workforce for risks associated with vaccine-preventable disease transmission and develop actions to mitigate these risks.
- The Commission: **Infection Prevention and Control eLearning Module: Health workforce screening and immunisation for vaccine-preventable diseases**.

### Other resource

- Australian Government Department of Health: ***Australian Immunisation Handbook*** – provides clinical guidelines for healthcare professionals and others about using vaccines safely and effectively.

# Infections in the workforce

## Action 3.12

The healthcare service has risk-based processes for preventing and managing infections in the workforce that:

a. Are consistent with the relevant state or territory work health safety regulation and the current edition of the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*
b. Align with state and territory public health requirements for workforce screening and exclusion periods
c. Manage risks to the workforce, patients and visitors, including for novel infections
d. Promote non-attendance or remote-attendance at work and avoiding visiting or volunteering when infection is present or suspected
e. Plan for, and manage, ongoing service provision during outbreaks and pandemics or events where there is increased risk of transmission of infection.

## Explanatory notes

This action aims to minimise the risks of transmission of acute infections via workers, patients and visitors as well as disruptions to health service delivery where healthcare providers are unable to practise due to suspected acute transmissible infections. Processes should be risk-based and applicable in response to outbreaks and pandemics. In some instances, physical distancing and screening of staff and visitors may be appropriate.

While the healthcare service has a duty of care to the workforce, staff members also have a responsibility to protect themselves and to not put others at risk.

The healthcare service should identify or develop policies, procedures or protocols that respond to areas in which there is the greatest risk of infection transmission. Development of policies, procedures or protocols should include consultation with the workforce and relevant key stakeholders where risks have been identified, where changes need to occur or improvements can be made to respond to risks, and consider:

- Identification of possible cases
- Implementation of other treatment options (for example, rescheduling procedures)
- Exclusion periods for elective services
- Suggested management options for suspected or confirmed infections that may be transmissible
- How impacts on treatment and recovery are minimised
- Workforce occupational risk.

Policies should be incorporated in workforce orientation and training programs to include key aspects of standard and transmission-based precautions. Evaluate attendance at, and content of, the orientation or induction programs for the workforce.

## Reflective questions

- What is your healthcare service's process for preventing and managing infections in the workforce?
- Who was consulted in the development of the process?
- How is service provision managed during outbreaks?

## Key tasks

- Define and implement a process for preventing and managing infections in the workforce. This should include
  - circumstances where members of the workforce should refrain from attending the healthcare service and interacting with patients, for example, when an infection is suspected or confirmed, or when they are at greater risk of infection or susceptible to adverse health outcomes
  - whether healthcare providers are able to work via remote-attendance and how this will be facilitated
  - if and how service provision will continue during periods of outbreaks and pandemics, or events where there is an increased risk of transmission of infection is common, for example, seasonal influenza or local outbreaks of viral gastroenteritis
  - how the healthcare service will access or be alerted to local state or territory public health orders or guidelines for the requirements for workforce screening and exclusion periods.
- Provide the workforce with training on preventing and managing exposure to infections.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- The healthcare service's process for preventing and managing infections in the workforce
- Observation of how the healthcare service is alerted to, or can access local state or territory public health orders
- Business continuity plans.

## Where to go for more information

### Commission resources

- **Addendum NSQHS Standards Accreditation Workbook 2021 Infection Prevention and Control Standard** – provides users with updated information on reflective questions and examples of evidence for the 2021 Preventing and Controlling Infections Standard within the NSQHS Standards. Principles and strategies are broadly applicable.
- **Infection Prevention and Control eLearning Module: Preventing and managing occupational exposures to infectious agents in health care course** – an eLearning module on hand hygiene and infection prevention and control.
- **Communicable Diseases Network Australia – Series of National Guidelines (SoNGs)** – provides nationally consistent advice and guidance to Public Health Units to help them respond to notifiable diseases using best practice.

### Other resources

- Australian Government Department of Health: **Local state and territory health departments**.
- National Health and Medical Research Council in collaboration with the Commission: ***Australian Guidelines for the Prevention and Control of Infection in Healthcare*** – Section 4.2 (2019) – developed to specifically support improved infection prevention and control in acute health settings. Provides a risk management framework to ensure that the basic principles of infection prevention and control can be applied to a wide range of healthcare settings.

## Reprocessing of reusable medical devices

### Action 3.13

Where reusable equipment, instruments and devices are used, the healthcare service has:

a. Processes for reprocessing that are consistent with relevant national and international standards, in conjunction with the manufacturer's guidelines

b. A process for critical equipment, instruments, and devices that are capable of identifying the
   - patient
   - procedure
   - reusable equipment, instruments and devices that were used for the procedure

c. Processes to plan and manage reprocessing requirements and additional controls for novel and emerging infections.

### Explanatory notes

**Note:** This action is only applicable if your healthcare service uses critical reusable equipment, instruments and devices in the provision of health care.

Reusable medical devices are used in health care for diagnostic and treatment purposes for patients and must be reprocessed according to their intended use and manufacturer's instructions. A reusable medical device must be included on the **Australian Register of Therapeutic Goods** before they can be supplied in Australia.

Where reusable equipment, instruments and devices are used , the healthcare service must minimise infection risks to patients and the workforce by ensuring adequate identification of, and procedures for, reprocessing reusable medical equipment. This includes cleaning, disinfection and sterilisation of reusable medical devices, equipment and instruments used, as well as processes and records to identify the patient, procedure and reusable equipment, instruments and devices that were used.

Critical medical equipment, instruments and devices are items that confer a high risk for infection if they are contaminated with microorganisms and must be sterile at the time of use. They include any objects that enter sterile tissue or the vascular system, because any microbial contamination could transmit disease.

Healthcare services must ensure that processes for reprocessing are consistent with the relevant **Australian Standard.** Where multiple Australian Standards may be applicable, the healthcare service should adhere to the standard most appropriate for their service context.

In developing processes for reprocessing, consider:

- Whether the healthcare service has the facilities and the ability to reprocess the required reusable equipment, instruments and devices on site?
- Whether sterilising services should be centralised or shared with another service?
- Are specialised reprocessing techniques required for some reusable medical devices (for example, low-temperature sterilisation or ethylene oxide) and are processes in place to achieve this?

- Could the purchase of commercial, pre-sterilised single-use items help to meet the healthcare service's needs?
- Could an external sterilising service be contracted to provide reprocessing services for critical equipment, instruments or devices? See the ***Australian Guidelines for the Prevention and Control of Infection in Healthcare*** for a description of critical items.
- If services are contracted, are activities such as contract development, documentation and record keeping conducted in consultation with key groups, including
  - an identified position with responsibility for the service's sterilising
  - senior management
  - the clinical workforce
  - consumer representatives.

If reprocessing of reusable equipment is to be carried out on-site, policies, procedures and protocols should include:

- Ensuring that the environment and infrastructure consists of enough dedicated space to safely carry out all the required steps for reprocessing
- Maintenance and replacement schedules for reprocessing equipment
- Appropriate storage to maintain the integrity of reprocessed equipment, instruments and devices before use, in all areas where they are stored
- Decontamination and safe packaging for transporting reusable equipment, instruments and devices from clinical areas that may be located away from the sterilising services
- A process for fault or variance reporting that includes responsibility, actions and risk management strategies
- Document control and record-keeping processes that allow data to be retrieved at any time
- Environmental controls, including water quality, air handling, access, maintenance schedules and cleaning activities
- Consumables, including packaging materials and personal protective equipment (PPE)
- Suitably trained members of the workforce who are available for sterilising services, and wherever decontamination of used reusable equipment, instruments or devices is undertaken
- Use of an incident management and investigation system to report any incidents relating to the reprocessing of reusable equipment, instruments and devices. Review the incident management and investigation system in the healthcare service to identify any variation between practice and policy, procedure or protocol and act to rectify the risks.

## Reflective questions

- Is there a process for identifying and registering the reusable equipment, instruments and devices that need to be reprocessed?
- How does your healthcare service ensure that reprocessing of reusable medical equipment, instruments and devices follows relevant standards and manufacturer's instructions?
- How does your healthcare service identify which reusable equipment, instruments and devices have been used during the care of a patient?
- What mechanism does your healthcare service have in place to recall those patients at risk of acquiring an infection as a result of the reusable equipment, instruments and devices used?
- How are the sterile stock and reprocessed equipment, instruments and devices transported, stored and maintained?

## Key tasks

- Identify the healthcare service's need for reusable critical equipment, instruments and devices.
- Develop and implement a process for the reprocessing of reusable critical equipment, instruments and devices used in the healthcare service. This process must
  - be consistent with the relevant Australian Standard and manufacturer's instructions
  - describe how the healthcare service will record and identify (if required) the patient, procedure and reusable equipment, instruments and devices that were used for the procedure
  - identify situations when processes may need to be reviewed
  - determine how additional controls for novel and emerging infections may be identified and incorporated.
- These processes may also be required for the reprocessing of semi-critical equipment, in accordance with the relevant Australian Standard, for example, where high-level disinfection of a semi-critical medical device is required.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Policies, procedures and/or protocols for processing reusable equipment, instruments and devices that are consistent with relevant national or international standards and manufacturer's instructions for use
- Examples of agreements or contracts in place to manage reprocessing services that include safety and quality measures such as incident and performance monitoring
- A register of reusable medical devices
- Access to, or copies of, manufacturer's instructions for each device
- Records that verify equipment installation, operation and reprocessing is consistent with the relevant national or international standards
- Maintenance schedules for equipment used to reprocess medical equipment, reusable instruments and devices are monitored and reviewed
- Registers of staff training and competency assessments
- Audits to ensure the integrity of sterile stock integrity and supply
- Relevant documentation where reports on cleaning, disinfection and sterilisation processes are reviewed and discussed
- Risk assessments where there are deviations in the requirements of relevant standards and the manufacturer's instructions
- Policies or procedures that specify which procedures should be used for single-use items
- Policies or procedures for the use of reusable items that reflect relevant risk management strategies to ensure safe clinical practice and determine when, for which procedures and/or where reusable items should be used
- Register or record of patients who have had procedures using reusable equipment, instruments and devices.

## Where to go for more information

### Commission resource

- **Addendum NSQHS Standards Accreditation Workbook 2021 Infection Prevention and Control Standard** – provides users with updated information on reflective questions and examples of evidence for the 2021 Preventing and Controlling Infections Standard within the NSQHS Standards. Principles and strategies are broadly applicable.

### Other resources

- National Health and Medical Research Council in collaboration with the Commission: ***Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019)*** **Section 3.1.4 Reprocessing of reusable medical devices** – developed to specifically support improved infection prevention and control in acute health settings and provides a risk management framework to ensure that the basic principles of infection prevention and control can be applied to a wide range of healthcare settings.
- Standards Australia: **Catalogue of Australian Standards** – Standards Australia is the nation's peak non-government, not-for-profit standards organisation.

# Antimicrobial stewardship

## Action 3.14

The healthcare service that prescribes, supplies and/or administers antimicrobials:

a. Provides healthcare providers with access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing
b. Incorporates core elements, recommendations and principles from the current *Antimicrobial Stewardship Clinical Care Standard* into service delivery
c. Supports healthcare providers who prescribe antimicrobials to review their compliance of antimicrobial prescribing against current local or Australian therapeutic guidelines
d. Supports healthcare providers to identify the areas of improvement and takes action to increase the appropriateness of antimicrobial usage
e. Has mechanisms to educate consumers about the risks, benefits and alternatives to antimicrobials for their condition.

## Explanatory notes

**Note:** This action is only applicable if your healthcare service prescribes, supplies or administers antimicrobial medicines.

Inappropriate use of antimicrobials contributes to the emergence of resistant microorganisms (including bacteria and viruses) and causes patient harm. Patients with antimicrobial-resistant infections are more likely to experience ineffective treatment, recurrent infection, delayed recovery or even death. Antimicrobial stewardship (AMS) is a coordinated set of strategies to improve the appropriateness of use and minimise the adverse effects of antimicrobial use.

The *Antimicrobial Stewardship Clinical Care Standard* provides guidance to healthcare providers and services on delivering appropriate care regarding antimicrobials. It includes eight quality statements:

- A patient with a life-threatening condition due to a suspected infection receives an appropriate antimicrobial immediately, without waiting for the results of investigations
- When a patient is prescribed an antimicrobial, this is done in accordance with the current therapeutic guidelines or evidence-based, locally endorsed guidelines and the antimicrobial formulary
- When an adverse reaction (including an allergy) to an antimicrobial is reported by a patient or recorded in their healthcare record, the active ingredient(s), date, nature and severity of the reaction are assessed and documented. This enables the most appropriate antimicrobial to be used when required
- A patient with a suspected infection has appropriate samples taken for microbiology testing as clinically indicated, preferably before starting antimicrobial therapy
- A patient with an infection, or at risk of an infection, is provided with information about their condition and treatment options in a way that they can understand. If antimicrobials are prescribed, information on how to use them, when to stop, potential side effects and a review plan is discussed with the patient
- When a patient is prescribed an antimicrobial, the indication, active ingredient, dose, frequency and route of administration, and the intended duration or review plan are documented in the patient's healthcare record
- A patient prescribed an antimicrobial has a regular clinical review of their therapy, with the frequency of review dependent on patient acuity and risk factors. The need for ongoing antimicrobial use, appropriate microbial spectrum of activity, dose, frequency and route of administration are assessed and adjusted accordingly; investigation results are reviewed promptly when they are reported
- A patient having surgery or a procedure is prescribed antimicrobial prophylaxis in accordance with the current therapeutic guidelines or evidence-based, locally endorsed guidelines. This includes recommendations about the need for prophylaxis, choice of antimicrobial, dose, route and timing of administration, and duration.

## Reflective questions

- How do healthcare providers access current therapeutic guidelines or evidence-based, locally endorsed guidelines at the point of care?
- How are healthcare providers supported to incorporate core elements, recommendations and principles from the current *Antimicrobial Stewardship Clinical Care Standard*?
- What information is communicated to patients when an antimicrobial is prescribed, supplied or administered? How is this information communicated?
- How are data on antimicrobials collected, reviewed and used for improvement action?

## Key tasks

- Ensure healthcare providers have access to, and promote, current guidelines for treatment and prophylaxis for common infections relevant to the patient population, the indications for use and the local antimicrobial resistance profile (if known). Information sources include
  - **Therapeutic Guidelines: Antibiotic**, one of the key national guidelines for antimicrobial prescribing in Australia
  - Health Pathways in a healthcare service's local Primary Health Network (PHN)
  - Local evidence-based guidelines, where available.

- Support healthcare providers to incorporate relevant core elements, recommendations and principles from the current ***Antimicrobial Stewardship Clinical Care Standard***, developed by the Commission.
- Review policies, clinical pathways, point-of-care tools and education programs to ensure that they incorporate the principles of the *Antimicrobial Stewardship Clinical Care Standard*.
- Collect and regularly review data on antimicrobial against the therapeutic guidelines or local pathways. Indicators specified in the *Antimicrobial Stewardship Clinical Care Standard* may be helpful.
- Use this analysis to identify areas for quality improvement and action to be taken.
- Provide access to and promote resources to educate consumers about the risks, benefits and alternatives to antimicrobials for their condition.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context, but could include:

- Observation of healthcare providers accessing electronic or printed copies of endorsed *Therapeutic Guidelines: Antibiotic*
- Examples of communication materials provided to patients regarding antimicrobials
- Guidance for healthcare providers on providing materials to patients regarding antimicrobials
- Requirements for and/or records of healthcare providers completing NPS MedicineWise antibiotic prescribing modules.

## Where to go for more information

### Commission resources

- **Antimicrobial stewardship in primary care** – outlines the important task of improving the safe and appropriate use of antimicrobials and reducing patient harm and the risk of antimicrobial resistance.
- ***Antimicrobial Stewardship Clinical Care Standard*** – supports quality improvement by health services and clinicians to help reduce antimicrobial resistance.
- **Options for implementation of AMS primary care Aboriginal Community Controlled Health Services** – provides guidance for healthcare services to support the implementation of antimicrobial stewardship programs in Aboriginal community-controlled health services.
- **Options for implementation of AMS primary care Community Health services** – provides guidance for healthcare services to support the implementation of antimicrobial stewardship programs in community health services.
- **Options for implementation of AMS primary care Allied Health including Optometry and Podiatry Practices** – provides guidance for healthcare services to support the implementation of antimicrobial stewardship programs in allied health.
- **Options for implementation of AMS primary care Dental Practice** – provides guidance for healthcare services to support the implementation of antimicrobial stewardship programs in dental practice.
- **Options for implementation of AMS primary care General Practice** – provides guidance for healthcare services to support the implementation of antimicrobial stewardship programs in general practice.

- **Options for implementation of AMS in community pharmacies** – provides guidance for healthcare services to support the implementation of antimicrobial stewardship programs in community pharmacies.
- ***Sepsis Clinical Care Standard*** – ensures that a patient presenting with signs and symptoms of sepsis receives optimal care, from symptom onset through to discharge from hospital and survivorship care.
- **Antimicrobial Stewardship in Australian Health Care Book** – additional evidence, information, and topic areas to inform antimicrobial stewardship (AMS) strategies, interventions, and implementation across a range of healthcare settings.

### Other resource

- Therapeutic Guidelines: **Antibiotic prescribing in primary care: Therapeutic Guidelines summary table 2019** – summarises the antibiotic management of common conditions in primary care.

# Medication safety

## Consumer outcome

*My risks from medicine-related events are assessed and minimised. I am supported to understand and make decisions about my medicines.*

### Intention of this standard

Systems are in place to support the safe, appropriate and effective use of medicines, reduce the risks associated with medicine-related events and improve the safety and quality of medicine use.

## Documentation, provision and access to medicines-related information

## Action 3.15

A healthcare service that prescribes, supplies and/or administers medicines has processes to ensure healthcare providers work within their scope of clinical practice to:

a. Take a best possible medication history on presentation or as early as possible in the episode of care
b. Ensure a patient's medicines-related information is included in a patient's healthcare record
c. Partner with patients, carers and families in the management of their medicines
d. Support patients, carers and families to maintain a current and accurate medicines list
e. Encourage patients to share their medicines list with other healthcare providers involved in their care and/or does so on a patient's behalf with their consent
f. Use information on a patient's medication history to minimise risks in the planning and delivery of health care.

### Explanatory notes

**Note:** This action is only applicable if your healthcare service prescribes, supplies and/or administers medicines.

Medicines are the most common treatment used in health care. Although the appropriate use of medicines contributes to significant improvements in health, medicines can also be associated with harm. Because they are so commonly used, medicines have the potential to be associated with a higher incidence of errors and adverse events when compared with other healthcare interventions.[27]

Some of these adverse events are costly, and up to 50% are potentially avoidable.[28] Errors affect both health outcomes for consumers and healthcare costs. Strengthening the systems for reducing medication errors can improve medication safety.[27]

### Best possible medication history

A best possible medication history (BPMH) is a list of all the medicines a patient is using at the time they receive care. The list includes the name, dose, route and frequency of the medicine, and is documented in a specific place (for example, template form or medicine record). All prescribed, over the counter and complementary medicines should be included.

The BPMH is generally obtained by a healthcare provider working within their scope of clinical practice who interviews the patient (and/or their carer); the information is confirmed, where appropriate, by using other sources of medicines information.

### Partnering with patients, carers and families

The patient is always the focus of the medication management pathway. Healthcare services should apply the principles of the Partnering with Consumers Standard, health literacy and shared decision making when developing, reviewing and implementing processes or practices within the medication management pathway.

Partnering with patients, carers and families in the management of their medicines occurs in order to support a patient's understanding of what medicines are being proposed, or why a new medicine, or change in medicine/treatment (including a dose change or ceasing a medicine), is recommended.

Patients should be involved in setting treatment goals and supported to understand the proposed outcomes of treatment. Discussion about medicines should include:

- Why the treatment is recommended or necessary
- If the medicine will cure their illness, or is required to control the symptoms of their chronic illness
- Duration of treatment and instructions for use
- Possible adverse effects that the medicine may have; their likelihood; and if experienced, what action should be taken.

**Links to Action 3.19 multidisciplinary collaboration**

## Reflective questions

- How do healthcare providers take a BPMH in your service?
- Where in a patient's healthcare record is the BPMH recorded?
- How are patients encouraged to keep their own medicine list and to share this with other relevant healthcare providers?
- How is informed consent incorporated into your process for sharing the patient's medicines list with other relevant healthcare providers on their behalf?

## Key tasks

Develop and implement a process for healthcare providers to, within their own scope of clinical practice:

- Take a BPMH as early as possible in the episode of care
- Record this information in a patient's healthcare record, including any adverse drug reactions
- Use structures and systems established in the Partnering with Consumers Standard to partner with patients, carers and families in the management of medicines
- Support patients, carers and families to keep an accurate medicines list
- Encourage patients to share their medicines list with other healthcare providers
- Share a patient's medicines list with other healthcare providers with a patient's consent
- Use this information in the planning and delivery of health care
- Make template medicines lists available to patients, carers and families.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on the context of each healthcare service. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Process for obtaining and documenting a BPMH
- Evidence that BPMHs are documented in a patient's healthcare record
- Information available to patients about the need for maintaining a current list of their medicine.

## Where to go for more information

### Resources

- Australian Digital Health Agency: **My Health Record** – information for healthcare providers on medication records in the **My Health Record** system. Patients can access their own record to view their own medicines list.
- Australian Digital Health Agency: **Keeping a medicines list** – a useful resource which can be shared with consumers about keeping a current list of their medications.
- World Health Organization: **5 Moments for Medication Safety** resources – this tool can be applied at different levels of care and in different settings and contexts.

## Action 3.16

The healthcare service has processes to ensure healthcare providers work within their scope of clinical practice to:

a. Provide information on medicines tailored to the patient's needs and preferences
b. Act when a healthcare provider or patient identifies a suspected medicines-related problem
c. Report suspected adverse drug reactions to the Therapeutic Goods Administration (TGA).

## Explanatory notes

Partnering with patients, carers and families in the management of their medicines occurs to support a patient's understanding on what medicines are being proposed; and why a new medicine or change in medicine/treatment (including a dose change or ceasing a medicine) is being recommended. Information on medicines that is provided to patients in a way that meets their needs and preferences should include:

- A rationale for medicine use
- The risk to the patient of both taking and not taking the medicine
- Instructions for effective administration
- The expected outcome of use
- Action to take if a problem is identified or expected outcomes do not occur.

Information on medicines provided should be relevant, evidence-based and up to date.

### Taking action when a suspected medicines-related problem is identified

When a suspected medicines-related problem is identified, healthcare providers must take action to minimise any risks of harm to patients. The specific action taken will be dependent on a healthcare provider's scope of clinical practice. For example, a prescriber may take action by reviewing medication and potentially changing therapy, while a healthcare provider not involved in medication management may refer the patient to their prescriber or most appropriate healthcare provider or may notify them directly. In some circumstances, emergency assistance may be sought.

Healthcare providers should ensure that the details of the occurrence and action taken are recorded in a patient's healthcare record.

### Reporting adverse events involving medicines

Any adverse event that may have been caused by a medicine is often referred to as a 'suspected adverse reaction' and can involve vaccines and prescription, over the counter and complementary medicines. Suspected adverse reactions (involving medicines) that people experience that have not been previously experienced or documented are considered to be new. The healthcare service is responsible for reporting new suspected adverse events involving medicines to the TGA. Healthcare services may need to consider training for members of the workforce who are responsible for reporting adverse events (involving medicines) online to the TGA.

**Links to Actions 1.05 Incident management and open disclosure; 1.19 Scope of clinical practice and 1.20 Evidence-based care**

## Reflective questions

- How do healthcare providers provide information on medicines, tailored to the patient's needs and preferences?
- What strategies are in place to support patients and carers to raise concerns about medicine-related risks and clarify the information they are provided?
- What processes are used to identify patients at risk of medicine-related problems or adverse events?
- What action is taken when an adverse event involving medicines is suspected?
- How are suspected adverse events (involving medicines) that are experienced by patients reported to the TGA?

## Key tasks

- Provide patients and carers with enough information about treatment options for them to make informed choices about their medicines, and to adhere to medicine-related treatment plans in the delivery of health care.
- Support healthcare providers to provide medicine-related information when treatment options are discussed and when treatment decisions have been made.
- Implement a process to report all new suspected adverse events involving medicines experienced by patients to the TGA and document these in the patient's healthcare record.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Observation of the healthcare provider accessing medicines information, or communicating with patients about medicines information in way that is tailored to their needs and preferences
- Samples of medicine-related information resources (for example, Consumer Medicines Information, newsletters or other communication material) for the workforce, patients, carers and families that are tailored to their specific needs and meet the health literacy actions of the Partnering with Consumers Standard (for example, appropriate print size and font of the resource in the patient's preferred language)
- Examples of medicines lists including where medicines lists have been tailored to the specific needs of recipients (for example, the patient, community pharmacist, general practitioner and rural generalists, nurse practitioner, allied healthcare provider or school nurse)
- Communication to the workforce explaining the process for reporting suspected adverse events involving medicines to the TGA
- Record of suspected adverse drug reaction reports submitted to the TGA
- Register of adverse events involving medicines that includes actions to address the identified risks
- Access to tools for reporting adverse events involving medicines, for example, via the TGA website or using clinical software
- Examples of incident records identifying potential medicine-related risks and associated actions to reduce risk or improve clinical safety outcomes
- Records of patient or carer feedback on medicine-related information provided during care.

## Where to go for more information

### Resources

- Better Health Channel: **Medicines information leaflets for consumers** – provide important information for consumers.
- Department of Veterans' Affairs: **Veterans' Medicines Advice and Therapeutics Education Services** (Veterans' MATES) – aims to improve the use of medicines and related health services in the veteran community.
- **Healthdirect website:** Provides health and medicines information for consumers.
- Medicines information for healthcare providers can be accessed via clinical software, medicines references.
- Therapeutic Goods Administration: **Reporting adverse events** – information on the important role everyone can play in monitoring the safety of therapeutic goods in Australia.

## Safe and secure storage and supply of medicines

### Action 3.17

The healthcare service that prescribes, supplies and/or administers medicines complies with manufacturer's instructions, legislative and jurisdictional requirements for the:

a. Safe and secure storage of medicines, including high-risk medicines
b. Storage of temperature-sensitive medicines and cold chain management
c. Supply of medicines
d. Disposal of unused, unwanted or expired medicines.

### Explanatory notes

**Note:** This action is only applicable if your healthcare service prescribes, stores, supplies and/or administers medicines.

The prescribing, supply, storage and administration of medicines is regulated by legislation and jurisdictional requirements. These include:

- ***Therapeutic Goods Act 1989***, Regulations and Orders set out the legal requirements for the import, export, manufacture and supply of therapeutic goods in Australia. This includes the requirements for inclusion of therapeutic goods in the Australian Register of Therapeutic Goods, including advertising, labelling and product appearance
- ***Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP)*** – commonly known as the Poisons Standard, collates decisions regarding the classification of drugs and poisons into different Schedules, and are included in relevant legislation of states and territories
- **Poisons and controlled substances legislation in each state and territory. State and territory medicines and poisons regulation units** – describe the legislative framework for who can prescribe, store, supply and administer medicines, based on the classification into different Schedules.

In addition, risks related to the prescribing, storage, supply and/or administration of medicines should be identified, recorded and mitigated where possible. For example, 'look-alike, sound-alike' (LASA) medicines are inherently at higher risk of errors in prescribing and supply. Strategies such as distinct signage, or separation of LASA medicines in storage areas may reduce the risks of these errors occurring. **Guidance** developed by the Commission outlines strategies and principles developed to address safe selection and storage of all medicines, including LASA medicines.

#### Temperature-sensitive medicines

Having effective processes in place will ensure that problems are detected early, responded to promptly, and managed before the integrity (safety, quality, potency and efficacy) of temperature-sensitive medicines is compromised.

Effective storage and response requirements will minimise the risk of ineffective vaccines or medicines being administered. Specific guidance is included in the latest edition of ***National Vaccine Storage Guidelines: Strive for 5***.

Healthcare services should develop guidance on effective processes to ensure the integrity of the cold chain that includes:

- Audits of temperature control of storage facilities, including room temperature, refrigeration and frozen storage
- Regular testing and maintenance schedules for temperature alarms and temperature recording devices
- Safe transportation or transfer of temperature-sensitive medicines between storage areas or facilities (this could include receipt from manufacturers or wholesalers)
- Workforce orientation and training on cold chain management
- Action required in the event of a cold chain breach or temperature excursion.

Refrigerators (or cool rooms) of adequate size should be made available for the exclusive storage of vaccines or medicines that require storage between 2 °C and 8 °C, or lower temperatures where required. Alarms may need to be installed on refrigerators, cool rooms and medicine storage areas to alert of temperature changes. Systems and processes should be in place to maintain power to all refrigerators and cool rooms within the healthcare service at all times, with specific attention to active monitoring and contingency plans in instances of power outage, refrigeration failure or temperature changes that may compromise stored vaccines or medicines.

### Implement policies, procedures and guidelines for disposal of unused, unwanted or expired medicines

Healthcare services that store medicines should review and implement work practices and distribution systems that minimise wastage, for example, by regular checking of stock expiry dates and stock rotation. Services should establish inventory management practices to eliminate wastage of medicines, such as minimising oversupply, and take a proactive and planned approach to changes to and routine review of the list of medicines held. The service should monitor usage patterns of medicines to identify unusual fluctuations and act based on this information.

The service should review and implement work practices that minimise waste, ensure safe handling and promote the efficient use of medicines. This includes consideration for the specific requirements for waste segregation and disposal of medicines.

## Reflective questions

- How does your healthcare service ensure that all medicines (including temperature-sensitive medicines) are stored and handled according to manufacturer's' directions?
- How does your healthcare service manage and report risks associated with the storage of medicines?
- How does your healthcare service ensure that processes for medicines disposal are consistent with state or territory requirements and the manufacturer's instructions?

## Key tasks

- Identify relevant legislative, regulatory and state or territory requirements and risks associated with medicines handling, storage and distribution across the organisation, and develop and implement evidence-based strategies to comply with requirements and reduce or mitigate these risks.
- Implement systems for storage and purpose-built equipment that continuously monitors and help to maintain the integrity of temperature-sensitive medicines.
- Implement policies, procedures and guidelines for the disposal of unused, unwanted or expired medicines.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Access to relevant poisons legislation
- Evidence that medicines are stored and secured in accordance with legislation (for example, Schedule 4 medicines out of reach of public, Schedule 8 medicines in a lockable safe)
- Evidence of professional qualifications of workforce handling Schedule 8 medicines
- Process for the management and disposal of unused, unwanted or expired medicines
- Examples of risk management or incident records in which the storage, distribution and disposal of medicines were considered, and action taken to improve clinical safety
- Orientation or training documents about storage, distribution and disposal of medicines
- Examples of action taken to manage identified risks regarding the storage (including secure storage), distribution and disposal of medicines
- Observation of workforce access to infrastructure and equipment necessary to comply with legislative requirements, policy, procedures and/or protocols, or documented agreement (contract) with a facility that provides a compliant disposal service
- Record of routine temperature monitoring and scheduled maintenance of the refrigerators used to store medicines and vaccines
- Records of supply of medicines.

## Where to go for more information

### Commission resources

- **National Tall Man Lettering List** – a typographic technique that uses selective capitalisation to help make LASA medicine name pairs easier to differentiate. The Commission developed the List to help clinicians reduce the risk of medicine selection errors for medicines with LASA medicine names.
- **Principles for the safe selection and storage of medicines: Guidance on the principles and survey tool** – provides information on the strategies and principles to ensure safe storage and selection of medicines. The principles developed for health service organisations can be applied within community pharmacy or other settings where medicines are stored by healthcare service providers.

### Other resources

- Australian Government Department of Health: ***Therapeutic Goods Act 1989***, Regulations and Orders – set out the legal requirements for the import, export, manufacture and supply of therapeutic goods in Australia. This includes the requirements for inclusion of therapeutic goods in the Australian Register of Therapeutic Goods, including advertising, labelling and product appearance.
- Australian Government Department of Health: ***Standard for the Uniform Scheduling of Medicines and Poisons (SUSMP)*** – commonly known as the Poisons Standard, collates decisions regarding the classification of drugs and poisons into different Schedules, and are included in relevant legislation of states and territories.
- Australian Government Department of Health: **Contacts for State/Territory medicines & poisons regulation units** – details relevant poisons and controlled substances legislation in each state and territory, which describe the legislative framework for who can prescribe, store, supply and administer medicines, based on the classification into different Schedules.
- Australian Government Department of Health: ***National Vaccine Storage Guidelines: Strive for 5*** – provides information and advice for vaccine storage management for Australian immunisation service providers.

- Australian Government Department of Health: The Return Unwanted Medicines (RUM) – a project funded by the Australian Government ensures that unwanted medicines are disposed of in accordance with regulatory and state or territory environment protection authority requirements.

## High-risk medicines

### Action 3.18

A healthcare service that prescribes, stores, supplies and/or administers medicines has processes to:

a. Identify high-risk medicines within the service
b. Safely store, prescribe, supply, administer and dispose of high-risk medicines.

### Explanatory notes

**Note:** This action is only applicable if your healthcare service prescribes, stores, supplies and/or administers medicines.

High-risk medicines have an increased risk of causing significant patient harm or death if they are misused or used in error. Errors with these medicines are not necessarily more common than with other medicines. Because they have a low margin of safety, the consequences of errors with high-risk medicines can be more devastating.

Healthcare services should implement high-risk medicine-related policies, procedures, guidelines and safe work practices about identifying, storing, prescribing, dispensing, administering and monitoring high-risk medicines.

The healthcare service should incorporate factors that contribute to safer use of high-risk medicines, or that reduce the opportunity for misuse or error, when considering:

- Storage of, access to, and disposal of high-risk medicines that comply with legislative requirements
- Safe prescribing (for example, active ingredient prescribing, prescribing restricted substances, electronic prescribing, dose-calculation tools)
- Safe selection, labelling and storage of all medicines (for example, look-alike, sound-alike [LASA] medicines)
- Design and layout of storage rooms or cupboards, and labelling requirements in these areas
- Alerts and safety checks in healthcare service's clinical software.

Consider how the use of high-risk medicines will be managed for specific population groups. The healthcare service should investigate incidents involving high-risk medicines, analyse the frequency and causal factors, and implement strategies to mitigate risks associated with high-risk medicine-related incidents.

**Links to Actions 1.04 Risk management and 1.05 Incident management and open disclosure**

## Reflective questions

- What processes are in place to identify medicines that are considered to be high risk?
- How does your healthcare service ensure safe and appropriate storage, prescribing, administration, distribution and disposal practices for high-risk medicines?

## Key tasks

- Identify high-risk medicines being prescribed, dispensed, stored or administered in the healthcare service.
- Regularly assess the use and misuse of high-risk medicines, relating to storage, prescribing, dispensing and administration.
- Develop and implement risk reduction strategies for the storage, prescribing, dispensing, administration and disposal of high-risk medicines relevant to your health service.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Processes for identifying, storing, prescribing, dispensing, administering, monitoring and disposing of high-risk medicines, where applicable
- List of high-risk medicines used in the healthcare service
- Orientation or training documents about high-risk medicines
- Results of analysis of incidents involving high-risk medicines
- Feedback to the workforce about incidents associated with high-risk medicines and risk prevention strategies
- Examples of communication (including education) with patients and carers about high-risk medicines
- Examples of improvement activities that have been implemented and evaluated to reduce the risks of storing, prescribing, dispensing and administering high-risk medicines.

## Where to go for more information

### Commission resources

- **APINCHS classification of high risk medicines** – the 'APINCHS' acronym and classification assists healthcare providers to focus on a group of medicines known to be associated with high potential for medication-related harm.
- **Active ingredient prescribing** – an initiative to support the uptake of generic and biosimilar medicines and improve the health literacy of consumers and prescribers about the active ingredient in medicines.
- **Safer naming and labelling of medicines** – the Commission works with national and international partners to improve the safety of medicines naming and labelling.

# Comprehensive care

## Consumer outcome

*My health care is safe, of high quality and is tailored to meet my needs and preferences.*

## Intention of this standard

Comprehensive care is the coordinated delivery of the total health care required with regard for a patient's preferences. It may be a discrete episode of care or part of an ongoing comprehensive care plan. This health care is planned and delivered in collaboration with the patient. It considers the effect of the patient's health issues on their life and wellbeing and is clinically appropriate.

## Multidisciplinary collaboration

### Action 3.19

The healthcare service:

a. Collaborates with other healthcare providers involved in a patient's care
b. Supports collaboration with other care providers to develop a coordinated approach to the planning and delivery of health care
c. Facilitates reporting to a patient's other relevant care providers.

## Explanatory notes

A substantial proportion of potentially preventable adverse events are underpinned by failures in communication and teamwork (between members of a single healthcare service or across multiple healthcare services).

Multidisciplinary collaboration, where healthcare providers involved in a patient's care communicate and work as a team, is an important element of comprehensive care. It includes referral to other healthcare providers, sending reports to a referring healthcare provider and discussions regarding a patient's care to ensure that a coordinated approach to care is provided.

### Referral process

The healthcare service should provide accessible guidance about referral processes to different services. This should outline the:

- Clinical or other criteria for referral
- Consent from patient to refer, and the information the patient consents to sharing
- Necessary patient information (for example, co-morbidities, medical history and medications)

- Process for making the referral (for example, referring to the service or to a particular healthcare provider, by phone or email)
- Processes for expediting urgent referrals
- Availability of different services (for example, after-hours)
- Expected response time
- Follow-up and escalation process for delayed response to a referral (if relevant).

### Collaboration with other healthcare providers

While healthcare providers deliver comprehensive care within their scope of clinical practice, no single healthcare provider can deliver all aspects of the care that a patient might need. Individual healthcare provider groups bring specific expertise. Effective collaboration relies on establishing and communicating clear and shared goals.

Collaboration with other healthcare providers can be supported by developing processes for effective communication, communicating critical information and documenting information.

Interventions to improve multidisciplinary collaboration vary, but broadly include:

- Training and education of individuals and the team (where present)
- Identifying opportunities for better multidisciplinary communication
- Detailing what information and decision need to be documented
- Communication of information and decisions to other healthcare providers, patients, carers and families
- Using structured communication processes and communication tools such as Introduction, Situation, Background, Assessment and Recommendation (ISBAR) to increase the reliability of communication
- Clear understanding of the roles, responsibilities and accountabilities of different healthcare providers in the delivery of safe and good quality care.

**Links to Actions 3.27 Communication to support patient referral and multidisciplinary collaboration; and 3.29 Communication of critical information**

### Rural and Remote Multidisciplinary Health Teams

Multidisciplinary teamwork is particularly relevant to the rural and remote healthcare context of service provision. Working in these teams strengthens the support for and connections between individual healthcare practitioners and communities.[29]

The Office of the National Rural Health Commissioner has developed the *Ngayubah Gadan Consensus Statement to define Rural and Remote Multidisciplinary Health Teams*. The statement recognises the contribution of the healthcare workforce in meeting the unique health needs in rural and remote communities. The Rural and Remote Multidisciplinary Health Team model provides the foundation to achieve appropriate, acceptable and locally determined healthcare services.[30]

## Reflective questions

- Which other healthcare providers are involved in the patient's care?
- What information is provided to another healthcare provider when a patient is referred to them?
- How does the workforce identify and record the details of other healthcare providers involved in a patient's health care?
- What training do healthcare providers undertake regarding multidisciplinary collaboration?

## Key tasks

- Support the workforce to collaborate with other healthcare providers, when relevant, in the planning and delivery of health care by
  - training (this may be part of formal qualifications or continuing professional development)
  - identifying other local healthcare providers
  - introducing processes for the workforce to identify and document other healthcare providers involved in a patient's care in their healthcare record
  - establishing processes for referral and/or reporting to a patient's other healthcare providers when relevant.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Process for referring a patient to another healthcare provider
- Evidence of training on processes to identify and document other healthcare providers involved in a patient's care in their healthcare record
- Referral documentation that uses structured communication processes
- Feedback from patients, carers and family members on their experience when seeing different health professionals during single or multiple episodes of care
- List of local healthcare providers
- Observation of collaborative work to plan and deliver care
- Demonstration of shared leadership and collaborative teamwork in multidisciplinary healthcare teams in rural and remote settings.

## Where to go for more information

### Resources

- Burgess A, van Diggele C, Roberts C. et al. Teaching clinical handover with ISBAR. *BMC Med Educ* 20 (Suppl 2), Article number 459 (2020). **https://doi.org/10.1186/s12909-020-02285-0**
- Office of the National Rural Health Commissioner: ***The Ngayubah Gadan Consensus Statement*** – defines and describes Rural and Remote Multidisciplinary Health Teams.
- Australian College of Midwives: ***National Midwifery Guidelines for Consultation and Referral***.

## Health promotion and prevention

### Action 3.20

The healthcare service has processes to support health education and promotion, illness prevention and early intervention for patients, considering its patient population.

### Explanatory notes

Healthcare services have an important role to play in supporting patients and consumers to stay healthy and well; almost half of all Australians have health conditions that could be prevented.[31,32]

Health promotion and prevention activities occur in almost all healthcare settings.[33] Healthcare services are encouraged to support health education and promotion, illness prevention and early intervention in their area of clinical practice, and tailor their messages to their specific patient population. For example, podiatrists working in a community with high rates of type 2 diabetes, or community health service working in an area with a large Aboriginal or Torres Strait Islander population will present prevention and promotion messages in different ways.

**Links to Actions 1.09 and 1.10 Patient populations and social determinants of health**

### Reflective questions

- What are the priority health issues for the patients and/or the community?
- What lifestyle or other factors can the service promote or provide more information on?
- Are there relevant health promotion events the service can promote, such as cancer awareness events?
- What evidence-based screening tools and referral services exist that might benefit the community?
- What trusted websites or health information can be recommended to support patients?

### Key tasks

- Establish processes for routinely supporting health promotion and prevention in your service. This will include
  - identifying the health education and promotion priorities relevant to the service's patient population
  - sourcing reliable and current health information and promotional material to aid discussion with patients or display in your service
  - having a process for conducting evidence-based screening and early intervention or referrals to another relevant healthcare provider, if appropriate.
- Incorporate prompts into assessment processes to discuss preventative health and health promotion with patients and their carers.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context, but could include:

- Health promotion or prevention material displayed in the service, including where patients and carers can access additional information
- Information on services available, including handouts, leaflets, QR codes directing patients to online information
- Observation of health promotion and prevention activities and discussions with patients and/or the community
- Records of workforce professional development opportunities to maintain the skills and knowledge of current evidence-based screening, care and treatment.

## Where to go for more information

### Resources

- Australian Government Department of Health: **About preventive health in Australia** – working to enable healthy living through supportive environments.
- Australian Government Department of Health: **National Preventive Health Strategy 2021–2030** – outlines the overarching, long-term approach to prevention in Australia over the next 10 years.
- Council for Intellectual Disability: **Easy Read resources for people with intellectual disability** – a collection of health fact sheets in Easy Read format for people with intellectual disability, their families and carers.
- **Better Health Channel website**: Health and medical information to improve the health and wellbeing of people and the communities they live in.
- **Health Translations**: a free online library with translated Australian health and wellbeing information.
- National Mental Health Commission: **Mental Health Calendar** – a calendar of mental health and wellbeing events and days for acknowledgement.
- Zenzano T, Davidson Allan J, Bigley MB, Bushart, RL. The Roles of Healthcare Professionals in Implementing Clinical Prevention and Population Health. ***American Journal of Preventive Medicine*** February 2011, 40(2):261-7. Available from: Doi:**10.1016/j.amepre.2010.10.023**

# Planning and delivering comprehensive care

## Action 3.21

The healthcare service has processes to ensure healthcare providers work within their scope of practice to plan and deliver comprehensive care by:

a. Conducting a risk screening and assessment
b. Conducting a clinical assessment and diagnosis
c. Identifying the patient's goals of care
d. Developing and agreeing a plan for care in partnership with the patient
e. Delivering comprehensive care in accordance with the agreed plan for health care
f. Recalling patients for follow-up health care when required
g. Reviewing and improving the processes of comprehensive care delivery
h. Receiving a current advance care plan and incorporating it into a patient's healthcare record.

### Explanatory notes

Comprehensive care is health care that is based on identified goals for care, which may be a discrete episode of care (for example, a hearing check) or as part of a comprehensive care plan (for example, services provided under a mental health care plan or chronic disease management plan). These goals are aligned with a 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.

Implementing comprehensive care requires effective processes to partner with patients in their own care, and to safely manage transitions between episodes of care and care providers. Achieving this action also relies on implementing the Partnering with Consumers Standard and Communicating for Safety Standard actions.

Planning and delivering comprehensive care involves several essential elements. The way in which these elements are implemented in practice varies between healthcare services, depending on a range of factors, such as the service context, size, location and patient population; the characteristics of the patient and their presenting problem, for example age, comorbidities and social circumstances.

Planning and delivering comprehensive care involves the following activities.

**Risk screening and assessment** – risk screening and assessment are a core part of healthcare delivery and comprehensive care. As well as identifying clinical issues, they also identify the likelihood of harm, and support decision-making about treatment and risk mitigation.

**Clinical assessment and diagnosis** – using report of symptoms from patients, carers and families where appropriate, information about course of illness or condition as well as other relevant patient history, healthcare providers evaluate clinical information to make a clinical assessment and diagnosis within their scope of practice and commence development of an appropriate and effective comprehensive care plan.

**Identifying goals of care** – identifying and settings goals of care in collaboration with the patient, rather than focusing on clinical goals alone, ensures care is individualised. Understanding a patient's values and their expectations and aspirations for their health and wellbeing, as well as clinical issues and risks of harm are all essential to the establishing shared goals of care.

**Agreeing a plan for care** – developing and agreeing a plan for care provides an opportunity to document a single, clear and holistic plan that addresses diagnoses, goals of care, identified risks, action taken and proposed and the key treatment information for the episode of care. It can also serve as a tool to support multidisciplinary collaboration where appropriate.

**Delivering comprehensive care** – align the delivery of comprehensive care with the comprehensive care plan and address the identified clinical and personal goals of care, diagnoses and risks.

**Recall to follow-up** – establish processes to contact and recall patients for subsequent health. This can be done by the healthcare service or through referral to another healthcare service. An example of patient recall is required is when follow-up care is required after diagnostic imaging or pathology results are received.

**Review and improvement of care delivery** – reviewing and improving care are iterative processes and can occur because of changes in a patient's condition, their diagnosis, their location, their goals or any other clinical and personal reason. These changes often require reassessment and adjustments in the care plan.

**Advance care plans** – an advance care plan documents the stated preferences about a person's health and personal care, and preferred health outcomes. An advance care plan ensures that patient's preferences are known if they are no longer able to speak for themselves. They can reduce the likelihood of unwanted or inappropriate treatment. Not all patients will have an advance care plan. Where they are in place, healthcare providers need to be able to accept and action as appropriate.

**Links to Actions 1.04 Risk management; 1.11 Healthcare records; 2.04 and 2.05 Shared decisions and planning care**

## Reflective questions

- What risk screening and assessment tools are used within the healthcare service?
- How are agreed plans for care documented?
- How are patients recalled for follow-up care? Is this process effective?
- How does the healthcare service ensure that, when a patient presents with an advance care plan, these are documented in the patient's healthcare record and that care is provided in accordance with these plans?

## Key tasks

- Identify relevant screening and assessment tools that may be used by the healthcare service.
- Support workforce access to continuing professional development and/or training to ensure planning and delivery of comprehensive care is in line with current best practice.
- Develop and implement a process to document agreed plans for care in a patient's healthcare record and recall patients for follow-up.
- Define and implement processes to receive, document, provide access to and communicate advance care plans.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Training records or documents relating to screening, assessment, diagnosis, goal setting and delivery of comprehensive care in relevant clinical areas
- Screening and assessment templates or forms
- Examples of documented care plans
- Documents outlining patient recall process
- Reviews of the use of advance care plans to evaluate alignment with actual care given
- Examples of healthcare records with advance care plans documented
- Examples of healthcare records indicating recall of patients.

## Where to go for more information

### Commission resources

The principles and strategies outlined in these resources are broadly applicable.

- **Implementing the Comprehensive Care Standard: Essential elements for delivering comprehensive care (August 2018)** – provides practical support for the implementation of the comprehensive care actions in the NSQHS Standards.
- **Implementing the Comprehensive Care Standard – Approaches to person-centred screening** – provides practical support for the implementation of the comprehensive care actions in the NSQHS Standards.
- **NSQHS Standards User Guide for health service organisations providing care for patients with cognitive impairment or at risk of delirium** – provides practical support for healthcare services where specific efforts or additional attention is required to meet the health needs of this patient population, based on the NSQHS Standards.
- **NSQHS Standards User Guide for Health Service Organisations Providing Care for Patients from Migrant and Refugee Backgrounds** – provides practical support for healthcare services where specific efforts or additional attention is required to meet the health needs of this patient population, based on the NSQHS Standards.
- **NSQHS Standards User Guide for health services providing care for people with mental health issues** – provides practical support for healthcare services where specific efforts or additional attention is required to meet the health needs of this patient population, based on the NSQHS Standards.

### Other resources

- **Advanced Care Planning Australia** – provides support about making decisions now about the health care the patient would or would not like to receive if they were to become seriously ill and unable to communicate their preferences or make treatment decisions.
- **CareSearch: Primary health care** – provides evidence-based guidance including triggers for consideration and recommendations for action, for health professionals working within primary health care.

## Action 3.22

The healthcare service has processes to:

a. Routinely ask if a patient is of Aboriginal and/or Torres Strait Islander origin
b. Record this information in the patient's healthcare record
c. Use this information to optimise the planning and delivery of health care.

## Explanatory notes

People of Aboriginal and Torres Strait Islander origin can be at greater risk of avoidable differences in health outcomes when compared with other Australians. A person's Aboriginal or Torres Strait Islander heritage is personal to them and generally, no formal letter of confirmation is required to identify as an Indigenous Australian.[34] Aboriginal and Torres Strait Islander peoples are more likely to feel comfortable identifying if they are in a welcoming and culturally safe environment, free of racism and discrimination.

**Links to Actions 1.09 and 1.10 Patient populations and social determinants of health; and 1.25 Safe environment**

Ensuring culturally safe opportunities for people to identify as Aboriginal and/or Torres Strait Islander will:

- Support Aboriginal and Torres Strait Islander peoples to feel comfortable and safe when using your service
- Assist your healthcare service deliver high-quality and culturally safe care to all Aboriginal and Torres Strait Islander peoples
- Reinforce self-identification as important in enabling access to services
- Support Aboriginal and Torres Strait Islander patients access to relevant services.

The ***National Best Practice Guidelines for Collecting Indigenous Status in Health Data Sets*** provides best-practice guidelines for:

- How to ask the question
- How to record responses
- Common scenarios, such as what to do when the workforce is reluctant to ask the question, and how to respond when a person wants to know why they are being asked.

## Reflective questions

- What processes are used to identify patients who identify as Aboriginal and/or Torres Strait Islander?
- How is this information recorded and used in care planning and delivery?
- What training does your workforce undertake to support them in asking the question?

## Key tasks

- Establish processes for people to self-identify as Aboriginal and/or Torres Strait Islanders.
- Facilitate access to training the workforce to build cultural safety capacity – training can be provided to the workforce via eLearning such as Asking the Question of Origin elearning module (identification training).

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context, but could include:

- Patient record form on which patients can identify as being of Aboriginal or Torres Strait Islander origin
- Communication material displayed in common areas that provides patients with information about why they will be asked if they identify as being of Aboriginal or Torres Strait Islander origin
- Evidence of workforce training on cultural safety and how to ask the question.

## Where to go for more information

### Commission resources

- **NSQHS Standards User guide for Aboriginal and Torres Strait Islander health** – provides practical support for the implementation of the Aboriginal and Torres Strait Islander-specific actions in the NSQHS Standards. The principles and strategies outlined in this resource are broadly applicable.

### Other resources

- AIATIS: **Proof of Aboriginality** – reviews the three 'working criteria' used as confirmation of Aboriginal or Torres Strait Islander heritage.
- AIHW: ***National best practice guidelines for collecting Indigenous status in health data sets*** – ensures the standard Indigenous status question is asked correctly and consistently of all clients of health services, and that this information is correctly recorded.
- Heart Foundation: **Asking the Question of Origin e-learning module (identification training)** – provides training for health professionals on how to identify Aboriginal and Torres Strait Islander patients.

## Action 3.23

The healthcare service supports its workforce to meet the individual needs of its patients, including those:

a. With disability
b. From diverse populations.

## Explanatory notes

This action focuses on the role of the healthcare service in supporting the workforce to meet the individual needs of its patients, including those with disability and from diverse backgrounds.

People with disability or from diverse populations are more likely to face barriers in accessing healthcare services, which can in turn lead to avoidable differences in health outcomes.[35]

Barriers may include inadequate staff training, cultural competency, expertise and capacity, limited access to skilled patient advocates, costs, accessibility of buildings and health care equipment and discriminatory attitudes.[35]

Information on patients from diverse populations that were identified from implementing Action 1.09 can be used to tailor strategies for individuals from different population groups. The strategies used may vary widely between groups and will need to be tailored to an individual's health needs. Health care and referral pathways delivered by the healthcare service should incorporate risk management strategies, for example, providing access to translators or mobility assistance.

### Reasonable adjustments

A 'reasonable adjustment' is when action is taken to meet the particular needs of a person with disability and prevent inequity. Reasonable adjustments can improve safety and quality in health care as they facilitate:

- Preventative health care
- Person-centred approaches
- Comprehensive care.

**Links to Actions 1.09 and 1.10 Patient populations and social determinants of health**

## Reflective questions

- What are the sociodemographic characteristics of the healthcare service's patient population?
- What strategies are being implemented to optimise health outcomes for these patients?
- What tools and resources are available for the workforce?

## Key tasks

- Periodically review local community and patient demographics to identify the diversity of the patients using the healthcare service and incorporate into planning for care.
- Build staff confidence and awareness of the issues for people with disability.
- Identify the reasonable adjustment of strategies or services that can be used when providing comprehensive care for patients who are more likely to face barriers in accessing healthcare services.
- Facilitate access to training to support planning and delivery of health care that is inclusive.
- Identify tools and resources that can be used to support safe care for people with disability and from diverse backgrounds.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context, but could include:

- Demographic data for the healthcare service's patient population and the local community that are used for planning purposes
- Evidence of culturally informed training and comprehensive care planning
- Tools and resources used by the workforce to support the safe care of people with disability and from diverse backgrounds

- Training documents on diversity and cultural awareness
- Consumer information that is available in different formats and languages that reflect the diversity of the patient population
- Observation of healthcare providers communicating with patients in their preferred language
- Equipment and principles of universal design to enable access to care for people living with a disability.

## Where to go for more information

### Commission resources

- ***Cognitive impairment: Clinicians can take action to reduce the risk of harm*** – lists the steps required and details a quality and safety pathway.
- **Cognitive impairment resources** – a range of resources to help improve the safety and quality of health care for people with cognitive impairment or at risk of delirium.
- **Delirium Clinical Care Standard** – describes the key components of care that patients can expect when they have delirium.

### Other resources

- **Acon: Pride Training** – offers training, information and educational services to assist health, wellbeing, and community organisations in increasing their knowledge of LGBTQI+ people and communities and provide guidance on inclusive practice.
- Australian Human Rights Commission: ***Access for all: Improving accessibility for consumers with disability*** – provides practical tips for businesses on improving access to goods, services, facilities, premises and information for consumers with disability.
- Australian Human Rights Commission: **Disability Rights** – promoting the rights of people with disabilities and building a more accessible, more inclusive community.
- Australian Government Department of Health: **National Roadmap for improving the health of people with intellectual disability** – aims to address serious health inequities faced by people with intellectual disability.
- Australian Government Department of Social Services: **National Disability Strategy 2021–2031** – a national framework that sets out a plan for continuing to improve the lives of people with disability in Australia over 10 years.
- Australian Government: **National Relay Service** – for people who are deaf and/or find it hard hearing or speaking with people who use a phone.
- Council for Intellectual Disability: **Resources for health practitioners** – resources for healthcare providers to support better appointments when working with people with intellectual disability.
- **Rainbow Health Australia: Supporting LGBTQI+ health and wellbeing** – research and knowledge translation, training, resources, policy advice and service accreditation through the Rainbow Tick.
- **Reconciliation Australia**: is the peak body for reconciliation in Australia – promotes and facilitates reconciliation by building relationships, respect and trust between the wider Australian community and Aboriginal and Torres Strait Islander peoples.
- **Translating and Interpreting Service (TIS)** – a free interpreting service, which aims to provide equitable access to key services for people with limited or no English language proficiency. TIS National delivers the Free Interpreting Service on behalf of the Australian Government.
- UNSW: **Department of Developmental Disability Neuropsychiatry resources for health professionals** – provides information and education on intellectual disability physical and mental health.

# Comprehensive care at the end of life

## Action 3.24

Healthcare providers use a healthcare service's processes that are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care to:

a. Identify patients who are at the end of life
b. Use this information to plan and deliver health care.

## Explanatory notes

**Note:** This action is only applicable if your healthcare service delivers end-of-life care.

End of life refers to the period when a patient is living with, and impaired by, a life-limiting condition, even if the trajectory is ambiguous or unknown. This period may be years in the case of patients with chronic or malignant disease, or very brief in the case of patients who suffer acute and unexpected illness or events, such as sepsis, stroke or trauma.

The health care that people receive in the last years, months and weeks of their lives can help to minimise the distress and grief associated with death and dying for the individual, and for their family, friends and carers. People living with a life-limiting illness have end-of-life care provided in many different settings – in their homes, acute hospitals, hospices (which may be community-based or led by tertiary facilities), general practices, specialist clinics, aged care facilities, and other organisations where people may be living (such as correctional facilities and locations caring for people living with severe mental illness or severe disabilities).

The **National Consensus Statement: Essential elements for safe and high-quality end-of-life care** describes guiding principles and essential elements of end-of-life care. Many of these are relevant to care delivered in primary and community healthcare settings.

Healthcare providers in primary and community healthcare settings have an important role to play in the delivery of care at the end of life, and there are increasing calls for **allied health professionals to be involved in a multidisciplinary approach**. Allied health professionals can help with symptom management including with nutrition, communication and mobility; help the person maintain function and independence, offer emotional support; share information about disease progression and help to plan future care; and help connect the person and families to support services.

The consensus statement describes triggers for recognising when patients are approaching the end of life. Considering the likelihood of a patient dying creates opportunities to identify their needs and preferences, review their goals and comprehensive care plan, and consider how best to align care with the individual's expressed values and wishes. Routine use of simple trigger tools and questions can prompt clinicians to use their clinical judgement to make a holistic assessment of whether a patient has end-of-life care needs.

## Reflective questions

- How does the healthcare service organisation identify patients who are at the end of their life?
- How does the healthcare service ensure that these processes are consistent with the National Consensus Statement: Essential elements for safe and high-quality end-of-life care?
- How does the healthcare service ensure care is provided in accordance with advance care plans?
- How does the healthcare service seek advice from other healthcare professionals including specialist palliative care services?
- How are clinicians supported to share decisions about end-of-life care with patients, carers and families?

## Key tasks

- Use the **National Consensus Statement: Essential elements for safe and high-quality end-of-life care** to implement processes for identifying patients with end-of-life care needs and improving end-of-life care.
- Describe key considerations and actions healthcare providers would take when planning and delivering health care for someone who is at the end of life.
- Where required, the healthcare service should seek specialist palliative care advice through referral pathways or informal contact with specialist palliative care services.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context, but could include:

- Communication (for example, posters on clinic walls, emails to clinicians, information on noticeboards) that outlines processes for accessing specialist palliative care advice
- Observation of clinicians accessing specialist palliative care advice
- Resources and tools to help clinicians identify patients who are at the end of life
- Training documents (for example, syllabus, attendance records, competency assessments) about identifying patients who are at the end of life
- Tools and resources for shared decision making with patients, carers and families about end-of-life care
- Observation of discussions on shared decision making about end-of-life care between clinicians, patients, carers and families
- Patient and carer information packages or resources about end-of-life care options.

## Where to go for more information

### Commission resources

The principles and strategies outlined in these resources are broadly applicable.

- **National Consensus Statement: Essential elements for safe and high-quality end-of-life care** – describes 10 essential elements for the provision of end-of-life care in settings where acute care is provided.
- **NSQHS Standards User Guide for health service organisations providing care for patients with cognitive impairment or at risk of delirium** – provides practical support for healthcare services where specific efforts or additional attention is required to meet the health needs of this patient population, based on the NSQHS Standards.

### Other resources

- **Advance Care Planning Australia**: Reviews the process of planning for future health care.
- ACON: **LGBTQI+ Toolkit for Palliative Care and End of Life Decisions** – consumer resources on end-of-life care through an LGBTQI+ lens.
- Australian Government Department of Health: **National Palliative Care Strategy 2018** – provides guidance across a range of health care settings to develop access protocols. The strategy articulates a cohesive national approach to the development and delivery of palliative care across Australia. The overarching vision as outlined in the strategy for palliative care in Australia is 'people affected by life-limiting illnesses get the care they need to live well'.
- **CareSearch website**: Consolidates online palliative care knowledge for health professionals, people needing palliative care and their families and for the general community.
- **End-of-life essentials website**: Provides online learning opportunities and practice resources for doctors, nurses and allied health professionals to improve the quality and safety of end-of-life care in hospitals.
- **End of Life Directions for Aged Care**: provides resources on palliative care and advance care planning to improve the care of older Australians.
- **Palliative Care Australia website**: Provides access to training and resources for patients, carers and service providers.
- **Talking End of Life (TEL) with people with intellectual disability website**: Resources for disability support professionals, healthcare providers, families and educators to teach people with intellectual disability about end of life.
- **Talking end of life with people with intellectual disability, tool kit**: Provides resources to help people with disability learn about and deal with dying and death, just as they learn about every other aspect of life.
- **Gwandalan National Palliative Care Project's eLearning Modules**: Provides training for healthcare providers to support cultural safety within palliative care services for Aboriginal and Torres Strait Islander peoples.
- **Indigenous Program of Experience in the Palliative Approach**: Provides education and training for the healthcare providers on palliative care for Aboriginal and Torres Strait Islander peoples.

# Communicating for safety

## Consumer outcome

*My healthcare providers communicate with each other about my health care, so I receive the health care I need.*

### Intention of this standard

Communicating for safety aims to ensure timely, purpose-driven and effective communication and documentation that supports continuous, coordinated and safe health care for patients.

## Processes for effective communication

## Action 3.25

The healthcare service has processes that use at least three patient identifiers to ensure patients are correctly identified.

### Explanatory notes

Healthcare services in primary and community settings often see patients on a regular basis and establish rapport and professional relationships over extended periods of time. However, where healthcare providers are unfamiliar with a patient, or in certain high-risk scenarios, patient identifiers should be used to help ensure correct care is delivered.

Patient identifiers are items of information that can be used to confirm a person's identity. There are a range of patient that can be used. Some examples may include:

- Legal name
- Preferred or affirmed name
- Date of birth
- Sex
- Gender
- Address (including postcode)
- Healthcare record number
- Last three digits of a patient's phone number.

Healthcare services should determine patient identifiers that will be most appropriate in their service context and consider the privacy implications when adopting a particular method. Using at least three patient identifiers reduces the risk of incorrect identification.[36]

When patients are known to the healthcare service, periodic confirmation of identity may be appropriate, for example, 'Do you still live at… I'd like to check that we have the correct details on record'.

**Links to Action 3.26 Processes for effective communication**

## Reflective questions

- How does the workforce confirm a patient's identity before providing care?
- What patient identifiers are used to confirm the identity of a patient?

## Key tasks

- Define a process for the reliable and correct identification of patients when health care, medicine, therapy and other services are provided.
- Agree a list of patient identifiers that can be used by the workforce.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- A documented process for patient identification
- Documentation on the agreed patient identifiers to be used
- Observation of the patient and procedure matching process
- Templates, checklists or documentation identifying and matching a patient to their intended care, for example, patient registration forms and healthcare records
- Communication materials or training records for the workforce on correct patient identification.

## Where to go for more information

### Commission resource

- **Communicating for safety resource portal** – provides practical support for implementing the communicating for safety actions in the NSQHS Standards. Resources are therefore primarily relevant in acute settings; however, the principles and strategies outlined in these resources are broadly applicable.

### Other resource

- Australian Bureau of Statistics: ***Standards for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables*** – developed to support the standardisation of the collection and dissemination of data relating to sex, gender, variations of sex characteristics and sexual orientation.

# Action 3.26

The healthcare service has processes to:

a. Correctly match patients to their health care
b. Ensure essential information is documented in a patient's healthcare record.

## Explanatory notes

Healthcare services should correctly match a patient to their care. This process should occur at occasions that require three approved identifiers to be used. These are:

- When a patient is unknown to the healthcare provider
- Before health care is delivered
- When making a referral to another healthcare provider.

### Essential information in a patient's healthcare record

Documentation is an essential component of effective communication. Given the complexity of health care, healthcare records are among the most important information sources available to healthcare providers. Undocumented or poorly documented information relies on memory and is less likely to be communicated and retained. This can lead to a loss of information, which can result in misdiagnosis, errors and patient harm.

Documentation can be paper-based, electronic or a mix of both. It can also take several forms, including the referrer's information, care plan, referrals, checklists, test results, notes and discharge or transition of care summaries. For this action, services are required to have in place systems to ensure that essential information about a person's care is documented in the healthcare record. For documentation to support the delivery of safe, high-quality care, it should:

- Define when documentation is required
- Be clear, legible, concise, contemporaneous, progressive and accurate
- Include information about assessments, action taken, outcomes, reassessment processes (if applicable), risks, complications and changes
- Meet all necessary medico-legal requirements for documentation, such as record retention timeframes, date and time or author's name and designation
- Ensure healthcare providers know how to gain access to the healthcare record, the healthcare service's templates, checklists or other tools and resources that support safe, high-quality documentation.

### What does high-quality documentation look like?

Regardless of the medium (paper or digital), high-quality documentation should follow the same guiding principles as outlined in **Table 5**.

**Table 5**: Guiding principles for high-quality documentation

| **Guiding principle** | **What does this look like?** |
|---|---|
| Person-centred | • Patient's goals of care are reflected in the care they receive<br>• Patient's culture, identify, beliefs and choices are recognised and respected<br>• Information documented is tailored to the specific care needs of the patient, taking into consideration what practical information is needed to support safe care |
| Compliant | • Legislative requirements are met (e.g. privacy and confidentiality)<br>• Standards, policies and procedures set by the relevant Australian, state and territory governments, health services and professional bodies are adhered to, including rules relating to both healthcare provider and patient identification<br>• Standardised language, terminology, symbols and approved abbreviations are used (medications and describing general health terms)<br>• Material is aligned with guidance on structured formats and on-screen presentation<br>• Healthcare providers provide the right documents and use them in the ways mandated such as providing care |
| Complete and accurate | • All relevant information is captured (consider any minimum information content requirements)<br>• Recorded information correctly reflects the event being documented |
| Integrated and up to date | • Information from all relevant sources is integrated. This includes information from multidisciplinary team members, the patient and their family or carer<br>• Information is up to date (e.g. new or emerging information is recorded, episode of care notes or care plans are documented, and referrals or updates to the patient's primary healthcare provider, such as their GP, are completed in a timely manner) |
| Accessible | • Documents are available to healthcare providers who need them, when they need them and in language that is easily understood<br>• Relevant, up-to-date information is immediately at hand and easy to locate or searchable (physical accessibility)<br>• The needs and the capabilities of those who will use the information are considered, and language does not exclude the people who will be using the information. This may include the patient, families, carers and other healthcare providers |
| Readable | • Documents are legible and be able to be understood by the intended audience<br>• Whether in electronic or paper form, forms and checklists must provide enough space for accurate and legible completion and must include clear instructions about how they should be completed<br>• Acronyms and abbreviations are avoided in both design and completion if there is any potential for ambiguity<br>• Be as specific as possible |
| Enduring | • Documents are materially durable (not loose paper that is likely to be lost or on thermal paper that can fade)<br>• The meaning of documents should be maintained, and written to be interpretable by a person who is not present at the time of the recording (self-explanatory)<br>• There should be evidence of critical thinking. For example, information should not just simply list tasks but provide enough information and justification to explain recommendations and instructions (actions to be taken and why), and details of the impact and outcome for the patient and family involved |

Source: Amended from **Documenting information, Communicating for Safety resource portal** (ACSQHC, 2022).

**Links to Actions 1.11, 1.12 Healthcare records and 3.25 Processes for effective communication**

## Reflective questions

- In your healthcare service when do you need to match patients to their health care and what processes are used?
- What documentation does your healthcare service require in the patient's healthcare record?
- What processes are in place to ensure that your patients' healthcare records are accurate and complete?
- How are healthcare records accessed by all those involved in the patient's care?

## Key tasks

- Develop and implement processes to correctly match patients with their intended health care using defined patient identifiers.
- Ensure that your healthcare service has relevant, accurate, complete and up to date information about patients' care documented in their healthcare record.
- Ensure that patients' healthcare records are available and accessible to those involved in their care.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context, but could include:

- Documents that describe how patients are matched to their care
- Communication materials or training records that demonstrate the workforce has been educated on the relevant protocol for correctly identifying a patient
- Observation of healthcare records where the information used to identify a patient and match them to their care is documented
- Observation of healthcare records being available to clinicians at the point of care.

## Where to go for more information

### Commission resources

- **Communicating for Safety resource portal** – provides practical support for the implementation of the communicating for safety actions in the NSQHS Standards. The principles and strategies outlined in these resources are broadly applicable.
- **NSQHS Standards User Guide for health service organisations providing care for patients with cognitive impairment or at risk of delirium** – provides practical support for healthcare services where specific efforts or additional attention is required to meet the health needs of this patient population, based on the NSQHS Standards. The principles and strategies outlined in this resource are broadly applicable.
- **Recommendations for terminology, abbreviations and symbols used in medicines documentation** – sets out principles for safe, clear and consistent terminology for medicines, and safe terms, abbreviations and dose designations for medicines.

### Other resource

- Primary Healthcare Network, Tasmania: **Shared Transfer of Care – templates and tools** – organised by strategies for implementing shared transfer of care.

# Communication to support patient referral and multidisciplinary collaboration

## Action 3.27

The healthcare service supports its healthcare providers to refer patients to other services and collaborate with other care providers by:

a. Using best-practice structured communication processes
b. Considering the patient's risks, goals and preferences for health care
c. Communicating information that is current, comprehensive and accurate.

## Explanatory notes

Australia's health system is complex and the delivery of health care involves a large network of services and providers, across multiple settings. This can include healthcare providers in primary and community healthcare settings, specialist services, acute emergency services and hospital-based services, as well as rehabilitation and palliative care.

It is common for a person to access multiple healthcare services and healthcare providers; and to be referred or transferred between these different providers and services. At transitions of care, situations when all or part of a person's care is transferred between healthcare locations or providers, and as the patient's conditions and care needs change, the risk of communication errors is increased.

Communication errors and ineffective communication between healthcare providers, multidisciplinary teams and with the patient and their family or carer can lead to poorer health outcomes, patient distress and inappropriate care. Therefore, the healthcare service should support its healthcare providers to refer to and collaborate with other care providers by:

- Using best-practice structured communication processes
- Considering the patient's risks, goals and preferences for health care when communicating with, and in referrals to, other providers and services
- Communicating information that is current, comprehensive and accurate
- Including the patient, their carer and family in communication processes.

Healthcare providers must be supported to:

- Know the healthcare service's processes, tools and forms for communicating at transitions of care
- Know who to communicate with and when they need to communicate for any transition of care
- Identify what minimum information is required to be communicated for any particular transition
- Have the skills to undertake structured communication
- Have the skills to communicate effectively with patients, families and carers, including agreeing what information they consent to be shared with other healthcare providers.

## Reflective questions

- What resources or processes does your healthcare service have to support communication and collaboration with other care providers when a patient is being referred?
- How is your workforce supported to develop and maintain skills for effective communication?

## Key tasks

- Identify the resources and tools that encourage effective communication processes and tailor resources to suit your healthcare service.
- Ensure that your workforce is trained in the use of your healthcare service's processes and resources to support effective communication.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Documents outlining the process for communicating emerging or changing critical information
- Templates to support clinical communication, such as referral forms, standardised comprehensive care plans, medication lists or checklists for referrals
- Templates or tools that support healthcare providers to partner with the patient to communicate critical information, risks and goals or preferences
- Examples of referrals or communication between healthcare providers and the patient
- Demonstration of shared leadership and collaborative teamwork in multidisciplinary healthcare teams in rural and remote settings.

## Where to go for more information

### Commission resource

- **Communicating for safety resource portal** – provides practical support for the implementation of the communicating for safety actions in the NSQHS Standards. The principles and strategies outlined in these resources are broadly applicable.

# Maximising patient attendance

## Action 3.28

The healthcare service has effective communication processes to maximise patient attendance at planned appointments.

## Explanatory notes

Effective communication with a patient about their appointment/s can maximise their attendance and supports more informed self-management.

Communication processes to maximise patient attendance at appointments include:

- Ensuring that the appointment details have been communicated with the patient in a manner that meets their needs and preferences (for example, using preferred name, language) and at an agreed time and date
- Including support workers, carers or a nominated contact in communications about planned appointments, if agreed with the patient
- Liaising with other healthcare providers involved in the patient's care such as a general practitioner, rural generalist or care coordinator to identify opportunities for patients to attend
- Considering opportunities to extend or varying operating hours

- Adopting a flexible rescheduling and cancellation policy
- Ensuring a safe and welcoming environment is provided for the patient population
- Providing a reminder service for patients either by phone, SMS or email.

To enable effective communications, patient contact details must be recorded at the time of appointment booking. Healthcare services should ensure that the patient's contact details remain up to date at each episode of care to facilitate future follow-up care and treatment.

For walk-in appointments, these communication strategies can be engaged for follow-up appointments where relevant.

### Reflective question

- How does your healthcare service communicate planned appointments to patients?

### Key task

- Develop and implement communication processes to maximise patient attendance at planned appointments.

### Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Process for booking appointments
- Communication processes used prior to an appointment
- Examples of appointment reminders such as phone records in patient healthcare records, text messages or email reminders.

### Where to go for more information

Resources relating to this Action may be added as they become available.

## Communication of critical information

### Action 3.29

The healthcare service uses its communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to:

a. Relevant healthcare providers involved in the patient's care
b. Patients, carers and families, in accordance with the patient's preferences.

### Explanatory notes

Through the course of delivering health care, healthcare providers may learn critical information that may be relevant to other healthcare providers involved in a patient's care. Sharing this information can lead to the best possible outcomes for patients and support multidisciplinary collaboration.

Healthcare providers can use existing communication processes to convey critical information, alerts and risks in a timely way when they emerge and change, to:

- Relevant healthcare providers involved in the patient’s care
- Patients, carers and families, in accordance with the patient’s preferences.

### Identifying critical information

The identification of critical information or a risk to patient care depends on factors such as the type of service delivered and patient risks. Types of critical information could include:

- Changes to medicines or treatment
- Missed referrals or results
- Wrong diagnosis or results
- Change in patient goals, preferences or condition
- Allergies or adverse drug reactions
- Issues with equipment or medical supplies
- Information that requires follow-up with another healthcare provider (for example, the general practitioner) or the patient (or carer or family, where appropriate).

### Communicating critical information

Healthcare services should have established processes to communicate critical information, alerts and risks to:

- Relevant healthcare providers in the same healthcare service
- Relevant healthcare providers in a different healthcare service
- Patients, carers and families.

The communication method adopted will depend on the information provided and the level of urgency involved. Examples include telephone call, referral, SMS or a combination of all.

**Links to Actions 1.12 Healthcare records and 3.26 Processes for effective communication**

## Reflective questions

- How does your healthcare service communicate critical information, alerts and risks to other healthcare providers within your healthcare service?
- How does your healthcare service communicate critical information, alerts and risks to healthcare providers in other healthcare services?
- How is a patient’s preferences determined for sharing their health information within your service, with other services and to their carers and families?

## Key tasks

- Define ‘critical information’ and ‘risks to patient’s care’ for your service.
- Use standardised processes to communicate critical information, alerts or risks to relevant healthcare providers and patients, carers and families in a timely manner.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- A document describing the types of critical information likely to be received and actions taken in response
- Processes for communicating critical information (for example, by telephone or secure electronic means) to the relevant healthcare providers including
  - method for communicating critical information to the patient, carer and family
  - time frames for communicating critical information
  - expectations for the healthcare provider and requirements for the patient's care
- Standardised templates to support communication of critical information, such as referrals, templates or progress notes that are updated in line with identified risks, patient feedback and recommendations
- Observation of critical information being discussed, shared with the appropriate healthcare provider or the patient, and acted upon.

## Where to go for more information

### Commission resources

The principles and strategies outlined in these resources are broadly applicable.

- **Communicating for safety resource portal** – provides practical support for the implementation of the communicating for safety actions in the NSQHS Standards.
- **NSQHS Standards User Guide for health services providing care for people with mental health issues** – provides practical support for healthcare services where specific efforts or additional attention is required to meet the health needs of this patient population, based on the NSQHS Standards.

## Action 3.30

The healthcare service has communication processes for patients, carers and families to directly communicate critical information and risks about health care to their healthcare providers.

## Explanatory notes

New critical information that affects a patient's health care comes from various sources, including patients, carers and families.

For the right care to be delivered and action to occur, critical information must be timely. Healthcare services must ensure that patient, carers and families know how best to communicate critical information to the healthcare provider. These processes must be straightforward and easy to follow.

The healthcare service should establish a process for patients, carers and families to communicate critical information:

- Before or at the initial appointment with the healthcare service
- At different points of care
- After the episode of care at the healthcare service.

This includes the patient's, carer's and family's information on:

- What could be considered critical information
- Their role in communicating this information
- Resources or communication tools to support the communication of critical information to their healthcare providers
- Who they communicate critical information to.

Information such as key persons and their contact details, or an after-hours emergency contact number can be communicated to patients, carers and families in different forms. These include:

- Displays in common areas of the healthcare service
- Providing a phone number for patients, carers and families to call if they are concerned, particularly if it is after the episode or care at the healthcare service
- Providing written or verbal information during consultation or treatment.

## Reflective questions

- How are patients, carers and families supported in communicating critical information to healthcare providers?
- What feedback processes are in place to let patients, carers and families know that they have been heard and any action that has been taken?

## Key tasks

- Develop and implement processes that describe when and how critical information and risks about a patient's health need to be communicated to healthcare providers.
- Support patients and carers to understand and use these processes.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context, but could include:

- Information provided to patients, carers and families about processes for communicating concerns to the healthcare providers
- Resources and information for patients, carers or families to use to communicate with healthcare providers, such as phone numbers or where to go for emergency assistance
- Patient notes that identify critical information provided by the patient or family and how this information was acted upon
- Results of a patient experience survey or patient, carer and family feedback about their communication with clinicians and, where necessary, how these results have informed improvement

- Information available online detailing the healthcare service's communication processes or emergency contact processes (for example, on the healthcare service's website or social media platform).

## Where to go for more information

The principles and strategies outlined in these resources are broadly applicable.

### Commission resources

- **Communicating for safety resource portal** – provides practical support for the implementation of the communicating for safety actions in the NSQHS Standards.
- **NSQHS Standards User Guide for health service organisations providing care for patients with cognitive impairment or at risk of delirium** – provides practical support for healthcare services where specific efforts or additional attention is required to meet the health needs of this patient population, based on the NSQHS Standards.
- **NSQHS Standards User Guide for health services providing care for people with mental health issues** – provides practical support for healthcare services where specific efforts or additional attention is required to meet the health needs of this patient population, based on the NSQHS Standards.

# Recognising and responding to serious deterioration and minimising harm

## Consumer outcome

*If my health deteriorates, I know I will receive the health care I need in a timely way.*

## Intention of this standard

Healthcare services have systems in place to recognise and respond to serious deterioration in patients and escalate health care appropriately.

## Recognising serious deterioration or distress and escalating care

## Action 3.31

Healthcare providers use the healthcare service's processes to:

a. Recognise deterioration in a patient's physical, mental or cognitive health
b. Respond to a patient within their scope of clinical practice and call for emergency assistance
c. Notify a patient's other relevant healthcare providers, carers or family when their health care is escalated.

## Explanatory notes

Serious deterioration in a patient's physical, mental or cognitive health may occur at any time. In some circumstances, healthcare providers may observe this change while delivering health care and be required to assist. In these instances, healthcare services should have a process for healthcare providers to:

- Respond appropriately to a patient within their scope of clinical practice, for example, the assistance that a physiotherapist may provide may differ from the assistance a nurse practitioner is able to provide, and will be dependent on the support, equipment and service offering of the healthcare service
- Call for emergency assistance, for example, in most instances this would be for an ambulance service; however, it may include direct transfer arrangements or emergency consultation with specialist healthcare providers based on formal or informal partnerships
- Notify other relevant healthcare providers, carers and family members.

Establishing processes to respond to serious deterioration and escalation of care and calling for emergency assistance will ensure that healthcare providers can respond consistently and effectively.

The mechanisms in place need to be appropriate for the size and location of the healthcare service and the population it serves. Other considerations include the available resources, healthcare provider skills mix and capacity to engage specialist help. Multiple mechanisms may be necessary in escalation systems to allow different responses to varying levels or types of deterioration. These mechanisms may include:

- Landline phones
- Mobile or satellite-navigation phones
- Two-way radio devices
- Dedicated mobile, on-call and emergency telephone numbers.

Consider:

- Distance and location of response services (ambulance or aerial medical service) providers
- Mechanisms that can assist the response service to locate the patient
- Backup systems or processes in the event of equipment failure
- Processes for maintaining any relevant equipment
- Training on the processes for escalating care, including for new, casual, locum, and agency members of the workforce
- Information for family members who care for unwell, aged or palliative care relatives about recognising and responding to serious deterioration.

In rural and remote community settings it may be helpful to develop processes for obtaining emergency advice from specialist providers – such as ambulance, aerial medical services, general practitioners or rural generalists, emergency or mental health services, or intensive care clinicians – by phone, video link or two-way radio.

## Reflective questions

- What are some examples of serious deterioration in a patient?
- What emergency assistance would be called for in the event of a patient experiencing serious deterioration, and why?
- What training do healthcare providers complete to support them to respond to a patient experiencing serious deterioration?

## Key tasks

- Develop a process to support healthcare providers to
  - recognise deterioration in a patient’s physical, mental or cognitive health
  - respond to a patient within their scope of practice and call for emergency assistance
  - notify a patient’s other relevant healthcare providers, carers or family when health care is escalated.
- Ensure that healthcare providers and the workforce have the necessary skills and equipment to recognise and respond to serious deterioration within their scope of clinical practice.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service , but could include:

- Healthcare service’s process for recognising and responding to serious deterioration or distress and escalating care
- Training documents about mechanisms for escalating care and calling for emergency assistance
- Posters and other resources such as flow charts that are accessible and displayed in appropriate locations for the workforce.

## Where to go for more information

### Commission resources

The principles and strategies outlined in these resources are broadly applicable.

- **NSQHS Standards User Guide for health service organisations providing care for patients with cognitive impairment or at risk of delirium** – provides practical support for healthcare services where specific efforts or additional attention is required to meet the health needs of this patient population, based on the NSQHS Standards.
- **NSQHS Standards User Guide for health services providing care for people with mental health issues** – provides practical support for healthcare services where specific efforts or additional attention is required to meet the health needs of this patient population, based on the NSQHS Standards.

# Planning for safety

## Action 3.32

The healthcare service:

a. Has processes to respond to patients who are distressed, have expressed thoughts of self-harm or suicide, or have self-harmed
b. Has processes to respond to patients who present a risk of harm to others
c. Provides information on accessing other services to patients with healthcare needs beyond the scope of the service
d. Has a process that supports crisis intervention that is aligned to legislation.

## Explanatory notes

### Risk of self-harm

Adverse outcomes relating to patients who are distressed or have thoughts of self-harm or suicide or who have self-harmed are prevented through early recognition and effective response. Always consider self-harm seriously.

Healthcare services should consider whether a patient may be at risk of experiencing harm from others. The level of risk may be increased by factors such as alcohol or drug use, disinhibition and other risk-taking behaviours, domestic and family violence, intimate partner violence, child abuse, discrimination and neglect.[37]

### Risk of harm to others

Healthcare services should consider how to respond appropriately to a patient who discloses thoughts of harm to others or if they are assessed as representing a risk to others. Situations where there is a higher risk of harm to others include where:

- Patients are experiencing mental health issues
- History of violence is evident or known
- Abuse of alcohol and/or other drugs is present or known
- Neglect to children is evident or known.

Responding to patients who present a risk of harm to others may include referring to a specialist mental health service for assessment or to an emergency service if a crisis response is needed, and notification to child welfare services. Information about when legislation requires crisis intervention should be made available to the workforce, patients, families and carers.

**Links to Actions 1.04 Risk management and 1.23 Safe environment**

## Reflective questions

- How does the workforce respond to patients who are distressed, have expressed thoughts of self-harm or suicide, or have self-harmed?
- What information on other services can the healthcare provider give to patients when their healthcare needs are beyond the scope of the healthcare service?

## Key tasks

- Develop and implement a process to
  - respond to patients who are distressed, have expressed thoughts of self-harm or suicide, or have self-harmed
  - respond to patients who present a risk of harm to others.
- Facilitate training for the workforce to effectively recognise and respond to patients who are distressed or exhibit aggression, have expressed thoughts of self-harm or suicide, or have self-harmed.
- Source and make information available on accessing other mental health services beyond the scope of the service. In most instances this will involve referring a patient to a general practitioner or rural generalist, community mental health service or hospital emergency department.

## Examples of evidence

The type and comprehensiveness of evidence used is dependent on each healthcare service context. The content and complexity of the policies and processes will likely depend on the size of the healthcare service, but could include:

- Processes that outline collaborative processes for identifying and treating patients at risk of self-harm or suicide, or who have self-harmed
- Crisis intervention support processes aligned to relevant legislation
- Training documents about identifying and responding to patients at risk of self-harm or suicide, or who have self-harmed
- Patient resources about strategies for accessing health services beyond the scope of the service.

## Where to go for more information

### Commission resource

- **NSQHS Standards User Guide for health services providing care for people with mental health issues** – provides practical support for healthcare services where specific efforts or additional attention is required to meet the health needs of this patient population, based on the NSQHS Standards. The principles and strategies outlined in this resource are broadly applicable.

## Other resources

- Australian Government Department of Health: **Mental health and suicide prevention resources** – a list of resources about mental health and suicide prevention in Australia.
- **Life in Mind: Suicide Prevention** – a knowledge exchange portal providing translated evidence, policy, data and resources in suicide prevention.
- **Mental Health First Aid** – offers skills based, early-intervention training programs to mobilise and empower communities by equipping people with the knowledge and confidence to recognise, connect and respond to someone experiencing a mental health problem or mental health crisis.
- National Institute for Health and Care Excellence: ***Violence and aggression: short-term management in mental health, health and community settings*** – aims to safeguard both staff and people who use services by helping to prevent violent situations and providing guidance to manage them safely when they occur.
- ***The Multi-Agency Risk Assessment and Management Framework*** (MARAM) – provides guidance for services that come into contact with individuals and families experiencing family violence.

# Glossary

**advance care directive**: a type of written advance care plan recognised by common law or specific legislation that is completed and signed by a competent adult. It can record the person's preferences for future care and appoint a substitute decision-maker to make decisions about health care and personal life management. In some states, these are known as advance health directives.[38] *See also* **advance care plan**

**advance care plan**: stated preferences about health and personal care, and preferred health outcomes. An advance care plan is usually the result of a process of planning for future health and personal care, whereby the person's values and preferences are made known so that they can guide decision-making at a future time when the person cannot make or communicate their decisions.[38] *See also* **advance care directive**

**adverse drug reaction**: a response to a medicine that is noxious and unintended and occurs at doses normally used or tested in humans for the prophylaxis, diagnosis or therapy of disease, or for the modification of physiological function.[39] An **allergy** is a type of **adverse drug reaction**.

**adverse event**: an incident that results, or could have resulted, in harm to a patient or consumer. A near miss is a type of adverse event. *See also* **near miss**

**alert**: warning of a potential risk to a patient.

**allergy**: occurs when a person's immune system reacts to allergens in the environment that are harmless for most people. Typical allergens include some medicines, foods and latex. An allergen may be encountered through inhalation, ingestion, injection or skin contact.[40,41] A medicine allergy is one type of **adverse drug reaction**.

**allied health (professionals)**: trained professionals who are not doctors, dentists or nurses. Allied health professionals use evidence-based practices to prevent, diagnose and treat various conditions and illnesses; they often work in multidisciplinary health teams to provide specialised support to suit an individual's needs.[42,43] An allied health professional is a **healthcare provider**.

**antimicrobial**: a chemical substance that inhibits or destroys bacteria, parasites, viruses or fungi and can be safely administered to humans and animals.[44]

**antimicrobial resistance**: failure of an antimicrobial to inhibit a microorganism at the antimicrobial concentrations usually achieved over time with standard dosing regimens.[44]

**antimicrobial stewardship**: an ongoing effort by a healthcare service to reduce the risks associated with increasing antimicrobial resistance and to extend the effectiveness of antimicrobial treatments. It may incorporate several strategies, including monitoring and review of antimicrobial use.[44]

**appropriate care**: patients are receiving the right care, and the right amount of care according to their needs and preferences, at the right time. The care offered should also be based on the best available evidence.[45]

**aseptic technique**: a set of practices aimed at minimising contamination and is particularly used to protect the patient from infection during procedures.[46]

**assessment**: a healthcare provider's evaluation of a disease or condition based on the patient's subjective report of the symptoms and course of the illness or condition, and their objective findings. These findings include data obtained through laboratory tests, physical examination and medical history; and information reported by carers, family members and other members of the healthcare team. The assessment is an essential element of a comprehensive care plan.[47]

**audit (clinical)**: a systematic review of clinical care against a predetermined set of criteria.[48]

**Australian Charter of Healthcare Rights**: specifies the key rights of patients when seeking or receiving healthcare services. The second edition was launched in August 2019.[7]

**Australian Open Disclosure Framework**: endorsed by health ministers in 2013, it provides a framework for healthcare services and healthcare providers to communicate openly with patients when health care does not go to plan.[49]

**best possible medication history**: a list of all the medicines a patient is using at presentation. The list includes the name, dose, route and frequency of the medicine, and is documented on a specific form or in a specific place. All prescribed, over the counter and complementary medicines should be included. This history is obtained by a healthcare provider working within their scope of clinical practice who interviews the patient (and/or their carer) and is confirmed, where appropriate, by using other sources of medicines information.[50]

**best practice**: when the diagnosis, treatment or health care provided is based on the best available evidence, which is used to achieve the best possible outcomes for patients.

**best-practice guidelines**: a set of recommended actions that are developed using the best available evidence. They provide healthcare providers with evidence-informed recommendations that support clinical practice, and guide healthcare provider and patient decisions about appropriate health care in specific clinical practice settings and circumstances.[51]

**business decision-making**: decision-making regarding service planning and management for a healthcare service. It covers the purchase of equipment, fixtures and fittings; program maintenance; workforce training for safe handling of equipment; and all issues for which business decisions are taken that might affect the safety and wellbeing of patients, visitors and the workforce.

**carer**: a person who provides personal care, support and assistance to another individual who needs it because they have a disability, medical condition (including a terminal or chronic illness) or mental illness, or they are frail or aged. An individual is not a carer merely because they are a spouse, de facto partner, parent, child, other relative or guardian of an individual, or live with an individual who requires care. A person is not considered a carer if they are paid, a volunteer for an organisation, or caring as part of a training or education program.[52]

**clinical care standards**: nationally relevant standards developed by the Commission, and agreed by health ministers, that identify and define the health care people should expect to be offered or receive for specific conditions.

**clinical governance**: the set of relationships and responsibilities established by a healthcare service between regulators and funders, owners and managers and governing bodies (where relevant), healthcare providers, the workforce, patients, consumers and other stakeholders to ensure optimal clinical outcomes.[53] It ensures that:

- The community can be confident there are systems in place to deliver safe and high-quality health care
- There is a commitment to continuously improve services
- Everyone is accountable to patients and the community for ensuring the delivery of safe, effective and high-quality health care. This includes healthcare providers, other members of the workforce and managers, owners and governing bodies (where they exist).

Depending on the size of the healthcare service, multiple roles may be carried out by the same individual.

**clinical governance framework**: describes the processes and structures that are needed to deliver safe and high-quality health care.[53] These include:

- Governance, leadership and culture
- Patient safety and quality improvement systems
- Clinical performance and effectiveness
- Safe environment for the delivery of health care
- Partnering with consumers.

**clinical practice**: the assessment, diagnosis, treatment and health care delivered to a patient.

**clinician**: *see* **healthcare provider**

**cold chain management**: the system of transporting and storing temperature-sensitive medicines and vaccines, within their defined temperature range at all times, from point of origin (manufacture) to point of administration, to ensure that the integrity of the product is maintained.

**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 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, carers and families 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 healthcare services. For example, a health 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.

**consumer advocate**: *see* **consumer representative**

**consumer representative**: a consumer who has taken up a specific role to provide advice on behalf of consumers, with the overall aim of improving health care.[54]

**cough etiquette**: *see* **respiratory hygiene and cough etiquette**

**critical equipment**: items that confer a high risk for infection if they are contaminated with any microorganism and must be sterile at the time of use. They include any objects that enter sterile tissue or the vascular system, because any microbial contamination could transmit disease.[46]

**critical information**: information that has a considerable impact on a patient's health, wellbeing or ongoing care (physical or psychological). The availability of critical information may require a healthcare provider to reassess or change a patient's comprehensive care plan.

**cultural safety**: The former Australian Health Ministers' Advisory Council identifies that consumers are safest when healthcare providers have considered power relations, cultural differences and patients' rights.[11] Essential features of cultural safety are:

- An understanding of one's culture
- An acknowledgement of difference, and requirement that healthcare providers are actively mindful and respectful of difference(s)
- Informed by the theory of power relations; any attempt to depoliticise cultural safety is to miss the point
- An appreciation of the historical context of colonisation, the practices of racism at individual and institutional levels, and their impact on Aboriginal and Torres Strait Islander people's living and wellbeing, both in the present and past
- That its presence or absence is determined by the experience of the recipient of care and not defined by the healthcare provider.

The intent and the content of issues covered is consistent the Australian Health Practitioners' Regulation Agency's definition of cultural safety.

**decision support tools**: tools that can help healthcare providers and consumers to draw on available evidence when making clinical decisions. The tools have several formats.

Some are explicitly designed to enable shared decision making (for example, decision aids). Others provide some of the information needed for some components of the shared decision making process (for example, risk calculators, evidence summaries), or provide ways of initiating and structuring conversations about health decisions (for example, communication frameworks, question prompt lists).[55] *See also* **shared decision making**

**disability**: The *Disability Discrimination Act 1992* (Cth) defines disability, in relation to a person, to mean:

- Total or partial loss of the person's bodily or mental functions; or
- Total or partial loss of a part of the body; or
- The presence in the body of organisms causing disease or illness; or
- The malfunction, malformation or disfigurement of a part of the person's body; or
- A disorder or malfunction that results in the person learning differently from a person without the disorder or malfunction; or
- A disorder, illness or disease that affects a person's thought processes, perception of reality, emotions or judgement that results in disturbed behaviour.[56]

The World Health Organization's *International classification of functioning disability and health* recognises that disability is multidimensional and is the product of an interaction between attributes of an individual and features of the person's physical, social and attitudinal environment. It broadens the perspective of disability and allows for the examination of medical, individual, social and environmental influences on functioning and disability.[57]

**diverse backgrounds**: The varying social, economic and geographic circumstances of consumers who use, or may use, the services of a healthcare service, as well as their cultural backgrounds, disability status, religions, beliefs and practices, languages spoken, sexual orientation, gender identity and gender expression, and sex characteristics.

**end of life**: the period when a patient is living with, and impaired by, a fatal condition, even if the trajectory is ambiguous or unknown. This period may be years in the case of patients with chronic or malignant disease, or very brief in the case of patients who suffer acute and unexpected illnesses or events, such as sepsis, stroke or trauma.[58]

**environment**: the context or surroundings in which health care is delivered. Environment can also include other patients, consumers, visitors and the workforce.

**episode of care**: a health problem from its first encounter with a healthcare provider through to the completion of the last encounter.[59]

**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 healthcare service between its management, workforce and stakeholders (including patients and consumers). 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. Governance structures are tailored to the size and complexity of an organisation.

**guidelines**: clinical practice guidelines are systematically developed statements to assist healthcare providers and consumer decisions about appropriate health care for specific circumstances.[60]

**hand hygiene**: a general term applying to processes aiming to reduce the number of microorganisms on hands. This includes: application of a waterless antimicrobial agent (e.g. alcohol-based hand rub) to the surface of the hands; and use of soap/solution (plain or antimicrobial) and water (if hands are visibly soiled) followed by patting dry with single-use towels.[46]

**healthcare identifiers**: are unique numbers assigned and used in health-related information to clearly identify the patient, the treating professional and the organisation where healthcare is provided to reduce the potential for errors with healthcare related information and communication.[61,62] In Australia, the Healthcare Identifiers (HI) Service is a national system for uniquely identifying, healthcare providers, healthcare organisations and individuals receiving healthcare. These include:

- IHI – identifies a patient (individual) receiving health care. An IHI uniquely identifies individuals who receive health care, including Australian citizens, permanent residents and visitors to Australia
- Healthcare Provider Identifier – Individual (HPI-I) – identifies an individual healthcare provider who provides health care, such as general practitioners, allied health professionals, specialists, nurses, dentists and pharmacists, among others
- Healthcare Provider Identifier – Organisation (HPI-O) – identifies the healthcare provider organisation where health care is provided, such as hospitals, medical practices, pathology or radiology laboratories and pharmacies.[61]

Healthcare providers (see definition) must be registered with the HI Service and assigned healthcare identifiers to access a patient's My Health Record (*see* definition).[63]

**health care**: the prevention, treatment and management of illness and injury, and the preservation of mental and physical wellbeing through the services offered by healthcare providers.[49]

**healthcare service**: a separately constituted organisation that is responsible for implementing clinical governance, administration and financial management of a service unit or service units providing health care to patients. It can be in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' homes, community and primary healthcare settings, practices and clinicians' rooms.

**health service organisation**: *see* **healthcare service**

**health practitioner**: *see* **healthcare provider**

**healthcare provider**: an individual who practises a profession relating to the provision of health care. Healthcare providers may be required maintain profession-specific registration with a national board under the National Registration and Accreditation Scheme or be self-regulated.[64] A healthcare provider may also be referred to as a health practitioner, clinician or profession-specific description.

**healthcare record**: a record of a patient's medical history, treatment notes, observations, correspondence, investigations, test results, photographs, prescription records and medication charts for an episode of care.

**healthcare record system**: a healthcare record and management system (that may be paper-based or electronic) that is used by healthcare providers in healthcare settings. Healthcare record information must be properly managed and safeguarded from start (record generation) to finish (record destruction) and the entire time in between.[65]

**health literacy**: the Commission separates health literacy into two components – individual health literacy and the health literacy environment. Individual health literacy is the skills, knowledge, motivation and capacity of a consumer to access, understand, appraise and apply information to make effective decisions about health and health care, and take appropriate action. The health literacy environment is the infrastructure, policies, processes, materials, people and relationships that make up the healthcare system, which affect the ways in which consumers access, understand, appraise and apply health-related information and services.[66]

**high-risk medicines**: medicines that have an increased risk of causing significant patient harm or death if they are misused or used in error. High-risk medicines may vary between healthcare settings, depending on the types of medicines used and patients treated. Errors with these medicines are not necessarily more common than with other medicines. Because they have a low margin of safety, the consequences of errors with high-risk medicines can be more devastating.[66,67] At a minimum, the following classes of high-risk medicines should be considered:

- Medicines with a narrow therapeutic index
- Medicines that present a high risk when other system errors occur, such as administration via the wrong route
- Schedule 8 medicines.

**hygienic environment**: an environment in which practical prevention and control measures are used to reduce the risk of infection from contamination by microbes.

**incident**: an event or circumstance that resulted, or could have resulted, in unintended or unnecessary harm to a patient or consumer; or a complaint, loss or damage. An incident may also be a near miss. *See also* **near miss**

**infection**: an infection occurs when a microorganism enters the body, increases in number and causes a reaction in the body.[68] This may cause tissue injury and disease.[69]

**information communications technology**: Diverse set of technological tools and resources used to transmit, store, create, share or exchange information. These technological tools and resources include computers, the Internet, live broadcasting technologies, recorded broadcasting technologies and telephony.[70]

**informed consent**: a process of communication between a patient and healthcare provider about options for treatment, health care processes or potential outcomes.[71] This communication results in the patient's authorisation or agreement to undergo a specific intervention or participate in planned care. The communication should ensure that the patient understands the health care they will receive, all the available options and the expected outcomes, including success rates and side effects for each option.[72]

**injury**: damage to tissues caused by an agent or circumstance.[73]

**invasive medical devices**: devices inserted through skin, mucosal barrier or internal cavity, including central lines, peripheral lines, urinary catheters, chest drains, peripherally inserted central catheters and endotracheal tubes.

**jurisdictional requirements**: systematically developed statements from state and territory governments about appropriate healthcare or service delivery for specific circumstances.[60] Jurisdictional requirements encompass several types of documents from state and territory governments, including legislation, regulations, guidelines, policies, directives and circulars. Terms used for each document may vary by state and territory.

**leadership**: having a vision of what can be achieved, and then communicating this to others and evolving strategies for realising the vision. Leaders motivate people and can negotiate for resources and other support to achieve goals.[74]

**local community**: the people living in a defined geographic region or from a specific group who receive services from a healthcare service.

**mandatory**: required by law or mandate in regulation, policy or other directive; compulsory.[75]

**medicine**: a chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease or otherwise improving the physical or mental wellbeing of people. These include prescription, non-prescription, investigational, clinical trial and complementary medicines, irrespective of how they are administered.[76]

**medicine-related event**: any event involving treatment with a medicine that has a negative effect on a patient's health or prevents a positive outcome. Consideration should be given to disease-specific, laboratory test-specific and patient-specific information. Medicine-related problems include issues with medicines such as:

- Underuse
- Overuse
- Use of inappropriate medicines (including therapeutic duplication)
- Adverse drug reactions, including interactions (medicine–medicine, medicine–disease, medicine–nutrient, medicine–laboratory test)
- Noncompliance.[77,78]

**medicines list**: a way to keep all the information about medicines a person takes together.[79] A medicines list contains, at a minimum:

- All medicines a patient is taking, including over the counter, complementary, prescription and non-prescription medicines; for each medicine, the medicine name, form, strength and directions for use must be included[80]
- Any medicines that should not be taken by the patient, including those causing allergies and adverse drug reactions.

Ideally, a medicines list also includes the intended use (indication) for each medicine.[81]

**multidisciplinary collaboration**: a process where healthcare providers from different disciplines and/or healthcare services share clinical information to optimise the delivery of comprehensive care for a patient.[82]

**My Health Record**: the secure online summary of a consumer's health information, managed by the System Operator of the national My Health Record system (the Australian Digital Health Agency). Healthcare providers are able to share health clinical documents to a consumer's My Health Record, according to the consumer's access controls. These may include information on medical history and treatments, diagnoses, medicines and allergies.[8]

**near miss**: an incident or potential incident that was averted and did not cause harm but had the potential to do so.[83]

**open disclosure**: an open discussion with a patient and carer about an incident that resulted in harm to the patient while receiving health care. The criteria of open disclosure are an expression of regret, and a factual explanation of what happened, the potential consequences and the steps taken to manage the event and prevent recurrence.[84]

**orientation**: a formal process of informing and training a worker starting in a new position or beginning work for an organisation, which covers the policies, processes and procedures applicable to the organisation.

**outcome**: the status of an individual, group of people or population that is wholly or partially attributable to an action, agent or circumstance.[84]

**partnership**: a situation that develops when patients and consumers are treated with dignity and respect, when information is shared with them, and when participation and collaboration in healthcare processes are encouraged and supported to the extent that patients and consumers choose. Partnerships can exist in different ways in a healthcare service, including at the level of individual interactions; at the level of a service, department or program; and at the level of the organisation. They can also exist with consumers and groups in the community. Generally, partnerships at all levels are necessary to ensure that the healthcare service is responsive to patient and consumer input and needs, although the nature of the activities for these different types of partnership will depend on the context of the healthcare service.

**patient**: a person who is receiving health care from a healthcare service.

**patient identifiers**: items of information for use in identification of a patient, including family and given names, date of birth, sex, address, healthcare record number and IHI.

**person-centred care**: an approach to the planning, delivery and evaluation of health care that is founded on mutually beneficial partnerships among healthcare providers and patients.[85] Person-centred care is respectful of, and responsive to, the preferences, needs and values of patients and consumers. Key dimensions of person-centred care include respect, emotional support, physical comfort, information and communication, continuity and transition, care coordination, involvement of carers and family, and access to care.[86] Also known as patient-centred care or consumer-centred care.

**point of care**: the time and location of an interaction between a patient and a healthcare provider for the purpose of delivering health care.

**policy**: a set of principles that reflect the organisation's mission and direction.

**primary health care**: primary health care is generally the first point of contact for individuals, families and communities with health services and brings health care as close as possible to where people live and work. It constitutes a large and essential part of the health care system.[87] Primary health care includes health promotion, prevention, early intervention, treatment of acute conditions, management of chronic conditions and end-of-life care.[88]

**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.[89]

**program**: an initiative, or series of initiatives, designed to deal with a particular issue, with resources, a time frame, objectives and deliverables allocated to it.

**protocol**: an established set of rules used to complete tasks 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.[90] Quality improvement activities may be undertaken in sequence, intermittently or continually.

**regularly**: occurring at recurring intervals. The specific interval for regular review, evaluation, audit or monitoring needs to be determined for each case. In the Primary and Community Healthcare Standards, the interval should be consistent with best practice, risk-based and determined by the subject and nature of the activity.

**reports (on patients)**: Documentation and information relating to a patient's health care, for example, patient records, referrals and scans.

**respiratory hygiene and cough etiquette**: A combination of measures designed to minimise the transmission of respiratory pathogens via droplet or airborne routes in healthcare settings.[46]

**reusable device**: a medical device that is designated by its manufacturer as suitable for reprocessing and reuse.[91]

**risk**: the chance of something happening that will have a negative impact. Risk is measured by the consequences of an event and its likelihood.

**risk assessment**: assessment, analysis and management of risks. It involves recognising which events may lead to harm in the future and minimising their likelihood and consequences.[92]

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

**safety culture**: a product of individual and group values, attitudes, perceptions, competencies and patterns of behaviour that determine the commitment to, and the style and proficiency of an organisation's health and safety management. Positive patient safety cultures have strong leadership that drives and prioritises safety as well as:

- Shared perceptions of the importance of safety
- Constructive communication
- Mutual trust
- A workforce that is engaged and always aware that things can go wrong
- Acknowledgement at all levels that mistakes occur
- Ability to recognise, respond to, give feedback about and learn from, adverse advents.

**scope of clinical practice**: the extent of an individual healthcare provider's approved clinical practice, based on the individual's skills, knowledge, professional registration (where applicable), performance and professional suitability and the needs and service capability of the organisation.[93]

**screening**: a process of identifying patients who are at risk, or already have a disease or injury. Screening requires enough knowledge to make a clinical judgement.[94]

**self-harm**: includes self-poisoning, overdoses and minor injury, as well as potentially dangerous and life-threatening forms of injury. Self-harm is a behaviour and not an illness. People self-harm to cope with distress or to communicate that they are distressed.[95]

**serious deterioration**: physiological, psychological or cognitive changes that may indicate a worsening of the patient's health status.

**service context**: the context in which health care is delivered. Health service delivery occurs in many different ways, and the service context will depend on the organisation's function, size and organisation of care regarding service delivery mode, location and workforce.[96]

**shared decision making**: a consultation process in which a healthcare provider 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.[55]

**standard**: agreed attributes and processes designed to ensure that a product, service or method will perform consistently at a designated level.[73]

**standard national terminologies**: a structured vocabulary used in clinical practice to accurately describe the care and treatment of patients. Healthcare providers around the world use specialised vocabulary to describe diseases, operations, clinical procedures, findings, treatments and medicines. In Australia, terminologies include SNOMED CT-AU and AMT.[97] Standard national terminologies are also referred to as clinical terminologies.

**standard precautions**: work practices that provide a first-line approach to infection prevention and control and are used for the care and treatment of all patients. Standard precautions include: hand hygiene, use of personal protective equipment (PPE; masks, gloves, gowns, protective eyewear) to prevent blood or bodily fluid exposure, routine environmental cleaning aligned to risk, safe use and disposal of sharps, reprocessing of reusable equipment and devices, respiratory hygiene and cough etiquette (including physical distancing), aseptic technique, linen and waste management.[46]

**substitute decision-maker**: a person appointed or identified by law to make health, medical, residential and other personal (but not financial or legal) decisions on behalf of a patient whose decision-making capacity is impaired. A substitute decision-maker may be appointed by the patient, appointed for (on behalf of) the person, or identified as the default decision-maker by legislation, which varies by state and territory.[47]

**supported decision-making**: enables a person with cognitive impairment to remain involved in decisions about their health care rather than having their decision-making capacity removed.[47]

**system**: the resources, policies, processes and procedures that are organised, integrated, regulated and administered to accomplish a stated goal. A system:

- Brings together risk management, governance, and operational processes and procedures, including education, training and orientation
- Deploys an active implementation plan; feedback mechanisms include agreed protocols and guidelines, decision support tools and other resource materials
- Uses several incentives and sanctions to influence behaviour and encourage compliance with policy, protocol, regulation and procedures.

The workforce is both a resource in the system and involved in all elements of systems development, implementation, monitoring, improvement and evaluation.

**telehealth**: the use of information and communications technologies (ICTs) to deliver health services and transmit health information over both long and short distances.[98]

**timely (communication)**: communication of information within a reasonable time frame. This will depend on how important or time critical the information is to a patient's ongoing health care or wellbeing, the context in which the service is provided and the clinical acuity of the patient.

**training**: the development of knowledge and skills.

**transitions of care**: situations when all or part of a patient's care is transferred between healthcare locations, providers or levels of care within the same location, as the patient's conditions and care needs change.[99]

**transmission-based precautions**: extra work practices used in situations when standard precautions alone may not be enough to prevent transmission of infection. Transmission-based precautions are used in conjunction with standard precautions and include droplet, contact and airborne precautions or a combination of these precautions based on the route of transmission of infection.[46]

**unwarranted variation**: where variation is not due to difference in patients' clinical needs or preferences. Unwarranted variation represents an opportunity for improvement.

**variation**: a difference in healthcare processes or outcomes, compared to peers or to a standard such as an evidence-based guideline recommendation.[45]

**virtual care**: any interaction between a patient and clinician, or between clinicians, occurring remotely with the use of information technologies.[100]

**workforce**: all people working in a healthcare service, including healthcare providers and any other employed or contracted, locum, agency, student, volunteer or peer workers. The workforce can be members of the healthcare service 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 healthcare service. *See also* **healthcare provider**

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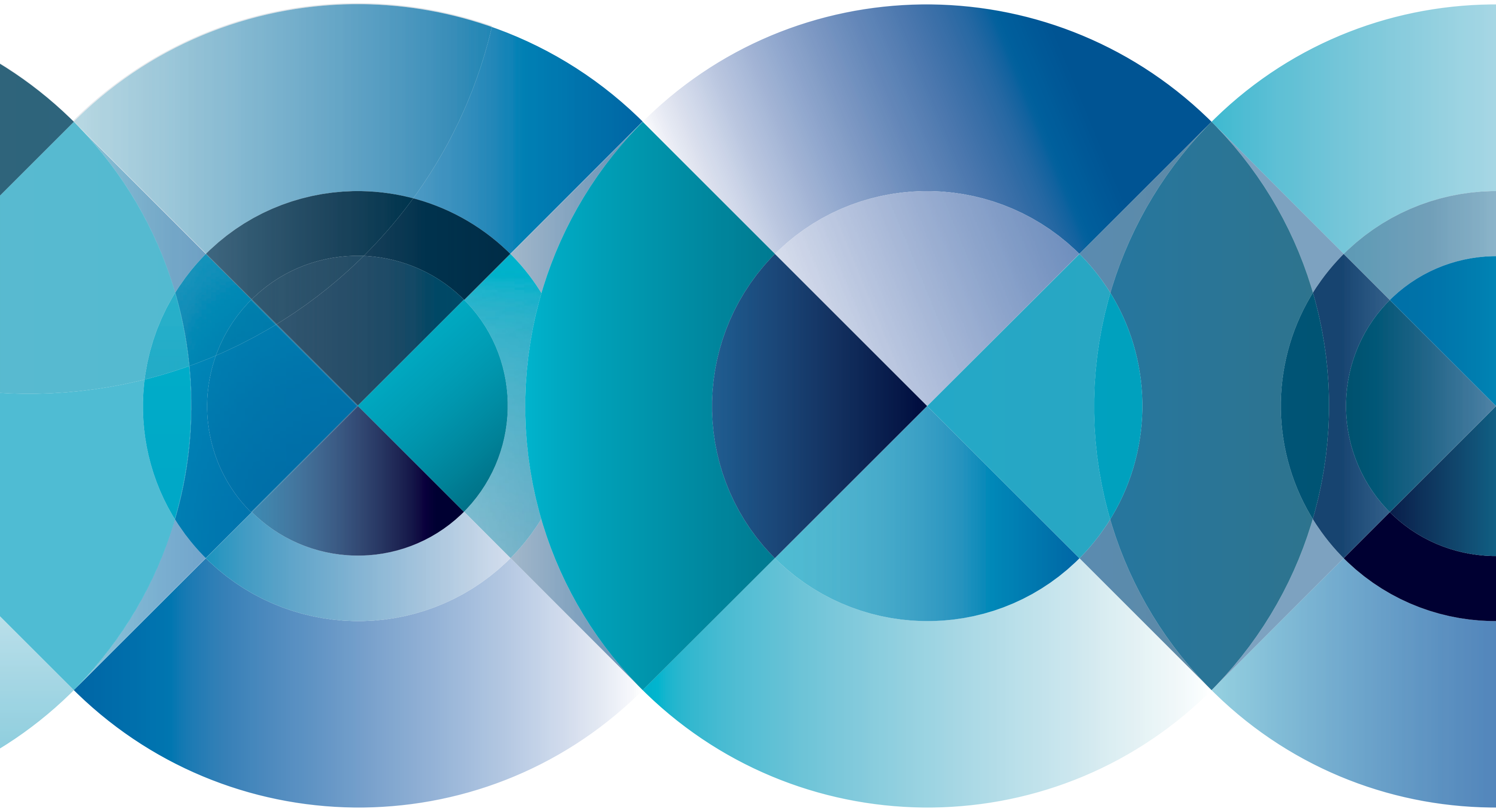

AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Level 5, 255 Elizabeth Street, Sydney NSW 2000

GPO Box 5480, Sydney NSW 2001

**Phone:** (02) 9126 3600

@ACSQHC

**www.safetyandquality.gov.au**