AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

NSQHS STANDARDS

National Safety and Quality Health Service Standards Guide for Ambulance Health Services

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Contents

The eight NSQHS Standards are:

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

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

Preventing and Controlling Infections, which describes the systems and strategies to prevent infections, manage infections effectively when they occur, limit the development of antimicrobial resistance through prudent use of antimicrobials (as part of effective antimicrobial stewardship), and promote appropriate and sustainable use of infection prevention and control resources.

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

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

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

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

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

Introduction

The National Safety and Quality Health Service (NSQHS) Standards[1] were developed by the Australian Commission on Safety and Quality in Health Care (the Commission) in collaboration with the Australian Government, states and territories, the private sector, clinical experts, patients and carers. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision in Australia.

The NSQHS Standards comprises eight standards that include 151 actions and provide a nationally consistent statement about the level of care consumers can expect from health service organisations in Australia. The NSQHS Standards are designed to be implemented in an integrated way. The Clinical Governance Standard and the Partnering with Consumers Standard set the overarching system requirements for the effective implementation of the remaining six standards, which consider specific high-risk clinical areas of patient care.

The first two actions in the Clinical Governance Standard are the explicit responsibility of the governing body as these actions set the strategic direction and architecture for the health service's safety and quality systems. The NSQHS Standards require the implementation of an organisation-wide clinical governance framework to ensure that clinical risk mitigation strategies are in place to reduce adverse events for those people identified at greatest risk of harm.

The NSQHS Standards apply to a broad range of healthcare services, including hospitals, day procedure services and ambulance health services. The NSQHS Standards provide a framework for improving the safety and quality of healthcare in Australia and are applicable to traditional, new and evolving ambulance health services.

When implementing the NSQHS Standards, it is important to identify the links between actions across each of the NSQHS Standards to ensure that the safety and quality systems are integrated effectively and reflect the patient care journey. The **NSQHS Communicating for Safety figure** describes some of the linkages between clinical governance, quality improvement and organisational systems to support effective clinical communication.

The Commission has developed the National Safety and Quality Health Service Standards Guide for Ambulance Health Services to assist organisations providing out of hospital care to align their patient safety and quality improvement programs using the framework of the NSQHS Standards.

Ambulance health services

In Australia, demand for ambulance health services is at an all-time high with 4.1 million incidents requiring response from ambulance service organisations and 3.5 million patients being assessed, treated or transported by ambulance health service organisations in 2020-21.[2] This is up from 3.1 million incidents and 2.6 million treated or transported patients in 2011-12 and includes both emergency and non-emergency care.[2] In Victoria alone, the demand for ambulance services increased by 29.2% between 2008 and 2015.[3]

The traditional emergency response and transportation role of ambulance health services has evolved to provide often complex 'mobile healthcare' in an integrated healthcare environment.[4] Ambulance health services are increasingly providing primary health care services and working within multidisciplinary teams to provide complex services to older, sicker and less mobile populations.[5]

Ambulance health services vary and are often designed around consumers, geography, and other environmental factors. Care is often provided in unique, decentralised, mobile environments using mechanisms such as digital technologies and virtual health care methods to provide care.[6] Models of care delivery are evolving and can provide support to communities in rural and remote areas where the full range of health services may not be easily accessible.[7]

The clinical workforce makeup will vary between ambulance health services and will include a range of health care professionals such as organisational leaders, paramedics, clinical volunteers, medical practitioners, nurses and varied allied health specialists. Depending upon the scope of the service, the workforce may be supported by agencies that provide aeromedical, retrieval and rescue services.

Ambulance health services in Australia work to promote health and reduce the adverse effects of emergency events by providing emergency medical care, out of hospital care and transport services[2] that are:

- Accessible, timely and sustainable
- High quality, safe, coordinated, responsive and proactive
- Appropriate and meet patients' needs.

Definition

For the purpose of this Guide, **'ambulance health services'** are defined as:

Multidisciplinary and bespoke, out of hospital health services that provide a complex range of emergency, urgent and non-urgent clinical care, in a variety of settings, including but not limited to the provision of patient transport to and from health facilities, retrieval and in some cases rescue services.

How to use this Guide

This Guide provides information and examples of strategies for ambulance health services implementing the NSQHS Standards to support the design of integrated safety and quality systems.

To assist an ambulance health service to meet the NSQHS Standards, each criterion listed under a standard includes a number of recommended actions. The criteria and actions included in the NSQHS Standards outline safety and quality outcomes that an ambulance health service **must** achieve to meet the Standards, whilst allowing services the flexibility to decide **how** to achieve these outcomes in a way that is appropriate for their context. Each action in this Guide includes:

- A description of the 'action'
- An overview of the intent of the action
- Reflective questions to assist ambulance health services consider the required action in their own service context
- Suggested strategies to meet the requirements of the NSQHS Standard
- Examples of evidence to meet the NSQHS Standard

Every effort has been made to ensure this Guide is relevant to the broad range of ambulance health services operating in Australia. The suggested strategies **are not mandatory** and ambulance health services will need to adapt the strategies to suit their individual contexts. An ambulance health service can implement alternative strategies specific to its service scope and context, consumer needs, the risk profile of its patient population and its priorities for improvement.

The examples of evidence **are not mandatory** or exhaustive. The evidence generated through quality improvement activities provides the evidence that will be reviewed at assessment.

Best practice requires that each ambulance health service uses a **risk-based approach** to identify specific risks in its patient population (for example, the acuity of the patient population, the location and type of service provided) and uses this information to guide implementation of safety and quality processes, tools, policies, procedures and protocols.

A range of resources to implement the NSQHS Standards is available on the **Commission's website**. While resources developed by other organisations are referenced in this Guide and on the website, this should not be interpreted as endorsement by the Commission. The resources are provided as examples that ambulance health services may consider, adapt or adopt as appropriate for their service. The NSQHS Standards **Advice Centre** also provides support for health service organisations implementing the NSQHS Standards.

This Guide was developed with the assistance of the Ambulance Health Services Working Group who provided valuable advice and feedback on the content and structure.

Language used in this Guide

This Guide uses the term **'patient'** and **'consumer'** to refer to a person or group receiving ambulance health services. 'Patient' is used when referring to an individual who is receiving care provided by ambulance health services.

A healthcare **'consumer'** may be an individual consumer representative or group of consumers who provide a consumer perspective, contribute consumer experiences, advocate for the interests of current and potential health service users, and take part in decision making processes.

The NSQHS Standards use the term **'health service organisation'**. Where the NSQHS Standards or resources are quoted or referenced, this term has been retained. However, it is intended that it be read in this Guide as **'ambulance health services'**.

This Guide will suggest ambulance health services apply the NSQHS Standards to their **'local'**, **'individual'** or **'own service context'**. This is encouraging services to consider the areas identified in their risk-assessment to design an approach which is appropriate for their service. This will include factors such as service population size and profile, geographic location, range of clinical and primary healthcare services provided, physical size of health service and anything else relevant to the health service operations, patient profile and workforce capability.

The words 'may' or 'could' are used interchangeably throughout the Guide. The words are used to introduce suggestions for consideration.

Clinical Governance Standard

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

Intention of this standard

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

Criteria

Governance, leadership and culture

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

Patient safety and quality systems

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

Clinical performance and effectiveness

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

Safe environment for the delivery of care

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

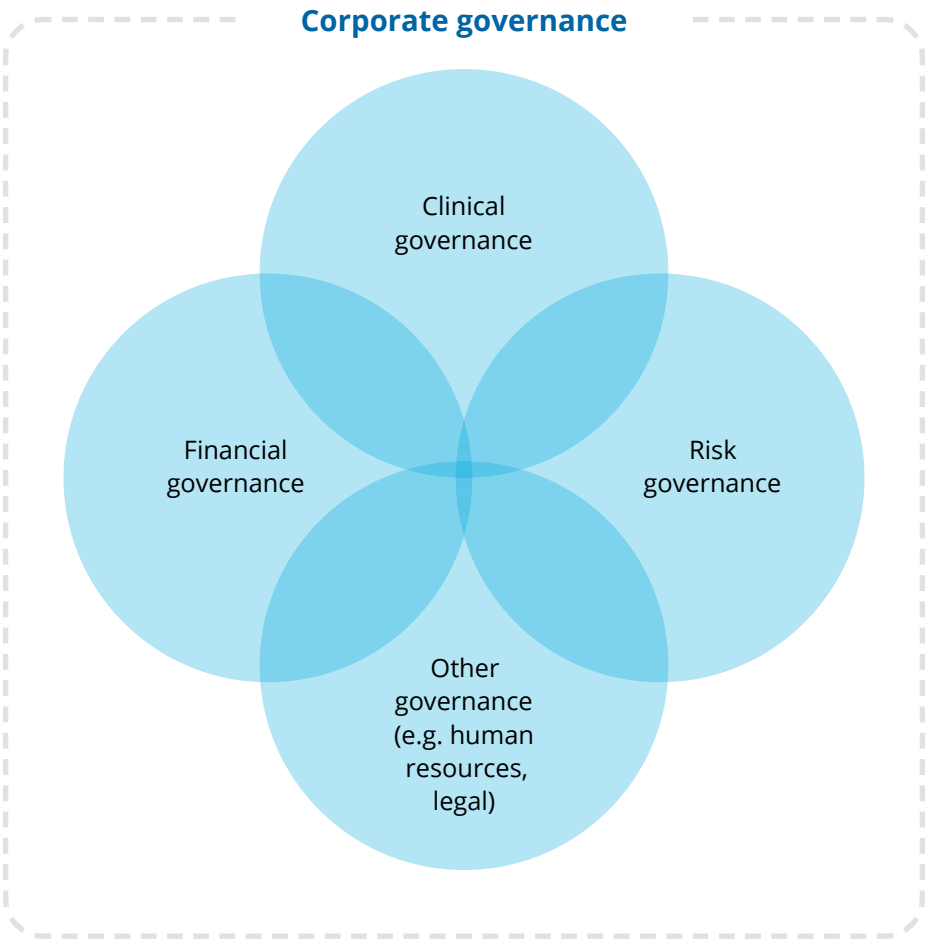
Introduction

Within a well-governed health service organisation, everyone, including frontline clinicians, managers and the governing body, is accountable for their contribution to the safety and quality of care delivered to patients. The roles and responsibilities of everyone involved in the organisation will be clear and understood, as will the roles of the state or territory government department of health, the national department of health, patients and consumers, and the corporate head office, if relevant to that health service organisation. Responsibilities can be both individual and collective to ensure the health service is functioning effectively.

Good corporate governance in a health service organisation can be pictured as an integrated system of clinical, financial and risk governance, and other business requirements such as human resources, compliance, administration and legal governance. Good governance is a system by which a health service organisation can demonstrate best practice in the way the organisation is controlled and operates to meet the needs of its community and deliver safe and high-quality care.

Clinical governance is a key component of the corporate governance of health service organisations. Clinical governance is essentially a system of policies, processes, relationships, culture, planning and improvement mechanisms within the bigger corporate governance system. It ensures that everyone is accountable to patients and the community for ensuring the delivery of health services that are safe, effective, high-quality and continuously improving.

Figure 1: The clinical governance system operates within a corporate governance system.[9]



Ambulance health services in Australia may have their clinical governance system provided at a corporate, national, or state and territory level.

Strategic and operational business decisions may be the responsibility of a national corporate office, or state or territory health department who have responsibility for making decisions about the safety and quality goals, objectives, and strategies of a particular service. However, responsibility and implementation, monitoring, reporting and evaluation of quality improvement strategies may occur at the local level.

Regardless of the size, or corporate structure of the organisation, the principles of clinical governance remain the same. There is no single approach and ambulance health services should implement strategies for clinical governance that consider the organisation's context and scope of services using a risk-based approach.

Whatever the system, strategies and structure to be implemented, it is vital that the clinical governance approach is supported by the governing body of the ambulance health service to ensure that clinical governance is understood and accepted by all members of the organisation.

The **National Model Clinical Governance Framework** supports the delivery of safe and high-quality care for patients and consumers.8 The framework has five components based on the criteria in the Clinical Governance Standard and the Partnering with Consumers Standard. Ambulance health services should refer to the framework for more details on clinical governance, and the associated roles and responsibilities. Also see the **NSQHS Standards User guide for governing bodies**.[9]

Governance, leadership and culture

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

Corporate governance systems and processes are used to shape, enable and oversee the management of an organisation. Governance responsibilities include finance, legal matters, work health and safety, and human resources. Governing bodies (often boards) actively formulate strategy, approve policy, supervise management, set the risk tolerance of an organisation and ensure risk management. Governing bodies also monitor organisational performance and the quality and timeliness of outcomes.

Clinical governance is an integrated component of corporate governance. It is directed towards ensuring good clinical outcomes for all consumers.

The clinical governance system:

- Is as important as other governance responsibilities
- Directly effects corporate governance, such as financial performance and risk management, and corporate governance decisions can affect the safety and quality of care
- Is the ultimate responsibility of the governing body
- Requires the active engagement of clinical leaders throughout the organisation
- Involves clinicians, managers and members of governing bodies. Each has individual and collective responsibilities for ensuring the safety and quality of clinical care.

Roles and responsibilities

Governing body

The governing body has a strategic focus and plans for the future. The governing body ensures the organisation is run well and is meeting its performance objectives.

The governing body is responsible for ensuring good governance.

Management

Management focuses on the operations of the organisation. Management is responsible for the implementation of policies and programs and managing the day-to-day business.

Management is responsible for providing the governing body with the information it requires to monitor organisational performance.

Action 1.01

The governing body:

a. **Provides leadership to develop a culture of safety and quality improvement, and satisfies itself that this culture exists within the organisation**
b. **Provides leadership to ensure partnering with patients, carers and consumers**
c. **Sets priorities and strategic directions for safe and high-quality clinical care, and ensures that these are communicated effectively to the workforce and the community**
d. **Endorses the organisation's clinical governance framework**
e. **Ensures that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce**
f. **Monitors the action taken as a result of analyses of clinical incidents**
g. **Reviews reports and monitors the organisation's progress on safety and quality performance.**

Intent

The governing body must assure itself that a culture of safety and quality improvement operates in the organisation.

Reflective questions

- How does the governing body lead, promote and support a positive safety and quality improvement culture in the ambulance health service?
- How does the governing body set strategic direction and define safety and quality roles and responsibilities?
- Has the clinical governance framework been endorsed and implemented?
- How is the clinical governance framework communicated to the individuals and teams within the ambulance health service?
- How is the effectiveness of the clinical governance framework monitored and reviewed?
- What mechanisms does the governing body use to measure the safety and quality performance of the ambulance health service?

Strategies for improvement

The first two actions in the Clinical Governance Standard are the explicit responsibility of the governing body. These actions set the strategic direction and architecture for the organisation's safety and quality systems.

Other actions across the NSQHS Standards also include responsibilities for the governing body but appear as actions for ambulance health service organisations or clinicians.

Define your organisation's safety culture

Safety culture is a commitment to safety from all levels of an organisation, from the clinical and administration workforce to executive management and the governing body.

The American Institute for Healthcare Improvement[10], identifies the common features of a safety culture as follows.

- Acknowledgement of the high-risk, error-prone nature of an organisation's activities.
- A blame-free environment in which individuals are able to report errors or near misses without fear of reprimand or punishment.
- An expectation of collaboration across all areas and levels of an organisation to seek solutions to vulnerabilities.
- A willingness of the organisation to direct resources to deal with safety concerns.[11]
- Safety culture plays an important role in influencing the safety and quality of care in an ambulance health service. Good safety culture involves setting the strategic direction, providing support to the workforce and monitoring safety and quality performance.[12, 13]

Commitment to a safety culture may be reflected in the organisation's mission statement, values and policies and procedures. Safety culture could be included in position descriptions, discussed at performance reviews and be a standing item on meeting agendas for staff to raise any improvement suggestions or concerns. Safety culture should be embedded across the organisation's performance measures and open discussion of safety culture be encouraged between all members of staff to ensure awareness and understanding and support constant improvement.

Positive safety culture requires strong leadership to drive and prioritise the safety of all.[14] The actions and attitudes of leaders and managers influence the perceptions, attitudes and behaviours of the workforce and visitors to the organisation.[15]

Define your organisation's safety and quality expectations

The governing body has ultimate responsibility for the clinical governance of the organisation. It has obligations to ensure that effective safety and quality systems and robust governance practices are in place and performing well.

The governing body should define its expectations for the safety and quality performance of the ambulance health service and the quality of patient experiences. These expectations can be described in the ambulance health service's vision, mission and goals, and safety and quality priorities and targets. Setting priorities and targets for safety and quality enables the ambulance health service to define the roles and responsibilities of the workforce to achieve these goals, and to set up systems that support quality patient experiences.

The governing body must ensure that safety and quality are consistently and effectively monitored, and that responses to safety and quality matters are prompt and appropriate.

Ensure the clinical governance framework is implemented and understood

A sound clinical governance system involves contributions by individuals and teams at all levels within the organisation. The governing body is responsible for ensuring everyone within the ambulance health service understands their roles and responsibilities in the safety and quality of care.

The governing body should use a communication strategy to engage the workforce and consumers in the implementation of the clinical governance framework and to ensure performance expectations and roles and responsibilities for everyone involved are understood. Feedback mechanisms and quality improvement processes should be incorporated into this process.

Involve consumers

The governing body should ensure active consumer engagement is promoted throughout the ambulance health service and consumer partnerships are created to inform quality improvement projects. Strategies may include:

- Allocating time in meeting agendas to hear and discuss patient stories or consumer feedback
- Ensuring that resources are available to support activities such as collecting patient experience data, engaging with the ambulance health service consumers, supporting workforce training in person-centred care, and developing or adapting shared decision support tools
- Inviting consumer representatives to be part of committees or working groups.

Define roles and responsibilities within the governance system

The governing body should ensure the roles and accountabilities for the safety and quality of care within the ambulance health service are clearly described and allocated as these are critical to the effective functioning of the organisation. This could include:

- A clear definition of reporting lines, responsibilities and accountabilities between the workforce, the ambulance health service and the governing body
- Position descriptions for all members of the workforce, with clearly documented responsibilities and accountabilities for the safety and quality of clinical care
- Safety and quality policies, procedures or protocols such as those that describe how patient safety is embedded in the operation of the service
- A structured performance-development system that incorporates a regular review of engagement in safety and quality activities for clinicians and managers.

See the **NSQHS Standards User Guide for Governing Bodies 2019** for further information on strategies for the governing body to meet the Clinical Governance Standard.[9]

Examples of evidence

- A documented clinical governance framework that is endorsed and monitored by the governing body
- Policy documents that describe the:
  - roles and responsibilities of the governing body
  - responsibilities and accountabilities of the workforce and other parties for reporting and reviewing safety and quality performance information
- Strategic, business or risk-management plans that describe the priorities and strategic directions for safe and high-quality clinical care, that are endorsed by the governing body
- An audit framework and schedule that is endorsed by the governing body
- Safety and quality performance data, compliance reports and reports of clinical incidents that are regularly reviewed by the governing body, managers and the clinical governance committee
- Committee and meeting records in which clinical governance, leadership, safety and quality culture are discussed and improvement actions identified
- Terms of reference, letters of appointment or position descriptions for members of the governing body that describe their safety and quality roles and responsibilities.

Action 1.02

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

Intent

The health needs of Aboriginal and Torres Strait Islander peoples are identified in partnership with local communities, and improvement actions are supported by the governing body.

Reflective questions

- How does the governing body identify and prioritise the health needs of its Aboriginal and Torres Strait Islander patients?
- How does the governing body know if the ambulance health service is effectively meeting the health needs of its Aboriginal and Torres Strait Islander patients?
- How do the actions identified to improve the health needs of Aboriginal and Torres Strait Islander peoples contribute to the **Closing the Gap** targets?
- What mechanisms does the governing body use to measure, review and improve its services to its Aboriginal and Torres Strait Islander communities?

Strategies for improvement

Safety and quality priorities should, whenever possible, align with the Closing the Gap priorities.

Closing the Gap in Aboriginal and Torres Strait Islander disadvantage is a national priority that the Australian Government and all state and territory governments are committed to addressing. It is the responsibility of all health service organisations to consider and action their part in closing the gap in health disparities experienced by Aboriginal and Torres Strait Islander peoples.

Set safety and quality priorities for improving care

The governing body has ultimate responsibility for the safety and quality of a health service organisation. Setting priorities for the health service organisation, including priorities for its Aboriginal and Torres Strait Islander consumers, is one way a governing body can direct effort and resources to improve care. For further information see the **NSQHS Standards User guide for governing bodies**.[10]

In collaboration with Aboriginal and Torres Strait Islander communities, consider the needs of Aboriginal and Torres Strait Islander peoples in strategic planning. This will support the governing body and ambulance health service workforce understand safety and quality issues and the priorities for delivering culturally safe and quality health care for Aboriginal and Torres Strait Islander peoples.[16] The governing body should:

- Assure itself that effective partnerships are established with Aboriginal and Torres Strait Islander consumers
- Endorse the organisation's Aboriginal and Torres Strait Islander Health Plan and review reports on progress against the implementation plan
- Ensure systems are in place to collect and report on Aboriginal and Torres Strait Islander specific data
- Ensure management reviews the effectiveness of the Aboriginal and Torres Strait Islander Health Plan.

Develop and maintain strategic action plans

Develop a strategic action plan, or a suite of plans, to improve the health of Aboriginal and Torres Strait Islander peoples. Plans may include Aboriginal health, cultural safety, reconciliation and Aboriginal employment plans, along with other health service plans, and actions for improvement of safety and quality. Ensure that the plan:

- Documents the health service organisation's commitment to implementing and measuring practical, long-term, sustainable actions that will have a mutual benefit for the health service organisation and for Aboriginal and Torres Strait Islander patients
- Aligns with, and complements, existing national and state or territory health plans and frameworks, whenever possible.

Identify, monitor and review goals and performance indicators

The effective collection and use of data and information will enable the ambulance health service and the governing body, to monitor, review and improve performance. A range of data reports should be provided regularly to the governing body. The governing body should use this information to inform ongoing strategic planning and priority setting for Aboriginal and Torres Strait Islander patients.

A systematic review of data to identify gaps and areas for improvement includes:

- Review information on the number of Aboriginal and Torres Strait Islander patients using the ambulance health service
- Review performance data relating to Aboriginal and Torres Strait Islander consumers, such as activity data, unplanned re-presentations, sentinel or leave events17
- Develop systems for collecting feedback such as validated patient reported outcome measures
- Review feedback, outcome data, incidents and complaints from Aboriginal and Torres Strait Islander patients
- Review workforce indicators, such as the proportion of the workforce who identify as being of Aboriginal or Torres Strait Islander origin
- Monitor participation and seek feedback on cultural safety training for the workforce.

See the **NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health**[18] and **Action 5.08** for further information.

Examples of evidence

- Policy documents that detail safety and quality, and health priorities for Aboriginal and Torres Strait Islander patients
- Minutes of meetings, plans or strategies relating to development, endorsement or implementation of Aboriginal and Torres Strait Islander priorities overseen by the governing body
- Affirmative action statements that are endorsed by the governing body and implemented by the ambulance health service
- Memorandums of understanding and service collaboration with Aboriginal and Torres Strait Islander health service providers and community organisations
- Documented goals and performance indicators that have been developed in partnership with Aboriginal and Torres Strait Islander communities and endorsed by the governing body
- Reports to the governing body detailing performance against the goals and indicators relating to Aboriginal and Torres Strait Islander patients, including analysis and discussion on what is and is not working, and suggested strategies for improvement
- Committee and meeting records indicating partnerships and collaboration with Aboriginal and Torres Strait Islander health service providers and communities
- Representation from Aboriginal and Torres Strait Islander peoples on committees and working groups.

Organisational leadership

Action 1.03

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

Intent

The clinical governance framework is comprehensive and effective in improving safety and quality

Reflective questions

- Has the clinical governance framework been documented, endorsed by the governing body and implemented across the ambulance health service?
- How is the effectiveness of the clinical governance framework monitored and reviewed?
- What processes does the ambulance health service use to evaluate and drive improvements in safety and quality?

Strategies for improvement

Implement well-designed clinical governance system

A well-designed and integrated clinical governance system will enable the ambulance health service to provide safe high-quality health care. This may include policies, processes and procedures for:

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

Communicate importance of clinical governance framework and systems

Leaders at all levels in the organisation have a responsibility to implement, communicate and evaluate the clinical governance systems to improve the safety and quality of health care. Clinical leadership plays a key role in driving improvements, promoting teamwork and creating a healthy and safe clinical work environment.[19]

Clearly defining and communicating the roles and responsibilities of clinical leaders and members of the workforce at all levels will ensure the clinical governance framework is effective.

Implement effective monitoring, evaluation and improvement mechanisms

To ensure the effectiveness of the clinical governance systems and processes, the clinical governance framework could require managers to systematically:

- Review policies, procedures and protocols to ensure that they align with the clinical governance framework
- Establish structures and responsibility for implementing the clinical governance framework
- Review results of clinical audits and system evaluation reports for compliance with the clinical governance framework
- Identify key performance indicators and benchmarks for process and outcome measures
- Monitor, analyse and report on performance
- Collect, analyse and report on workforce and consumer feedback
- Report safety and quality issues to the governing body and actions taken to address identified gaps
- Ensure that workforce members are aware of their roles and responsibilities for clinical leadership and improving safety and quality
- Identify priority areas for improvement.

See the **National Model Clinical Governance Framework** for further information.

Examples of evidence

- Documented and endorsed clinical governance framework
- Documented safety and quality goals and performance indicators benchmarked to best practice
- Documented organisational and committee structure that is aligned to the clinical governance framework
- Dashboards or reports identifying patient safety and quality results under the clinical governance framework
- Minutes of meetings reviewing reports that are required under the clinical governance framework
- Audit results of compliance with the ambulance health service's clinical governance framework, and management of relevant safety and quality risks
- Reviews or evaluation reports on the effectiveness of the ambulance health service's safety and quality systems.

Action 1.04

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

Intent

Strategies to improve the safety and quality of care provided to Aboriginal and Torres Strait Islander peoples are implemented and monitored for effectiveness

Reflective questions

- What strategies does the ambulance health service use to improve outcomes for Aboriginal and Torres Strait Islander patients?
- How does the ambulance health service monitor, evaluate and report on these strategies?

Strategies for improvement

Design and implement improvement strategies in priority areas

By working with local Aboriginal and Torres Strait Islander communities, the ambulance health service will improve its understanding and be able to acknowledge the healthcare needs of the communities, and the risks and barriers the communities experience in accessing health care.

Under the direction of the governing body, the ambulance health service should identify and agree priorities to improve Aboriginal and Torres Strait Islander health. This includes allocating resources; developing, collecting and analysing indicators; monitoring progress and reporting against targets; and evaluating the effectiveness of the systems that are being used. Strategies include:

- Developing an Aboriginal and Torres Strait Islander Health Action Plan
- Establishing or reviewing the organisation's Aboriginal and Torres Strait Islander employment strategy and set targets
- Improving care coordination to recognise the complex health needs of Aboriginal and Torres Strait Islander patients, including spiritual and cultural needs
- Use the organisation's strategic plans and priorities to implement improvements in safety and quality for Aboriginal and Torres Strait Islander peoples
- Develop or adopt an indicator set to measure change in processes and patient outcomes.

Develop a monitoring and reporting framework

- Select a set of measures to be reported to the governing body
- Routinely report processes, targets and measures of success to the governing body
- Use the monitoring and reporting framework to monitor achievements against the organisation's safety and quality priorities for Aboriginal and Torres Strait Islander peoples
- Use the information generated to improve safety and quality
- Establish a reporting schedule and format for the governing body, the workforce, and the Aboriginal and Torres Strait Islander consumers.

See the **NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health**[18] for further strategies and examples from across Australia.

Examples of evidence

- Policy documents that incorporate safety and quality priorities for Aboriginal and Torres Strait Islander peoples
- Records of ongoing engagement with Aboriginal and Torres Strait Islander peoples to develop and evaluate services or strategies
- Mandatory cultural safety training, schedule and attendance reports
- Feedback from the workforce and consumers on the cultural safety of the organisation
- Documented goals and performance indicators for Aboriginal and Torres Strait Islander health outcomes and employment targets that are regularly monitored and reported to the governing body
- Committee or meeting records that describe the safety and quality priorities for Aboriginal and Torres Strait Islander peoples and implementation strategies
- Examples of specific quality improvement strategies that have been implemented and reviewed.

Action 1.05

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

Intent

Decisions relating to equipment, plant, building works, consumables, staffing and other resources consider the safety and quality implications for patients.

Reflective questions

- How does the ambulance health service ensure patient safety and quality issues are considered when making strategic and operational business decisions?
- How does the ambulance health service document decisions about safety and quality of care?
- How are any conflicts between patient safety and business decisions resolved?
- If a business decision results in increased risk or harm to a patient, what mechanisms are in place to address this risk?

Strategies for improvement

Include safety and quality goals, objectives and strategies in business and strategic plans

It is important that all strategic and decision making processes consider the safety and quality of the services being provided, as well as the implications of a business decision on safety and quality. This could include ensuring:

- The demand for services is monitored and reviewed to inform resource demand management strategies[3]
- Templates for business proposals being submitted to the governing body and management identify potential impacts on safety and quality
- The workforce is trained to consider safety and quality issues when developing business cases or when involved in business decisions
- Requirements for safety and quality performance are included on the agenda for business planning committees
- Patient safety considerations are documented as part of the decision making cycle
- Safety and quality goals are included in the terms of reference for committees and the governing body responsibilities
- Processes for the procurement of building, plant, consumables and equipment are fit for purpose, comply with relevant standards and take into consideration safety and quality issues
- Processes for workforce education are evidence-based, comply with relevant standards and take into consideration safety and quality issues
- Safety and quality performance data, feedback and complaints may be used to measure the impact of business decisions on safety and quality.

Examples of evidence

- Policy documents that describe:
  - roles and responsibilities for business decision making and strategic planning
  - responsibilities and accountabilities for reviewing and approving new business proposals
  - processes for developing and reviewing new business proposals that include assessment of their safety and quality impact
- Committee and meeting records that document that safety and quality of health care are considered in business decision making
- Strategic plans, operational plans or business plans that identify potential impacts on the provision of safety and quality of care
- Business proposal templates that capture risks to patient safety and quality of care
- Register of safety and quality risks that includes actions to manage the identified risk
- Records of quality improvement activities that have been implemented and evaluated.

Clinical leadership

Action 1.06

Clinical leaders support clinicians to:

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

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

Intent

Clinical leaders and leaders of clinical services work with other clinicians to optimise the safety and quality of care.

Reflective questions

- How does the ambulance health service support its clinical leaders and the workforce to optimise the safety and quality of care?
- How do clinical leaders engage with the workforce and monitor safety and quality matters?
- How does the ambulance health service ensure that the workforce operates within the clinical governance framework?

Strategies for improvement

Delegate safety and quality roles and responsibilities to clinical leaders

Strong clinical leadership can drive safety and quality improvements and ensure safety and quality are a priority across the ambulance health service. Demonstrated commitment from leaders is important because their actions and attitudes influence the perceptions, attitudes and behaviours of the workforce.[20]

The ambulance health service should identify and delegate safety and quality roles and responsibilities to clinical leaders. These may include implementing strategic direction, managing the operation of the clinical governance system, reporting on safety and quality, and implementing the organisation's safety culture. Strategies to achieve this may include:

- Conducting performance appraisals and auditing clinical practice to ensure that clinicians operate within the clinical governance framework
- Ensuring the workforce is aware of, and has access to, information about their expected roles and responsibilities for safety and quality, and the documented clinical governance framework
- Documenting reporting lines and relationships for safety and quality performance
- Reviewing clinical audit results and taking action to manage identified issues
- Reporting the audit findings to the workforce and governing body
- Providing performance feedback to the workforce on their safety and quality outcomes.

Provide safety and quality training and ongoing education for clinicians

With appropriate training and supervision, clinical leaders may support other clinicians to:

- Manage and monitor the operation of the clinical governance system
- Report on safety and quality performance to the governing body
- Support and monitor the health service organisation's safety culture
- Monitor workforce engagement in clinical safety and quality improvement
- Orientate and train new staff to use clinical governance systems
- Supervise members of the workforce
- Model behaviours that promote a good safety and quality culture.

Examples of evidence

- Policy documents that identify and outline the delegated safety and quality roles and responsibilities of clinical leaders and the workforce
- Results of clinical audits and actions taken to rectify identified issues
- Quality improvement initiatives implemented and evaluated
- Employment documents that describe the safety and quality roles and responsibilities of clinical leaders and the workforce
- Documented workforce performance appraisals or peer reviews, that include performance of safety and quality roles and responsibilities
- Reports outlining trends in workforce compliance and patient safety and quality outcomes
- Communication that highlights clinical leadership
- Training documents relating to clinical leaders, managers and workforce safety and quality roles and responsibilities.

Patient safety and quality systems

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

The effectiveness of an ambulance health service's safety and quality systems is reflected in its approach to, and success in, delivering and supporting clinical care.

Safety and quality systems, and the monitoring and evaluation of those systems, should be embedded throughout the policies, procedures, protocols and clinical practice guidelines of the ambulance health service to actively improve the safety and quality of health care for patients.

Effective clinical governance in ensuring the safety and quality systems are integrated with governance processes, creates and promotes a learning environment across the organisation, and supports a comprehensive program of continuous quality improvement.[21]

Best practice patient safety and quality systems include:

- Providing evidence-based training and resources to the workforce
- Monitoring and reporting clinical performance
- Managing clinical risk[22]
- Managing and reporting adverse events, including reporting on sentinel events
- Analysing and investigating incidents to improve the care provided
- Managing complaints and compliments
- Managing open disclosure
- Engaging clinicians in planned, systematic audits of clinical services following agreed protocols and schedules.[23, 24]

Quality improvement

Quality improvement involves the use of a systematic and coordinated approach to solving a problem using specific methods and tools with the aim of bringing about a measurable improvement within a healthcare setting.[25]

Quality improvement draws on a wide variety of methodologies, approaches, and tools. Key principles are required to support positive, sustainable change and embed improvements.[25]

Quality improvement approaches include:

- Engagement with leadership to involve patients and members of the workforce in developing, designing and implementing changes
- Building skills and knowledge
- Establishing mechanisms for effectively communicating progress and reporting outcomes.

The dimensions of quality

People working in systems deliver care that is:

- **Safe:** delivering care in a way that minimises things going wrong and maximises things going right
- **Effective:** providing services that are informed by consistent and up-to-date high-quality training, guidelines and evidence
- **Caring:** delivering care with compassion, dignity and mutual respect
- **Responsive and personalised:** ensuring services are shaped by what matters to people, and empowering people to make informed decisions and design their own care.

Ambulance health services and systems are:

- **Well-led:** driven by collective and compassionate leadership, underpinned by a shared vision, values and learning, a just and inclusive culture and proportionate governance
- **Sustainably-resourced:** focused on delivering optimum outcomes within available finances, and reducing the negative impact on public health and the environment
- **Equitable:** committed to understanding and reducing variation and inequalities and ensuring that everybody has access to high-quality care and outcomes.

Policies and procedures

Action 1.07

The health service organisation uses a risk management approach to:

a. **Set out, review and maintain the currency and effectiveness of policies, procedures and protocols**
b. **Monitor and take action to improve adherence to policies, procedures and protocols**
c. **Review compliance with legislation, regulation and jurisdictional requirements.**

Intent

The ambulance health service has current, comprehensive and effective policies, procedures and protocols that cover safety and quality risks.

Reflective questions

- How does the ambulance health service ensure that its policy documents are current, comprehensive and effective?
- How does the ambulance health service ensure that its policy documents comply with legislation, regulation, and state or territory requirements?
- How does the ambulance health service measure workforce understanding of and compliance with policies, procedures, protocols and current clinical practice and drug therapy guidelines?

Strategies for improvement

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

Develop policies, procedures and protocols

The governing body must clearly delegate responsibility for developing and maintaining policies, procedures and protocols. This includes identifying a custodian to ensure that the processes are maintained for developing, reviewing and monitoring compliance with policies, procedures and protocols.

Clinical policies may be developed or adapted at different levels within the organisation. All policy, procedure and protocol documents should be incorporated into a single coherent suite to maximise the effectiveness of the policy development process. Maximum effectiveness can be achieved by:

- Documenting in employment documents or terms of reference those responsible for developing and maintaining policies, procedures, protocols and current clinical practice and drug therapy guidelines
- Identifying individuals or committees who have the authority to amend, endorse or rescind policies, procedures, protocols and clinical practice and drug therapy guidelines
- Implementing systems for the coordination of processes for the development, implementation and review of policies, procedures, protocols and clinical practice and drug therapy guidelines
- Developing a single, coherent system to maximise the effectiveness of policy development, implementation and review processes

- Developing systems for the workforce to access current policies, procedures, protocols and clinical practice and drug therapy guidelines
- Implementing systems to identify and disseminate service-specific emerging evidence, or national standards, to the workforce.

Monitor compliance with legislation, regulation and state or territory requirements

Develop strategies for the monitoring and review of policies and procedures including:

- Position descriptions, contracts, by-laws or other mechanisms that require the workforce to comply with published policies, procedures and clinical practice and drug therapy guidelines in accordance with roles, responsibilities and accountabilities
- Audit and reporting compliance with current policies, procedures and protocols
- Education and training of the workforce
- Evaluation of workforce ability to access current policies, procedures and clinical practice and drug therapy guidelines
- Seeking feedback from the workforce on organisational policies, procedures and clinical practice guidelines
- Incorporating identified risks into the organisation's risk register
- Maintaining a well-designed legislative compliance process
- Maintaining a compliance register to ensure that policies are regularly updated in response to regulatory changes, compliance issues or case law.

Examples of evidence

- Documented processes for developing, authorising and monitoring the implementation of policies and guidelines
- Register of policy document reviews, including the date of effect, and schedule for review and amendments
- Mechanisms to:
  - develop and maintain the currency of policies, procedures and protocols
  - align policies, procedures and protocols to state or territory requirements
  - ensure policies, procedures and protocols reflect current best practice and evidence
- Committee or meeting records that describe the governance structure, delegations, roles and responsibilities for overseeing the development of policy documents
- Audit results of compliance with policies, procedures and clinical practice drug therapy guidelines
- Reports from the risk management, incident management and complaints management systems about policies, procedures, clinical practice guidelines and drug therapy guidelines
- Reports from safety and quality systems and corrective actions implemented and reviewed
- Feedback from the workforce about policies, procedures and protocols
- Training on the use of policy documents
- Examples of communication with the workforce about new or updated policy documents.

Measurements and quality improvement

Action 1.08

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

a. **Identify safety and quality measures, and monitor and report performance and outcomes**
b. **Identify areas for improvement in safety and quality**
c. **Implement and monitor safety and quality improvement strategies**
d. **Involve consumers and the workforce in the review of safety and quality performance and systems.**

Intent

An effective quality improvement system is operating across the organisation.

Reflective questions

- How does the ambulance health service define, describe and measure 'quality'?
- How does the quality improvement system identify and address the ambulance health service's safety and quality priorities and strategic direction?
- What processes are used to ensure that quality improvement strategies address identified safety and quality risks?

Strategies for improvement

Develop a quality improvement system

Ambulance health services should develop a long-term, integrated, quality improvement system that provides a framework to improve the safety and quality of patient care. A priority will be to identify routinely available data to set priorities and drive quality improvement programs.[4]

It is vital to actively engage the workforce and consumers in routinely monitoring and reviewing audit results. This can include seeking feedback on strategies to address gaps and improve performance. See Action 2.11 which outlines strategies for involving consumers in partnership to measure and evaluate health care.

An organisation-wide quality improvement system includes:

- Clearly defined objectives and safety and quality indicators aligned to the organisation's mission and values
- Clearly defined and allocated roles and responsibilities for implementing and monitoring improvement strategies
- Strategies for quality improvement that address identified risks and support improvements
- A schedule and process for the conduct and reporting of results
- Orientation and training for the workforce in safety and quality.

Define 'Quality' and how it will be measured

Ambulance health services should identify routinely collected measures to benchmark safety and quality and measure performance over time. Although there is a lack of consensus about which outcome measures should be used,[26] and there may be some limitations in gathering data after an episode of care, ambulance health services should define the elements of process, operational or outcome measures to be used by the organisation.[27]

Examples of measurements include adverse patient incidents, cardiac arrest survival rates and unscheduled re-presentations after ambulance attendance. Ambulance health services should:

- Identify organisation-specific data that can be evaluated over time
- Where relevant, identify peer comparison or benchmarks to achieve consistency across services
- Provide a common language and understanding for the design, implementation and monitoring of safety and quality performance. Jurisdictions may identify requirements for individual services.

Conduct regular reviews and audits

Each action within the **NSQHS Standards**[1] contains a criterion for clinical governance and quality improvement, which is also one of the five components of the **National Model Clinical Governance Framework**.[9] This criterion highlights the importance of audit, monitoring and feedback as key strategies within the NSQHS Standards to improve the safety and quality of health care.

Clinical audit and feedback should be an iterative, flexible process designed within the quality improvement framework and include:

- Schedules of reviews and audits using a risk-based approach
- Engagement of clinicians and consumers
- Audit outcomes including actions taken reported to the governing body, the workforce and patients and consumers.

Examples of evidence

- Policy documents that describe the processes and accountabilities for monitoring the safety and quality of care provided by the ambulance health service
- Local arrangements for monitoring and improving safety and quality, including identifying local roles or groups with responsibility for oversight of clinical safety and quality risk management
- The organisation has defined 'high quality' for its service context (for example, effectiveness, safety, consumer experience) and has identified quality indicators and targets, benchmarked as appropriate, against which it can measure improvement
- The quality improvement system reflects the ambulance health service's vision, mission, values and the governing health service's strategic direction, where applicable
- Documented safety and quality performance measures and objectives
- Audit schedule, reports, presentations and analysis of safety and quality performance data
- Training records and feedback from the workforce about the use of the safety and quality systems
- Quality improvement plan that includes actions to manage identified risks
- Examples of specific quality improvement activities that have been implemented and evaluated
- Committee and meeting records in which safety and quality performance data are regularly reviewed and reported to the governing body, managers or relevant committees
- Communication with the workforce, patients and carers regarding safety and quality performance data
- Records showing that recommended actions have been implemented and outcomes evaluated and reported to the workforce and patients
- Consumer membership of groups tasked with reviewing organisational safety and quality performance and quality improvement activities.

Action 1.09

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

a. **The governing body**
b. **The workforce**
c. **Consumers and the local community**
d. **Other relevant health service organisations.**

Intent

Ambulance health services provide accurate and timely information on safety and quality performance to key stakeholders

Reflective questions

- What processes are used to ensure that key stakeholders are provided with accurate and timely information about safety and quality performance?
- How does the ambulance health service ensure that key stakeholders are receiving safety and quality performance information that aligns with that stakeholder's role and responsibilities?

Strategies for improvement

Implement a schedule of reporting on safety and quality performance

Routinely collecting process and outcome data, and monitoring for trends and reporting clinical incidents, adverse events or near misses, enables organisations to comprehensively understand and respond to deviations from expected safety and quality outcomes.

Safety and quality indicators include:

- Key relevant national priority indicators
- Regulatory or funding requirements
- Indicators covering safety and clinical effectiveness
- Patient experience data
- Access and efficiency across the ambulance health service
- Trends in reported clinical incidents, adverse events or near misses[23]
- Patient disposition decisions[28], including non-conveyance[29]
- Feedback from the workforce and consumer surveys
- Compliance with best-practice pathways or guidelines[30, 31]

Ambulance health services should:

- Develop a schedule of audit and reporting that outlines the topic areas, format and frequency of reporting on safety and quality performance
- Develop processes to ensure the accuracy, validity and comprehensiveness of data and information
- Provide the governing body and the workforce with safety and quality reports and access to the organisation's safety and quality indicators
- Implement systems for timely response to safety and quality issues identified
- Publish data in a variety of formats tailored to meet the needs of identified stakeholder groups.

Examples include:

- developing resources such as posters to provide information on safety and quality performance to a range of audiences
- real time electronic dashboards accessible by the workforce
- publishing annual performance reports publishing safety and quality performance information on digital platforms such as the intranet, website or social media channels
- presenting information on safety and quality performance at key stakeholder meetings.

Examples of evidence

- Reports on safety and quality performance that are provided to the governing body, managers, committees, the workforce, consumers, other relevant stakeholders or health service organisations
- Committee or meeting records in which information on safety and quality indicators, data, performance or recommendations by the governing body is discussed
- A reporting schedule that outlines the topic areas, format and frequency of reports on safety and quality to key stakeholders
- Communication strategies that describe processes for disseminating information on safety and quality performance to consumers and the community
- Records of safety and quality performance information published in annual reports, newsletters, newspaper articles, radio items, website or other media
- Documentation that the ambulance health service's audit program has been reviewed to ensure that it collects relevant and comprehensive information about the service's safety and quality performance
- Reports to the workforce, consumers and external organisations
- Reporting templates and calendars.

Risk management

Action 1.10

The health service organisation:

a. **Identifies and documents organisational risks**
b. **Uses clinical and other data collections to support risk assessments**
c. **Acts to reduce risks**
d. **Regularly reviews and acts to improve the effectiveness of the risk management system**
e. **Reports on risks to the workforce and consumers**
f. **Plans for, and manages, internal and external emergencies and disasters.**

Intent

The ambulance health service identifies and manages risk effectively.

Reflective questions

- How does the ambulance health service classify, identify and document risk?
- What processes does the ambulance health service use to set priorities for, and manage, risks?
- How does the ambulance health service use the risk management system to monitor and measure risk remediation strategies?
- How does the ambulance health service use the risk management system to improve safety and quality?

What is the process and who is involved in the review and reporting of risks?

Define the governing body's responsibility

The governing body is responsible for ensuring the integrity of the organisational risk management system. When developing and maintaining a risk management system, the governing body should:

- Determine the organisation's risk appetite and tolerance – that is, the amount and type of risk that an organisation is willing to take to meet its strategic objectives
- Document the organisation's risk management system in policies, procedures and protocols that define:
  - the principles and objectives
  - the systems and processes
  - responsibilities
  - how outcomes will be measured
  - the link between the organisations' risk register and quality improvement program
- Ensure that enough resources are allocated to the organisation's risk management system to support effective functioning
- Foster an organisational culture that focuses on clinical safety and continuous improvement in identifying and managing risk
- Ensure appropriate integration of clinical and non-clinical risk in all risk systems
- Review outcomes and recommendations of specific audits including those of high-risk areas[32]

- Identify the capacity and scope for the ambulance health service to participate with other agencies to plan for and manage emergencies and disasters.

Plan for, and manage, emergencies and disasters

Planning for and managing emergencies and disasters can be informed by:

- Using the risk management system to prepare for potential emergencies and disaster management
- Working with other agencies to develop systems for emergency and disaster planning and management
- Identifying lessons learned from previous national and international experiences
- Utilising the safety and quality systems to identify potential risks and opportunities for improvement
- Reviewing resources and the capacity to scale up in an emergency or disaster
- Developing strategies for scaling up in different locations and scenarios
- Reviewing infrastructure, plant, equipment and facilities that may be required during emergencies and disasters
- Developing processes for business continuity planning, recovery and returning services to normal following an emergency
- Providing workforce training in evacuation systems and emergency drills
- Planning for the coordination of workforce rosters and reporting lines during an emergency.

A number of national agencies provide support, resources and assistance including:

- **The National Emergency Management Agency**
- **The Australian Institute for Disaster Resilience (AIDR)** develops a range of resources and checklists based upon disaster resilience principles in Australia. **The Emergency Planning Handbook** provides a generic guide and nationally agreed principles for good practice in emergency planning.[33]

Embed a systems approach to risk management by:

- Maintaining risk management policies, procedures and protocols that follow current best practice, and ensuring that all clinical leaders, managers and other members of the workforce are familiar with them
- Maintaining a comprehensive, accurate and up-to-date risk register, which can be used as a practical tool for risk management
- Establishing a reliable and systematic process of hazard identification across all areas
- Actively encouraging and supporting the workforce, patients and other stakeholders to report potential or actual risks
- Evaluating performance to ensure capacity to adequately and efficiently respond to users of the service
- Describing and establishing a mechanism for capturing non-clinical risks in the risk management system
- Assigning all risks to a 'risk owner' who is responsible for managing and monitoring risks and ensuring that appropriate accountability arrangements are in place
- Ensuring that the risk management system includes strategies, resources and clear accountability for remedying risks
- Systematically providing appropriate information, orientation, education and training to members of the workforce on using the risk management system
- Regularly auditing the risk management system and reporting outcomes to the workforce and consumers
- Systematically monitoring and assessing performance regarding risk, within a defined performance monitoring framework, at all levels of the organisation, including the governing body and management.
- Ensuring that the organisation has a reliable system to scan for, identify and respond to emerging hazards and risks (for example, from the scientific literature, government agencies, insurers,

coroners, or safety and quality commissions)
- Conducting planned, systematic reviews of the design and performance of the safety and quality systems, in collaboration with clinicians and consumers
- Making use of available clinical registers.

Engage the clinical workforce

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

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

Examples of evidence

- Policies, procedures and protocols that describe the organisational processes for implementing and monitoring the risk management system
- Risk register that includes clinical and non-clinical risks that includes actions to manage identified risks
- Reports on safety and quality data to identify and monitor safety and quality trends; clinical incidents, adverse event or near misses; high-risk incidents and sentinel events
- Documentation that shows the effectiveness of the risk management system has been reviewed to ensure it is appropriately designed, resourced, maintained and monitored
- Data analysis and reports on safety and quality performance
- Training documents relating to risk management
- Feedback from the workforce on safety and quality risks and the effectiveness of the risk management system
- Documentation that establishes clear allocation of roles, responsibilities and accountabilities for maintaining the risk management system
- Audit schedule and reports on compliance with policies, procedures or protocols regarding the ambulance health service's risk management system
- Committee or meeting records regarding oversight of the risk management system, or the review of clinical data
- Committee or meeting records in which risk and safety and quality performance reports have been discussed
- Examples of communication to the workforce and consumers on risks and risk management
- Records of safety and quality performance information published in annual reports, newsletters, newspaper articles, radio items, websites or other media
- Business continuity plan or emergency and disaster management plan.

Incident management systems and open disclosure

Action 1.11

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

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

Intent

Clinical incidents are identified and managed appropriately, and action is taken to improve safety and quality.

Reflective questions

- How are incidents recognised, reported and managed?
- How are the workforce and consumers involved in reviewing incidents?
- Are mechanisms for timely, closed loop feedback incorporated into the incident management and investigation system?
- How is the incident management and investigation system used to improve safety and quality?

Strategies for improvement

An incident is 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 be a near miss. Incidents may also be associated with omissions where patients are not provided with a medical intervention from which they would have likely benefited.

The nature of the risks faced by organisations varies according to the type of organisation and the context of service delivery. A well-designed incident management system will assist patients, carers, families and the workforce to identify, report, manage and learn from incidents.

The Commission has developed a **guide to support incident management**. The guide consolidates best practice approaches based on literature reviews and Australian states' and territories' incident management policies. The guide highlights the importance of evaluating the effectiveness of incident management and investigation systems at the local level.

Review the incident management and investigation system

A well-designed incident management and investigation system should support the workforce to identify, report, manage and learn from incidents. Ambulance health services should implement a comprehensive incident management and investigation system that:

- Complies with state or territory requirements
- Links with safety and quality systems
- Defines the governing body's responsibilities
- Is appropriately resourced, maintained and monitored
- Provides a definition and rating system for incidents
- Establishes links to the organisation's open disclosure, risk management, credentialing and scope of clinical practice systems
- Supports the workforce to recognise and report incidents by fostering a safety 'no-blame 'culture
- Routinely analyses information from the incident management system and uses the data to inform its quality improvement activities
- Includes closed-loop communications to ensure that:
  - changes are implemented
  - there is ongoing evaluation to monitor changes in workforce behaviour and prevent recurrence
  - information and recommendations are fed back in multiple and appropriate forms to all levels of the ambulance health service's workforce
- Provides training to the workforce on the use of the incident management and investigation system
- Collaborates with the workforce to identify and implement quality improvement solutions for issues that are identified
- Clearly documented reporting lines, and protocols for reporting information about incidents and their quality improvement implications to the governing body, managers and relevant external organisations, such as indemnity insurers.

Support the workforce

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

A policy framework should be developed that defines the key elements of the incident management, reporting and investigation system, including the types of incidents to be reported and responsibilities of the workforce. This should include requirements for:

- Workforce orientation, training and ongoing education
- Documenting, reporting, investigating, analysing and monitoring incidents
- Engaging the workforce to find solutions to identified gaps
- Delegated roles, responsibilities and accountabilities of individuals for incident analysis, identification of trends, opportunities for improvement and reporting
- Responsibilities for closed loop communication and ongoing evaluation to ensure that improvements have been made.

Support patients, carers and families

Patients, carers and their families should be supported to report incidents and concerns. This can be achieved by:

- Establishing a range of mechanisms for providing feedback including electronic, verbal and written modes
- Providing information on feedback mechanisms in a range of accessible formats (e.g., interpreters, text-to-speech)
- Responding to feedback in a timely manner with an outline of how the feedback will be investigated and a timeframe for reporting back to the person providing the feedback.

Report on, and review, incidents

The ambulance health service should define a reporting framework that clearly identifies the data that will be available and reported at each level in the organisation including to consumers. It should also:

- Set up classification and escalation and management processes for serious incidents and incidents associated with major risk including external reviews
- Ensure that the system facilitates timely and effective review of information about clinical incidents, and that information is used at all levels of the organisation to improve the safety and quality of care.

The ambulance health service should support review of incidents by members of the workforce and managers. This enables lessons to be learned and local improvements to be implemented. A system to verify that managers follow up incidents appropriately will ensure integrity of the risk management system. Provide comprehensive information to the governing body and management on all serious incidents, and summary information about all other incidents. Include information about:

- Recommendations arising from investigations and actions taken
- Ongoing monitoring within the agreed time frames
- How agreed strategies will be evaluated
- How feedback will be provided to key stakeholders, members of the workforce and consumers.

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

Examples of evidence

- Policies and procedures that describe processes for identifying, reporting and investigating incidents
- An incident management and investigation system that complies with best practice principles and state or territory requirements
- Reports on clinical incidents, adverse events and near misses and the actions taken to manage identified risks
- Designated roles and responsibilities and resources to maintain and monitor the system
- Evidence of linkages between the incident management and investigation system and other safety and quality systems
- Training documents relating to recognising, reporting, investigating and analysing clinical incidents, adverse events and near misses
- Committee or meeting records that demonstrate discussion about incidents and actions take to address identified risks
- Information and resources, including incident reporting forms and tools, that are accessible to the workforce
- Results of completed incident investigations
- Audit results of compliance with the incident management and investigation system
- Feedback from the workforce and consumers regarding their involvement in the review and analysis of safety and quality data relating to incidents
- Examples of specific quality improvement activities that have been implemented and evaluated in response to identified incidents.

Action 1.12

The health service organisation:

a. **Uses an open disclosure program that is consistent with the Australian Open Disclosure Framework[34]**

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

Intent

An open disclosure process is used to enable the ambulance health service and clinicians to communicate openly with patients following unexpected healthcare outcomes and harm.

Reflective questions

- Does the ambulance health service have an open disclosure program consistent with the **Australian Open Disclosure Framework**?[34]
- How is the workforce trained and supported to discuss incidents that caused harm with patients?
- How is information from the open disclosure program used to improve safety and quality performance?
- How does the ambulance health service monitor the effectiveness of its open disclosure program?

Strategies for improvement

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

- A patient and consumer right
- An essential professional requirement and institutional obligation
- A normal part of care provision should the unexpected occur
- An attribute of a high-quality ambulance health service and integral to quality improvement.

Open disclosure includes:

- An apology or expression of regret
- A factual explanation of what happened
- An opportunity for the patient to relate their experience
- An explanation of the steps being taken to manage the event and prevent a recurrence.

The open disclosure program should include:

- Policies, procedures or protocols that are consistent with the **Australian Open Disclosure Framework**[34]
- Delegated resources and responsibilities for implementing, monitoring and reporting the framework to ensure that identified gaps are followed up and improvements actioned
- Ensuring that the responsibility for implementing the framework is allocated to an individual or committee
- Systems to monitor compliance with the framework and processes for investigating variations

- Regular reporting to the governing body and managers about the ambulance health service's performance of open disclosure and consistency with the principles and processes of the framework
- Orientation, education and training provided to the workforce on open disclosure.

See the **Australian Open Disclosure Framework**[34] web page for more information.

Examples of evidence

- Policy documents that are consistent with the principles and processes outlined in the **Australian Open Disclosure Framework**[34]
- Reports on the open disclosure program that are produced by the ambulance health service and provided to the governing body and managers
- Committee and meeting records about issues and outcomes relating to the open disclosure program
- Training documents (e.g., syllabus, attendance records, competency assessments) relating to the open disclosure program
- Documents that indicate service managers and clinical leaders have also received training in open disclosure processes
- Audit results of compliance with the ambulance health service's open disclosure program, and results of investigations into variations when incidents have occurred.

Feedback and complaints management

Action 1.13

The health service organisation:

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

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

c. **Uses this information to improve safety and quality systems.**

Intent

Feedback from the workforce, patients and carers is used to improve safety and quality.

Reflective questions

- How does the ambulance health service collect consumer experience feedback?
- How does the ambulance health service collect feedback from the workforce?
- How does the ambulance health service use patient experience data and workforce feedback to improve safety and quality?
- How does the ambulance health service monitor the effectiveness of its processes to collect feedback and patient experience data?

Strategies for improvement

Complaints management is an integral element of clinical governance and quality improvement processes.[35] Feedback and complaints mechanisms are elements of the **Australian Charter of Healthcare Rights**[36] and are essential for monitoring and improving delivery of health care.

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

An effective complaints management system involves collecting and analysing complaints data, as well as responding and acting upon the information.[37] Providing feedback[38] and reporting outcomes are crucial factors to the success of complaints management systems.

Consider patient diversity and health literacy capabilities in designing a complaints management system

An individual's knowledge, language proficiency and cultural background can influence a person's willingness to provide feedback or make a complaint[39] and how they prefer to express their feedback. The ambulance health service should:

- Adopt a validated and reliable method to systematically seek feedback from patients and carers
- Allocate enough resources to support the feedback system and designate individual responsibility for maintaining the system
- Regularly collect, analyse and report feedback in a timely way

- Analyse feedback to identify gaps and support quality improvement programs
- Report outcomes, including lessons learned and actions taken
- Involve members of the workforce and consumers in complaints management processes[40]
- Provide workforce orientation, education and training on feedback and complaints management
- Benchmark or compare performance with available data.

Mechanisms to collect feedback

There are several mechanisms for collecting consumer and workforce feedback and complaints including survey methods. Ambulance health services can explore alternate strategies for collecting feedback including:

- Consumer experience surveys, electronic or via mailout
- Telephoning patients following an episode of care
- Electronic patient survey conducted at transitions of care
- Convening small groups of patients and consumers to obtain feedback
- Talking with patients while they wait for care or services
- De-identified data from the workforce performance review system
- Audit data from clinical and administrative systems
- Surveys of the workforce
- Suggestions and other informal advice received from the workforce.

Examples of evidence

- Policy documents that describe the processes for obtaining recording, managing and reporting consumer and workforce feedback
- Feedback register that includes a summary of key responses and actions to manage identified issues, and its schedule for review
- Training documents about the consumer and staff feedback management system
- Data collection tools for collecting workforce, patient and carer feedback
- The availability of validated and reliable tools for systematically obtaining patient experience feedback that are appropriate and accessible for the ambulance health service context. See the Council of Ambulance Authorities: **Patient Experience Survey**
- Committee or meeting records that identify trends that demonstrate the review of workforce, consumer and carer feedback
- Data analysis and reports of consumer feedback or surveys used to evaluate the ambulance health service's performance
- Strategic, business and quality improvement plans that incorporate workforce, patient and carer feedback
- Committee and meeting records in which trends are discussed and actions identified and evaluated
- Reports or briefings on consumer and workforce feedback provided to the governing body, the workforce or consumers
- Quality improvement plan that includes actions to manage identified issues
- Examples of improvement activities that have been implemented and evaluated.

Action 1.14

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

a. **Encourages and supports patients, carers and families, and the workforce to report complaints**
b. **Involves the workforce and consumers in the review of complaints**
c. **Resolves complaints in a timely way**
d. **Provides timely feedback to the governing body, the workforce and consumers on the analysis of complaints and actions taken**
e. **Uses information from the analysis of complaints to inform improvements in safety and quality systems**
f. **Records the risks identified from the analysis of complaints in the risk management system**
g. **Regularly reviews and acts to improve the effectiveness of the complaints management system.**

Intent

An effective complaints management system is in place and used to improve safety and quality.

Reflective questions

- What processes are used to ensure that complaints are received, reviewed and resolved in a timely manner?
- How are members of the workforce, patients and carers involved in the review of complaints?
- How are complaints data used to improve services and care as well as safety and quality systems?
- What processes are used to review the effectiveness of the complaints management system?

Strategies for improvement

Feedback and complaints are essential elements of developing and monitoring service delivery. Ensure all consumers are afforded equal opportunity to provide frank, confidential feedback in their preferred language or communication style.

A well-designed complaints management system will have a clear policy framework that defines the key elements of the system. The complaints management system should enable prompt and effective review of information about complaints in line with the organisation's policies, procedures or protocols and include:

- Processes for receiving, investigating and managing complaints
- Criteria for grading complaints and escalation processes where immediate action is required
- Delegated responsibility for maintaining the integrity of the system and coordinating the management of complaints
- Workforce roles, responsibilities and accountabilities for responding to, reporting and reviewing complaints
- Mechanisms to encourage and support patients and the workforce to report complaints

- Processes for complaints data and trend analysis to be reviewed by the governing body, managers and others with responsibility for risk management
- Orientation, education and training for the workforce on reporting, investigating and managing complaints
- Integration of the organisation-wide complaints management system with other patient safety and quality systems (see **Actions 1.07 to 1.18**)
- Supporting equal access for people to provide feedback and submit complaints by providing information in plain language and in at least one accessible format
- Providing a range of methods for submission of complaints and feedback (anonymously, via a client advocate, online, in person, by phone, in writing)
- Seeking the views of consumers and the workforce to inform improvement initiatives with the complaints processes.

Examples of evidence

- Policy documents that describe the processes for reporting, investigating and analysing feedback and complaints
- A framework for reporting and reviewing complaints, and incorporating identified risks into the ambulance health service's quality improvement system
- Complaints register that includes actions taken
- Workforce training documents relating to the complaints management system
- Reports on complaints data and actions taken to manage identified issues
- Patient and carer information about how to provide feedback or make a complaint
- Feedback from patients, carers and the workforce about the complaints processes
- Committee and meeting records in which complaints management and trends are discussed
- Processes to involve members of the workforce, patients and carers in the review of complaints
- Reports about feedback and complaints provided to the governing body, managers, the workforce and consumers
- Examples of improvement activities that have been implemented in response to complaints.

Diversity and high-risk groups

Action 1.15

The health service organisation:

a. **Identifies the diversity of the consumers using its services**
b. **Identifies groups of patients using its services who are at higher risk of harm**
c. **Incorporates information on the diversity of its consumers and higher-risk groups into the planning and delivery of care.**

Intent

The diversity of consumers and high-risk groups are considered in the planning and delivery of care and services.

Reflective questions

- What are the sociodemographic and morbidity characteristics of the ambulance health service's patient population that might increase a patient's risk of harm?
- What actions have been taken by the ambulance health service to decrease the risk of harm to at-risk patients?
- How does the ambulance health service use this information to plan service delivery and manage inherent risks for patients?
- How does the ambulance health service monitor and respond to changes in the risk profile of the patient population?

Strategies for improvement

Understanding the characteristics of consumers using the ambulance health service allows organisations to identify groups of patients that may be at a greater risk of harm. Ambulance health services should implement systems to identify the groups of patients who are at increased risk of harm and implement strategies to proactively manage these risks.

Utilisation of ambulance health services will vary by geographical area and certain population characteristics.[41] For example, there is evidence that non-conveyed patients have significantly different demographic characteristics compared to conveyed patients. Non-conveyed patients are often younger, are more likely to be in (highly) rural areas and more often have reasons for care related to mental, behavioural and neurodevelopmental disorders.[42] Some people are more likely to have a poor experience of health care because of a physical or intellectual disability, their age, gender, cultural background, religion, preferred language or sexuality.

Where specific risks are associated with particular groups of patients or treatments, these should be included in the risk register and incorporated into the organisation's quality improvement system.

Develop systems to review the cultural safety of the organisation

Adopt a whole of organisation approach to the elimination of institutional discrimination and the development of cultural responsiveness. This should include developing systems to review the cultural safety of the organisation.

To enhance privacy and trust in the data collection process, information should be provided regarding confidentiality and identifying who will have access to the data and how the information will be stored, accessed, used and reported.[43] Strategies include:

- Obtaining and reviewing demographic data to understand the diversity of the patient population
- Developing evidence-based supportive tools to guide non-conveyance decision making for different patient groups[44]
- Analysing relevant data to identify the key risks faced by different demographic groups, in alignment with strategies from the **Partnering with Consumers Standard**
- Conducting a risk assessment and document a risk management plan for groups of patients, procedures or treatments that are known to be high risk
- Seeking feedback on risk remediation strategies from members of the workforce and consumers.

Strategies to reduce risks for specific medical conditions or patient groups may need to be tailored, and clinical guidelines or treatment pathways should incorporate risk management strategies for individual patients wherever relevant.

It is important to monitor external sources of information, such as coroner's reports and sociodemographic and morbidity characteristics of the patient population to identify emerging risks.

Examples of evidence

- Demographic data for the patients using the service collected, collated and used for organisational planning purposes
- Organisational risk profile that details patient safety and quality risks, and their potential impact
- Audit reports on the clinical and administrative data systems to identify patients who may be at increased risk of harm
- Strategies to identify patients at increased risk of harm, and mechanisms to provide additional safety and quality protections for these patients
- Committee or meeting records in which high-risk patient groups and risk mitigation strategies are discussed
- Examples of improvement activities that address the identified needs of high-risk patients.
- Strategic or business plans that reflect the diversity of the patient population
- Workforce training documents on diversity and cultural safety
- Consumer information that is available in different formats and languages including plain English
- List of interpreters and the collection and reporting of data on the interpreter services
- Details of consumer advocacy services
- Examples of actions taken to meet the needs of high-risk patient populations
- Ambulance health service representation at local health or community network meetings
- Collaboration with peak consumer bodies or community group representatives.

Healthcare records

Action 1.16

The health service organisation has healthcare record systems that:

a. **Make the healthcare record available to clinicians at the point of care**
b. **Support the workforce to maintain accurate and complete healthcare records**
c. **Comply with security and privacy regulations**
d. **Support systematic audit of clinical information**
e. **Integrate multiple information systems, where they are used.**

Intent

Comprehensive, accurate, integrated and accessible healthcare records are available to clinicians at the point of care.

Reflective questions

- How does the ambulance health service ensure that the workforce has point of care access to accurate and integrated healthcare records?
- How does the ambulance health service ensure that its workforce maintains accurate and complete health care records?
- How does the ambulance health service ensure the privacy and security of healthcare records?
- How does the ambulance health service enable the use of de-identified clinical data from the health care record for audit and review purposes?

Strategies for improvement

Provision of comprehensive care and shared decision making are best informed by reviewing a person's past and current health information. Ambulance health services may face unique challenges in relation to access, transfer and the security of healthcare records, particularly accessing health care records out-of-hours.[45] System incompatibility also poses additional challenges between providers[46], with a variety of digital tools being used by the health sector.[47]

The ambulance health service should review current best practice and undertake a risk assessment to mitigate risks such as incomplete medical history, access, transfer, confidentiality, security, damage or loss of health care records and interoperability of systems.[48] Strategies should be developed to mitigate the identified risks. An effective healthcare records system should include:

- Policies, procedures and protocols that address the:
  - management of healthcare records that are consistent with relevant standards, legislation and best-practice guidelines
  - standards for documentation, communication and use of patient healthcare information
  - privacy and confidentiality requirements that comply with relevant standards, professional and legislative requirements
  - access and sharing of healthcare records
  - storage and retrieval

- Workforce orientation, education and training regarding policies, procedures and protocols for healthcare record documentation
- Documented accountability for healthcare record systems
- Documented responsibility and workforce obligations to protect patient privacy and confidentiality
- Access for the workforce to records at the point of care and at transitions of care
- The capacity to support continuity of care by providing copies of health care records to either the patient on request, or another health care provider or service
- Requirements for confidentiality and privacy of patient information
- Integration and compatibility with other healthcare record systems, where applicable
- Audits of compliance with policies, procedures and protocols
- Reports from incident management or complaints systems relating to healthcare records
- Use of the organisation's quality improvement systems to identify and prioritise improvements to the healthcare records systems.

Examples of evidence

- Policy documents about healthcare record management, including access, storage, security, confidentiality, sharing of patient information and management of record loss or unauthorised access or disclosure
- Audit results compliance with policies, procedures or protocols on healthcare records management, including access to healthcare records and sharing of information
- Code of conduct that includes privacy and confidentiality of consumer information
- Signed workforce confidentiality agreements
- Secure transportation, holding archival storage and disposal systems
- Observation of secure storage systems for healthcare records
- Observation that healthcare records are accessible at the point of patient care and at transitions of care
- Committee or meeting records in which the governance of healthcare records system is monitored or discussed
- Reports from the incident management system involving health care records
- Documents describing processes to prevent loss associated with moving records between multiple sites of care delivery
- Orientation, education and training for the workforce relating to the healthcare records system
- Systems to ensure secure storage, back-up, retrieval and archiving consistent with state and territory legislation.

Action 1.17

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

a. **Are designed to optimise the safety and quality of health care for patients**
b. **Use national patient and provider identifiers**
c. **Use standard national terminologies.**

Intent

Ambulance health services securely share a patient's clinical information with authorised clinicians in other settings, including the My Health Record system.

Reflective questions

- Does the ambulance health service access or use the My Health Record system?
- What processes are used to ensure that the ambulance health service's clinical information systems comply with the requirements of the My Health Record system?
- How does the ambulance health service ensure that the workforce is appropriately trained in the use of the My Health Record system, including the use of identifiers and terminology?

Strategies for improvement

The My Health Record system allows secure collection, storage and exchange of health information between consumers and providers. It supports continuity of care and clinical handover at transitions of care, by enabling accessibility of clinical information from a range of settings.

Implementation of this action will depend on the ambulance health service's current and strategic engagement with the My Health Record system, resources available and the ambulance health service's current healthcare records system.

The ambulance health service should review its healthcare records system against the participation requirements for secure operation of the My Health Record system as set out in **Part 5 of the My Health Records Rule 2016**.[49] Results of the gap analysis should be incorporated into the ambulance health service's risk management and quality improvement systems, and be used to develop a detailed implementation plan.

The My Health Record system uses unique national identifiers for patients, clinicians and health service organisations to ensure secure access to healthcare records. Unique identifiers also help to ensure that the correct information is associated with the correct individual at the point of care.

National patient identifiers can help prevent duplication of records and minimise the chance of information being assigned to the wrong patient. Unique identifiers are issued for individuals, health practitioners and health service organisations. For more information, see **Healthcare Identifiers Service – frequently asked questions**.[50]

Consider the adoption of standard national clinical terminology to increase the likelihood that information captured in healthcare record systems can be readily understood by other clinicians accessing this information. See the **National Clinical Terminology Service** for more information.[51]

Other examples include:

- **International Medical Device Regulators Forum** (IMDRF)[52] adverse event codes for medical devices
- **Global Medical Device Nomenclature**[53] (or Unique Device Identification (UDI) into the future) to identify and record medical devices that may have been implanted.
- For more information, see the **Australian Digital Health Agency** website.[54]
- For more information on the My Health Record system, visit the Commission's **e-health Safety web page**.[55]

Examples of evidence

- Policy documents about the healthcare records management system
- Strategic plans, operational plans or business plans that outline time frames, milestones and deliverables for implementing the My Health Record system
- Committee and meeting records in which the results of the gap analysis and implementation plan are tabled and discussed
- Committee and meeting records in which the governance of the ambulance health service's data and IT systems is monitored or discussed.
- Progress towards clinical information systems using individual healthcare identifiers and standard national terminologies
- Quality improvement activities that have been implemented as part of the implementation plan for the My Health Record system.

Action 1.18

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

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

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

Intent

Clinical information held in the My Health Record system is accurate, complete and accessible by authorised clinicians.

Reflective questions

- Does the ambulance health service access or use the My Health Record system?
- How does the ambulance health service manage the policy implications and risks associated with introducing the My Health Record system?
- How does the ambulance health service check the accuracy and completeness of clinical information uploaded to the My Health Record system?

Strategies for improvement

The *My Health Records Act 2012*[56] requires that health service organisations take reasonable steps to ensure that clinical documents provided to the My Health Record system are accurate at the time of loading.

Ambulance health services that input information or load documents into the My Health Record system are required to develop and maintain a My Health Record system policy outlining:

- Processes for authorising members of the workforce to use the system and for deactivating accounts of those who no longer require access
- Orientation, education and training provided to the workforce on their professional and legal obligations in using the system
- Physical and technical security measures to control access to the system
- Identification and management of system-related security risks to be escalated to the governing body
- Audit schedule of the ambulance health service's use of the My Health Record system to ensure:
  - the workforce is loading documents into or amending information in the My Health Record system according to organisation's policies, procedures and protocols
  - access to data and records complies with legislative requirements
- Analysis, reports and feedback on the audit results including steps taken to remedy identified issues
- Processes to ensure the most complete and accurate information is uploaded into the My Health Record system.

See the **Australian Digital Health Agency** website for more information about the My Health Record system.[54]

Examples of evidence

- Policy documents about the healthcare records management system, including the use of the My Health Record system
- Orientation, education and training for the workforce on how to access and contribute patient information to the My Health Record system using the local clinical information system
- Audit results of compliance with policies, procedures or protocols relating to the My Health Record system
- Incidents relating to the My Health Record system (e.g., wrong patient healthcare record loaded into the My Health Record system) are recorded and escalated to ensure the wrong record is removed and the correct record is loaded
- Observation of the use of the My Health Record system.

Clinical performance and effectiveness

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

Clinical performance and effectiveness is one of the five components of the **National Model Clinical Governance Framework**.[9] To ensure the workforce has the right qualifications, skills and supervision to provide safe, high-quality health care to patients, there must be systems in place for orientation, education and credentialing, and access to ongoing training and supervision.

Even if systems of care are well designed, the safety and quality of care will be at risk if the workforce does not have the education, skills and experience to match their roles and responsibilities. Ambulance health services should ensure there are systems in place which are subject to periodic review of performance for:

- Orientation
- Supervision
- Credentialing and defining scope of clinical practice
- Whole-of-organisation ongoing clinical, and safety and quality education and training
- Performance monitoring and management.

Orientation

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

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

Oversight and supervision

Ambulance health services are accountable for ensuring adequate clinical and line management supervision of the clinical workforce. In particular, this applies to those who may require additional supervision, oversight and regular review of their clinical practice.

The purpose of supervision is to ensure that the practice of less experienced clinicians is of an acceptable standard, and to identify opportunities for learning and development. This may include those who are:

- Registered but not yet credentialled by their employer
- Employed as an Ambulance Officer and studying to be a Paramedic – and not yet covered by a national standard
- Volunteers with a scope of practice outside of a national standard
- Volunteers who do not have a nationally recognised qualification.

Credentialing

Credentialing is a formal administrative process used to confirm a clinician's education, competence, experience and professional suitability to provide safe, high-quality care. It is the process for formally confirming a practitioner's scope of clinical practice within the organisation. This involves delineating the extent of an individual clinician's practice within the organisation based on their competence, performance and professional suitability, and the needs and capability of the organisation.

Ongoing clinical, and safety and quality education and training

Good clinical governance promotes clinical practice that is effective and based on evidence. Ambulance health services need to support clinicians to use the best available evidence to provide safe, high-quality care. Effective quality improvement systems should identify the extent of variation from agreed clinical guidelines or pathways, and how such variation is managed.

The introduction, use, monitoring and evaluation of evidence-based clinical pathways support the provision of effective care. **Clinical Care Standards** also support the delivery of appropriate care, reduce unwarranted variation in care, and promote shared decision making between patients, carers and clinicians.

Performance monitoring

Performance development programs enable an organisation to ensure that members of its clinical workforce meet their professional registration and continuing professional development requirements.

Clinicians are accountable for their own practice. This includes compliance with accepted clinical guidelines or pathways. Oversight of clinical practice should enable the early identification and management of practices that place patients at risk of harm. The values of transparency fairness, accountability and support underpin effective systems of performance development and monitoring.

Safety and quality training

Action 1.19

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

a. **Members of the governing body**

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

Intent

Members of the governing body and the workforce understand the approach to, and the roles and responsibilities for, safe and high-quality performance in the organisation.

Reflective questions

- What information does the ambulance health service provide to new members of the governing body and workforce (salaried and volunteer staff) about their roles, responsibilities and accountabilities for safety and quality?
- How are locums, agency, students, non-operational volunteers and new members of the ambulance health service's workforce (salaried and volunteer) orientated to their role?
- How does the ambulance health service ensure the orientation processes are effective?

Strategies for improvement

The governing body should ensure that its members are orientated to the organisation and their role; are given training to promote their own understanding of how to fulfil their governance and leadership roles; and can interpret safety and quality reports and evaluations.

The governing body should also be assured that ongoing education and training programs support the competency of the workforce to provide safe care in their clinical roles and to meet the quality objectives of the organisation, as well as ensuring they understand their safety and quality roles.
To support safety and quality training ambulance health services can:

- Review orientation policies and programs, and consider whether they provide appropriate and effective orientation in safety, quality and clinical governance
- Implement orientation programs that link to organisational safety and quality systems
- Support members of the governing body and managers to develop or maintain their competence and expertise in clinical governance
- Evaluate existing orientation and induction programs to ensure they reliably provide all members of the workforce, including contracted, locum, agency, student and non-operational volunteer members with a clear understanding of safety and quality systems, and their roles, responsibilities and accountabilities
- Seek feedback from members of the workforce (salaried and volunteer) on the content and effectiveness of safety and quality programs.

Examples of evidence

- Orientation and induction documents that detail the ambulance health service's safety and quality systems, and roles, responsibilities and accountabilities of the workforce
- Attendance records for orientation and inductions programs
- Reports on evaluation of and engagement with the content and effectiveness of the ambulance health service's orientation and induction training program.

Action 1.20

The health service organisation uses its training systems to:

a. **Assess the competency and training needs of its workforce**
b. **Implement a mandatory training program to meet its requirements arising from these standards**
c. **Provide access to training to meet its safety and quality training needs**
d. **Monitor the workforce's participation in training.**

Intent

The workforce is appropriately trained to meet the need of the ambulance health service to provide safe and high-quality care.

Reflective questions

- How does the ambulance health service identify workforce training needs to ensure that workforce skills are current and meet the ambulance health service's requirements for service delivery and patient safety?
- What orientation, education and training does the ambulance health service provide on safety and quality?
- How does the ambulance health service assess the competency of the workforce?
- How are the training needs of the locum, agency, student and non-operational volunteer workforce identified and addressed?
- How does the ambulance health service monitor the effectiveness of the workforce competency processes and procedures?

Strategies for improvement

Maintaining a competent and capable workforce requires education and training. All ambulance health services have a responsibility to provide access to ongoing education and training for their workforce. Organisational culture, professional subcultural dynamics[57] and individual role conflict can impact training, performance measurement and attitudes to change.[58]

Utilising a risk management approach, ambulance health services should review their education and training programs and develop a schedule of training programs that include safety, quality and clinical governance. The governing body and management should consider the workforce orientation, education and training program and ensure that it:

- Defines mandatory education and training requirements in relevant aspects of safety, quality, leadership and clinical risk for all members of the workforce
- Supports the provision of education and training to the workforce based on comprehensive assessment of needs
- Requires evaluation of the outcomes of education and training in safety, quality leadership and risk
- Ensures that appropriate records are maintained of orientation, education and training undertaken by each member of the workforce
- Provides members of the workforce with the opportunity to discuss with their manager their education and training needs, and strategies to achieve these goals.

Implement processes to ensure orientation, education and training is effectively provided to the whole workforce

An ambulance health service should ensure agency, locum, contracted, casual and volunteer staff have the required qualifications, orientation, education, training and skills to effectively perform their roles. This can be done by:

- Stipulating in contracts requirements for qualifications, training and skills
- Implementing a formal process to verify that credentialed clinicians have the required qualifications, training and skills
- Providing training at orientation and induction to all members of the workforce, including casual, locum and volunteers.

An ambulance health service should establish reporting lines to provide feedback to the governing body about training needs and implement processes to regularly review the training needs of the workforce. Organisations should implement processes to provide training in response to emerging risks, updated evidence or system changes by:

- Performing a needs analysis linked to the clinical governance, quality improvement and policy development systems
- Seeking feedback from the workforce on professional development activities
- Analysing incident management and investigation systems
- Evaluating complaints and feedback from consumers
- Auditing education and training attendance records

Training can be provided in a variety of formats by either internal or external providers.

Maintain records of attendance at education and training events for all members of the workforce.

Examples of evidence

- Policy documents about orientation, education and training of the workforce
- Position descriptions and employment records that detail the skills and competencies required for each position
- Evidence of delegations and safety and quality roles and responsibilities
- Evidence of assessment of the education and training needs of members of the workforce
- Schedule of workforce education and training that includes the requirements of the NSQHS Standards
- Feedback from consumers and members of the workforce on the effectiveness of education and training programs
- Register of workforce completion of education and training programs, including the mandatory requirements
- Minutes of key organisational meetings where orientation programs and mandatory competency assessments are discussed
- Orientation manuals and education resources that support ongoing workforce education and training
- Audit results of the proportion of the workforce who have completed mandatory training
- Evidence of completed performance reviews for members of the workforce
- Feedback from the workforce about their training needs
- Review and evaluation reports of education and training programs.

Action 1.21

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

Intent

Ambulance health services provide a supportive environment and clear processes for the workforce to explore the cultural needs of Aboriginal and Torres Strait Islander patients.

Reflective questions

- How does the ambulance health service assess the cultural safety of the workforce?
- How does the ambulance health service work to meet the needs of Aboriginal and Torres Strait Islander patients?
- How does the ambulance health service monitor the implementation and effectiveness of these strategies?

Strategies for improvement

Cultural safety requires an organisation to have a defined set of values and principles, and demonstrated behaviours, attitudes, policies and structures that enable its workforce to work effectively across cultures.

The requirements are set by the governing body, see **Action 1.02**.

Cultural safety of a health service can only be determined by the people receiving care. It is essential to routinely seek their feedback to determine if an organisation's services are culturally safe.

Partner with Aboriginal and Torres Strait Islander communities to develop a cultural safety strategy

Develop a whole-of-organisation and whole-of-system approach to improvements for Aboriginal and Torres Strait Islander peoples. A culturally safe workforce considers power relations, cultural differences and the rights of the patient, and encourages workers to reflect on their own attitudes and beliefs. Cultural respect is achieved when individuals feel safe and cultural differences are respected.

Ambulance health services should identify strategies to increase the organisation's cultural safety. This might include:

- In collaboration with Aboriginal and Torres Strait Islander communities, developing and evaluating a cultural safety strategy
- Providing access to workforce training on cultural awareness and cultural safety
- Seeking feedback about the cultural safety of the organisation
- Seeking community input through mechanisms such as yarning circles, surveys or feedback from community representatives on the cultural safety of the organisation
- Implementing and evaluating an Aboriginal and Torres Strait Islander employment strategy

- Seeking feedback and sharing Aboriginal and Torres Strait Islander patient experience stories
- Providing cultural safety coaching and mentoring
- Including process and outcome indicators of cultural safety
- Further strategies are available in NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health.[19]

Implement an ongoing program of cultural awareness and cultural safety training

Cultural safety extends beyond individual skills or knowledge to influence the way that a system or service operates across cultures. A culturally safe environment requires more than one off training. It requires ongoing partnerships, education and evaluation of strategies to track changes over time, identify gaps and set priorities. The governing body has a role in monitoring the implementation and effectiveness of the organisation's cultural safety plan.

To support continuous, sustained change ambulance health services should consider:

- Incorporating cultural awareness and cultural safety training into the mandatory training program
- Implementing an ongoing professional development program of cultural awareness and cultural safety
- Developing and maintaining mechanisms to partner with Aboriginal and Torres Strait Islander communities to review workforce training
- Evaluating the effectiveness of cultural awareness and cultural competency strategies
- Using continuous quality improvement processes to improve the cultural safety of the ambulance health service
- Supporting access to Aboriginal and Torres Strait Islander liaison clinicians and interpreters
- Reporting on the effectiveness of the cultural awareness and cultural safety training to the governing body, the workforce, and the Aboriginal and Torres Strait Islander community.

Examples of evidence

- Evidence of assessment of the cultural safety of the organisation and workforce
- Data and reports on evaluation of the cultural safety of the ambulance health service
- Provision of cultural safety training that has been evaluated by Aboriginal and Torres Strait Islander communities
- Schedule of cultural safety training
- Cultural safety and responsiveness policies, procedures, guidelines or protocols
- Patient experience surveys and feedback
- Reports on outcome measures for Aboriginal and Torres Strait Islander patients such as leave events
- Documentation from meetings at which the cultural needs of Aboriginal and Torres Strait Islander employees are identified, monitored or evaluated
- An Aboriginal and Torres Strait Islander employment strategy
- Reports provided to the governing body on strategies to improve cultural awareness and cultural safety
- Workforce targets on proportion of Aboriginal and Torres Strait Islander employees in clinical and non-clinical areas of the organisation, how these targets were established and how they are monitored.

Performance management

Action 1.22

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

a. **Require members of the workforce to regularly take part in a review of their performance**
b. **Identify needs for training and development in safety and quality**
c. **Incorporate information on training requirements into the organisation's training system.**

Intent

The ambulance health service routinely reviews and discusses individuals' performance and systematically collects information on individuals' safety and quality training needs.

Reflective questions

- What are the ambulance health service's performance review processes?
- What process is used by the ambulance health service to identify the orientation, education and training needs of the workforce?
- How does the ambulance health service's processes for performance review link to the training system?

Strategies for improvement

Implement a performance development system for the entire workforce

Establish an organisation-wide performance development and review system that is appropriately designed, resourced, maintained and monitored.59 The system should clearly document the designated person(s) with responsibility for ensuring compliance with, and effectiveness of, the performance development system. Effective performance development systems rely on continuous, constructive interaction between members of the workforce and their managers.[57]

The professional goals and outcomes of performance reviews should be incorporated into the ambulance health service's training program to address workforce orientation, education and training needs. The performance development system should assist members of the workforce to:

- Understand the aims and objectives of the ambulance health service
- Engage in processes to review their performance
- Set professional goals that are consistent with these objectives

Work collaboratively to achieve professional and organisational goals.

Clarify performance responsibilities

Performance review processes present an opportunity for managers and members of the workforce to clarify reciprocal obligations between the organisation and the workforce. Through performance review processes, organisations can state how they will meet their responsibility to individual members of the workforce, and individual members of the workforce can clarify their obligations to the organisation. The ambulance health service is responsible for:

- Establishing a culture in which safe, high-quality care can be delivered
- Evaluating the performance development system and responding to training and development needs
- Assisting members of the workforce to develop their competence and performance by supporting them to achieve agreed goals
- Implementing processes to performance manage those members of the workforce who are employed indirectly and who may not participate in formal performance development processes
- Clearly documenting the requirements of and compliance with the organisation's performance development system.

Examples of evidence

- Policy documents about the performance review process that outline roles, responsibilities and accountabilities for managers and members of the workforce
- Documented performance development system that meets professional development guidelines and credentialing requirements
- Audit results of completed performance reviews, including actions taken to address identified training and development needs
- Evaluation of the performance development system to ensure it is appropriately designed, resourced and monitored
- Mentoring or peer-review reports
- Processes to review the workforce's participation in regular reviews of their performance
- Review and evaluation reports of education and training
- Committee and meeting records in which performance review and credentialing of clinicians are discussed
- Feedback from the workforce about their training needs.

Credentialing and scope of clinical practice

Action 1.23

The health service organisation has processes to:

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

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

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

Intent

Clinicians are appropriately skilled and experienced to perform their roles safely, and to provide services within agreed scope of clinical practice.

Reflective questions

- How is the scope of clinical practice for clinician's determined by the ambulance health service?
- What processes are used to ensure that clinicians understand their scope of clinical practice and are working within the agreed scope when providing patient care?
- How does the ambulance health service assess the safety and quality of a new clinical service, procedure, technology, clinical practice guidelines or care pathway and align that with a clinician's scope of clinical practice?

Strategies for improvement

Processes for defining clinicians' scope of clinical practice are key elements for ensuring patient safety. The aim of these processes is to ensure that only clinicians who are suitably experienced, trained and qualified to practice in a competent and ethical manner can provide care to patients.[60]

The governing body should ensure that processes are in place for monitoring and maintaining effective processes for defining scope of clinical practice. Ambulance health service managers should ensure that processes are implemented for monitoring and maintaining effective systems for defining scope of clinical practice and credentialing. Reports and feedback on these processes should be provided through the established reporting lines to the governing body, which is responsible for ensuring compliance and investigating variations.

All clinicians providing care in an ambulance health service must have their scope of clinical practice clearly defined. The process describes the mutual commitment between the organisation and each member of the clinical workforce to provide safe, high-quality care.

Ambulance health services policies for defining scope of clinical practice should describe structures and processes that ensure:

- Clear definition of clinicians' scope of clinical practice in the context of the organisation's needs and capability
- Minimum competency and training requirements as per national regulation such as **Civil Aviation Safety Authority** (CASA), where relevant
- Regular review of clinicians' scope of clinical practice
- Safe and appropriate introduction of new clinical services, procedures and other technologies
- Appropriate supervision of clinicians, when required
- Effective processes for reviewing clinicians' competence and performance
- Procedures and protocols to be followed if a concern arises about the capability of a clinician
- The processes for defining scope of clinical practice, including:
  - developing a position description
  - conducting a credentialing process
  - describing the clinician's role in a contract for services
  - obligations of licence holders credentialed to operate vehicles to report changes in licence status.

Examples of evidence

- Policy documents about the scope of clinical practice for clinicians in the context of the ambulance health service's needs and capability
- Committee or meeting documents that include information about the roles, responsibilities, accountabilities and monitoring of scope of clinical practice for the clinical workforce
- Reports of key performance indicators for clinicians
- Audit results of role designation in patient healthcare records
- Workforce performance appraisal and feedback records that show a review of the scope of clinical practice for the clinical workforce
- Peer-review reports
- Evaluation of the ambulance health service's clinical services targets
- Audit results of position descriptions, duty statements and employment contracts against the requirements and recommendations of clinical practice and professional guidelines
- Evaluation of the process for defining scope of clinical practice to ensure it is appropriately designed, resourced, maintained and monitored
- Planning documents to introduce new services including workforce, equipment, procedures and scope of clinical practice applications
- Audit results of clinical documentation reviews that include review of clinical practice by clinicians
- Regular review and assessment of position descriptions by the incumbent and line manager to ensure they are current and reflect current practice.

Action 1.24

The health service organisation:

a. **Conducts processes to ensure that clinicians are credentialed, where relevant**
b. **Monitors and improves the effectiveness of the credentialing process.**

Intent

A formal process is used to ensure that clinicians have the appropriate qualifications, experience and skills to fulfil their delegated roles and responsibilities.

Reflective questions

- What processes does the ambulance health service use to ensure that clinicians have the appropriate qualifications, experience, professional standing, competencies and other relevant professional attributes?
- How does the ambulance health service monitor changes to the national regulations or registration requirements to ensure its processes are current?

Strategies for improvement

Ambulance health services are required to appoint clinicians who are suitably experienced, skilled and qualified to practice in a competent and ethical manner, taking into account service needs and organisational capability. Organisations have several processes to ensure that clinicians are suitably credentialed and that members of the workforce understand their roles, responsibilities and accountabilities for ensuring the safety and quality of care.

The processes that the ambulance health service chooses will depend on the clinician being engaged and the clinical autonomy of the role they are being engaged to perform. These processes are detailed in **Credentialing Health Practitioners and Defining their Scope of Clinical Practice: A guide for managers and practitioners**.[60]

As part of any recruitment process, ambulance health services will need to collect evidence of clinicians' minimum credentials and reconsider this evidence when there is a change in circumstances or a change in role for clinicians. The ambulance health service should collect evidence for each of the following areas:[60]

- Current registration of clinicians with the relevant national board
- Education, qualifications and formal training
- Current aviation or drivers licence relevant to scope of clinical practice
- Previous experience, including relevant clinical activity and experience in similar settings to the relevant scope of clinical practice
- Professional indemnity insurance
- Other documentation and pre-employment checks, such as curriculum vitae, proof of identity, Police or Working with Children checks

- Clinician references and referee checks
- Continuing education that relates to a role in which the clinician is engaged and that is relevant to the scope of clinical practice

For more information, see **Credentialing Health Practitioners and Defining Scope of Clinical Practice: A guide for managers and practitioners**.[60]

Examples of evidence

- Policy, procedures and protocol documents that describe the formal credentialing processes for clinicians
- Committee or meeting records from the credentialing committee
- Register of workforce qualifications and areas of credentialed practice
- Documented recruitment processes that ensure that clinicians are matched to positions, required skills, experience and qualifications to perform their roles and responsibilities
- Employment documents that define the roles of clinical supervisors and trainees
- Evidence that the ambulance health service has verified clinicians' qualifications before employment
- Documented performance reviews or peer reviews for the clinical workforce
- Audit results of workforce compliance with guidelines, policies, procedures or protocols
- Documented process for credentialing
- Templates or examples of documents for clinicians applying to the credentialing committee
- Documented processes for granting temporary or emergency scope of clinical practice prior to formal credentialing.

Safety and quality roles and responsibilities

Action 1.25

The health service organisation has processes to:

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

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

Intent

Every member of the workforce understands and enacts their safety and quality roles and responsibilities.

Reflective questions

- How are members of the ambulance health service's workforce informed about, and supported to fulfil their roles, responsibilities and accountabilities for safety and quality of care?
- How does the ambulance health service monitor the effectiveness of the processes to inform the workforce?

Strategies for improvement

Document roles, responsibilities and accountabilities

Ambulance health services should implement the governance arrangements determined by the governing body and ensure that the workforce understands their roles, responsibilities and accountabilities for safety and quality. Clinical governance system should be supported by:

- Definitions and delegation of reporting lines and responsibilities for safety and quality
- Clearly documented accountabilities for safety and quality of clinical care within the position descriptions and contractual responsibilities of the chief executive, management and clinicians
- Descriptions of roles, responsibilities and accountabilities for supervising the performance of the clinical workforce within the position descriptions and contractual responsibilities of senior clinicians
- Safety and quality policies, procedures or protocols that allocate responsibility to specific roles within the organisation
- A structured performance development system for all clinicians and managers, incorporating regular review of:
  - their engagement in safety and quality, and in specific activities such as peer review and audit
  - supervision of the junior workforce.

Implement educational programs

Ambulance health services should educate and train members of the workforce in their governance roles and responsibilities, including:

- Clinical risk from the patient's perspective
- Clinical governance responsibilities for safety and quality

- Legislative responsibilities related to patient harm and reportable incidents
- Incident investigation methods
- Human error and human factors principles
- Principles of teamwork and leadership style
- Open disclosure
- Creating and sustaining a patient safety culture that has person-centred care at its centre
- Applying evidence-based practices to develop and support effective multidisciplinary teams.

Delegate roles and responsibilities

Ambulance health services should ensure that safety and quality roles, responsibilities and accountabilities are clearly defined by:

- Reviewing workforce position descriptions
- Identifying professional development opportunities in safety and quality, leadership and risk
- Scheduling training in clinical governance
- Discussing safety and quality responsibilities in routine performance management processes
- Providing information to the workforce about their safety and quality roles and responsibilities[61]
- Seeking feedback from the workforce about their understanding of their safety and quality roles, responsibilities and accountabilities
- Ensuring that contractual arrangements are in place for agency and locum workforce, and verifying that credentialing and scope of clinical practice are undertaken
- Providing agency, volunteer and locum members of the workforce with orientation to the ambulance health service's safety and quality, and clinical governance systems.

Examples of evidence

- Policy documents that outline the delegated safety and quality roles and responsibilities of the workforce
- Employment documents that describe the safety and quality roles, responsibilities and accountabilities of the workforce
- Audit reports showing that the governing body and managers appropriately delegate roles, responsibilities and accountabilities for safety and quality
- Review of the organisational structure, position descriptions and contract templates for managers, clinicians and other members of the workforce to ensure that responsibility for safety and quality is clearly defined for all levels of the ambulance health service
- Review of the ambulance health service's performance development policy to ensure that it incorporates safety and quality performance measures for all members of the workforce
- Contracts for locum and the agency workforce that specify designated safety and quality roles and responsibilities
- Organisational chart and delegations' policy that demonstrates clinical governance reporting lines and relationships
- Orientation, education and training documents about the safety and quality roles, responsibilities and accountabilities of the workforce
- Performance appraisals that include feedback to the workforce about delegated safety and quality roles and responsibilities
- Results of workforce surveys or feedback regarding their safety and quality roles and responsibilities.

Action 1.26

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

Intent

The clinical workforce is appropriately supervised as and when required to ensure the provision of safe, high-quality care.

Reflective questions

- How does the ambulance health service monitor and support clinicians to safely fulfil their designated roles?
- How does the ambulance health service identify clinicians that need support and supervision?

Strategies for improvement

Effective clinical supervision enables health professionals to practice effectively and enhances patient safety. Supervision is a key safeguard for safe and high-quality care. A key goal of supervision is to safely develop a clinician's capabilities. Supervision of junior clinicians should be appropriate to their assessed capabilities and be consistent with organisational policies, procedures and protocols.

For clinicians who are in training, an ambulance health service should formally document their roles, responsibilities and accountabilities in position descriptions and training programs. The roles and responsibilities of clinical supervisors should be clearly defined in contracts of employment, position descriptions and relevant organisational policies, and integrated with the performance development system.

Supervision may also be required for a range of other clinical development, or performance reasons, or as part of routine line management. Clinical supervisors should:[60]

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

Examples of evidence

- Policy documents that describe processes for supervising junior clinicians, clinicians in training, clinicians who are expanding their scope of clinical practice and clinicians who require oversight of their performance
- Employment documents that describe roles, responsibilities and accountabilities of clinical supervisors
- Evidence of assessment of the workforce's need for supervision and appropriate clinical supervisors
- Individual performance reviews for the clinical workforce, including requirements for supervision
- Audit of the extent and effectiveness of supervision
- Mentoring or peer-review reports
- Audit results of members of the clinical workforce who have completed performance reviews, including supervision (if required), and actions taken to support identified training and development needs.

Evidence-based care

Action 1.27

The health service organisation has processes that:

a. **Provide clinicians with ready access to best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice**
b. **Support clinicians to use the best available evidence, including relevant clinical care standards developed by the Australian Commission on Safety and Quality in Health Care.**

Intent

The clinical workforce is supported to use the best available evidence.

Reflective questions

- How does the ambulance health service decide which best-practice guidelines, integrated care pathways, clinical pathways, decision support tools and clinical care standards are to be used?
- How does the ambulance health service support and monitor clinicians' use of these tools?

Strategies for improvement

Good clinical governance promotes clinical practice that is effective and evidence based.[62] The introduction, use, monitoring and evaluation of evidence-based clinical pathways support effective care, and promote an organisational culture in which evaluation of organisational and clinical performance, including clinical audit, is expected.

Use clinical guidelines and pathways

An ambulance health service should promote clinical effectiveness by developing or adopting guidelines, protocols or pathways for particular diseases and clinical interventions.[63]

An ambulance health service should also:

- Implement organisational systems for the approval, dissemination and evaluation of evidence based clinical practice guidelines, integrated care pathways, clinical pathways, decision support tools, and clinical care standards[64]
- Implement systems to provide clinicians with ready access to clinical practice guidelines, integrated care pathways, clinical pathways, decision support tools, and relevant **clinical care standards** developed by the Commission
- Promote accountability of clinicians for their practice, including compliance with approved clinical practice guidelines, integrated care pathways, clinical pathways, decision support tools, and clinical care standards
- Establish governance oversight such as a Clinical Advisory Committee with responsibility for approving and reviewing the use of best-practice guidelines, integrated care pathways, clinical pathways, **clinical care standards** and decision support tools, and for communicating this information to the workforce

- Establish quality improvement systems to identify the extent of variation from agreed clinical guidelines or pathways, and how such variation is managed[65]
- Report outcomes to the workforce, managers and the governing body.

Use clinical care standards

Clinical care standards support the delivery of appropriate care, reduce unwarranted variation in care, and promote shared decision making between patients, carers and clinicians.

Clinical care standards target key areas and provide opportunities to better align clinical practice with the best evidence. **See Fact sheet 11: Applicability of Clinical Care Standards**. Each clinical care standard includes nationally agreed quality statements outlining key areas of care and are designed to:

- Inform patients about the care they can expect to receive
- Provide guidance to clinicians on delivering appropriate, high-quality care

Ambulance health services should identify relevant clinical care standards and implement those that will reduce risk to patients, improve quality, and address areas of unwarranted variation from best practice, according to their local quality improvement priorities.

Where appropriate, build the requirements of clinical care standards into the organisation's policies, processes or protocols, and give clinicians access to relevant clinical care standards. Identify the systems that organisations need to have in place to support and monitor appropriate care.

Support evidence-based practice

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

- Monitoring, auditing and reporting compliance with, and variations from, approved clinical practice guidelines, integrated care pathways, clinical pathways, decision support tools, and clinical care standards
- Using data from safety and quality systems to identify quality improvement opportunities
- Providing reports to the governing body, workforce and consumers
- Making resources available to implement clinical guidelines, pathways or clinical care standards
- Establishing processes that enable peer-based feedback to the clinical workforce about compliance with evidence and management of variation
- Seeking feedback from the workforce on barriers to utilising approved clinical practice guidelines, integrated care pathways, clinical pathways, decision support tools, and clinical care standards.[63]

Examples of evidence

- Policy documents about access to, and use of, best-practice guidelines, pathways, decision support tools and clinical care standards
- Committee or meeting records in which decisions about the implementation and use of best-practice guidelines, pathways, decision support tools and clinical care standards were discussed
- Orientation, education and training documents relating to best-practice guidelines, pathways, decision support tools and clinical care standards
- List of approved best-practice guidelines, pathways, decision support tools and clinical care standards endorsed for use by the clinical workforce
- Processes for members of the workforce to access approved pathways, decision support tools and clinical care standards
- Audit results of adherence to endorsed best-practice guidelines, pathways, decision support tools and clinical care standards
- Reports of compliance with and variations in practice from approved evidence-based clinical guidelines or pathways
- Observation of workforce use of best-practice guidelines, pathways, decision support tools and clinical care standards.

Variation in clinical practice and health outcomes

Action 1.28

The health service organisation has systems to:

a. **Monitor variation in practice against expected health outcomes**
b. **Provide feedback to clinicians on variation in practice and health outcomes**
c. **Review performance against external measures**
d. **Support clinicians to take part in clinical review of their practice**
e. **Use information on unwarranted clinical variation to inform improvements in safety and quality systems**
f. **Record the risks identified from unwarranted clinical variation in the risk management system.**

Intent

Clinical practice levels of activity, processes of care and outcomes are reviewed regularly and compared with data on performance from external sources and other similar ambulance health services.

Reflective questions

- How does the ambulance health service use both external and internal systems for monitoring and improving clinical and patient outcomes?
- How does the ambulance health service interact with clinicians regarding their clinical practice and the health outcomes of their patients?

Strategies for improvement

People expect to receive care that is appropriate for their needs and informed by evidence. However, use of healthcare interventions and outcomes of care, particularly in the out of hospital setting, can vary for different populations, across geographic areas, and among services and clinicians.[44] Understanding this variation is critical to improving the quality, value and appropriateness of health care.

Some variation is desirable and warranted – it reflects differences in people's healthcare needs. If variation is unwarranted, it signals that people are not getting appropriate care.

To examine variations in care, the ambulance health service should:

- Identify internal and external data sources, and select quality metrics that are relevant to the population served and the services provided[26, 64]
- Review and monitor the data to identify variances in performance over time
- Investigate outlying data and the reasons for variation
- Identify unwarranted variation in the safety and quality of care
- Where available, compare against peer organisations, or from state, territory or national performance data[48]
- Support clinicians to take part in data collection and analysis
- Collaborate with clinicians to identify and implement approaches to manage unwarranted variation.

Following analysis, data should be:

- Used to identify issues and solutions to manage them
- Summarised and results reported to members of the workforce and consumers
- Used to support sustainable change to care delivery
- Reported to the governing body and to other relevant key stakeholders
- Used to monitor ongoing performance and impact of improvement strategies.
- For more information on variation in healthcare provision across Australia, see the **Australian Atlas of Healthcare Variation**.[66]

Examples of evidence

- Reports on data analyses that are used to identify variation in clinical practice and areas of risk associated with variation in clinical practice
- Reports that compare clinical practice and outcomes with those of similar services or peer organisations
- Reports that identify potential reasons for variation, areas of risk and actions taken to reduce variation
- Comparative data analysis on clinical variation using external sources where available such as the Australian Atlas of Healthcare Variation, or data provided by peer organisations, or states and territories
- Committee or meeting records in which reports on clinical variation were discussed
- Audit results of clinical practice against recommended best-practice guidelines, pathways or clinical care standards, and reports on findings that are provided to all relevant clinicians, managers and committees
- Records of clinical participation in audits of clinical care
- Records of resource allocation to support clinical practice changes
- Risk management system that includes actions to manage identified risks associated with unwarranted variation
- Quality improvement system that includes actions to manage identified issues
- A schedule of data and reports provided to the governing body, the workforce and consumers
- Examples of improvement activities that have been implemented and evaluated to reduce unwarranted variation.

Safe environment for the delivery of care

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

National and state and territory legislation cover building codes and workplace health and safety issues and guide organisations to design and manage a health service environment that promotes the safe and quality care of patients.

The health service environment, which includes all facilities, plant and vehicles, needs to be fit for purpose and maintained in good working order to reduce hazards and ensure patient and workforce safety.[67] Good design can contribute to safe and high-quality care by promoting safe practices, removing hazards and reducing the potential for accidents and adverse events.[61]

The out of hospital physical environment creates unique design challenges due to the increased complexity and acuity of patients requiring transport. Factors such as limited space, availability of power, unpredictable movement and noise[68] can contribute to negative responses from the sympathetic nervous system and increase anxiety, stress and levels of pain for patients.[69] A number of measures such as the use of artwork, light, colour and music[70] can decrease stress, anxiety and pain and improve physiological measures.[68] However, these strategies may be difficult to implement in many out of hospital settings.

Safe environment

Action 1.29

The health service organisation maximises safety and quality of care:

a. **Through the design of the environment**

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

Intent

The physical environment supports safe and high-quality care and reflects the patient's clinical needs.

Reflective questions

- How does the ambulance health service ensure that the design of the environment supports the safety and quality of patient care?
- How does the ambulance health service ensure that vehicles and equipment are safe and maintained in good working order?
- What systems and processes are in place to report and manage maintenance issues, and improve the design of the physical environment?
- How does the ambulance health service minimise risk and provide safe care when care is provided in variable locations?

Strategies for improvement

The out of hospital physical environment can be unpredictable and have a major impact on safety and quality performance. The challenges of providing care in a moving work environment can increase risks to patients and members of the workforce. In some circumstances there may be limited ability to control the environment and risk assessment and mitigation strategies can be a dynamic process.

Design of systems and processes for delivering care should consider ergonomic principles, access to equipment and consumables from a safe working position, access to hands free or automated equipment.[71] Good design can contribute to safe and high-quality care by promoting safe working practices and removing potential hazards.[72]

The safety attitudes of an organisation and its workforce can improve behavioural response and use of safety equipment, reduce healthcare-associated infections and medical errors,[73] reduce workforce injury, improve patient and workforce satisfaction, and increase organisational performance.[74]

Australian standards and manufacturers guidelines are available for buildings, devices, vehicles and equipment[75], and these should be reflected in the organisation's policies, procedures and protocols so that purchases, repairs and replacements are carried out following specified guidelines or standards.

Use evidence-based design principles to promote safe practice

The ambulance health service should ensure that relevant standards, codes and guidelines are identified and reflected in the service's policies, procedures or protocols to ensure that purchases, repairs and replacement of vehicle, equipment, plant and buildings are compliant. Strategies can include:

- Developing a comprehensive maintenance plan that includes:
  - a register of all plant, equipment and vehicles
  - details of their date of purchase
  - required maintenance schedule
  - performance of testing, maintenance and service history
  - location and serial number
- Implementing systems for the conduct of risk assessments prior to and during provision of care
- Conducting environmental safety audits
- Conducting accessibility audits
- Conducting maintenance reviews
- Reporting safety audits and reviews to the committee responsible and the governing body
- Incorporating identified risks into the organisation-wide risk management and quality improvement systems
- Automating processes, when appropriate
- Designing spaces to prevent and reduce adverse events such as falls or collisions.

Examples of evidence

- Policy documents that describe the ambulance health service's:
  - requirements for maintaining buildings, vehicles, plant, equipment, utilities and devices
  - reporting lines and accountability for actions
  - processes for purchasing and repairing buildings, plant, vehicles, equipment or devices
- Policy documents that identify relevant standards, codes or guidelines related to buildings, vehicles, plant, equipment or devices used by the ambulance health service to deliver care
- Strategic plan for facilities and capital works
- Maintenance schedule for buildings, plant, vehicles, equipment and devices
- Audit results of compliance with maintenance schedules and inspections of equipment
- Completed risk audits conducted in a variety of locations, and actions taken to address the risks
- Reports of environmental and accessibility audits
- Meeting papers where results of environmental and accessibility audits are discussed and actions taken to reduce risks
- Register of all plant and equipment that includes details of their maintenance schedule and completed repairs
- Observation of design and use of the environment to reduce identified risks
- Observation that the physical environment includes consideration of safety and quality
- Risk register and quality improvement plans that include identified issues with vehicles, buildings, plant, equipment or devices.

Action 1.30

The health service organisation:

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

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

Intent

Aspects of the environment that can increase risks of harm are identified and managed.

Reflective questions

- How does the ambulance health service identify and manage aspects of the environment and other factors that can increase risks of harm?
- What processes are in place to assess the appropriateness of the physical environment for people at high risk of harm?

Strategies for improvement

Out of hospital environments can be stressful – people respond to stress in different ways. Uncertainty, pain, fear, anxiety, intoxication, substance abuse and the unfamiliar environment can increase peoples stress and risks of unpredictable behaviour. These factors can contribute to members of the workforce being exposed to increased rates of aggression, violence and unpredictable behaviour.[67]

Ambulance health services should review the design of the clinical environment to identify safety risks for patients, carers, families and the workforce. Conduct a risk assessment to identify areas where there is a high risk of unpredictable behaviours.

Develop strategies to manage identified risks and implement measures to reduce risks and enhance the well-being and safety for members of the workforce.[76] These are likely to be multifaceted and include both individual and organisational strategies to manage and reduce risks for consumers and members of the workforce.[77]

Screening and assessment processes can assist to identify patients with a high risk of unpredictable behaviour. The screening and assessment processes listed under **Actions 5.10** and **5.11** could also be used to demonstrate the management of the risks included in **Action 1.30a**.

Examples of evidence

- Policy documents for safe work practices and emergency situations
- Audit results of patient healthcare records for completed risk assessments of patients at high risk of unpredictable behaviours and development of strategies to manage the identified risks
- Orientation, education and training documents about safe work practices, de-escalation strategies and processes for seeking assistance
- Information regarding ways to create a calm and quiet environment and where available, options for sensory adjustment and creation of safe spaces
- Observation that the physical design of the environment includes consideration of safety and quality
- Security contracts and surveillance systems.

Action 1.31

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

Intent

Patients, carers and visitors can locate relevant facilities and services.

Reflective questions

- How does the ambulance health service 'signpost' users to its services?
- How does the ambulance health service utilise wayfinding strategies at public events?
- How does the ambulance health service collect feedback and suggestions for improvement on its 'signposting'?

Strategies for improvement

Strategies to direct patients and carers to services will vary depending upon the scope of ambulance health service and may include:

- Information about accessing and using triple zero
- Strategies to support people with low health literacy, limited English language proficiency, visual or hearing impairment or intellectual or cognitive disability to access triple zero
- Websites, phone numbers, feedback options, escalation of care options
- Information on booking patient transport services
- Signage at public events
- Access to services by telephone, national relay, SMS or teletypewriter
- Access to fixed sites such as treatment rooms
- Health advice services such as health direct
- Education to consumers and healthcare professionals about the options and use of ambulance health services
- Information for families and carers on locating a patient that has been transported.

Examples of evidence

- Policy documents related to signage, or communications to service users via electronic methods
- Information that describes how to access the ambulance health service (may be web based)
- Information for consumers that meets their communication needs
- In fixed sites, or at public events, signage and directions where applicable.

Action 1.32

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

This Action is not applicable for ambulance health services.

See **Advisory AS23/02: Advice on not applicable actions for Ambulance Health Services**.

Where this Action is applicable, refer to the **NSQHS Standards Guide for Hospitals**.

Action 1.33

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

Intent

Aboriginal and Torres Strait Islander peoples feel welcome and respected when receiving care.

Reflective questions

- How does the ambulance health service make Aboriginal and Torres Strait Islander patients feel welcome and safe when accessing care?
- How does the physical environment meet the needs of Aboriginal and Torres Strait Islander patients, carers and families?
- How does the ambulance health service encourage feedback and suggestions for improvement to monitor and evaluate its approach to making Aboriginal and Torres Strait Islander peoples feel welcome and respected?

Strategies for improvement

A welcoming environment 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. Welcoming spaces enable Aboriginal and Torres Strait Islander individuals, families and employees to uphold their cultural practices and beliefs.[78]

Providing a welcoming, culturally responsive, and safe environment for Aboriginal and Torres Strait Islander peoples may improve the patient and carer experience during an episode of care.[16] Creating a welcoming environment requires a culturally competent workforce providing culturally safe care, which might include:

- Developing an organisational Reconciliation Action Plans (or working toward)
- Seeking input from the Aboriginal and Torres Strait Islander community on strategies to create and maintain a welcoming environment, including culturally appropriate, art work and symbols
- Establishing relationships with Aboriginal and Torres Strait Islander communities
- Identifying factors that create a welcoming environment for Aboriginal and Torres Strait Islander peoples
- Engaging the community in the development of messages to explain processes for accessing the ambulance health service
- Evidence of implementation of goals or actions identified in the organisational Reconciliation Action Plan
- Supporting Aboriginal and Torres Strait Islander consumers to have access to culturally appropriate services
- Further strategies are available in the **NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health**.[18]

Examples of evidence

- Policy documents about cultural diversity and needs of Aboriginal and Torres Strait Islander patients, their carers and families
- Committee or meeting records demonstrating input from Aboriginal and Torres Strait Islander peoples about cultural beliefs and practices
- Availability or access to Aboriginal support workers
- Information on support for Aboriginal and Torres Strait Islander patients accessing care
- Examples of services developed in collaboration with Aboriginal and Torres Strait Islander patients
- Statements of reconciliation and acknowledgement of traditional custodians
- Results of consumer satisfaction surveys on actions to meet the needs of Aboriginal and Torres Strait Islander patients
- Evidence of recognising culturally important days of significance, such as National Reconciliation Week and National Aborigines and Islanders Day Observance Committee (NAIDOC) week
- Review of information from data systems on Aboriginal and Torres Strait Islander peoples' experience of cultural safety
- Incident management system data about Aboriginal and Torres Strait Islander patients
- Aboriginal and Torres Strait Islander patients' engagement in complaints management
- Data on Aboriginal and Torres Strait Islander patient outcomes
- Reports on management of complaints from people of Aboriginal and Torres Strait Islander descent.

Partnering with Consumers Standard

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

Intention of this standard

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

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

Criteria

Clinical governance and quality improvement systems to support partnering with consumers

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

Patient safety and quality systems

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

Clinical performance and effectiveness

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

Safe environment for the delivery of care

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

Introduction

The NSQHS Standards use the term consumer when talking about partnerships to include patients, consumers, families, carers and other support people.

Healthcare professionals and clinicians are not consumers.

The specific definitions used by the NSQHS Standards are:

Patient is a person who is receiving care in a health service organisation.

Consumer is a person who has used, or may potentially use, health services, or is a carer for a patient using health services.

Consumer representative is a person who provides a consumer perspective, contributes consumer experiences, advocates for the interests of current and potential health service users, and take part in decision-making processes.

Consumers of a health service are often the only people with a perspective of the entire patient journey.[79] Consumers can have invaluable insights into how well health service operational systems and processes are interacting, what is and isn't working, and what can be done to improve the systems and processes.[80] This is a key reason why consumer partnerships in health care are now recognised and accepted as integral to the development, implementation and evaluation of health policies, programs and services.

Consumer partnerships also inform person-centred care. Person-centred care is care that focuses on the relationship between a patient and a clinician, and recognises that trust, mutual respect and sharing of knowledge are needed for the best health outcomes.

Consumer partnerships add value

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

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

Consumer partnerships should be meaningful and not tokenistic. In the same way that clinicians and other organisational partners are respected for their areas of expertise, consumers need to be recognised and valued for their unique perspective on the patient experience. Consumer partnerships should be valued for the expert skills and knowledge which are brought to the table.

Consumer partnerships should take many forms at many levels

When health services, patients, consumers and support people work in partnership, the quality and safety of health care improves and patient and workforce satisfaction increases.[81]

Different types of partnerships with patients and consumers exist within the healthcare system. These partnerships are not mutually exclusive and are needed at all levels to ensure that the best possible outcome is achieved for all parties.

Partnerships can be applied to a broad range of activities such as quality improvement strategies,[82-84] co-design of services,[85] adaptability of programs for specific populations such as Aboriginal and Torres Strait Islander peoples or culturally and linguistically diverse peoples.

A successful partnership requires effective communication based on trust, understanding, empathy and cooperation. Communication is one of the most important contributors to valuable consumer engagement.

Partnerships at Individual and Community level

Partnering with consumers, provides capacity for the ambulance health service to understand all facets of the patient's relationship with the healthcare system. This includes those facets that might be more difficult to evaluate such as:

- The 'insider perspective of the illness experience'[86]
- Within the cultural and social determinants of health[87]
- Across organisational and community settings
- Between episodes of clinical care.

Partnerships at Ambulance Health Service, or program of care level

At the level of a service, or program of care, partnerships relate to the organisation and delivery of care within specific areas. Ambulance health services should foster a culture where consumers feel welcomed, supported and genuinely engaged in overall governance, policy, evaluation and planning.

Meaningful methods of engagement include representation on committees and boards, participation in consumer advisory committees, contributions at focus groups, and feedback received through surveys or social media.[88] When selecting methods of consumer participation, consider the diversity of the consumer population that uses the ambulance health service.

Consumer partnerships should not be viewed in isolation, but as a continuum of activity, embedded across policy and practice. Consumers and the consumer perspective need to be represented at the highest levels of governance for their input to have the greatest impact.

A diverse community means diverse partnerships

Organisational policies and processes should reflect the culture of the organisation and the diversity of the community it serves. Successful co-design relies on understanding the needs, priorities and concerns of individuals and groups within the community. A well-considered engagement plan should ensure cultural and psychological safety, clearly define purpose and expectations, and identify inclusive practices with the necessary resources to manage relationships that build trust, reputation, impact, and sustainability.

To maximise the benefits from community engagement, it is important to investigate which stakeholders are best able to provide an informed and representative voice about the needs of the patients accessing the service. This may include partnering with religious or community leaders and multicultural organisations. Or involving key stakeholders and consumers with 'lived experiences' when developing specific clinical care strategies such as those for people with mental health illness.

Sustained reciprocal relationships require support and resources for people to value the partnerships and participate fully in the development and evaluation of health care services.

Organisational leadership and support are essential to nurture consumer partnerships

Regardless of the mechanisms used, all forms of consumer partnerships require organisational commitment, support and appropriate resourcing.

By demonstrating support for consumer partnerships regularly and openly, executive leadership and governing bodies will influence the culture and attitude of the workforce to lay a solid foundation for welcoming and adopting consumer partnerships at the service level.

Organisational leadership will also ensure that appropriate resourcing is made available to support consumer partnerships. This may include consumer training, workforce roles that focus on nurturing consumer partnerships, and remuneration and reimbursement to support consumers to actively participate.

Ambulance health services will have different contexts and resources available to embed consumer partnerships in their systems and partnering approaches can be adapted to the nature and context of the health service organisation. Although capacity and resource limitations may appear to pose a barrier to forming consumer partnerships, a simple approach to partnering can often be the most effective.

Evaluating the success of consumer partnerships

Monitoring and measuring the success of partnerships between the workforce and patients is important for ensuring that systems and processes are relevant and useful to consumers and the ambulance health service.[89, 90] Mechanisms such as recording patient experience and patient-reported outcome measures can provide quality insights and meaningful data to monitor, evaluate and improve consumer partnerships.

The ambulance health service should collect feedback from patients, carers, family and substitute decision-makers about their experience and satisfaction with the level of engagement in their care. The outcome of these evaluations should be used to set realistic improvement goals for partnering with consumers.

The **NSQHS Standards User Guide for Measuring and Evaluating Partnering with Consumers**[91] is designed to support the development of evaluation and monitoring plans for the **Partnering with Consumers Standard**.

Clinical governance and quality improvement systems to support partnering with consumers

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

Good governance systems promote the effective delivery of health care, empower patients and contribute to improvements in health outcomes. Consumer engagement at multiple levels of governance is a key element for effective and sustainable governance systems.

This criterion requires organisation-wide governance, leadership and commitment to partnering with consumers. To meet this criterion, ambulance health services are required to:

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

This criterion aligns closely with the **Clinical Governance Standard**.

Integrating clinical governance

Action 2.01

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

a. Implementing policies and procedures for partnering with consumers

b. Managing risks associated with partnering with consumers

c. Identifying training requirements for partnering with consumers.

Intent

Safety and quality systems support clinicians in partnering with consumers in the delivery of care.

Reflective questions

- How are the ambulance health service's safety and quality systems used to:
  - identify the most appropriate consumer partnerships for the service?
  - support implementation of policies and procedures for partnering with consumers?
  - identify and manage risks associated with partnering with consumers?
  - identify training requirements for partnering with consumers?

Strategies for improvement

Implement policies and procedures

Ambulance health services need to ensure that all actions in the **Partnering with Consumers Standard** have appropriate governance structures and support from the governing body and management. Policies, procedures and protocols should include:

- Healthcare rights
- Informed consent, including financial consent
- Shared decision making and person-centred care planning
- Health literacy and effective communication with patients, carers, families and users of the service
- Partnering with consumers in governance matters.

Manage risks

Risk management systems (see **Action 1.10**) should be used to identify, monitor, manage and review risks associated with partnering with consumers. Develop processes to manage identified risks within the ambulance health service for:

- Different population groups
- Workforce
- Clinical and workplace
- Organisational risks.

Information from a variety of sources should be used to inform and update risk assessments and the risk management systems. This may include the:

- Organisational audit program

- Quality improvement systems
- Feedback and complaints systems
- Workforce feedback
- Consumer feedback and patient outcome data.

Identify training requirements

The provision of education has been recognised as an enabler of effective consumer and community involvement. Members of the workforce need the appropriate attitudes, skills and knowledge for authentic and effective partnerships to succeed.

Consumer representatives should be provided with orientation, training, education and support to afford them the best opportunity to contribute meaningfully and effectively. Capability frameworks are available that describe core knowledge, skills, values, attitudes, and behaviours and guide learning and development at individual and organisational levels.[92] Ambulance health services should:

- Assess the competency and training needs of the workforce and consumer representatives in line with the requirements of **Actions 1.19**, **1.20** and **1.21**
- Perform a risk assessment to inform the workforce and consumer representative training plan and to set priorities
- Develop, or provide access to, orientation, training and education resources to meet the needs of the workforce and consumer representatives with regard to partnering with consumers
- Consider engaging with organisations such as the State-based carer association93 to assist with building the capacity and skills of the workforce
- Implement orientation, education and training for members of the workforce and consumer representatives to support understanding and awareness of:
  - person-centred care
  - shared decision making
  - communication techniques
  - health literacy
  - consumer stories and presentations
  - consumer input in development and evaluation of training materials.

Examples of evidence

- Policy documents that describe the ambulance health service's processes for partnering with consumers, including the:
  - mechanisms available to engage with consumers
  - resources that are available to support consumer participation
- Committee or meeting records that show workforce and consumer involvement in consumer engagement strategies
- Evaluation of workforce and consumer requirements for orientation, education and training in relation to partnering with consumers
- A training schedule and documents for consumers and the workforce aimed at building skills and capacity for partnering with consumers
- Data from the ambulance health service's risk management and reporting systems on risks associated with partnering with consumers
- Results from safety and quality systems used to identify opportunities for improvement
- Reports that demonstrate that recommended actions have been implemented and outcomes evaluated
- Documentation that demonstrates consumer feedback including complaints have been used to inform workforce training
- Feedback from consumers, consumer representatives, consumer organisations and carers on their experience of engagement with the ambulance health service.

Applying quality improvement systems

Action 2.02

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

a. **Monitoring processes for partnering with consumers**
b. **Implementing strategies to improve processes for partnering with consumers**
c. **Reporting on partnering with consumers.**

Intent

Quality improvement systems are used to support processes for partnering with consumers at the level of the organisation.

Reflective questions

- How are the ambulance health service's processes for partnering with consumers continuously evaluated and improved?
- How are recommendations and improvements for partnering with consumers reported to the governing body, managers, the workforce and consumers?

Strategies for improvement

The ambulance health service's quality improvement system should be used to identify and set priorities for improving its processes for partnering with consumers. This may include:

- Developing or adopting meaningful performance indicators that can be used to measure improvements in consumer partnerships
- Conducting an internal evaluation of consumer partnerships across governance, strategic leadership, safety and quality, and performance management systems. Self-Assessment tools are available such as the one developed by **Cancer Australia: Organisational Self-Assessment Survey for Consumer Engagement**.
- Engaging independent, or state or territory-based consumer peak organisations to provide an external perspective on the organisation's consumer partnership system
- Integrating consumer partnership into the overall goals of the organisation, so that it is assessed alongside strategic and business goals
- Conducting a gap analysis to identify areas for improvement
- Collecting feedback from consumers via a range of methods which may include surveys, feedback and complaints mechanisms, suggestion boxes, follow-up phone calls, and formal or informal consultation
- Seeking feedback from consumer representatives about their experiences of consumer partnerships.

Implement quality improvement strategies

The ambulance health service should engage in a range of activities involving consumers, the workforce, managers and members of the governing body to generate improvement ideas.[94]

Ambulance health services should engage managers or clinical leaders to act as champions of consumer partnerships, and provide education to the workforce to reinforce the role of consumers.[95]

See **Action 2.11** for identifying opportunities and strategies for improving systems of partnership.

Report outcomes

Ambulance health services should develop formal progress and evaluation reports for members of the organisation's leadership and governing body, the workforce, consumers and consumer organisations, and the wider community.

Ambulance health services should also:

- Report the outcomes of reviews using internal newsletters or memos to share information about the service's consumer partnerships and effectiveness of processes with the workforce
- Use formal reporting lines and relationships to make reports and recommendations to the governing body and managers about the effectiveness of processes for partnering with consumers
- Use media to disseminate stories about the outcomes and effectiveness of consumer partnerships
- Publish profiles or stories of consumers involved in consumer partnerships on its website, social media platforms, annual report or noticeboards throughout the service.

Examples of evidence

- Organisation-wide quality improvement system that includes performance measures for partnering with consumers
- Audit of the ambulance health service performance against identified measures for partnering with consumers
- Results of consumer and carer experience surveys reviewed by the governing body, managers and members of the workforce
- Review of the incident monitoring system to identify areas of concern in consumer partnerships
- Committee or meeting records in which feedback from consumers and the workforce on the ambulance health service's safety and quality systems is reported
- Quality improvement plan that includes strategies to improve consumer partnerships
- Examples of improvement activities that have been implemented and evaluated to maximise the engagement of patients and consumers
- Consumer and carer information or resources about the ambulance health service's processes for partnering with consumers
- Reports on the ambulance health service's performance published in annual reports, newsletters, newspaper articles, radio items, websites or other media
- Records of meetings involving consumers at which processes for partnering with consumers are discussed
- Communication with the workforce and consumers on outcomes of consumer partnerships
- Formal progress reports or evaluation reports provided to members of the governing body and managers.

Partnering with patients in their own care

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

Person-centred care is care that focuses on the relationship between a patient and a clinician, and recognises that trust, mutual respect and sharing of knowledge are needed for the best health outcomes. Person-centred care is globally recognised as the gold standard approach to healthcare delivery and underpins the principles and expectations of the **NSQHS Standards**.[1] It is a diverse and evolving practice, encompassing concepts such as patient engagement, patient empowerment and shared decision making.

A well-informed patient can actively participate in the decision making process about their care, and better understand the likely or potential outcomes of their treatment.[96] Health care workers and patients have mutual rights and responsibilities in communicating effectively (speaking and listening) during an episode of care. It is important that the benefits, risks and alternatives of treatment, and the patient's personal circumstances, beliefs and priorities are taken into account as part of the decision making process.

Within the context of the out of hospital setting, the extent to which a patient or clinician takes responsibility for the decision making process will vary between individuals according to the clinical circumstances, the context in which the decision is occurring and professional and regulatory boundaries.

Partnerships with patients comprise many different, interwoven practices that encourage patients to become partners in their own care.[97] In the out of hospital setting this may include:

- Supporting patients and their families to participate in shared decision making including discussions about transitions or escalation of care
- Self-management support such as control of emergency therapies (e.g., Ventolin and adrenaline injectors such as EpiPen® and Anapen®)
- Publication of clinical practice guidelines and development of care pathways
- Participating in community health initiatives such as advanced healthcare directives, immunisation and other public health programs
- Providing education to support self-management.

Healthcare rights and informed consent

Action 2.03

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

a. Consistent with the Australian Charter of Healthcare Rights36

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

Intent

Consumers are provided with information about their healthcare rights.

Reflective questions

- Does the ambulance health service have a charter of rights that is consistent with the Australian Charter of Healthcare Rights?
- How is information about healthcare rights communicated to consumers?
- How does the ambulance health service ensure patients understand their healthcare rights?

Strategies for improvement

The ambulance health service should adopt the **Australian Charter of Healthcare Rights**[36] or develop a charter that is consistent with the Australian Charter of Healthcare Rights.

The ambulance health service can suppo[r]t effective adoption of the charter by:

- 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
- Conducting 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
- Incorporating the charter into organisational processes, policies and codes of conduct
- Ensuring the charter is accessible to patients and carers in formats that they understand. Such as accessible **versions developed by the Commission**, or the **Queensland Digital Health Consumer Charter**[98]
- Promoting the charter to patients by:
  - displaying information advertising the charter
  - including information about the charter in communication with patients, such as in information brochures or attaching to consent forms
  - seeking support from external agencies, such as translation and interpreting services
  - making the charter available in areas where care or treatment is provided.

Review the effectiveness of the charter

The ambulance health service should measure the impact of the charter to see whether promotion efforts are successful and whether this affects patient experience. Strategies may include:

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

Using the **Australian Charter of Healthcare Rights in Your Health Service** is a guide that outlines ways in which health service organisations can provide information about health rights and incorporate a charter in their systems.

Examples of evidence

- Policy documents that describe the use of the charter
- Charter of rights that is consistent with the **Australian Charter of Healthcare Rights**[36]
- Charter of rights available in easy English and different languages and formats consistent with the ambulance health service's community profile
- Observation that the charter of rights is displayed in areas that are accessible
- Evidence that patients and carers received information about their healthcare rights and responsibilities, such as audits of patients, interviews or surveys
- Feedback from patients and the workforce about their awareness and understanding of the charter of rights.

Action 2.04

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

Intent

Patients are involved in appropriate informed consent processes.

Reflective questions

- How does the ambulance health service ensure its informed consent policy complies with legislation and current best practice?
- How does the ambulance health service monitor compliance with consent processes?

Strategies for improvement

Informed consent is a person's voluntary decision about their health care that is made with knowledge and understanding of the benefits and risks involved. Ensuring informed consent is properly obtained is a legal, ethical and professional requirement on the part of all treating health professionals and supports person-centred care.

Good clinical practice involves ensuring that informed consent is validly obtained and appropriately timed. Policies, procedures and protocols for informed consent should comply with relevant national, state or territory legislation and best-practice principles. See **Informed Consent - Fact sheet for clinicians**.

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, treatment options, the benefits and risks relevant to them, and alternative options for them to make an informed decision to consent.
- Be provided with the opportunity to ask questions and discuss concerns

Implement training, monitoring and evaluation and communication support tools

Obtaining informed consent relies on skilled and knowledgeable healthcare providers who can effectively communicate and partner with the patient to ensure the patient fully understands and consents to the healthcare treatment, procedure or other intervention.

An effective informed consent process requires members of the workforce to be trained and ongoing monitoring and evaluation to ensure compliance with best-practice principles.

Patients who are not able to communicate through written or spoken English must have access to interpreters or information in their preferred language to meet the legal requirements of informed consent. Consent may not be valid if it is obtained through third parties. Consider current best-practice guidelines when developing local policies relating to access to accredited interpreters, family members or workers with bilingual skills.

Policies, procedures and protocols that distinguish the different types of consent (written, verbal, implied) and identify the situations when these principles should be employed and meet the common law and legal requirements. Best practice principles for informed consent systems include[99]:

- Assessing a patient's capacity to provide valid consent and the use of substitute decision makers
- Providing information to patients in a way that they can understand before asking for their consent, such as via interpreting services
- Informing patients and, if applicable, their carers and substitute decision-makers about the risks, benefits and alternatives of proposed treatment, including any costs
- Determining patient preferences for treatment, such as those documented in advanced health directives
- Obtaining and documenting informed consent to treatment, before providing care or treatment
- Providing the workforce with training on requirements for informed consent
- Evaluating the design and performance of informed consent processes to evaluate whether they comply with best-practice principles
- Auditing workforce compliance with informed consent policies, procedures and protocols
- Seeking patient and workforce feedback to identify opportunities for improvement.

Examples of evidence

- Informed consent policy documents that reference relevant legislation and current best practice. These should outline:
  - circumstances in which verbal, written or implied consent is required
  - assessing capacity to consent
  - requirements for consent to be valid
  - obtaining consent from patients from culturally and linguistically diverse backgrounds or minors
  - when and how to contact the guardianship authority
  - what the workforce should do when consent cannot be obtained or treatment is declined
- Standardised consent forms and resources for consumers to support informed consent
- Audit results of patient healthcare records for compliance with informed consent policies, procedures and protocols
- The use of decision aid tools such as:
  - **Decision support tools for specific conditions**
  - **Guide to Informed Decision making in Health Care** (Queensland Health)[101]
  - **Advanced Care Planning Australia**

Action 2.05

The health service organisation has processes to identify:

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

Intent

Patients who do not have the capacity to make decisions about their care are identified, and systems are put in place so that they, or agreed substitute decision makers, are involved in decision making, including informed consent.

Reflective questions

- What processes does the ambulance health service have in place to support the workforce to identify a patient's capacity to make decisions about their own care?
- How does the ambulance health service support the workforce to identify an advance care plan or substitute decision-maker?

Strategies for improvement

Review processes for determining patients' capacity to make decisions

Under Australian legislation, all adults are presumed to have the capacity to decide whether they wish to receive health care, except when it can be shown that they lack the capacity to do so. Decision making capacity can be decision and situation specific. This means that a person's capacity can vary at different times, in different circumstances and between different types of decisions.

A person has the 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.

Consider whether a patient has an advanced care plan or directive

The ambulance health service should ensure processes are in place to identify patients who do not have the capacity to make decisions about their own health care and to identify appropriate substitute decision-makers who can make decisions on behalf of the patient.

If a patient does not have the capacity to make decisions about their own care, a substitute decision-maker may be appointed. It should also be established if the person has an advance care plan or directive in place which articulates a person's values, beliefs and preferences for their health care.

An advance care plan or directive is a document written at a time when a patient has capacity to make decisions, and which is intended to act as their substitute decision-maker at a later time when they no longer have such capacity. A valid advance care plan or directive takes precedence over health care requests made by family members or substitute decision-makers. An advance care plan or directive is not applicable where the patient has or regains capacity and can make their own decisions.[100]

See the **National framework for advance care planning documents**.

Implement effective policies, procedures and protocols

The ambulance health service should implement policies, procedures and protocols to assess the capacity of a patient to make decisions about their own care. These should:

- Comply with relevant state or territory legislation regarding the criteria for a patient to be considered capable of making decisions about their own care, and incorporate these criteria
- Incorporate systems to identify if a person has an advance care plan in place (see **Action 5.09**)
- Support members of the workforce to discuss and implement an individual's values and preferences into medical treatment decisions, including consent or refusal for treatment or transportation (when clinically indicated)
- Outline the requirements of the workforce to assess patients for their capacity to make healthcare decisions
- Include procedures for identifying and appointing a substitute decision-maker
- Identify processes for members of the workforce to access and enact an advance care plan or directive
- Be developed in consultation with consumers and the workforce responsible for assessing patients' capacity to consent
- Incorporate a list of appropriate substitute decision-makers
- Include processes to review and resolve disputes related to the enactment of advance care plans or directives.

Educate the workforce during orientation and ongoing training sessions

The ambulance health service should ensure that the workforce is trained in assessing a person's capacity to make decisions about their care and identifying substitute decision-makers.

The ambulance health service should consider organising training through external providers such as **Capacity Australia** and making resources and tools readily available to the workforce, for example, those developed by:

- Office of the Public Advocate: **Resources to promote Healthy Discussions**
- SA Health's **Impaired Decision Making Factsheet**.[101]

Periodically review processes, procedures and protocols to evaluate whether they meet the needs of patients and reflect current best practice

The ambulance health service should consider:

- collecting feedback from patients to assess if they felt involved in their healthcare decision making
- surveying consumers on their experience and satisfaction with the level of engagement they had in their healthcare decision making.

Examples of evidence

- Policy documents and procedures for:
  - identifying a patient's capacity for making decisions about their care
  - identifying a substitute decision-maker, if a patient does not have the capacity to make decisions about their care
  - documenting substitute decision-makers such as next of kin, advocates, people with power of attorney and legal guardians
  - accepting and implementing advance care plans or directives
- Screening and assessment tools that identify the patient's capacity for decision making
- Audit results of patient healthcare records that identify the process for assessing a patients' capacity to make decisions
- Audit results of compliance with policies, procedures or protocols for determining a patient's capacity and determining a substitute decision-maker

- Training documentation on systems for assessing a person's capacity to make decisions about their own health care
- Patient information or 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
- Examples of applications regarding guardianship or use of the Office of the Public Advocate.

Sharing decisions and planning care

Action 2.06

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

Intent

Patients receive safe and high-quality care by being involved in decisions and planning about current and future care.

Reflective questions

- What systems and processes does the ambulance health service have in place to support the workforce to partner with patients or their substitute decision-maker to plan, communicate, set goals and makes decisions about current and future care?
- How does the ambulance health service review the use and outcomes of systems and processes for partnering with patients or their substitute decision-maker?
- How does the ambulance health service demonstrate patients are supported to be actively involved in their own care?

Strategies for improvement

Partnering with patients in their own care is integral to the delivery of safe and high-quality person-centred health care. Shared decision making supports person-centred care and is a process in which clinicians and patients work together to clarify treatment, management or self-management support goals, sharing information about options and preferred outcomes with the aim of reaching mutual agreement on the best course of action.[102]

There is often a misconception that patients do not have the desire, capacity, or skills to participate in shared decision making.[103] Patients and their families can contribute unique insight to the clinical encounter by sharing their knowledge about their lived experiences and personal preferences. Patients can be partners in their own care in many ways, including shared decision making, self-management of their condition and personalised care planning.[104]

Communication is key

Good communication is vital to foster trust and respect between the workforce and patients. It is important that the ambulance health service ensures that health information is timely, appropriate and tailored to the health literacy levels of the community. **Actions 2.08 – 2.10** provide guidance on how an ambulance health service can build a health literacy environment that supports effective partnerships with consumers.

Create a supportive organisational culture

Supportive organisational climates are vital for achieving person-centred care in which partnerships between clinicians and patients become the established norm. Strategies the ambulance health service should consider include:

- Engaging leadership and governing bodies to act as champions for partnerships between clinicians and patients
- Incorporating the importance of clinician and consumer partnerships into the organisation's strategic planning, vision and goals
- Engaging consumers in organisational governance and strategic planning to support organisational redesign (see **Action 2.01**)
- Providing enough resources to support clinicians to partner with patients in their care
- Providing education and training to equip clinicians to partner with patients in their care.

Further information on education and training for clinicians is provided in **Action 2.07**.

Develop strategies to encourage communication and knowledge exchange between the workforce and patients

The ambulance health service should engage consumers to review health information provided to patients to identify communication barriers and areas for improvement. Other strategies that should be considered include:

- Developing policies and processes to involve patients or their substitute decision-maker in planning, communication, goal setting and decision making for their current or future care
- Providing patients or their substitute decision-makers with access to information and resources in a format that meets their needs. This may include:
  - general information about their health, specific condition, medicines and procedures
  - information and tools about how they can be involved in their own care
- Providing orientation, education, training and resources to support the workforce to partner with patients or their substitute decision-maker in their own care
- Encouraging the workforce to create an environment in which patients feel confident asking questions
- Using technology, such as telehealth, mobile or tablet apps, to interact and share information with patients, ensuring that any healthcare records transmitted electronically are encrypted or aligned with privacy regulations
- Supporting patients to take part in shared decision making using decision support tools
- Developing strategies for engaging with patients' carers, families and substitute decision makers. Information from carers and families should be obtained with consent and knowledge of the patient wherever practicable
- Providing a mechanism to support the clinical workforce in achieving agreed goals of care where possible
- Developing processes for the workforce to access translation services to support shared decision making
- Reviewing workforce compliance with systems and processes for partnering with patients or their substitute decision-maker in their own care.

The following publicly available resources to support the workforce to partner with patients or their substitute decision-maker could be adapted for the ambulance health setting:

- **Top Tips for Safe Health Care** can help consumers, carers, families and other support people get the most out of their health care[105]
- The **Agency for Healthcare Research and Quality** provides practical advice for improving communication between patients and clinicians.[106]

Develop policies and procedures to guide care planning in partnership with patients

An individual's values and preferences could be captured in a number of different documents, including Advance Care Directives, Advance Care Plans, Comprehensive Care Plans and Goals of Care documents, including those for children and young people.[107]

The ambulance health service should:

- Implement systems to facilitate identification and receipt of advance care plans or other documents indicating an individual's future care preference (see **Action 5.09**)
- Support the workforce to discuss patient preferences and identify goals of care (see **Action 5.13b**).

See Figure 2 on page 104 for advice on what documents might contain information about an individual's future care preference.

Develop measures to monitor and evaluate patient partnerships

Monitoring and measuring the success of clinician and patient care partnerships is important for ensuring that systems are relevant and useful to consumers and the ambulance health service. Strategies for monitoring and measuring the success of the systems may include:

- Seeking feedback from consumers and members of the workforce
- Using the outcomes to set realistic goals for improving partnerships between clinicians and patients.

Examples of evidence

- Policy documents that describe the ambulance health service's systems and processes for partnering with consumers or their substitute decision maker in their care
- Training documents about communication, interpersonal skills and shared decision making
- Tools to support shared decision making, care planning and development of goals of care
- Audit results of patient healthcare records that demonstrate shared decision making and support patients to set goals, and makes decisions about current and future care
- Patient information or resources about care options in different languages and formats consistent with the diversity of the patient population
- De-identified examples of patient notes and electronic healthcare record entries which demonstrate the engagement and discussions regarding planning and involvement in care
- Results of patient, substitute decision maker and carer experience surveys, and actions taken to managing issues identified regarding partnering in decision making processes.

Action 2.07

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

Intent

Clinicians work with patients to enable them to be partners in their own care.

Reflective questions

- How does the ambulance health service support the workforce to form partnerships with patients so that they can be actively involved in their own care?
- How does the ambulance health service monitor and evaluate patient engagement?

Strategies for improvement

Develop the workforce's interpersonal and communication skills

Members of the workforce require good interpersonal and communication skills to effectively partner with patients in their care.

A strategic plan should be developed to support the workforce develop skills and confidence in approaching consumer partnerships. Consideration should be given to identifying factors that can influence a patient's capacity and desire to engage with the health system and partner in their own care. Reasons can include lack of understanding about facilities and services, embarrassment, fear and mistrust of authority, power imbalance, lack of institutional cultural safety, discrimination or perceived racism.[108]

Embed ways to support shared decision making throughout organisational policies and procedures

Ambulance health services should evaluate and devise effective ways for supporting shared decision making and embed shared decision making into systems, processes and workforce attitudes, skills and behaviours. In the out of hospital setting this may include:

- implementation of a patient's current action plan (i.e., asthma, allergy, hypoglycaemia, obstetric and newborn emergencies)
- implementation of patient and carer escalation protocols, such as Ryan's rule
- support of patient-controlled emergency therapies.

Create additional supports for patients with different communication needs

The ambulance health service should establish a framework to consider the communication requirements for people who may need additional support such as those with low health literacy, limited English language proficiency, visual or hearing impairment or intellectual or cognitive disability.

Professional development and training activities aimed at improving the cultural safety of health service organisations are recognised as an essential strategy to improve outcomes for consumers, carers and communities as well as health care providers.[109]

Implement an education and training program

Training resources can be tailored to meet the language, cultural, and health literacy needs of people accessing the service. Gaps in knowledge can be identified and training modified by seeking feedback from the workforce. Education and professional development may include:

- Best practice communication and interpersonal skills
- Techniques for shared decision making and involving patients in their own care
- Identifying barriers to shared decision making
- Awareness of individual health literacy and the health literacy environment.

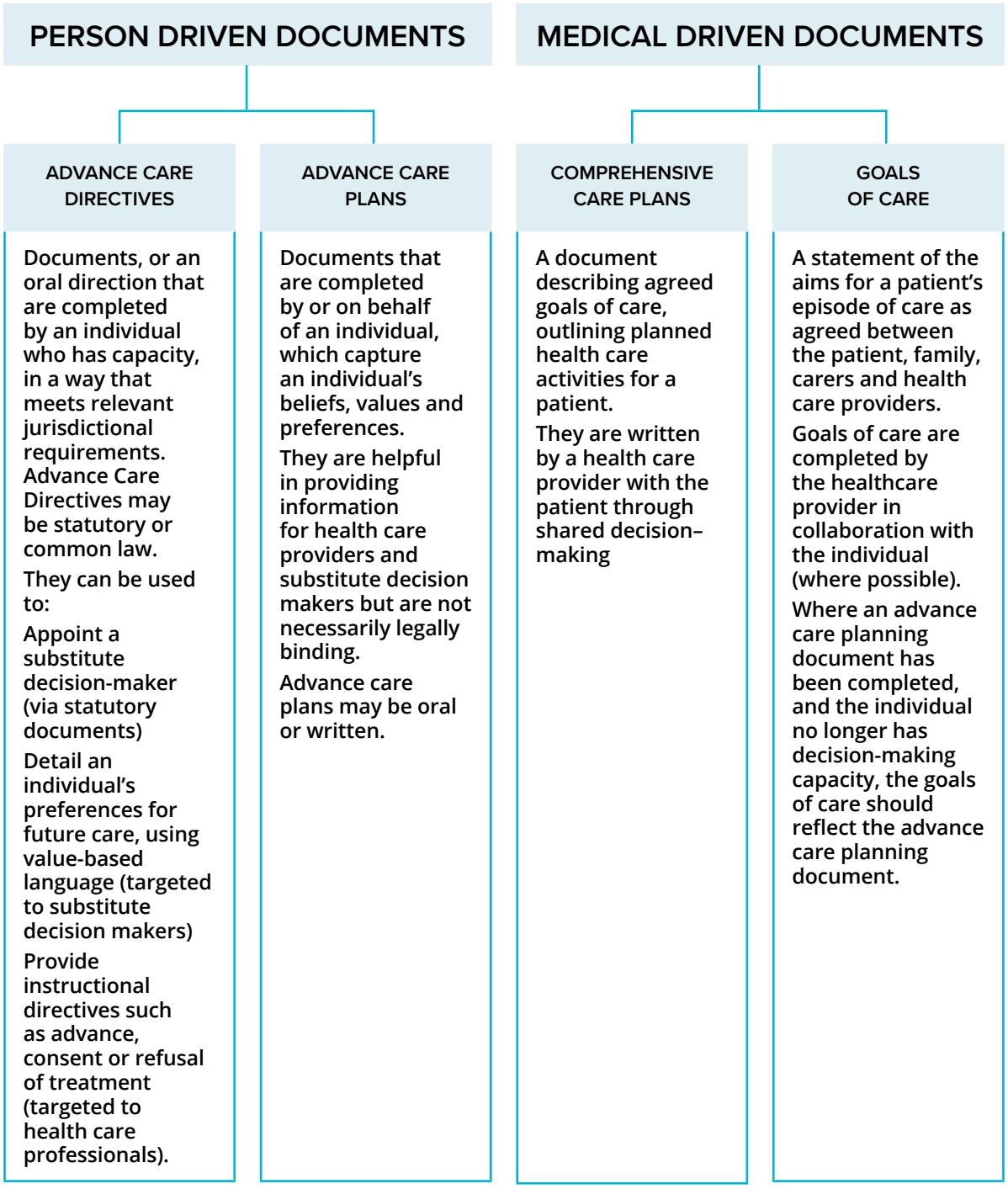
Education and training can be developed by the ambulance health service in partnership with consumers, or may be sourced from an external provider such as:

- **The Health Issues Centre** and other state-based health consumer organisations that provide consumer engagement training for the health workforce[110]
- The **Point of Care Foundation's Patient and Family-Centred Care toolkit**, which provides a step-by-step method to help the workforce understand the importance of partnering with consumers[111]
- The Agency for Healthcare Research and Quality's **Communicating to Improve Quality Strategy**, which provides a MS PowerPoint© presentation and handout on communication competencies for the health workforce[106]
- **'Hear Me'** – a play created by the Australian Institute for Patient and Family Centred Care and the University of Technology Sydney.[112]

Examples of evidence

- Policy documents that outline strategies to support the workforce to partner with consumers in their care
- Schedule of workforce education and training about partnering with consumers in their care
- Documentation about education and training on partnering with consumers
- Feedback from the workforce about their training needs.

Figure 2: Documents that might contain information about an individual's future care preferences*



*Adapted from the National framework for advance care planning documents 08 June 2021.[113] Refer to jurisdictional legislation and common law precedent

Health literacy

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

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

For the purposes of implementing the NSQHS Standards, health literacy is separated into two components:[114]

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

Individual health literacy

Almost 60 per cent of the general adult population in Australia are reported to have low individual health literacy. This affects a person's capacity to make decisions and manage their health needs. More than one in five (21 per cent) of Australians speak a language other than English at home and almost four per cent of Australians say they speak English poorly or not at all.[115] Negotiating health systems demands a high level of health literacy.

Individual health literacy is shaped by a range of personal, social, environmental and cultural factors which can influence the extent to which a person wishes to partner in their healthcare and impact the extent to which a person accesses, understands and acts upon health information provided. Previous experiences of the health care system, and knowledge of their own health condition, may also influence a person's preferences for shared decision making and partnering in their own care.

Low individual health literacy and limited English language proficiency are major barriers people face when accessing health care services. Low individual health literacy exacerbates barriers to accessing health care resulting in lower quality health care, poorer outcomes, disempowerment and loss of autonomy.[116] Communication barriers increase the risk of medication errors[117], adverse events[118], unnecessary tests and treatments and higher hospital readmission rates, resulting in poorer quality of care and worse health outcomes overall.[119]

Health literacy is complex and challenging. Poor communication between health care providers and patients is a serious organisational risk and safety concern, and a common root cause of adverse events.[120] Collecting and analysing patient data is essential to understanding patient communication needs and developing or improving communication mechanisms to meet these needs.

Ambulance health services have a duty of care to communicate effectively, in particular when obtaining informed consent. Communication is one of the seven rights in the **Australian Charter of Healthcare Rights**.[36] The charter states patients have the right to:

- receive clear information about their condition, the possible benefits and risks of different tests and treatments to be able to give informed consent
- be given assistance where required to help understand and use health information.

Working with interpreters is one strategy to ensure that these rights are upheld.[121] In many health care settings however, there is a general lack of access to, and underuse of interpreters and culturally appropriate resources.[122]

Health literacy environment

Ambulance health services have a responsibility to build a health literacy environment that supports effective partnerships with consumers. This may involve:

- Developing and implementing plain English and health literacy policies and processes
- Providing and supporting access to training and education for clinicians in health literacy and interpersonal communication
- Implementing mechanisms and systems for the development of resources and access to interpreters
- Strategies for effective interpersonal communication include the use of decision support aids, shared decision making processes
- Providing education programs for consumers to develop health knowledge and emergency care skills.

Communication that supports effective partnerships

Action 2.08

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

Intent

Consumers receive the information they need in a way that is appropriate for them.

Reflective questions

- How does the ambulance health service identify the communication needs of its patients and consumers?
- What strategies does the ambulance health service use to tailor communication to meet the needs of the patient population?

Strategies for improvement

Determine the diversity of consumers and the local community

Patient and community data are essential to understanding the communication needs of the patient population and developing communication strategies to meet those needs. This supports person-centred care, which is respectful of, and responsive to, the preferences, needs and values of the individual. The principles of person-centred care provide an opportunity to address the health inequities facing groups who may be at increased risk of harm.

Review current communication strategies

Effective communication is essential for the provision of safe, high-quality care. It is linked to reduced errors, improved health outcomes and patient satisfaction, increased comprehension and adherence to clinical instructions.

Conversely, ineffective communication can result in limited, delayed, inefficient care, leading to more costly treatment and intervention, as well as negatively impacting the person's understanding of, and trust in, the healthcare system.

Ambulance health services should develop a communications framework that considers a range of communication strategies including:

- Developing policies and position statements on health literacy
- Adopting a plain English language policy
- Policies on accessing interpreting services
- Establishing systems to engage Auslan, Deaf Relay or foreign sign language interpreters
- Assessing the cultural safety and confidence of the workforce in communicating with diverse patient populations
- Developing policies for the use of web-based translation tools, noting that web-based translation tools in health care settings carry a high risk of miscommunication.[123]

Determine whether the ambulance health service's current communication systems meet the needs of its patient population and are:

- Culturally appropriate
- Available in a variety of community languages
- Available in a variety of accessible formats.

The provision of 'language services'

The provision of 'language services' is defined as measures taken to assist people who have limited ability to communicate in English. Language services may include:

- Provision of interpreters either face-to-face or via telephone or video conference
- Translation of documents from English into community languages and vice versa
- The use of plain English and story boards
- Employment of, or access to, multilingual staff
- Use of culturally appropriate, multilingual information and educational material
- Use of Auslan language services.
- Develop policies and processes for the engagement of interpreters, including guidance on:
  - obtaining informed consent
  - situations where an interpreter is not available
  - use of bilingual members of the workforce
  - the use of families and carers to interpret.
- Provide training for the workforce in the use of interpreter services and evaluate training
- Seek feedback from the workforce to identify ongoing requirements for training
- Provide technology to support the use of online, or telephone interpreter services.

Monitor and review systems for the provision of language services

The ambulance health service should routinely collect data on the use of interpreting services and review failures to engage interpreter, when needed. The service should also:

- Monitor the delivery of interpreting services, such as wait times, quality and safety of outcomes for individuals
- Engage with consumers and key stakeholders to evaluate the provision of language services.
- Monitor workforce compliance with policies, procedures and protocols
- Audit health care records on the provision of interpreter services

A number of tools and resources can help guide effective and tailored communication including:

- **One Size Does Not Fit All: Meeting the healthcare needs of diverse populations**[116]
- SA Health **Guide for Engaging with Consumers and the Ambulance, Tool 3: Tips for communicating clearly**[124]
- **Health Translations directory**, which provides links to reliable translated health resources produced in Australia[125]
- Eastern Health **Cue cards in community languages**[126]
- Victoria Health: **Understanding language services**
- **NSQHS Standards User Guide for health services providing care to people with mental health issues**[127]
- **NSQHS Standards User Guide for health service organisations providing care for patients with cognitive impairment or at risk of delirium**[128]
- Western Health have implemented **iPad** and **iTunes** apps and **CALD Assist** to support non-English speaking patients communication
- The **NALscribe app** which continuously transcribes speech into large, easy-to-read text on an iPad screen in real-time.

Examples of evidence

- Policy documents about communication that identify how the communication needs of different patient populations will be met
- Demographic data that are used for strategic and communication planning to meet the communication needs of patients and carers
- Policies and procedures on supporting people with low health literacy and low English literacy
- Policies and procedures on language support and the engagement of interpreters
- Agreements, contractual arrangements, invoices or schedules with interpreting service provider(s)
- Protocols for assessing the need for an interpreter and identifying patient preferences
- Policies, procedures or protocols for assessing decision making capacity, obtaining informed consent and communicating complex instructions for patients with communication barriers
- Audit results on interpreter engagement
- Reports on improvement projects aimed at reducing barriers to health literacy
- Resources for consumers on accessing language services
- Feedback from patients and carers about communication processes and resources
- Training documents on best practice for improving communication and engagement of interpreters
- Reports from the incident management system or complaints register relating to failures in communication
- Feedback from the workforce, consumers, families and carers on their experiences with language support and access to interpreter services.

Action 2.09

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

Intent

Consumers are involved in the development of information about health and health services, so it easy to understand and act on.

Reflective questions

- How does the ambulance health service involve consumers in the development and review of patient information?
- How does the ambulance health service evaluate the effectiveness of its processes for involving consumers in the development of consumer information?

Strategies for improvement

Consumers can play an important role in supporting ambulance health services to provide information that is clear, easy to understand, and relevant to the needs of consumers and the patients that use the service.[95, 129]

Where an ambulance health service does not have the capacity to develop its own consumer information, it is recommended that the service explore existing publications which have been developed in partnership with consumers. Publications developed by state and territory health departments, professional associations or respected external providers will usually be of a high-quality and considerate of health literacy requirements. The publications should be tested and adapted to meet the needs of the ambulance health service's patient population.

Involve consumers where possible

Actions to involve consumers may include:

- Establishing a consumer-based patient information working group to lead and advise on consumer information
- Holding focus groups or workshops to plan, develop and review consumer information
- Engaging consumers to co-design information
- Collaborating with health consumer organisations to develop or test information
- Seeking feedback from consumers to inform the development of existing or new publications
- Providing feedback on changes that were made.

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

- The Agency for Healthcare Research and Quality's **Health Literacy Universal Precautions Toolkit**[130]
- **Can They Understand?** Testing patient education materials with intended readers[131]
- **Consumer Representatives Program Agency Handbook**[132]

Examples of evidence

- Committee or meeting records that show consumer involvement in the development and review of consumer information resources
- Samples of patient information which have been developed in conjunction with consumers
- Feedback from consumers who have used the ambulance health service's information publications
- Evaluation reports on existing consumer information publications
- Examples of publications that have been amended in response to consumer feedback
- Feedback from consumers into the development or review of resources about changes made in response to their feedback.

Action 2.10

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

a. **Information is provided in a way that meets the needs of patients, carers, families and consumers**
b. **Information provided is easy to understand and use**
c. **The clinical needs of patients are addressed while they are in the health service organisation**
d. **Information needs for ongoing care are provided on discharge.**

Intent

Consumers receive the information they need to get the best health outcomes, and this information is easy to understand and act on.

Reflective questions

- How does the ambulance health service ensure that the information provided by the workforce to consumers meets consumers' needs?
- How does the ambulance health service support the workforce to meet the information needs of patients for ongoing care and self-management?

Strategies for improvement

The importance of interpersonal communication between consumers and healthcare providers is well recognised, as is the quality and appropriateness of information provided to consumers. Effective communication has been linked to improved consumer health outcomes and is closely associated with patient safety.[133]

Review information and resources about treatment options to ensure appropriate health literacy levels

Information and resources used by the workforce should be produced in plain English and be free of jargon or medicalised language. Visual diagrams, decision aids and cue cards may be useful when communicating with patients whose first language is not English or those with low health literacy. See **Actions 1.15** and **2.09**.

Ensure a health care environment that supports health literacy

The ambulance health service should ensure that the health care environment supports open and effective communication between patients and the healthcare workforce. This could be achieved by:[114, 134]

- Implementing a plain-language policy
- Asking patients how they would like their health information communicated to them
- Auditing the health literacy environment
- Providing the workforce with access to training on health literacy and communications skills (see **Action 2.07**)
- Ensuring patients have access to interpreters when needed

- Involving patients and carers in developing information and resources about communication processes that may include information about:
  - the role that patients and carers play in providing information to the healthcare team
  - alternative methods for communicating concerns to the healthcare team
- Monitoring and assessing the effectiveness of the workforce in communicating with patients by:
  - auditing healthcare records to assess the information provided to patients and carers
  - providing a mechanism for patients to give feedback about the communication and information they receive during an episode of care
  - seeking feedback on communication strategies and information resources in use.

Examples of evidence

- Policy documents for the development and selection of consumer information materials and resources in plain language
- Examples of resources for patients and carers that are available in different languages and formats
- Multilingual emergency phrase books
- Audit results of the health literacy environment
- Results of patient and carer experience surveys regarding the information provided about their care
- Training documents and records of workforce attendance at training programs on health literacy and communication skills.

Partnering with consumers in organisational design and governance

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

In Australia's healthcare system, partnering with consumers and the community is now viewed as an essential element in the design, implementation and evaluation of health policies, programs and services.[135, 136] Consumers have a unique perspective that can help ambulance health services identify risks and opportunities for improvement and optimise the way health care services are provided.

Effective partnerships with consumers that are reflective of the diversity of the patient population improves cultural safety by integrating culture into the delivery of health services.[137]

Ambulance health services will vary in their approach, however key elements to consider include partnering with target populations, community development, capacity building and peer education.[138] Specific methods of partnership can be informal, one-off events, feedback through social media, or formal and ongoing participation on boards and committees. Consumers can be engaged as individuals, or in small or large groups. Consider the diversity of the patient population and the organisation's design and governance needs. The use of mixed methods supports the concept that not all consumers will engage with health services in the same way.[135]

The established methodologies and resources mentioned in this Guide can support ambulance health services to partner with consumers for design, governance and overall improvement activities.

Partnerships in healthcare governance planning, design, measurement and evaluation

Action 2.11

The health service organisation:

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

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

Intent

Consumers help shape the way the health service organisation operates to achieve mutually beneficial outcomes, and these consumers are reflective of the diversity of the people who use its services or, if relevant, the local community.

Reflective questions

- How are consumers involved in the governance planning, and the design, measurement and evaluation of care provided by the ambulance health service?
- How does the ambulance health service ensure that the diversity of consumers and patients that use the service are reflected in these partnerships?

Strategies for improvement

Integrate partnering with consumers into governance systems

Consumers can make effective and meaningful contributions to health service planning and development through their involvement in organisational governance and decision making. To enable these contributions, ambulance health services should integrate partnering with consumers into the governance systems of the organisation.

To maximise the benefits from community engagement, it is important to investigate which stakeholders are best able to provide an informed and representative voice about the patient population. There may be times when attempts to engage consumers are unsuccessful and a range of strategies may need to be employed. Mechanisms for actively involving consumers include:

- Developing or adapting, policies and processes for engaging consumers in governance, design, measurement and evaluation activities
- Developing Reconciliation Action Plans, Disability Action Plans, Gender Equality Actions Plans and other Diversity and Inclusion Plans
- Implementing a framework for the ambulance health service to engage consumers in the governance planning, and design and evaluation of care
- Providing consumer representatives with orientation and training for the role
- Inviting consumers to be part of working groups or safety and quality committees

- Incorporating consumer stories into governance and leadership meetings to keep consumers' needs and perspectives in mind
- Including consumers as part of the governance group or strategic planning team
- Establishing a consumer advisory group that meets to provide advice and input into the formal governance group.
- Using data about consumer experiences to help identify key issues and opportunities for improvement
- Meeting with community and consumer organisations to identify key issues and opportunities for improvement
- Holding a joint workshop with members of the workforce and consumers.

Assess if the current level of engagement with consumers is effective

Ambulance health services can consider the current level of engagement with consumers by:

- Conducting a self-assessment of the service's engagement with consumers, including how the consumers found out about the ambulance health service
- Making a list of current committees or working groups involved in strategic planning, service design, and monitoring of safety and quality performance, and identifying the level of consumer involvement in these groups
- Forming a Consumer Consultative Committee that has an executive sponsor and includes a diverse range of consumers. Ensure this is linked to the organisation's governance structure
- Interviewing consumers who regularly take part in committees and working groups and find out whether they feel their voice is being heard
- Talking to the workforce involved in strategic planning, service design and monitoring safety and quality improvement to find out how they engage consumers.

Examples of evidence

- Policy documents that describe the process for involving consumers in partnerships to design, measure and evaluate health care
- Descriptions of the roles and responsibilities of consumers in strategic, operational and service planning partnerships
- Membership of groups tasked with steering design and redesign projects, including consumers who are representative of the patient population
- Committee and meeting records that show consumer involvement in activities relating to governance, design, measurement and evaluation of care provided by the ambulance health service
- Feedback from consumers engaged in partnerships with the ambulance health service about their experience of their role
- Reports that detail consumer participation in activities to design, measure and evaluate care provided by the ambulance health service.

Action 2.12

The health service organisation provides orientation, support and education to consumers who are partnering in the governance, design, measurement and evaluation of the organisation.

Intent

Consumers partnering in organisational design and governance have the skills and knowledge they need to be able to contribute effectively.

Reflective questions

- What training and support are provided to consumers who are partnering in the governance, design, measurement and evaluation of the ambulance health service?
- How does the ambulance health service use feedback from consumers to evaluate and improve the effectiveness of the support provided?
- How does the ambulance health service include people who have specific literacy, cultural or communication requirements to ensure their voice is incorporated?

Strategies for improvement

Provide access to quality and effective training and support

The ambulance health service should provide training and support for consumers involved in the organisation's governance process, and those who take part in design, measurement or evaluation activities. This gives people the best opportunity to contribute meaningfully and effectively to the organisation. Training can be provided face to face, through take-home resources or through online portals, and may include:

- Work health and safety training
- Orientation to the ambulance health service
- Orientation to health service decision making processes for consumers
- Meeting procedures
- Communication skills.

Consumers on such committees should:

- Be given the committee terms of reference
- Be provided with an explanation of expectations and their responsibilities
- Be included in opportunities to co-design and evaluate programs or activities
- Sign confidentiality agreements
- Preferably be remunerated for their time.

A key member of the workforce should meet with consumer representatives regularly to:

- maintain the consumer's engagement
- identify additional information required to support the consumer in their role
- identify skills the consumer would like to develop as part of their role.

Examples of evidence

- Policy documents that describe the orientation and ongoing training provided to consumers who have formed partnerships with the ambulance health service
- Training documents about partnering with organisations and records of attendance at training events by consumer representatives
- Feedback from consumer representatives on their experience of orientation, support and education for involvement in governance, design, measurement and evaluation.

Action 2.13

The health service organisation works in partnership with Aboriginal and Torres Strait Islander communities to meet their healthcare needs.

Intent

Aboriginal and Torres Strait Islander peoples receive health care that meets their needs.

Reflective questions

- Does the ambulance health service have a framework to support partnerships with Aboriginal and Torres Strait Islander peoples?
- How does the ambulance health service ensure its approach to supporting partnerships with Aboriginal and Torres Strait Islander peoples is culturally appropriate and effective?

Strategies for improvement

The intent of this action is to build effective and ongoing relationships with Aboriginal and Torres Strait Islander communities, organisations and groups that represent this population. This will enable the ambulance health service to identify priorities, understand cultural beliefs and practices, and involve Aboriginal and Torres Strait Islander peoples in determining their own health priorities.

Establish partnerships with Aboriginal and Torres Strait Islander groups, services and organisations

The ambulance health service should develop a framework and associated principles that determine agreed structures, mechanisms and responsibilities of partnerships. The structures and mechanisms of partnerships and the responsibilities of all partners involved should focus on supporting ongoing, sustainable and mutually beneficial relationships and effective communication. Approaches will differ depending upon the location and scope of the ambulance health service but might include:

- Building long-term relationships with Aboriginal and Torres Strait Islander and consumer organisations
- The involvement of Aboriginal and Torres Strait Islander peoples on boards or advisory committees involved in the design and evaluation of health care
- Employing Aboriginal and Torres Strait Islander peoples in positions such as Aboriginal health workers, liaison officers or education and training officers
- Partnering with Aboriginal and Torres Strait Islander organisations and agencies
- Policies or processes that aid access to culturally appropriate and safe health care for Aboriginal and Torres Strait Islander peoples
- Ensuring that resources are culturally safe and designed with input from Aboriginal and Torres Strait Islander communities.

Review resources for Aboriginal and Torres Strait Islander peoples

It is estimated that there are over 120 Aboriginal and Torres Strait Islander language groups across Australia. These consumers may face difficulties in understanding information provided by the organisation because of poor general and individual health literacy.18 Strategies to address this include:

- Understanding the range of languages spoken by the patient population
- Engaging with members of Aboriginal and Torres Strait Islander communities to review resources
- Providing language services or translate written materials
- Seeking endorsement from the Aboriginal and Torres Strait Islander workforce or partner organisations for resources to ensure they are culturally safe and appropriate.

Create a culturally safe environment for Aboriginal and Torres Strait Islander peoples

Bringing together the cultures of a health service organisation and its Aboriginal and Torres Strait Islander communities can improve access to health care for Aboriginal and Torres Strait Islander peoples. Strategies may include:

- Providing cultural safety training
- Participating in and acknowledging major cultural events such as National Aborigines and Islanders Day Observance Committee (NAIDOC) week and Reconciliation Day
- Allocating a safe space within the health service that can be used for the spiritual and cultural needs of Aboriginal and Torres Strait Islander patients, their families and communities.

Further strategies are available in **NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health**.[18]

Promote a holistic model of health and wellbeing

Aboriginal and Torres Strait Islander peoples have a holistic view of health that is not adequately met by the biomedical model of health care.18 Providing flexibility in health service delivery and the patient journey can improve the safety and quality of care provided to Aboriginal and Torres Strait Islander peoples.

Ambulance health services should implement processes that support transitions of care for Aboriginal and Torres Strait Islander peoples and foster a culture of continual improvement in Aboriginal and Torres Strait Islander health. This may include collaboration with integrated health care services and alternate care pathway planning.

Examples of evidence

- Policy documents that describe the ambulance health service's approach to providing culturally appropriate and safe care for Aboriginal and Torres Strait Islander peoples
- Membership of committees and working groups that include representatives from the Aboriginal and Torres Strait Islander communities
- Committee and meeting records that include involvement of Aboriginal and Torres Strait Islander peoples in governance, design, measurement and evaluation activities
- Memorandums of understanding, or similar formal agreements with Aboriginal and Torres Strait Islander communities, on strategies to address the healthcare needs of Aboriginal and Torres Strait Islander peoples and communities.

Action 2.14

The health service organisation works in partnership with consumers to incorporate their views and experiences into training and education for the workforce.

Intent

The workforce has an understanding of health care from the consumer's perspective and the value that consumers can bring to organisational design and governance.

Reflective questions

- How does the ambulance health service involve consumers in the design, delivery and evaluation of workforce training and education?

Strategies for improvement

Develop or adapt policies or processes on workforce orientation, training and education to include consumer involvement. Consider the current processes for training and identify whether they can be modified to address this action.

Strategies to involve consumers in the development of training could include:

- Involving consumers in the development or review of training materials and resources
- Seeking consumers' input on resources and workforce training in person-centred care and partnerships
- Approaching community groups or consumer organisations to provide feedback or input into the development of training materials and resources
- Inviting consumers or consumer organisations to speak to members of the workforce
- Including patient stories in training to provide a unique perspective of the consumer experience of the ambulance health service
- Seeking feedback about consumers' experiences through the complaints management system, consumer feedback survey or patient experience surveys
- Ensuring the consumer feedback and complaints are discussed in training programs for the workforce
- Reviewing workforce mandatory orientation, training and education programs to assess the level of consumer involvement.

Examples of evidence

- Project plans that describe the involvement of consumers in the development of training curriculums and materials
- Training documents and materials that incorporate consumers' views and experiences
- Reports on patient experience feedback surveys and complaints management provided to the workforce
- Records of training or presentations provided to the workforce by consumers
- Feedback from consumers that have participated in the delivery of training and education to the workforce.

Preventing and Controlling Infections Standard

Leaders of a health service organisation develop, implement and monitor systems to prevent, manage, and control infections and antimicrobial resistance; reduce harm for patients, consumers and members of the workforce; and achieve good health outcomes for patients. The workforce uses these systems to minimise and manage risks to patients and consumers

This Standard supersedes the 2017 Preventing and Controlling Healthcare-Associated Infection Standard. It was revised to accommodate lessons learned from the response to SARS-CoV-2 (COVID-19) and to better support health service organisations to prevent, control and respond to infections that cause outbreaks, epidemics or pandemics including novel and emerging infections.

Strategies to reduce risks of infection, including design and cleaning regimens, will be tailored to the setting using the best available evidence.

Intention of this standard

To:

- reduce the risk to patients, members of the workforce and consumers of acquiring preventable infections
- effectively manage infections, if they occur
- prevent and contain antimicrobial resistance
- promote appropriate prescribing and use of antimicrobials as part of antimicrobial stewardship
- promote appropriate and sustainable use of infection prevention and control resources.

The actions within the NSQHS Standards use the word **'facility'**.

For the purposes of this Guide, 'facility' is used in the context of the out of hospital setting which could include temporary workspaces in public settings, a 'mode' of transport, clinic location or other location where patient assessment or clinical care occurs.

Strategies to reduce risks of infection, including design and cleaning regimens, will be tailored to the setting using the best available evidence.

Criteria

Clinical governance and quality improvement systems are in place to prevent and control infections, and support antimicrobial stewardship and sustainable use of infection prevention and control resources

Systems are in place to support and promote prevention and control of infections, improve antimicrobial stewardship and support appropriate, safe and sustainable use of infection prevention and control resources in the ambulance health service.

Infection prevention and control systems

Evidence-based systems are used to mitigate the risk of infection. These systems account for individual risk factors for infection, as well as the risks associated with the clinical intervention and the clinical setting in which care is provided. A precautionary approach is warranted when evidence is emerging or rapidly evolving.

Patients, consumers and members of the workforce with suspected or confirmed infections are identified promptly, and appropriate action is taken. This includes persons with risk factors for transmitting or acquiring infection or colonisation with an organism of local, national or global significance.

Reprocessing of reusable equipment and devices

Reprocessing of reusable equipment and devices meets current best practice and is consistent with current national standards.

Reusable devices are defined as a **medical device** that is designated by its manufacturer as suitable for reprocessing and reuse.

This criterion includes cleaning, disinfection and sterilisation of reusable equipment and devices used in the ambulance health service. These actions are not applicable where single-use items are in use for critical and semi-critical equipment, instruments and devices.

Reprocessing of reusable devices and equipment should be consistent with the current edition of the **Australian Guidelines for the Prevention and Control of Infection in Healthcare** and meet current relevant national and international standards in conjunction with manufacturers' guidelines.

Antimicrobial stewardship

The ambulance health service implements systems for the safe and appropriate prescribing and use of antimicrobials as part of an antimicrobial stewardship program.

Implementation of antimicrobial stewardship actions will depend upon the scope and complexity of the ambulance health service, the care or treatment it provides, the risks associated with the population it serves, and national, state or territory requirements.

Services may have a range of health professionals working with differing scopes of clinical practice. Some may be prescribing in the more traditional way where all antimicrobial stewardship actions will apply. Other members of the workforce may be dispensing or administering under limited approved standing orders in line with local, or national clinical and therapeutic guidelines. In these circumstances, antimicrobial stewardship is regulated and monitored through locally endorsed clinical governance and safety and quality systems.

Ambulance health services can apply to register actions 'not applicable' where evidence is provided that the service does not administer or prescribe antimicrobials. See **Advisory AS23/02: Advice on not applicable actions for Ambulance Health Services**.

Clinical governance and quality improvement systems are in place to prevent and control infections, and support antimicrobial stewardship and sustainable use of infection prevention and control resources

Systems are in place to support and promote prevention and control of infections, improve antimicrobial stewardship and support appropriate, safe and sustainable use of infection prevention and control resources in the ambulance health service.

This criterion requires organisation-wide governance, leadership and commitment to prevent and control infections and support antimicrobial stewardship. The principles of clinical governance apply regardless of the setting, but the management structure associated with infection prevention and control will differ with the size and structure of the ambulance health service, its context, and the nature and complexity of services delivered.

To meet this criterion, ambulance health services are required to:

- Apply safety and quality systems to prevent and control infections, and support antimicrobial stewardship
- Use quality improvement systems to monitor, review and improve the systems to prevent and control infections and to support antimicrobial stewardship
- Apply principles of partnering with consumers when designing and implementing systems to prevent and control infections and support antimicrobial stewardship.

The governance framework and risk management principles for preventing and controlling infections are outlined in the **Australian Guidelines for the Prevention and Control of Infection in Healthcare**.[139]

This criterion aligns closely with the **Clinical Governance Standard** and the **Partnering with Consumers Standard**.

Integrating clinical governance

Action 3.01

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

a. **Implementing policies and procedures for infection prevention and control**
b. **Identifying and managing risks associated with infections**
c. **Implementing policies and procedures for antimicrobial stewardship**
d. **Identifying and managing antimicrobial stewardship risks.**

Intent

Safety and quality systems support and promote prevention and control of infections, improve antimicrobial stewardship and support appropriate, safe and sustainable use of infection prevention and control resources.

Reflective questions

- How do the ambulance health service's safety and quality systems:
  - Support implementation, monitoring and evaluation of an infection control program?
  - identify and manage risks associated with infections using the hierarchy of controls?
  - identify and manage risks associated with antimicrobial stewardship?
- How does the governing body of the ambulance health service determine an appropriate level of surveillance?
- How does the ambulance health service monitor its responsiveness to risks?

Strategies for improvement

Implement policies and procedures

Establish systems for the development, implementation and evaluation of current best-practice policies, procedures, protocols and guidelines describing:

- Standard and transmission-based precautions
- Implementation, monitoring and evaluation of an infection control program
- Prevention and management of occupational hazards
- Maintenance, repairs, refurbishment and upgrade of infrastructure, vehicles, equipment, fixtures and fittings
- Decontamination of clinical areas including temporary workspaces
- Contributing to surveillance where state and territory systems are in operation such as the **NSW Public Health Rapid, Emergency, Disease and Syndromic Surveillance (PHREDSS) system**

- Responding to and managing outbreaks of infection or communicable disease, including having an outbreak management plan that:
  - includes notification to the local Public Health Unit and contributes to contract tracing where required
  - includes requirements for documentation at transitions of care to enable receiving services to notify relevant departments such as the Infection Control Unit
  - advises about exclusion periods for attending health services for treatment or work if applied to the workforce
  - addresses workforce occupational risk
  - includes requirements for product procurement, management and evaluation of existing and new products, equipment and devices
- Monitoring compliance with policies, procedures and protocols and seeking feedback from the workforce
- Providing training to the workforce and seeking feedback to identify ongoing education requirements.

Manage risks

The ambulance health service should establish safety and quality systems for the risk management of infections and antimicrobial stewardship. It should also:

- Develop processes to manage risks including organisational, clinical, workplace and workforce risks
- Develop processes to manage risks for the populations served by the ambulance health service
- Use established risk management systems using the hierarchy of controls (see **Action 1.10**) to identify, monitor, manage and review risks associated with preventing and controlling infections
- Use information from measurement and quality improvement systems, adverse events, clinical outcomes and patient experiences to inform the risk management system
- Seek feedback from the workforce and patients on the risk management of infections and antimicrobial stewardship systems
- Report risks related to infections and antimicrobial stewardship to the workforce.

Identify training requirements

- The ambulance health service should establish systems to provide infection prevention and control training to the workforce, as well as:
- Setting priorities for ongoing training and education based upon emerging risks identified from the patient safety systems
- Evaluating orientation, training and education provided to the workforce.

Examples of evidence

- Infection prevention and control program
- Risk assessments and risk management plans
- Surveillance and reporting systems to monitor infection and antimicrobial stewardship
- Incident management system reports and actions to reduce risks and improve processes
- Minutes of meetings where safety and quality systems were discussed
- Attendance records and evaluation reports on training for the workforce
- Audit reports
- Reports of the ambulance health service's performance on infection prevention and control and antimicrobial stewardship activities published in the annual report and other resources
- Examples of quality assurance or other projects that demonstrate the ambulance health service's performance on infection prevention and control and antimicrobial stewardship activities.

Action 3.02

The health service organisation:

a. **Establishes multidisciplinary teams to identify and manage risks associated with infections using the hierarchy of controls in conjunction with infection prevention and control systems**
b. **Identifies requirements for and provides the workforce with access to training to prevent and control infections**
c. **Has processes to ensure the workforce has the capacity, skills and access to equipment to implement systems to prevent and control infections**
d. **Establishes multidisciplinary teams, or processes, to promote effective antimicrobial stewardship**
e. **Identifies requirements for and provides access to training to support the workforce to conduct antimicrobial stewardship activities**
f. **Has processes to ensure the workforce has the capacity and skills to implement antimicrobial stewardship**
g. **Plans for public health and pandemic risks**

Intent

Safety and quality systems support and promote prevention and control of infections, improve antimicrobial stewardship, and support appropriate, safe and sustainable use of infection prevention and control resources in the ambulance health service.

Reflective questions

- How does the ambulance health service apply the hierarchy of controls to identify and manage risks associated with infections?
- How does the ambulance health service evaluate the effectiveness of the infection control program?
- How does the ambulance health service prepare the organisation and its workforce for public health and pandemic risks?
- How does the ambulance health service identify training requirements to prevent and control infections, and improve antimicrobial stewardship?
- How does the ambulance health service ensure that the workforce has the capacity and skills and equipment to implement systems to prevent and control infections and implement antimicrobial stewardship?

Strategies for improvement

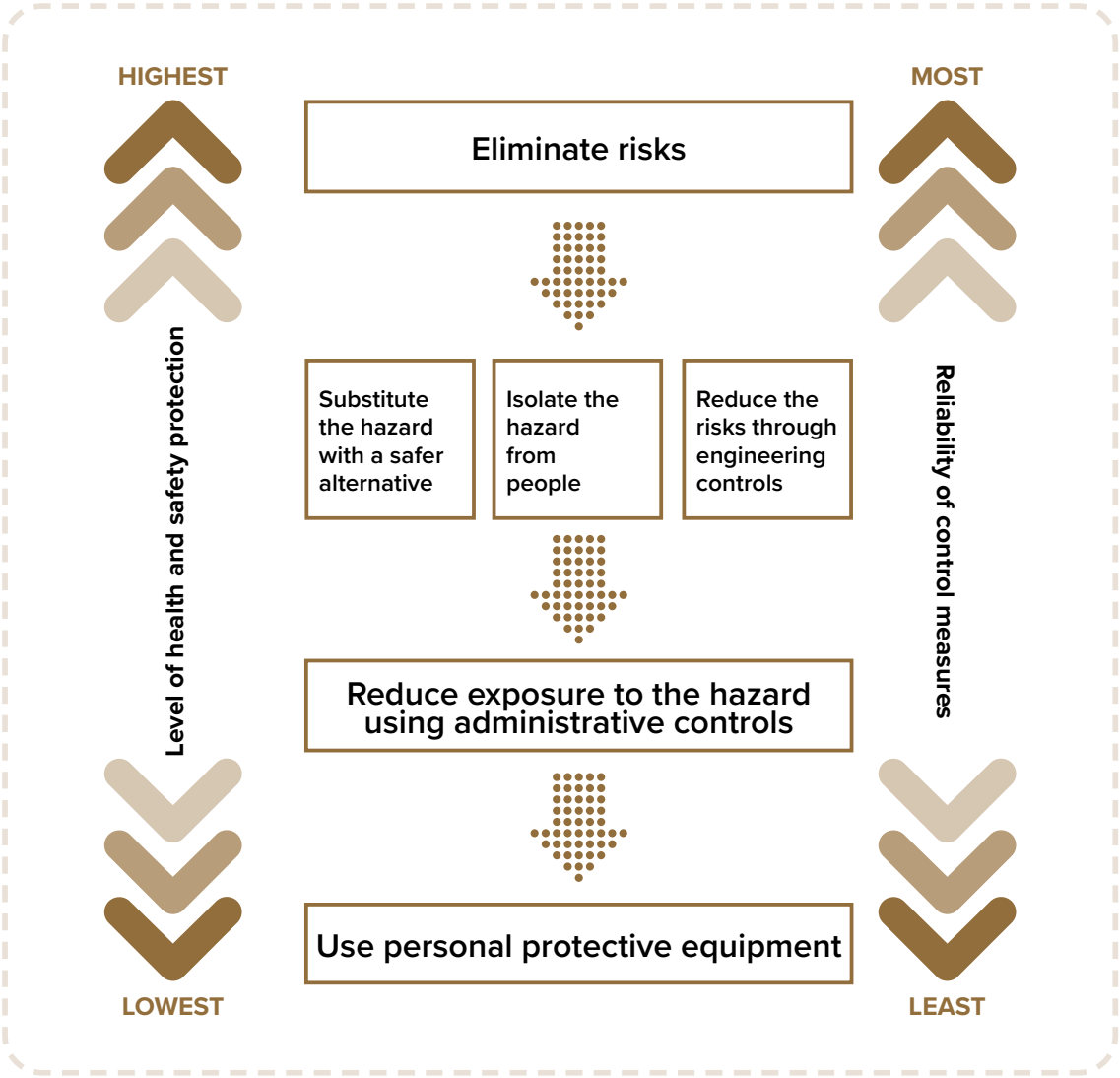
Hierarchy of controls

The 'hierarchy of controls' is a model used in work health and safety risk management. It is a step-by-step approach to controlling hazards that ranks controls from most reliable to least reliable (see Figure 3 below).

The hierarchy of controls, used in conjunction with infection prevention and control systems, supports the design of health service organisation infection prevention and control programs.

If it is not reasonably practical to eliminate risks, then risks must be minimised as far as is reasonably practicable by using one or a combination of substitution, isolation or engineering controls. Administrative controls and personal protective equipment (PPE) should then be considered.

Figure 3: Hierarchy of Controls[140]



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Examples of controls for each element of the hierarchy of controls include:

- Eliminating risks where possible
- Substituting the hazard with a safer alternative, such as using:
  - spacers to administer aerosolised medication instead of nebulisers[139]
  - environmental adjustments
  - particulate filter respirators (P2/N95 respirators) for endotracheal intubation.[141]
- Conducting a ventilation assessment[139]
- Isolating people from the hazard, including the use of physical barriers between treatment areas and drivers where physical distancing is difficult to maintain
- Reducing the risk through engineering controls, such as reviewing and optimising ventilation including:
  - air exchange rates

  - air flow and air filtration systems
  - temperature and ambient humidity
- Using a multidisciplinary approach to sourcing and selection of Therapeutic Goods Administration (TGA) approved equipment and products that are fit for purpose in operational settings
- Reducing exposure to the hazard using administrative controls, including:
  - promoting and supporting non-attendance at work by staff when unwell
  - separating key groups of staff to minimise the risk of transmission, i.e. separating operations centre and clinical members of the workforce
- Selection and use of PPE, including effective education and communication on appropriate PPE use for standard and transmission-based precautions
- Development of best practices for disinfecting and cleaning the facility environment (vehicle and or equipment) both during and following an episode of patient care.[142]

As with managing risks within any complex system, successful infection prevention and control requires the involvement of a range of experts and multiple, integrated strategies across all levels of the healthcare system. These strategies should include:

- Sound and integrated corporate and clinical governance
- Risk identification and practical management
- Surveillance to identify areas for action and quality improvement activities, such as auditing of compliance with hand hygiene, PPE use and aseptic technique requirements and environmental cleaning performance. For some organisations this may include reviewing surveillance data from local public health units relating to community acquired infections
- Safe and appropriate prescribing and use of antimicrobial agents guided by antimicrobial stewardship and consumer engagement
- Safe and appropriate application of standard and transmission-based precautions, including patient placement and the use of PPE.

Identify training requirements

The ambulance health service should assess the competency and training needs of the workforce in line with the requirements of **Actions 1.19–1.21**. It should also:

- Perform a risk assessment to set priorities and inform the training schedule for members of the workforce who require training
- Develop or provide access to training and education resources to meet the needs of the workforce regarding infection prevention and control activities and antimicrobial prescribing
- Seek feedback from the workforce and consumers on the training program and use feedback to evaluate, identify gaps and improve the program
- When appropriate, use a competency-based assessment process that is aligned with the organisation's policies, procedures and protocols for standard and transmission-based precautions
- Link training to incident management and investigation systems
- Use incident management and investigation systems to inform risk management, and the planning and implementation of quality improvement processes to mitigate risks
- Review the ambulance health service's induction, orientation and ongoing training and education programs to ensure that they include relevant information, tools and instructions on infection prevention and control policies and procedures for new and existing employees and contractors
- Use the systems set up for performance management (see **Action 1.22**) to review or introduce an appraisal process for the workforce that incorporates:
  - understanding and use of relevant policies, procedures and protocols relating to infection risks in the workplace
  - education, training or competency-based assessment for processes with high infection risks
  - use and analysis of data from incident management and investigation systems for infection prevention.

Examples of evidence

- An infection control program that incorporates the hierarchy of controls to manage risks associated with infections
- Observation of the workforce applying the hierarchy of controls
- Evidence the workforce has been involved in planning and participating in local outbreak and pandemic planning scenarios
- Evidence of the assessment of workforce needs for training and education in relation to infection prevention and control systems and antimicrobial stewardship
- Evidence of workforce participation in training programs
- Evidence that multidisciplinary approaches have been used for sourcing and review of TGA approved products and equipment, such as alcohol hand rub, gowns and masks
- Training calendars and curriculums
- Reports on evaluation of the training programs
- Minutes from meetings where systems for implementing and evaluating the hierarchy of controls were discussed.

Applying quality improvement systems

Action 3.03

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

a. **Monitoring the performance of infection prevention and control systems**
b. **Implementing strategies to improve infection prevention and control systems**
c. **Reporting to the governance body, the workforce, patients and other relevant groups on the performance of infection prevention and control systems**
d. **Monitoring the effectiveness of the antimicrobial stewardship program**
e. **Implementing strategies to improve antimicrobial stewardship outcomes**
f. **Reporting to the governance body, the workforce, patients and other relevant groups on antimicrobial stewardship outcomes**
g. **Supporting and monitoring the safe and sustainable use of infection prevention and control resources**

Intent

Safety and quality systems support and promote prevention and control of infections, improve antimicrobial stewardship, and support appropriate, safe and sustainable use of infection prevention and control resources in the ambulance health service.

Reflective questions

- How are the ambulance health services' systems for prevention and control of infections continuously evaluated and improved?
- How does the ambulance health service use data to identify areas for improvement and implement change?
- How does the ambulance health service support the workforce to ensure infection prevention and control resources are used safely and sustainably?
- If the ambulance health service has an antimicrobial stewardship program, how is it continuously evaluated and improved?

Strategies for improvement

Refer to the **Clinical Governance Standard** and the specific actions (see **Actions 1.08**, **1.09** and **1.11**) to inform the development of a safety and quality system to support infection prevention and control.

Develop a safety and quality system to support infection prevention and control

The ambulance health service should use the incident management and investigation system to identify and improve safety and quality activities for infection prevention and control. It can also:

- Measure performance and identify opportunities for preventing infection and reducing harm from infection
- Evaluate and report on the antimicrobial stewardship program and use the available data to inform prescribing practice and the use of antimicrobials
- Implement systems to evaluate compliance with policies, procedures and protocols relating to infection prevention and control and antimicrobial stewardship
- Contribute to surveillance systems (where available) and report on infection prevention and control processes to the organisation's leadership, workforce, consumers and (when appropriate) other health service organisations
- Seek feedback from consumers and the workforce on the safety and quality systems
- Engage with consumers to review the performance of safety and quality activities related to infection prevention and control. This could be achieved through a range of consumer engagement activities and membership of working groups
- Communicate the outcomes of infection prevention and control quality improvement activities in newsletters and publications.

Implement quality improvement strategies

The ambulance health service should use the results of monitoring activities to show improvements or areas where improvement is required. The service should also:

- Use the results of the organisational risk assessment to identify gaps, plan and set priorities for areas for investigation or action
- Identify where the organisation is performing well, including where infection risks have been minimised or eliminated
- Identify what strategies worked well and can be employed elsewhere in the organisation
- Monitor the prevalence of infections via agreed monitoring systems. This may include reviewing information from the national, state or territory department of health, local public health unit or via surveillance programs led by acute facilities.

Report outcomes

Communicate performance and articulate priorities for investigation and action to the governing body, the workforce, patients and other relevant groups.

Examples of evidence

- A safety and quality system for the monitoring, reporting and implementation of quality improvement strategies for infections and antimicrobial stewardship
- Policies on the safe and sustainable use of infection prevention and control resources
- Procurement processes that assess for the safe and sustainable use of infection prevention and control resources
- Monitoring and surveillance processes and outcomes measures used for infection prevention and control
- Ongoing quality improvement plan that is informed by the results of monitoring and surveillance for infection prevention and control
- Reports reviewing data from existing monitoring systems
- Evidence of infection surveillance programs in place
- Evidence of antimicrobial prescribing and use[143]
- Documentation demonstrating the implementation of the **National Hand Hygiene Initiative**[144]
- Evidence of incident management systems and their effectiveness
- Patient reported outcomes measures (where available)
- Evidence of contributions to the **National Notifiable Diseases Surveillance System**

- Quality improvement data and reports on infection prevention and control performance measures and improvement strategies for identified risks
- Audit results of workforce compliance with policies, procedures and protocols for infection prevention and control, antimicrobial stewardship (where applicable) and hand hygiene audits
- Reports to the governing body, the workforce, patients and other relevant groups on the performance of infection prevention and control systems and antimicrobial stewardship outcomes
- Reports of the ambulance health service's performance on infection prevention and control and antimicrobial stewardship activities published in the annual report and other resources
- Feedback from the workforce and consumers on the safety and quality systems
- Communication with the workforce and consumers on the effectiveness and outcomes of the infection prevention and control system
- Communication with other healthcare organisations that provide care to the same patient population on the effectiveness and outcomes of the infection prevention and control system used at transitions of care.

Partnering with consumers

Action 3.04

Clinicians use organisational processes consistent with the Partnering with Consumers Standard when assessing risks and preventing and managing infections, and implementing the antimicrobial stewardship program to:

a. Actively involve patients in their own care

b. Meet the patient's information needs

c. Share decision making

Intent

Clinicians partner with consumers to support and promote prevention and control of infections, improve antimicrobial stewardship, and support appropriate, safe and sustainable use of infection prevention and control resources in the ambulance health service.

Reflective questions

- How does the ambulance health service use the processes for partnering with consumers to involve patients in planning and decision-making about infection prevention and control?
- How does the ambulance health service communicate the quality use of antimicrobials to patients?

Strategies for improvement

The **Partnering with Consumers Standard** has specific actions (**Actions 2.03 - 2.10**) related to processes for involving patients in their own care, shared decision making, informed consent and effective communication.

The strategies included in the **Partnering with Consumers Standard** can be used to inform the implementation of actions for managing infection prevention and control.

The ambulance health service should identify opportunities to support clinicians to engage with patients in shared decision making activities to reduce or manage the risk of infections.

The service should also:

- Identify and evaluate resources to inform patients about infection prevention and control
- Provide information tailored to meet the needs of the diversity and health literacy of the patient population (including electronically)
- Support patients to make informed choices about their medicines or treatment plans for antimicrobials
- Evaluate feedback from consumers about infection prevention and control resources.

Action 4.11 includes specific strategies for providing information to patients about their individual medicines needs and risks.

Examples of evidence

- Policy documents about partnering with consumers on infection prevention and control
- Observations of the workforce using processes for partnering with consumers when discussing infection prevention and control
- Evaluation and feedback from the workforce on the processes for partnering with consumers
- Examples of resources available to support patient's decision making about infection prevention and control strategies
- Feedback from consumers about the strategies implemented to prevent and control infections
- Evidence of consumer engagement in the ambulance health service's infection prevention and control program.

Surveillance

Action 3.05

The health service organisation has a surveillance strategy for infections, infection risk and antimicrobial use and prescribing that:

a. **Incorporates national and jurisdictional information in a timely manner**
b. **Collects data on healthcare-associated and other infections relevant to the size and scope of the organisation**
c. **Monitors, assesses and uses surveillance data to reduce the risks associated with infections**
d. **Reports surveillance data on infections to the workforce, the governing body, consumers and other relevant groups**
e. **Collects data on the volume and appropriateness of antimicrobial use relevant to the size and scope of the organisation**
f. **Monitors, assesses and uses surveillance data to support appropriate antimicrobial prescribing**
g. **Monitors responsiveness to risks identified through surveillance**
h. **Reports surveillance data on the volume and appropriateness of antimicrobial use to the workforce, the governing body, consumers and other relevant groups.**

Intent

Surveillance activities provide data to support prevention and control of infections, improve antimicrobial stewardship and support appropriate, safe and sustainable use of infection prevention and control resources in the ambulance health service.

Reflective questions

- How does the ambulance health service collect surveillance data on infections and antimicrobial use?
- How does the ambulance health service use data to monitor, assess and reduce risks relating to infections?
- What systems are in place in the ambulance health service to ensure national and jurisdictional information relevant to the **Preventing and Controlling Infections Standard** are incorporated in a timely manner?
- How does the ambulance health service report this information to the workforce, the governing body, consumers and other relevant groups?

Strategies for improvement

Develop and implement surveillance strategies endorsed by the governing body

Surveillance activities will be determined by the complexity of the ambulance health service, the care or treatment it provides, the risks associated with the population it serves and national, state or territory requirements. In the out of hospital environment this may include contribution to syndromic surveillance systems.[145, 146]

Ambulance health services should use information from the organisational risk management system to determine the appropriate surveillance activities for the size and scope of the service. Note, surveillance activities may focus on monitoring process measures and/or infection outcome measures.

The ambulance health service should use surveillance strategies to support infection prevention and control activities, identify gaps and set priorities for action to minimise the risk of infections. This can be supported by:

- Auditing infection prevention and control processes
- Auditing compliance with infection prevention and control policies
- Using the results of surveillance activities to inform the risk management process
- Implementing and evaluating training on surveillance strategies for the workforce
- Providing reports of surveillance strategies to the organisation's governing body, workforce and consumers
- Participating in local, state based or other national surveillance activities such as:
  - monitoring reported notifiable diseases
  - surveillance through audit of compliance with infection prevention and control policies and processes
  - contributing to syndromic surveillance
  - identification of breakdowns in infection prevention and control processes
  - compliance with established outbreak management processes
  - reviewing antimicrobial prescribing for consistency with the **Therapeutic Guidelines—Antibiotic eTG**[147]
  - participating in national surveillance activities relating to antimicrobial stewardship, including the relevant surveys, as appropriate
  - monitoring the prevalence of infections through local incident management systems, or with input from the local public health unit, or feedback from infection surveillance programs led by acute facilities
- Establishing systems to receive relevant surveillance data from facilities that patients are transported to or from
- Auditing compliance of antimicrobials with the current **Therapeutic Guidelines - Antibiotic eTG**[147]
- Reviewing and adapting (where appropriate) the **National infection surveillance definitions**[148] for local use
- Establishing linkages with external organisations to provide support and an integrated approach to infection prevention and control.

Examples of evidence

- Policies for infection prevention and control processes
- Surveillance strategies for infections, infection prevention and control processes that are appropriate for the identified risks and complexity for the care and treatment provided by the ambulance health service
- Audit reports of infection prevention and control processes
- Reports of surveillance activities for infections that are provided to the workforce, governing body, consumers and other relevant groups
- Processes for results from surveillance activities to inform risk management strategies, quality improvement action plans and review of policies
- Evidence of national and state or territory information relevant to this Standard having been incorporated and applied by the ambulance health service
- Meeting records in which surveillance data on infections are reported and discussed
- Review of data from existing monitoring systems (where available), such as the **National Hand Hygiene Initiative**,[144] incident management systems, patient reported outcomes and the **National Notifiable Diseases Surveillance System**
- Monitoring and surveillance of infection prevention and control processes (e.g., hand hygiene, environmental cleaning audits), infection outcomes and antimicrobial prescribing and use
- Workforce training records and evaluation reports.

Infection prevention and control systems

Evidence-based systems are used to mitigate the risk of infection. These systems account for individual risk factors for infection, as well as the risks associated with the clinical intervention and the clinical setting in which care is provided. A precautionary approach is warranted when evidence is emerging or rapidly evolving.

Ambulance health services should have systems in place to ensure patients, consumers and members of the workforce with suspected or confirmed infection are identified promptly and appropriate action is taken. This includes persons with risk factors for transmitting or acquiring infection or colonisation with an organism of local, national or global significance.

Infection prevention and control is an important health and safety issue. All people working in the ambulance health service are responsible for providing a safe environment for consumers and the workforce. Provision of clinical care should occur in a setting that is well-maintained and configured to provide ergonomically safe systems that can reduce the risks of infection and cross contamination to patients and members of the workforce.[149]

Vehicles used in out of hospital settings have been found to have high numbers of potentially harmful bacteria which:

- Can contribute to the transmission of healthcare acquired infections
- May increase risks to consumers and the workforce[150]
- Contribute to the spread of antibiotic-resistant bacteria in out of hospital care settings.[151]

Two-tiered approach to preventing the transmission of infectious agents

Successful infection prevention and control measures involve implementing work practices that prevent the transmission of infectious agents using a two-tiered approach:

- Standard precautions
- Transmission-based precautions.

Standard precautions

Standard precautions are basic infection prevention and control strategies that apply to everyone, regardless of their perceived or confirmed infectious status. Strategies include hand hygiene, personal protective equipment, cleaning, and appropriate handling and disposal of sharps.

These strategies are a first-line approach to infection prevention and control in ambulance health services and are routinely applied as an essential strategy for minimising the spread of infections.

Standard precautions minimise the risk of transmission of infectious agents from one person or place to another, even in high-risk situations, and render and maintain objects and areas as free as possible from infectious agents. Standard precautions include:

- Hand hygiene
- Use of personal protective equipment (masks, gloves, gowns, protective eyewear) to prevent blood or body fluid exposure
- Routine environmental cleaning, including vehicles, harnesses, stretchers and other patient equipment
- 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.

Transmission-based precautions

Transmission-based precautions are specific interventions to interrupt the mode of transmission of infectious agents. They are used to control infection risk with patients who are suspected or confirmed to be colonised or infected with agents transmitted by contact, droplet or airborne routes.

Transmission-based precautions are recommended as extra work practices in situations when standard precautions alone may be insufficient to prevent transmission. Transmission-based precautions are also used during outbreaks to help contain the outbreak and prevent further infection. Transmission-based precautions should be tailored to the infectious agent involved and its mode of transmission and may involve a combination of practices. Transmission-based precautions include:

- Droplet, contact and airborne precautions
- A combination of these precautions based on the route of transmission of infection

For further information on implementing systems for standard and transmission-based precautions, refer to Section 3 in the **Australian Guidelines for the Prevention and Control of Infection in Healthcare**.[139]

Standard and transmission-based precautions

Action 3.06

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

Intent

The risk of infection to patients, the workforce and visitors is minimised by the routine application of infection prevention and control strategies that include standard and transmission-based precautions.

Reflective questions

- How does the ambulance health service ensure that its standard and transmission-based precautions are consistent with the **Australian Guidelines for the Prevention and Control of Infection in Healthcare**?[139]
- How does the ambulance health service apply the **Australian Guidelines for the Prevention and Control of Infection in Healthcare**[139] in all environments where care is provided?

Strategies for improvement

Implement policies, procedures and protocols

The ambulance health service should ensure its policies, procedures and protocols can respond to areas in its service where there is the greatest risk of infection transmission. It should also:

- Ensure that the **Australian Guidelines for the Prevention and Control of Infection in Healthcare**[139] and relevant state or territory requirements are available and accessible to the workforce when reviewing practice, policy, procedures and protocols
- Evaluate the risk management systems, identify and set priorities for when, where and how compliance with standard and transmission-based precautions can be monitored, assessed and reviewed
- Where direct observation is not available, alternate strategies can be considered including:
  - auditing stock usage
  - review of documentation
  - consumer feedback
  - scenario-based training
  - seeking feedback from other stakeholder organisations
- Prioritise competency assessment for aseptic technique procedures that have been identified as high risk
- Review incident reports such as sharps injury, waste management, occupational exposures and environmental cleaning
- Review systems for intravascular device management and the use of sterile single use or reprocessed devices
- Evaluate protocols for wound management

- Establish processes for the procurement of equipment, vehicles, supplies and products to minimise the risk of infection transmission
- Provide orientation, training and education for the workforce on transmission-based precautions
- Develop or review **standard and transmission-based precautions signage**, on screen alert systems, information and reminder systems and resources to ensure consistency with the **Australian Guidelines for the Prevention and Control of Infection in Healthcare**.[139]

Examples of evidence

- Policy and guideline documents that are available to the workforce about standard and transmission-based precautions that are consistent with the current edition of the **Australian Guidelines for the Prevention and Control of Infection in Healthcare**[139]
- Integration of specific adjustments to clinical practice to reduce risk based on standard and transmission-based precautions
- Audit results of workforce compliance with standard and transmission-based precautions
- Training documents relating to standard and transmission-based precautions
- Examples of improvement activities that have been implemented and evaluated to reduce risks and improve compliance with standard and transmission-based precautions
- Committee and meeting records at which compliance standard and transmission-based precautions were discussed
- Observation of standardised practice consistent with the **Australian Guidelines for the Prevention and Control of Infection in Healthcare**.[139]

Action 3.07

The health service organisation has:

a. **Collaborative and consultative processes for the assessment and communication of infection risks to patients and the workforce**

b. **Infection prevention and control systems, in conjunction with the hierarchy of controls, in place to reduce transmission of infections so far as is reasonably practicable**

c. **Processes for the use, training, testing and fitting of personal protective equipment by the workforce**

d. **Processes to monitor and respond to changes in scientific and technical knowledge about infections, relevant national or jurisdictional guidance, policy and legislation**

e. **Processes to audit compliance with standard and transmission-based precautions**

f. **Processes to assess competence of the workforce in appropriate use of standard and transmission-based precautions**

g. **Processes to improve compliance with standard and transmission-based precautions.**

Intent

Infection risks are assessed, managed and monitored, using the hierarchy of controls in conjunction with infection prevention and control systems, and the workforce has the capacity to apply infection prevention and control practices.

Reflective questions

- How does the ambulance health service incorporate infection prevention and control systems, including the hierarchy of controls, to reduce transmission of infections?
- How does the ambulance health service use the **Communicating for Safety Standard** to develop collaborative and consultative processes to assess and communicate infection risks to patients and the workforce?
- How does the ambulance health service train the workforce in the appropriate use of personal protective equipment (PPE)?
- How does the ambulance health service ensure it keeps updated on evidence, policy or legislative changes relating to infectious diseases?

Strategies for improvement

The ambulance health service should develop a clinical governance framework that identifies the governing body's roles, responsibilities and accountabilities in relation to:

- the appropriate application of the hierarchy of controls
- procurement and evaluation of personal protective equipment for the workforce
- monitoring workforce compliance and effective use of standard and transmission-based precautions.

The ambulance health service should also:

- Establish infection prevention and control working groups or committees with responsibilities for oversight and reporting of infection prevention and control systems
- Develop infection prevention and control policies and procedures in line with current evidence and best practice protocols
- Audit and report on workforce compliance with policies and processes for standard and transmission-based precautions
- Establish and evaluate infection prevention and control orientation, training and education programs
- Audit and report on the use of infection alerts and flags documented in patient healthcare records at transitions of care
- Evaluate infection control signage such as **standard and transmission-based precautions posters**
- Establish the criteria for annual fit testing for members of the workforce
- Audit schedule and reports on workforce compliance with PPE
- Establish educational tools such as peer review or PPE 'buddy checklists'
- Review and report to the workforce and executive committees results from quality improvement systems to reduce infection risk
- Support the workforce to provide information about infection risks and the use of PPE with patients and their families
- Seek feedback from the workforce and consumers on infection prevention and control systems
- Collaborate with external services to provide expert advice regarding infection prevention and control initiatives.

Examples of evidence

- A Clinical Governance Framework that outlines the systems; roles, responsibilities and accountabilities; and reporting requirements for infection prevention and control
- Policies and protocols for infection prevention and control that document the ambulance health service's systems, including the hierarchy of controls to reduce transmission of infections
- Processes for orientation, training and education that provide the workforce with knowledge and skills to:
  - demonstrate compliance with the use of standard and transmission-based precautions
  - test and fit personal protective equipment
  - communicate infections risks
  - monitor and respond to changes in evidence, legislation or policies relating to infection prevention and control
- Audit reports on infection and control systems and outcomes
- Results from validated patient reported experience or outcome data sets
- Examples of quality improvement strategies regarding infection prevention and control systems that have been implemented and evaluated
- Meeting minutes where infection prevention and control systems were discussed
- Reports from the workforce on infection prevention and control systems
- Reports of consumer and carer experience surveys, and actions taken to manage issues identified with infection prevention and control systems
- Memorandum of understanding or similar formal agreements with external expert organisations to support infection prevention and control strategies.

Action 3.08

Members of the workforce apply standard precautions and transmission-based precautions whenever required, and consider:

a. **Patients' risks, which are evaluated at referral, on admission or on presentation for care, and re-evaluated during care**
b. **Whether a patient has a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance**
c. **Accommodation needs and patient placement to prevent and manage infection risks**
d. **The risks to the wellbeing of patients in isolation**
e. **Environmental control measures to reduce risk, including but not limited to heating, ventilation and water systems; work flow design; facility design; surface finishes**
f. **Precautions required when a patient is moved within the facility or between external services**
g. **The need for additional environmental cleaning or disinfection processes and resources**
h. **The type of procedure being performed**
i. **Equipment required for routine care.**

Intent

Exposure of patients or the workforce to infectious agents that cannot be contained by standard precautions alone is minimised. Risk is assessed at all access opportunities to the ambulance health service and necessary precautions are implemented and maintained for as long as necessary.

Reflective questions

- How does the ambulance health service support the workforce to apply standard and transmission-based precautions?
- How does the ambulance health service's workforce collaborate on assessing, managing and communicating infection risks during an episode of or at transitions of care?
- How are the **Partnering with Consumers** and **Comprehensive Care Standards** used to assess and support the wellbeing of patients in isolation during transportation?
- How does the ambulance health service manage infection risks of facilities and vehicles, and assess the level of environmental cleaning that is required?

Strategies for improvement

Identify strategies for the workforce to apply standard precautions and transmission-based precautions

The ambulance health service should develop policy documents about the assessment of infection risks and implementation of standard and transmission-based precautions to manage risks. It should also:

- Implement systems to monitor and report infectious agents of local, national or international significance that require standard and transmission-based precautions

- Audit and report on processes and workforce compliance with policies and processes for standard and transmission-based precautions
- Establish and evaluate orientation, training and education programs for standard and transmission-based precautions
- Seek feedback from the workforce and consumers on standard and transmission-based precautions
- Develop and evaluate resources for patients on standard and transmission-based precautions.

Consider environmental and patient risks and implement systems to reduce risks

The ambulance health service should review and assess the processes that will inform risk management strategies to minimise exposure of patients, the workforce and the organisation to infectious agents. This may include considering:

- How the risk of a communicable disease, or an existing or a pre-existing colonisation or infection with organisms of local or national significance, is assessed and communicated on presentation or transfer of care?
- The processes to reassess the risks when clinically indicated during care
- How infection risks are documented, managed and reported at transitions of care?
- The processes to inform the workforce or external services of a risk of exposure, transmission and infection
- How standard and transmission-based precautions are addressed and reviewed in contracts and service performance agreements with external providers of goods?

The ambulance health service should develop procedures and guidelines to support the wellbeing of patients during transportation in line with the **Partnering with Consumers** and **Comprehensive Care Standards**. It should also:

- Collaborate with external partners such as the local Public Health Unit to plan for the management of risks such as infections during a natural disaster or pandemic
- Develop strategies to respond to risks identified as part of a public health response or pandemic planning
- Include identified risks in the organisation's quality improvement program
- Implement schedules for cleaning and maintenance of vehicles and equipment
- Provide the workforce with access to the **Australian Guidelines for the Prevention and Control of Infection in Healthcare**.[139]

Examples of evidence

- Policy documents about the assessment of infection risks and implementation of standard and transmission-based precautions to manage the risks
- Procedures and guidelines for the use of standard and transmission-based precautions
- Surveillance data and reports from the organisation and other sources that have been gathered using national systems and definitions, if available, e.g., corporate, national, or state and territory surveillance reports
- Reports on infectious agents of local, national or international significance that require standard and transmission-based precautions
- Incident reports relating to transmission of infectious agents
- Infection flags documented in health care records provided at transitions of care, where known
- Consumer and workforce feedback on standard and transmission-based precautions
- Maintenance or service history and microbiology reports to identify appropriate monitoring of air-handling systems, water supply systems and other relevant equipment
- Data on locally approved cleaning and disinfection regimes and schedules
- Patient documentation that demonstrates assessment of infection risks and precautions to manage risks

- Committee and meeting records in which infection risks and precautions to manage them were discussed
- Audit results of the use of precautions for infection risks
- Training documents and records of workforce attendance relating to assessing infection risks and precautions to manage the risks
- Examples of activities that have been implemented and evaluated to improve assessment and management of infection risks
- Observation of physical and environmental controls for managing the risk of transmission of infectious agents
- Observation that relevant equipment, including personal protective equipment, is available to the workforce
- List of communicable diseases, or infectious agents of local, national and international significance that affect the ambulance health service, patients and the workforce
- Examples of communication with the workforce and patients about the risk of infectious agents and communicable diseases, and measures that can be used to reduce the risks.

Action 3.09

The health service organisation has processes to:

a. **Review data on and respond to infections in the community that may impact patients and the workforce**
b. **Communicate details of a patient's infectious status during an episode of care and at transitions of care**
c. **Provide relevant information to a patient, their family and carers about their infectious status, infection risks and precautions and their duration to minimise the spread of infection**

Intent

Local epidemiology of infections is considered, and a patient's known or suspected colonisation or infection risks are communicated to an admitting, transferring or referring facility to minimise exposure of patients, the workforce and visitors to infectious agents.

Reflective questions

- What processes exist to support the ambulance health service's workforce to access and interpret data on infections in the community and to be able to respond in a timely manner?
- How does the ambulance health service communicate the patient's infectious status when care is transferred?
- What measures does the ambulance health service use to ensure the appropriate handling of sensitive patient information related to infection status?
- Does the workforce know how to access factsheets on infectious diseases published by their state or territory health department?
- How does the ambulance health service monitor the effectiveness of its processes to maintain currency with the local epidemiology of infections?

Strategies for improvement

The strategies included in the **Communicating for Safety Standard** relate to processes for communication whenever responsibility of care is transferred

Implement processes to communicate infection risks

The ambulance health service should develop or review processes to communicate relevant information relating to a patient's infection status whenever responsibility for care is transferred.

The ambulance health service should implement systems to inform clinicians about infection risks and the requirements to minimise risks. Infection prevention and control risks may be documented in:

- Requests for transportation
- Referral documentation
- Patient health records
- Clinical handover reports

- Notification, alert or flag systems for infection status, and precautions required for current and future care and treatment
- Syndromic Surveillance Systems[146]
- State or territory surveillance systems such as the **NSW Public Health Rapid, Emergency, Disease and Syndromic Surveillance (PHREDSS) system**.

Formalised and agreed systems for communication and reporting between the ambulance health service and primary care providers and others involved in the patients care in the community are vital.

Ambulance health services should use resources, including posters and electronic means, to inform the workforce, patients and visitors of relevant infection risks, and infection prevention and control strategies to minimise risk to patients, carers and the workforce.

Examples of evidence

- Policy documents about communicating information about risks associated with a patient's infectious status when care is transferred between clinicians or health service organisations
- Healthcare records documenting that the patient has been advised and supported in their understanding of their infectious status
- Healthcare records documenting the patient's infectious status at transitions of care or clinical handover
- Alerts in the patient's healthcare records
- Processes that include actions to communicate a patient's infectious status (where known) to clinicians at transitions of care
- Examples of clinical communication that highlight infectious status, such as handover sheets, health care forms and electronic communication
- Audit results of compliance with the processes for communicating infectious status, such as reviewing clinical communication documents or related incident reports
- Resources for patients and their carers about infection risks, and infection prevention and control strategies - these may be accessed electronically and developed by state or national organisations using feedback from consumers
- Feedback from the workforce and consumers about communication of infectious status.

Hand hygiene

Action 3.10

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

a. **Is consistent with the current National Hand Hygiene Initiative and jurisdictional requirements**
b. **Addresses non-compliance or inconsistency with benchmarks and the current National Hand Hygiene Initiative**
c. **Provides timely reports on the results of hand hygiene compliance audits, and action in response to audits, to the workforce, the governing body, consumers and other relevant groups**
d. **Uses the results of audits to improve hand hygiene compliance**

Intent

Support implementation of a hand hygiene program that is consistent with the current National Hand Hygiene Initiative.

Reflective questions

- What processes are used to ensure that the ambulance health service's hand hygiene program is consistent with the current National Hand Hygiene Initiative and with state or territory requirements?
- How does the ambulance health service measure compliance with the current National Hand Hygiene Initiative?
- What action has the ambulance health service taken to improve compliance?
- How does the ambulance health service communicate hand hygiene compliance to the workforce, the governing body, consumers and other stakeholders?

Strategies for improvement

Effective hand hygiene is a fundamental infection prevention and control strategy. Hand hygiene performed at critical points during patient contact is essential to prevent the onward spread of disease to others, and limits contamination of the healthcare environment.

Paramedics' compliance with hand hygiene has been reported to be as low as 3% before patient contact, and sees an over-reliance on gloves.

Ambulance health services are required to implement a hand hygiene program consistent with the National Hand Hygiene Initiative which includes (but is not necessarily limited to) direct observation auditing. Where auditing of hand hygiene practice by direct observation is not practical or appropriate, alternate strategies can be implemented such as:

- Monitoring and auditing hand hygiene product placement and usage
- Staff hand hygiene knowledge surveys
- **Practical hand hygiene competency audits**
- Peer review
- **Client or patient experience surveys**
- Collaborating with hospitals or emergency departments to participate in, or seek results from, hand hygiene audits which include the ambulance workforce.

A range of resources to support alternative methods of hand hygiene monitoring are available: **National Hand Hygiene Initiative**.[145]

Ambulance health services should implement systems to assess compliance with the service's hand hygiene program using one or more measures applicable to the organisation's scope, size and activities. Where an organisation is providing acute care, it should undertake direct observation auditing of hand hygiene. Where barriers to performing hand hygiene has been identified, investigate barriers and enablers to improve hand hygiene rates.[152]

Support for hand hygiene program should be sought from the highest level of governance in the ambulance health service to:

- meet the requirements of the National Hand Hygiene Initiative
- determine how the ambulance health service's hand hygiene program will be resourced and managed
- delineate roles and responsibilities for the hand hygiene program

The ambulance health service should provide the workforce with hand hygiene orientation, training and education, such as the **NHHI Hand hygiene eLearning modules**. It should also:

- Review current resources including the **5 Moments for Hand Hygiene** and adapt to the service context. See the work of the Council of Ambulance Authorities hand hygiene initiative: **Take Five for Hand Hygiene**
- Audit the hand hygiene program as per National Hand Hygiene Initiative and state or territory requirements and recommendations for non-acute care settings
- Investigate collaborating with health care facilities and emergency departments to receive audit data relating to the ambulance health service workforce
- Implement strategies such as peer review and ride-a-longs to witness and observe practice
- Analyse and report hand hygiene compliance using a range of strategies
- Provide feedback to clinicians on the performance of the hand hygiene program and results of hand hygiene activities

- Develop a plan to respond to identified gaps, barriers and enablers for hand hygiene compliance
- Promote hand hygiene and seek feedback from patients and carers on hand hygiene compliance
- Review and evaluate the types of products used for hand hygiene and the availability of alcohol-based products at the point of care.

Examples of evidence

- Policy documents about a hand hygiene program that is consistent with the current National Hand Hygiene Initiative and state or territory requirements
- Examples of resources which may be adapted to the local context
- Training documents relating to the hand hygiene program such as, syllabus, attendance records or competency assessments
- Audit results of compliance with the hand hygiene program
- Audit results of evaluation of the hand hygiene program, including use and availability of equipment, supplies and products for hand hygiene
- Strategies to reduce workforce gaps or inconsistency with the current National Hand Hygiene Initiative
- Examples of quality improvement initiatives introduced and evaluated based upon audit feedback
- Committee and meeting records in which inconsistencies with the hand hygiene program were discussed
- Communication with clinicians and consumers about the results of hand hygiene programs and compliance rates of the workforce
- Orientation manuals, education resources and records of attendance at training by the workforce on hand hygiene practices
- Memorandums, newsletters or other communication material on hand hygiene provided to the workforce and consumers
- Committee records showing audit results have been used to improve hand hygiene compliance
- Availability of hand hygiene products and promotional material.

Aseptic technique

Action 3.11

The health service organisation has processes for aseptic technique that:

a. **Identify the procedures where aseptic technique applies**
b. **Assess the competence of the workforce in performing aseptic technique**
c. **Provide training to address gaps in competency**
d. **Monitor compliance with the organisation's policies on aseptic technique**

Intent

A risk-based process is implemented that will prevent or minimise the risk of introducing infectious agents during clinical procedures and activities.

Reflective questions

- What process are in place across the ambulance health service to identify the procedures performed by aseptic technique?
- What processes does the ambulance health service use to ensure that the workforce is competent in aseptic technique?

Strategies for improvement

Aseptic technique is a set of practices that protect patients from healthcare-associated infections and protects healthcare workers from contact with blood, body fluid and body tissue.[139] It protects patients during invasive clinical procedures by utilising infection prevention and control measures that minimise the presence of micro-organisms.

Aseptic technique is achievable in out of hospital settings by applying five essential principles:

- Sequencing
- Environmental control
- Hand hygiene
- Maintenance of aseptic fields
- Personal protective equipment (PPE)

Identify procedures and risks

Ambulance health services should conduct a risk assessment to identify the areas of the service that have the highest risk when performing aseptic procedures. It should also:

- Develop policies and procedures for the conduct of aseptic technique. These should include processes and steps for modifying practice to mitigate infection risk where immediate intervention is required

- Identify clinical procedures and activities for which aseptic technique should performed and identify strategies to reduce risks in situations where elements of effective aseptic technique cannot be fully employed
- Consider technological advances to improve aseptic technique in practice, such as:
  - equipment bundles
  - sterile 'starter' packs.

Provide training and assess competence

Aseptic technique orientation, training, education and assessment programs are essential for the workforce. Ambulance health services should consider the validity and currency of previous training, and how often training should be repeated to maintain competence. The service should:

- Assess the competence of members of the workforce who are required to perform aseptic technique and provide training to reduce gaps in competence
- Set priorities for training based on risk assessment
- Identify opportunities to review practice to improve aseptic technique
- Use surveillance data, if available, to monitor for outbreaks, results of hand hygiene compliance audits, aseptic technique audits and incident reports to help set priorities for assessment and training needs.

Examples of evidence

- Policy documents that identify clinical procedures and activities for which aseptic technique is required
- Evidence of the assessment of workforce competence in performing aseptic technique
- Training documents relating to aseptic technique, including training to reduce gaps in competence, such as syllabus, attendance records and competency assessments)
- Completion certificates or register for training modules undertaken by the workforce
- Audit results of compliance with aseptic technique procedures and action plan for improving or maintaining results
- Communication of audit results to the workforce, patients and carers
- Actions taken to reduce identified risks associated with aseptic technique
- Meeting minutes where aseptic technique reports were discussed.

Invasive medical devices

Action 3.12

The health service organisation has processes for the appropriate use and management of invasive medical devices that are consistent with the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare[139]

Intent

Infections are minimised by the appropriate selection, safe insertion and maintenance, and timely removal of invasive medical devices.

Reflective questions

- How does the ambulance health service ensure that the workforce considers the need for invasive medical devices using appropriate, safe practices for selecting, inserting, maintaining, reviewing and removal of invasive devices safely?
- How does the ambulance health service monitor the use of invasive devices to reduce patient harm?

Strategies for improvement

Ambulance health services should establish systems for the safe selection, use and surveillance of invasive medical devices, this may include the use of a risk assessment matrix to support decision making. All invasive medical devices used with the service should be identified and maintained in a register of approved devices.

Develop policies, procedures and protocols for the use of invasive medical devices

It is important that policies developed by the ambulance health service are consistent with the current edition of the **Australian Guidelines for the Prevention and Control of Infection in Healthcare**.[139] Policies and protocols should include guidance relating to the rationale, selection, insertion, maintenance and removal of invasive medical devices that include:

- Scope of practice for the use and maintenance of invasive medical devices
- Fault management, recall and disposal
- Reference to relevant clinical care standards such as the **Peripheral Intravenous Catheters Clinical Care Standard**[32]
- Systems for procurement and evaluation
- Orientation, training and competency assessment of the workforce.

The ambulance health service should develop systems to notify the receiving facility where a peripheral access device was inserted in an environment that precludes using all the elements of effective aseptic technique. It should also:

- Develop systems for review and reporting incidents relating to invasive devices. This may include collaborating and seeking feedback from external health care providers
- Provide orientation, training and education for members of the workforce who handle and use invasive devices

- Identify requirements for documentation in the patient's healthcare record such as:
  - the date and reasons for insertion
  - ongoing management
  - observation of the insertion site and device
  - removal date
  - adverse events/reactions and actions taken.

Examples of evidence

- Policy documents about the indications for, selection, insertion, maintenance and removal of invasive medical devices
- Risk assessment matrix to support decision making
- Policies for the transportation and disposal of equipment and procedures for mitigating risks in the community
- Committee or meeting records in which use of invasive medical devices was discussed
- Review of infection surveillance data about invasive medical devices
- Actions taken to manage identified risks with the selection, insertion, maintenance and removal of invasive medical devices
- List of approved invasive medical devices, e.g., a register of medical devices
- Audit results of workforce compliance with processes for the selection, insertion, maintenance and removal of invasive medical devices
- Feedback from external data sources on relevant surveillance data
- Assessment of aseptic technique
- Evaluation of variation of use against established policies and guidelines
- Where practicable observation of a device being inserted or maintained
- Evidence of patient monitoring activities relating to invasive medical devices
- Use of the organisation's incident reporting process
- Review of incident reports relating to invasive medical devices
- Documentation of removal of an invasive device.

Clean and safe environment

Action 3.13

The health service organisation 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[139] and jurisdictional requirements – to:

a. **Respond to environmental 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**
d. **Audit the effectiveness of cleaning practice and compliance with its environmental cleaning policy**
e. **Use the results of audits to improve environmental cleaning processes and compliance with policy**

Intent

Ambulance health services identify and respond to environmental and infection risks by providing a clean environment for patients and the workforce.

Reflective questions

- What processes does the ambulance health service use to maintain a clean and hygienic environment in line with state or territory requirements and the current edition of the **Australian Guidelines for the Prevention and Control of Infection in Healthcare**,[139] while also taking into consideration the local service delivery environmental factors and population?
- Does the ambulance health service have an environmental cleaning policy that includes the need to audit compliance and use the audit results to improve environmental cleaning processes?
- How does the ambulance health service train the workforce in cleaning processes for routine and outbreak situations, and novel infections?

Strategies for improvement

In collaboration with members of the workforce, the ambulance health service should develop policies, procedures and guidelines for environmental cleaning, and:

- Consider current best practice for cleaning vehicles and facilities and who is best placed to perform this, such as contracting external specialist cleaning staff
- Include environmental cleaning risks in the ambulance health service's risk management strategies
- Implement evidence-based strategies for a clean environment incorporating a risk management focus
- Where external cleaning services are employed, provide training and develop systems of governance to monitor, document and report issues
- Develop cleaning and disinfection schedules that meet the requirements outlined in the Australian Guidelines for the Prevention and Control of Infection in Healthcare[140] and relevant state or territory

requirements. These schedules should include:
  - frequency and type of activity
  - products and equipment to be used
  - specialised personal protective equipment, if required
  - safety instructions.
- Develop and maintain position descriptions and duty lists and audit compliance with environmental cleaning and disinfection schedules
- Work with external organisations to identify resources to support the environmental cleaning program
- Provide the workforce with training and information on the principles of infection prevention and control
- Select chemicals and cleaning products approved by the Therapeutic Goods Administration (TGA) and make available current safety data sheets to employed or contract staff
- Provide the workforce with additional support to comply with the clean environment policy where they are working in challenging environments, such as by the roadside.

Monitor performance

Ambulance health services should monitor and report on processes for environmental cleaning and disinfection, and:

- Identify areas that require audit and evaluation of environmental cleaning and disinfection processes
- Review the incident management and investigation system to identify incidents relating to environmental cleaning activities and report to the governing body
- Implement a quality improvement program respond to identified gaps
- Review equipment requirements and maintenance, such as colour coded cloths, single use mop heads and vacuum filter changes
- Audit compliance with the environmental cleaning policy and report the findings
- Establish systems for effective contract management and monitoring infection prevention and control requirements
- Establish mechanisms for consumers or the workforce to raise concerns about environmental infection control.

Examples of evidence

- Policies, procedures and protocols for environmental cleaning that are consistent with current guidelines such as the **Australian Guidelines for the Prevention and Control of Infections in Health Care**[139] and relevant state and territory requirements
- Documented maintenance schedules and evidence that maintenance has been completed for infrastructure in the ambulance health service
- Material safety data sheets or chemical register of cleaning resources used
- Audit results which have been used to evaluate the effectiveness of the cleaning program and ensure it complies with the **Australian Guidelines for the Prevention and Control of Infections in Health Care**[139]
- Cleaning schedules that include the environment and any equipment or aids that are used
- Service schedules for infection prevention and control equipment
- Waste management plan that includes actions to address identified risks
- Environmental risk assessment that includes actions to address identified risks
- Training and education logs of workforce attendance
- Feedback from consumers and the workforce on environmental cleaning
- Documentation from committees and other meetings where environmental cleaning policies and procedures are reviewed and discussed.

Action 3.14

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

a. **New and existing equipment, devices and products used in the organisation**
b. **Clinical and non-clinical areas, and workplace amenity areas**
c. **Maintenance, repair and upgrade of buildings, equipment, furnishings and fittings**
d. **Handling, transporting and storing linen**
e. **Novel infections, and risks identified as part of a public health response or pandemic planning**

Intent

The ambulance health service minimises infection risks to patients and the workforce from equipment, device, product and environmental hazards.

Reflective questions

- What processes are in place for the ambulance health service and its workforce to respond to risks identified as part of a public health response or pandemic planning?
- What systems does the ambulance health service have in place for the cleaning and maintenance of facilities, fleet, equipment and devices in accordance with manufacturer's instructions?
- What systems does the ambulance health service have in place to assess infection control risks for new procedures, technology, devices, equipment and vehicles?

Strategies for improvement

The ambulance health service should develop systems to respond to risks identified as part of a public health response or pandemic planning, and:

- Develop policies and procedures to assess infection risks when introducing new devices, products or equipment into the ambulance health service
- Establish roles, responsibilities and accountabilities for the introduction of new technologies, devices, products or equipment to the service including:
  - how the introduction of a new product or technology aligns with the organisation's quality and risk management systems
  - training and education for the workforce
  - the maintenance program and management of infection risks
  - coordination of product recalls, alerts and decommissioning
- Establish processes and networks to consult with specialist services such as engineering, environmental cleaning, reprocessing of reusable medical devices, infection prevention and control services
- Review external service contracts and include requirements for participation in quality improvement strategies as outlined in the **Clinical Governance Standard**
- Develop processes for the cleaning and maintenance of equipment and devices in accordance with manufacturer's instructions
- Audit compliance with published policies and procedures

- Use audit reports and data to inform policies, procedures and protocols for preventing and controlling infections
- Review processes for the segregation and transport of clean and dirty items
- Where linen is used review the movement, supply, handling and storage of clean and used linen to minimise infection risks for both patients and the workforce.

Examples of evidence

- Systems for the ambulance health service to respond to risks identified as part of a public health response or pandemic planning
- Policies and procedures for the assessment of infection risks for new devices, products or equipment
- Policy documents about evaluating and responding to the risks associated with equipment, vehicles, devices, furnishings, fittings and buildings where clinical care is provided
- Minutes of meetings regarding introduction of new devices, vehicles or equipment where infection prevention and control evaluation processes have been discussed
- Cleaning schedule and tasks of contracted cleaning staff
- Policy and procedures for reporting unsatisfactory practices by contracted cleaning staff
- Contracts with external linen providers for managing clean and used linen
- Schedules for the maintenance of vehicles, buildings, equipment, furnishings and fittings
- Audit results of compliance with the maintenance schedules for vehicles, buildings, equipment, furnishings and fittings
- Records of business decision making about repairs and upgrades to vehicles, buildings, equipment, furnishings and fittings.

Workforce screening and immunisation

Action 3.15

The health service organisation has a risk-based workforce vaccine-preventable diseases screening and immunisation policy and program that:

a. **Is consistent with the current edition of the Australian Immunisation Handbook[153]**
b. **Is consistent with jurisdictional requirements for vaccine-preventable diseases**
c. **Addresses specific risks to the workforce, consumers and patients**

Intent

The ambulance health service has a risk-based vaccine-preventable diseases screening and immunisation policy and program to protect the workforce, consumers and patients.

Reflective questions

- Does the ambulance health service have an immunisation program consistent with the national immunisation guidelines and state or territory requirements?
- How does the ambulance health service assess compliance with the policy?

Strategies for improvement

The ambulance health service should conduct a risk assessment to establish consistency of the organisation's workforce immunisation program with the current edition of the Australian Immunisation Handbook and state or territory requirements.

The ambulance health service's immunisation program should be consistent with the national immunisation guidelines and state or territory requirements that includes:

- Policies, procedures and protocols for the ambulance health services workforce
- Employer and employee responsibilities for managing occupational risks for vaccine-preventable diseases
- Reference to the infection prevention and control program
- A statement of the risks in the organisation and how the risks are to be managed, including identifying high-risk areas and at-risk members of the workforce
- How the program aligns with the workplace health and safety program
- The vaccination requirements for the workforce, including volunteers, students and contractors
- Systems for the maintenance and secure storage of workforce vaccination records
- Processes for communicating information regarding vaccine-preventable diseases to the workforce, patients and their carers
- A documented management process for vaccine refusal or inability to participate that includes reducing the risk to members of the workforce and reducing the risk of a healthcare worker transmitting disease to vulnerable patients.

Examples of evidence

- Policies, procedures and protocols for workforce and student immunisation that are consistent with national guidelines, state and territory requirements
- A process for reporting change in the vaccination status of the workforce, students and contractors
- Evidence that the immunisation status of the workforce is readily available to authorised personnel
- Audit results of workforce vaccination compliance
- Committee or meeting records in which workforce vaccination compliance was discussed
- Documents accessible to authorised personnel that:
  - identify the requirements for vaccination as part of the recruitment of workforce or placement of contractors and students
  - demonstrate maintenance of vaccination rates of the workforce
  - identify additional vaccination requirements for relevant members of the workforce
  - record immunisation refusal or inability to participate and the organisational risk management response
- Evidence that information relating to prevention strategies and risks associated with vaccine preventable diseases is available to the workforce and patients.

Infections in the workforce

Action 3.16

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

a. **Are consistent with the relevant state or territory work health and safety regulation and the current edition of the Australian Guidelines for the Prevention and Control of Infection in Healthcare[139]**
b. **Align with state and territory public health requirements for workforce screening and exclusion periods**
c. **Manage risks to the workforce, patients and consumers, including for novel infections**
d. **Promote non-attendance at work and avoiding visiting or volunteering when infection is suspected or actual**
e. **Monitor and manage the movement of staff between clinical areas, care settings, amenity areas and health service organisations**
f. **Manage and support members of the workforce who are required to isolate and quarantine following exposure to or acquisition of an infection**
g. **Provide for outbreak monitoring, investigation and management**
h. **Plan for and manage ongoing service provision during outbreaks and pandemics or events where there is increased risk of transmission of infection**

Intent

The ambulance health service has processes for preventing and managing infections in the workforce to minimise the risks to the workforce, patients and consumers, including for novel infections and during outbreaks.

Reflective questions

- What systems does the ambulance health service have in place to facilitate workforce compliance with policies and procedures to prevent and manage infections in the workforce?
- What support does the ambulance health service provide to members of the workforce who have acquired an infection or are required to isolate?
- How does the ambulance health service ensure high-quality care continues when the workforce numbers decrease due to mandatory workforce absences?
- How does the ambulance health service monitor the effectiveness of its processes for managing infections in the workforce?

Strategies for improvement

The ambulance health service should incorporate risk-based processes for preventing and managing infections in the Clinical Governance Framework, and:

- Develop policies for defining, tracking and reporting exposure prone procedures . This includes invasive procedures where there is potential for direct contact between the skin of the healthcare worker and sharp objects or surgical instruments. See the **Australian Guidelines for the Prevention and Control of Infections in Health Care**[139]
- Develop policies, procedures and protocols to manage infections in the workforce
- Establish employer and employee responsibilities for adopting protective behaviours, such as complying with non-attendance at work if unwell and cooperating with contact tracing and exclusion periods
- Document processes for managing workforce vaccine refusal and inability to comply with infection prevention and control guidance that includes reducing the risk to members of the workforce and reducing the risk of a healthcare worker transmitting disease to patients
- Identify in the risk management plan high-risk areas and at-risk members of the workforce and how they will be managed
- Document how the processes for preventing and managing infections align with the workplace health and safety program
- Identify appropriately qualified or trained personnel to manage the processes for preventing and managing infections
- Securely store workforce health records and restrict access to maintain privacy and confidentiality
- Provide the workforce with access to the **Australian Guidelines for the Prevention and Control of Infection in Healthcare**[139]
- Provide information about relevant transmissible diseases to the workforce, patients and their carers.

Examples of evidence

- Policies, procedures and protocols for preventing and managing infections in the workforce that are consistent with state or territory work health and safety regulation and the current edition of the **Australian Guidelines for the Prevention and Control of Infection in Healthcare**[139]
- A register of exposure-prone procedures likely to take place in the ambulance health service setting
- Registers of staff orientation, training and competency assessments including volunteer and casual members of the workforce
- Processes for reporting notifiable diseases and appropriate follow up
- Documentation from committees or meetings where quality improvement initiatives and reports on preventing and managing infections policies and procedures are discussed.

Reprocessing of reusable equipment and devices

Reprocessing of reusable equipment and devices meets current best practice and is consistent with current national standards.

This criterion includes cleaning, disinfection and sterilisation of reusable medical devices, equipment and instrumentation used in the ambulance health service.

Reprocessing of reusable medical devices, equipment and instruments should be consistent with the current edition of the **Australian Guidelines for the Prevention and Control of Infection in Healthcare**[139] and meet current relevant national and international standards.

The transport and storage of reusable medical devices may also need to be considered.

This Action only applies to ambulance health services that reprocess reusable items or use reusable items reprocessed elsewhere. This action is 'not applicable' where single use items are used.

Reprocessing of reusable equipment and devices

Action 3.17

Where reusable equipment and devices are used, the health service organisation has:

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

b. A traceability process for critical and semi-critical equipment, instruments and devices that is capable of identifying:

- **the patient**
- **the procedure**
- **the reusable equipment, instruments and devices that were used for the procedure**

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

Intent

Where reusable equipment and devices are used, the ambulance health service minimises infection risks to patients and the workforce by ensuring adequate identification of, and procedures for reprocessing, reusable medical equipment.

Reflective questions

- What processes does the ambulance health service have in place for reprocessing reusable medical devices in line with relevant national standards and manufacturers' instructions?
- What system does the ambulance health service use for managing, storing and transporting reusable medical devices to maintain integrity and sterility?
- How does the ambulance health service identify and trace reusable devices when used during patient care?

Strategies for improvement

Implement systems for reprocessing reusable equipment, instruments and devices

Identify the ambulance health services capacity to reprocess reusable equipment, instruments and devices on site. The core principles for the reprocessing of reusable devices are cited in the latest version of the **Australian Guidelines for the Prevention and Control of Infections in Healthcare**.[139]

- Identify the critical or semi-critical equipment, instruments or devices that require reprocessing. See the **Australian Guidelines for the Prevention and Control of Infection in Healthcare** for a description of critical and semi-critical items[139]
- Identify requirements for reusable equipment, instruments and devices as part of the ambulance health service's risk assessment
- Develop or review policies, procedures and protocols for reprocessing and storage of sterile stock that are consistent with relevant national or international standards, including where reprocessing is contracted to an external provider
- Develop processes for decontamination of reusable equipment, instruments and devices for transporting to reprocessing services

- Where reprocessing is managed by external services, establish a Memorandum of Understanding (MOU) identifying the formalised agreement with an externally contracted sterilisation provider
- Develop policies and procedures for the safe transport of reusable medical devices to and from the reprocessing site[154]
- Identify local governance and responsibility for the reprocessing service.

Implement training and monitoring systems

The ambulance health service should implement schedules for monitoring, servicing and maintaining reprocessing equipment.

The incident management and investigation system should be used to report incidents relating to reprocessing of reusable medical devices, instruments and equipment and act to rectify gaps in compliance.

The implementation of monitoring and quality improvement systems should include:

- Storage requirements for all sterile stock, including storing in a way that maintains their level of reprocessing
- A fault reporting process that includes responsibility, actions and risk management strategies
- Requirements for documentation and record-keeping of reprocessed medical devices
- Environmental controls, including water quality, air handling, access, maintenance schedules and cleaning activities
- Requirements for personal protective equipment when reprocessing
- Ensuring suitably trained members of the workforce are available for decontamination and reprocessing of used medical devises and equipment.

Examples of evidence

- Policies and procedures for processing reusable medical equipment, instruments and devices that are consistent with relevant national or international standards and manufacturer's instructions for use
- Memorandum of Understanding (MOU) identifying the formalised agreement with an externally contracted sterilisation provider
- A register of reusable medical devices
- Access to copies of manufacturer's instructions for reusable medical devices
- Records of sterilisation that verify instrument reprocessing is consistent with relevant national or international standards
- Maintenance schedules for equipment used to reprocess equipment
- Infection prevention and control audits of sterilising services
- Registers of staff training and competency assessments
- Audit of validation and compliance monitoring systems for sterilisers
- Audits of sterile stock integrity and supply
- Documentation including reports from committees or meetings where 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, procedures and protocols for the use of single-use items
- Audit of healthcare records where reusable medical devices have been used
- A traceability system that allows individual identification of patients and the reusable medical device, equipment or instrument used.

Antimicrobial stewardship

The health service organisation implements systems for the safe and appropriate prescribing and use of antimicrobials as part of an antimicrobial stewardship program.

Antimicrobial stewardship (AMS) programs involve strategies and interventions that aim to reduce unnecessary antimicrobial use and promote the use of agents that are less likely to select for resistant microorganisms. AMS programs promote the use of the right antimicrobial, at the right dose, for the right duration, at the right time and by the right route.[155] Along with environmental cleaning, infection control, hand hygiene and surveillance, AMS programs are a key strategy in preventing antimicrobial resistance and decreasing preventable infections.

The content and implementation strategies for this criterion have been drawn from **Antimicrobial Stewardship in Australian Health Care**[155], which summarises the evidence about AMS programs and details strategies for implementing and sustaining these programs. It is recommended that ambulance health services consult this publication when planning and implementing an AMS program.

Although antimicrobial use is reported to be low in out of hospital settings, the principles should be tailored to the complexity and size of the ambulance health service.[155]

A number of resources provide examples of how strategies to support AMS might be implemented in different contexts. These examples can be used as a starting point for ambulance health services to consider ways in which different strategies can be applied to their own settings.

- **Options for Implementation of Antimicrobial Stewardship in Different Facilities**[156]
- **Antimicrobial Stewardship site**.[157]

Consider the actions in this criterion in relation to the criteria and actions in the **Medication Safety Standard**.

Antimicrobial stewardship

Action 3.18

The health service organisation has an antimicrobial stewardship program that:

a. **Includes an antimicrobial stewardship policy**
b. **Provides access to, and promotes the use of, current evidence-based Australian therapeutic guidelines and resources on antimicrobial prescribing**
c. **Has an antimicrobial formulary that is informed by current evidence-based Australian therapeutic guidelines or resources, and includes restriction rules and approval processes**
d. **Incorporates core elements, recommendations and principles from the current Antimicrobial Stewardship Clinical Care Standard**[158]
e. **Acts on the results of antimicrobial use and appwropriateness audits to promote continuous quality improvement**

Intent

The ambulance health service has systems for the safe and appropriate prescribing and use of antimicrobials as part of an antimicrobial stewardship program.

Reflective questions

- Does the ambulance health service have an overarching antimicrobial stewardship (AMS) program?
- What systems does the ambulance health service have in place to support appropriate prescribing and use of antimicrobials?
- Is antimicrobial prescribing in the ambulance health service consistent with the **Therapeutic Guidelines: Antibiotic eTG**?[147]
- Does the ambulance health service have an infectious disease physician, clinical microbiologist or pharmacist resource available if required?

Strategies for improvement

Plan the AMS program

Ambulance health services that administer or prescribe antimicrobials are required to have an overarching AMS program. A combination of strategies and interventions may be required to optimise antimicrobial use and can include:

- Performing a gap analysis to develop an AMS program based on the risks, gaps and priorities for the ambulance health service
- Seeking endorsement from the governing body for the AMS program
- Identifying roles, responsibilities and accountabilities
- Providing training and education about the AMS program

It is important that an AMS program is integrated within the ambulance health service's safety and quality systems, and:

- Supports the workforce to prescribe in alignment with the **Therapeutic Guidelines: Antibiotic eTG**[147] or evidence-based guidelines that have been endorsed by a state or territory AMS committee
- Incorporates quality statements and indicators from the **Antimicrobial Stewardship Clinical Care Standard**[158]
- Lists restricted antimicrobials and procedures for obtaining approval for use of these agents
- Specifies processes for monitoring compliance with antimicrobial use
- Outlines systems for obtaining specialist advice for complex procedures or conditions.

Review formulary, approval and restrictions

Develop an antimicrobial formulary that aligns with recommendations in current evidence-based **Therapeutic Guidelines: Antibiotic eTG**[147] or local guidelines that includes:

- Restriction rules, including restriction of broad-spectrum antimicrobials to patients in whom their use is clinically justified[159]
- Processes for obtaining approval for use of restricted agents and systems to inform prescribers of these procedures
- The use of medication charts consistent with the **national standard medication charts (NSMC)**.[160]

Ensure access and compliance with approved guidelines

Ambulance health services should provide clinicians with ready access to guidelines, the local antimicrobial formulary and the current version of **Therapeutic Guidelines: Antibiotic eTG**.[147]

Ambulance health services should also:

- Seek feedback on guidelines and tailor strategies where gaps are identified
- Implement systems to notify the workforce when changes to prescribing guidelines have occurred.

Incorporate the principles of the Antimicrobial Stewardship Clinical Care Standard into the AMS program

The ambulance health service should use the **Antimicrobial Stewardship Clinical Care Standard**[158] principles to inform the ambulance health service's AMS program, as well as:

- Identifying clinical pathways that include best practice principles for antimicrobial therapy
- Setting benchmarks for documenting in the patient's healthcare record the indication; the medicine name, dose, route of administration and intended duration; and the treatment review plan
- Reviewing clinical incidents, adverse events and near misses relating to antimicrobial use, including assessment and management of reported antibiotic–allergy mismatch.
- Educating patients and carers about safe and appropriate use of antimicrobials, including the importance of review and stop dates for prescriptions, potential adverse reactions and what to do in the event of a reaction
- Using process measures to monitor the AMS program and to identify opportunities for improvement. Possible measures include the **Antimicrobial Stewardship Clinical Care Standard**[158] indicators and quality use of medicines indicators.

Review the AMS Program

Review the program to identify what is working well, gaps and areas for improvement.

Examples of evidence

- An AMS policy incorporating best practice principles
- A documented organisational chart that describes AMS responsibilities
- Results of risk assessments to identify areas of priority
- Documented AMS action plan
- Orientation manuals, education resources and records of attendance at training by prescribers and the clinicians administering antimicrobials on antimicrobial usage
- Documentation demonstrating that the AMS program is reviewed and discussed with external experts such as a pharmacist when appropriate
- Restriction, approval or review systems to guide the use of antimicrobials
- Referral process to infectious disease physician or clinical microbiologist
- Access to the **Therapeutic Guidelines: Antibiotic eTG**[147] is provided for all clinicians authorised to prescribe
- Locally adapted guidelines in use that are consistent with current endorsed **Therapeutic Guidelines: Antibiotic eTG**.[147]

Action 3.19

The antimicrobial stewardship program will:

a. **Review antimicrobial prescribing and use**
b. **Use surveillance data on antimicrobial resistance and use to support appropriate prescribing**
c. **Evaluate performance of the program, identify areas for improvement, and take action to improve the appropriateness of antimicrobial prescribing and use**
d. **Report to clinicians and the governing body regarding:**
   - **compliance with the antimicrobial stewardship policy and guidance**
   - **areas of action for antimicrobial resistance**
   - **areas of action to improve appropriateness of prescribing and compliance with current evidence-based Australian therapeutic guidelines or resources on antimicrobial prescribing the health service organisation's performance over time for use and appropriateness of use of antimicrobials**

Intent

The ambulance health service has systems for the safe and appropriate prescribing and use of antimicrobials as part of an antimicrobial stewardship program.

Reflective questions

How does the ambulance health service use surveillance data on antimicrobial resistance and use this to support appropriate prescribing?

- What processes does the ambulance health service have in place to evaluate antimicrobial use?
- What actions has the ambulance health service taken to improve the effectiveness of the AMS processes, for example, ensuring endorsed antibiotic treatment protocols are followed?
- How does the ambulance health service report on prescribing data and use of antimicrobials to clinicians and the governing body?

Strategies for improvement

Monitoring and analysing antimicrobial use is critical to understanding patterns of prescribing, the impact on patient safety and antimicrobial resistance, as well as to measure the effectiveness of, and identify means to improve the AMS program.

Antimicrobial use can be measured in terms of quantity and quality - that is the appropriateness of prescribing according to published guidelines. This can be achieved by:

- Using the risk assessment principles outlined in **Action 3.01** to decide on priority areas for monitoring and improvement
- Monitoring antimicrobial use appropriate to the scope of services and procedures undertaken. Priorities will include procedures associated with high levels of antimicrobial use or antimicrobials on the **Priority Antibacterial List for Antimicrobial Resistance Containment**[159]
- Conducting audits and reviews as part of the AMS program
- Working with clinical microbiology or pathology services to ensure reporting of selective susceptibilities and reviewing antimicrobial use data in association with resistance data to identify any patterns.

Decide on areas for monitoring and improvement

Map current data collection systems to identify those that can be used to support monitoring and evaluation of AMS. Where possible, use routinely collected data to avoid duplication of effort. Examples include:

- Pharmacy data collection systems for information about trends in antimicrobial use
- Data on volume of use of antimicrobials
- Healthcare record systems to identify compliance with policies and processes and documentation of antimicrobial allergies
- Purchasing data for antimicrobials
- Point prevalence surveys.

Act to improve prescribing

The ambulance health service should provide an AMS program that:

- Uses data from audits of prescribing and antimicrobial use to implement change and provide feedback
- Publishes reports on antimicrobial use and appropriateness
- Provides resources and tools to promote appropriate antimicrobial prescribing
- Implements or reviews clinical pathways for specific procedures and conditions
- Promotes education and training regarding **Quality Use of Medicines**
- Provides regular updates about the AMS program to members of the clinical workforce
- Takes part in annual Antimicrobial Awareness Week activities
- Ensures that patients and carers receive current Australian education materials on safe and appropriate use of antimicrobials, including in electronic format
- Develops processes to ensure that information on antimicrobial use is provided at transitions of care.

Monitor and evaluate the AMS program

The ambulance health service should develop and encourage participation in AMS program evaluation activities and identify opportunities and actions for improvement. Evaluation activities should involve the:

- Assessment of current antimicrobial use, results of prescribing audits, available incident data, current AMS activities and resources to support AMS strategies
- Contribution of data on antimicrobial use and appropriateness to relevant programs to enable benchmarking as part of program evaluation.

Report on AMS program processes and outcomes

The governing body is responsible and accountable for monitoring the effectiveness of the AMS program. They also have a role in allocating resources to achieve program goals and outcomes. The governing body should receive regular reports and contribute to improvements to the AMS program.

Examples of evidence

- Committee or meeting records in which compliance with the AMS policy and antimicrobial prescribing were discussed
- Results of analysis of surveillance data on antimicrobial use and resistance
- Audit results about appropriateness of prescribing, for example results from the **Quality Improvement National Antimicrobial Prescribing Survey** (QI NAPS)
- Improvement activities that have been implemented and evaluated
- Communications with clinicians on antimicrobial use, resistance and stewardship
- Memorandums, newsletters or other communication material provided to the workforce and consumers on appropriate use of antimicrobials
- Records of prescribers completing antibiotic prescribing modules from the Commission's **Quality Use of Medicines Stewardship program**.

Medication Safety Standard

Leaders of a health service organisation describe, implement and monitor systems to reduce the likely occurrence of medication incidents, and improve the safety and quality of medication use. The workforce uses these systems.

Intention of this standard

To ensure clinicians are competent to safely administer, dispense and where applicable prescribe, appropriate medicines and to monitor medicine use. To ensure consumers are informed about medicines and understand their individual medicine needs and risks.

Criteria

Clinical governance and quality improvement to support medication management

Organisation-wide systems are used to support and promote safety for procuring, supplying, storing, prescribing, administering, disposal, record keeping and monitoring the effects of medicines.

Documentation of patient information

A patient's best possible medication history is recorded in a timely manner following commencement of an episode of care. The best possible medication history and information relating to medicine allergies and adverse drug reactions are available to clinicians.

Continuity of medication management

A patient's medicines are reviewed, and information is provided to them about their medicine needs and risks. Where medication management risks have been identified, this may include referring the patient for advice from their primary care provider.

Where applicable, a medicines list should be provided at completion or transition of an episode of care.

Medication management processes

Ambulance health services procure medicines for safety. Clinicians are supported to supply, store, prescribe, administer, monitor and safely dispose of medicines.

Introduction

Medicines are the most common treatment used in health care.[161] Although appropriate use of medicines contributes to substantial improvements in health and well-being, medicines can also be associated with an increased risk of patient harm that can contribute to a significant cost burden on healthcare systems.[162]

The use of prescription medicines in Australia is steadily increasing, with over 80% of Australians aged 65 years and over, and 70% aged 45−64 years regularly using medicines.[163] However, it has been reported that 30–50% of prescribed medicines for long term conditions are not taken as recommended[164] and a total of 1.2 million Australians have reportedly experienced a medicine-related adverse event in the previous six months.[161] In Australia, medication-related problems account for 250,000 hospital admissions annually resulting in estimated costs of $1.4 billion.[163]

Medication errors have many contributing factors

In the out of hospital setting, it is reported that errors can occur in up to 13% of medication administrations in high-acuity and complex patient cohorts.[165] However, medication errors are poorly defined in the literature and may be underreported.[166] A range of issues can contribute to medication administration errors including environmental factors, system failures, communication breakdown, cognitive factors (such as fatigue), inadequate reporting systems and a culture of blame and fear of reprisal.[167]

Suboptimal safety and quality systems and human factors can increase the risk of medication errors occurring at any juncture of the patient journey.[163] As the patient journey continues, studies have reported increased risk of medication errors at completion or transition of an episode of care.[161]

Medication management is complex often traversing multiple disciplines, time and locations, requiring coordinated interactions between a range of services and health professionals. Interrelated system factors include a lack of organisational systems, frequent changes to policies and protocols, ineffective training programs and physical and environmental distractions.[166]

Poor documentation at transitions of care can lead to missed medications, dose errors and emergency medications being ceased accidentally or missed.[168] The introduction of new drugs, polypharmacy, patient age and acuity can also increase risks of medication errors.[169]

Strategies to support safe management of medication

Multi-faceted strategies are required to reduce the number of medicine related errors during the patient health journey.[166, 170] Strategies for improvement include supporting consumer health literacy, improving workforce training and implementing systems for standardisation of clinical handover, medicines labelling and storage, and remediating risks of medicines administration.[161,166]

Consumer engagement has been identified as a key factor in reducing medicine related errors.[171] This requires health professionals to actively engage patients and families in discussions about medications, providing education and referral options.[172]

Where medicines form part of the care provided by an ambulance health service, systems that support safe and quality use of medicines need to be in place to meet the Medication Safety Standard. Medication safety strategies and monitoring processes may need to be adapted to the service context and the extent of medication management activities undertaken.

Ambulance health services may need to draw upon the expertise of pharmaceutical services or health or private hospital group networks to review and refine existing processes, establish systems and standardise referral processes to enhance communication with other health service providers.[161, 163]

Scope of this standard

Where medicine use does not form part of the services provided by the ambulance health service, an understanding of medication safety is still required for the workforce to know when and how to refer to other appropriate services.

The Medication Safety Standard addresses areas of medication management that have a known risk of error, often because of unsafe processes and variation in clinical practices. The Medication Safety Standard requires ambulance health services to assess medication management and implement systems that:

- Provide a governance framework for the safe and quality use of medicines
- Minimise the occurrence of medicine-related incidents and the potential for patient harm from medicines
- Delineate the role and scope of practice for clinicians with authority to prescribe and administer medicines
- Monitor compliance with policies and processes
- Provide orientation, training and education, and monitor competence
- Inform patients about their medicines and involve them in decision making where appropriate.

Key links with other standards

The Medication Safety Standard should be applied in conjunction with other NSQHS Standards including the **Clinical Governance Standard**, **Partnering with Consumers Standard** and the **Communicating for Safety Standard**. Synergies with other NSQHS Standards will also need to be identified. This will ensure that medication safety and quality systems, policies and processes for medication management are integrated and reduce duplication of effort.

Medication Management Pathway

Ambulance health services may not engage in all medicines related activities when providing an episode of care. However, best practice principles should be employed where these activities are performed.

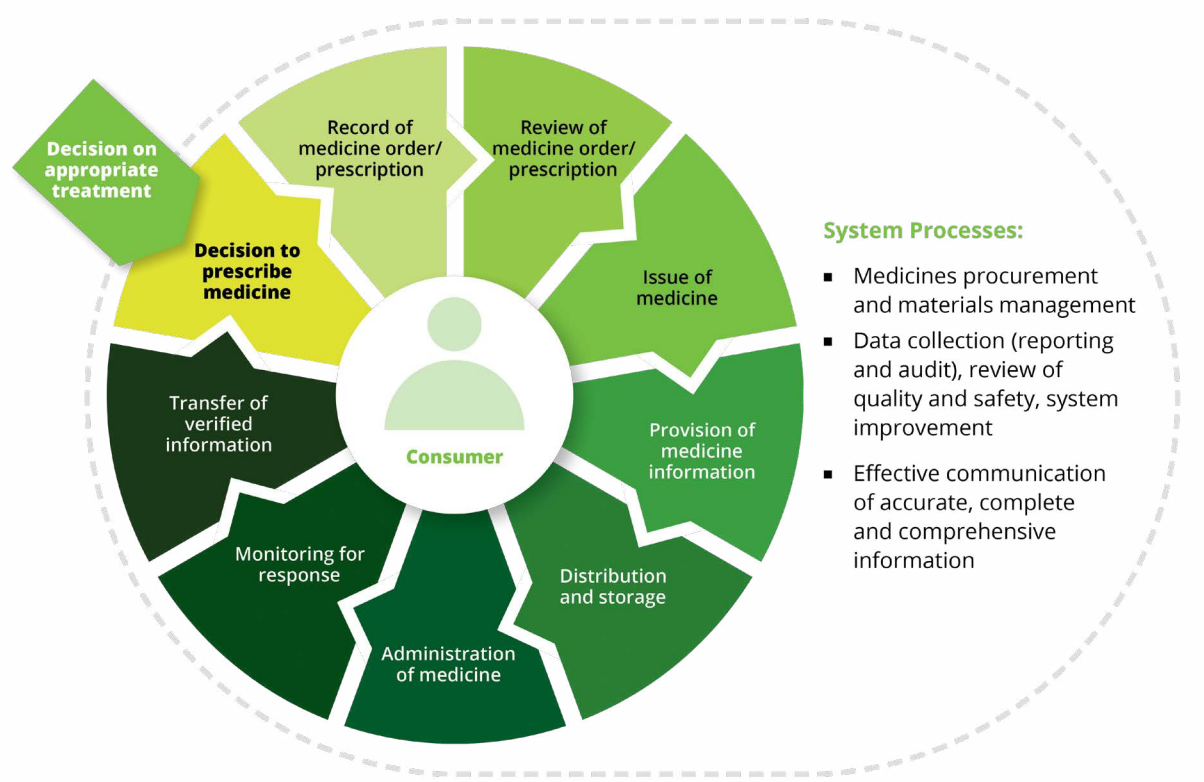
The 'medication management pathway' comprises multiple activities and three system processes to manage the safe and effective use of medicines for patients (and consumers) at each episode of care.[173, 174] Figure 4 details the medication management pathway.

A combination of safe processes and practices are required for all activities in the medication management pathway. These activities include procuring, supplying, storing, prescribing, administering, disposal, record keeping and monitoring the effects of medicines. Steps taken early in the medication management pathway can improve safe and effective use of medicines and prevent adverse events occurring later in the pathway. The pathway provides a framework for:

- Identifying when and where there is potential for errors or harm
- Responding with strategies to reduce the opportunity for error.

Following a decision on appropriate treatment, the patient (consumer) is central to each of the nine stages of the medication management pathway. Ambulance health services should apply the principles of partnering with consumers, health literacy and shared decision making when developing, reviewing and implementing processes or practices within the medication management pathway. The medication management pathway will at times be applied with an understanding of the time critical, acute nature of the out of hospital environment.

Figure 4: Medication management pathway



Source: Adapted from Australian Pharmaceutical Advisory Council[174]

Clinical governance and quality improvement to support medication management

Organisation-wide systems are used to support and promote safety for procuring, supplying, storing, prescribing, dispensing, administering and monitoring the effects of medicines.

The compounding, manufacturing or dispensing of medicines will generally be out of scope for ambulance health services. Medication responsibilities may only relate to the promotion and provision of safe administration of medicines.

An organisations-wide risk-based approach should be taken to inform clinical governance requirements and identify the most appropriate systems to support and promote safe medication management practices in the ambulance health service. This may require seeking external expert advice or drawing upon the expertise of the local health service network.

This criterion aligns closely with the **Clinical Governance Standard** and the **Partnering with Consumers Standard** and requires governance, leadership and commitment from across the ambulance health service to support the safe and effective use of medicines.

Meeting the Medication Safety Standard may require the ambulance health service to modify existing systems or introduce new processes to reduce the risk of medication error. Project teams should be multidisciplinary and include clinicians responsible for a range of medication management activities. Partnering with patients and carers in these processes can result in improved services and a higher level of satisfaction.[175]

Data from evaluation of medication management systems should be communicated back to all levels of the organisation including consumers. Feedback processes contribute to a culture of transparency and accountability and can be a powerful driver for change in clinical practice and encourages participation in quality improvement activities.[176-178]

Implementation of the Medication Safety Standard will require ambulance health services to:

- Apply safety and quality systems to support medication management
- Use quality improvement systems to monitor, review and improve medication management
- Apply principles of partnering with patients when designing and implementing systems for medication management
- Define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians
- Train, educate and support the workforce to understand their roles, responsibilities and accountabilities in delivering safe and effective use of medicines
- Support the workforce to participate in quality improvement initiatives.

Integrating clinical governance

Action 4.01

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

a. **Implementing policies and procedures for medication management**
b. **Managing risks associated with medication management**
c. **Identifying training requirements for medication management**

Intent

Safety and quality systems support clinicians in the safe and effective use of medicines and reduce medicine-related risk.

Reflective questions

- Does the ambulance health service's overarching governance framework include medication safety?
- How are the ambulance health service's safety and quality systems used to:
  - ensure appropriate governance of medication management?
  - support development, implementation and communication of policies and procedures for medication management?
  - identify and manage risks associated with medication management?
  - identify orientation, training and education requirements for medication management?
  - evaluate and improve processes for medication management?

Strategies for improvement

The **Clinical Governance Standard** has specific actions relating to safety and quality systems which are relevant to this action:

- **Action 1.07** – policies and procedures
- **Action 1.10** – risk management systems
- **Actions 1.19**, **1.20** and **1.21** – education and training

Establish and implement medication management governance

The ambulance health service should establish a governance group that has responsibility for medication management across the organisation and formally reports to the governing body. The governance group could be a quality use of medicines, medication safety or advisory committee. The governance group should:

- Identify high-risk medicines and high-risk procedures involving medicines
- Be multidisciplinary and include consumer representation
- Reflect the size of the organisation and the services provided[179]

- Develop, review and oversee medicine-related policy
- Develop the organisation's medication safety and quality improvement strategies
- Monitor quality improvement activities (related to **Action 4.02**)
- Monitor medicine-related incidents
- Implement and evaluate risk reduction strategies[180]
- Investigate current best practice and use of technology to improve medication management activities
- Identify external individuals or groups to provide medication management services or expert advice, where required,

Implement policies and procedures

The ambulance health service should develop medication management policy documents that include information regarding:

- Procurement, supply, storage and disposal
- Prescribing and administration
- Reconciliation, review and monitoring of effects
- Medicine evaluation and list of approved medicines (formulary)
- Procedures for managing high-risk medicines
- Recording of a best possible medication history
- Use of standard forms
- Standardisation of medication storage and the equipment used to administer medications
- Strategies to support the workforce to involve consumers and carers in decision making about medicines, when applicable or possible
- Provision of tailored, appropriate information about medicines to patients and carers
- User-applied labelling
- Avoiding use of error-prone abbreviations
- Safe implementation and use of electronic medication management
- Use of standardised electronic display of medicines information
- Management and reporting of medication incidents and suspected adverse drug reactions
- documenting and reporting medication incidents and suspected adverse drug reactions at transitions of care

The ambulance health service should ensure that current versions of all relevant policies and procedures are readily available and accessible to the workforce and that changes are highlighted through effective communication and training. It should also:

- Identify roles, responsibilities and management of contracted pharmacy services such as the local hospital pharmacy or community pharmacy or those provided by pharmacists on a sessional basis when the ambulance health service does not possess internal pharmaceutical expertise
- Implement incident reporting systems that are user-friendly, transparent and provide the capacity for anonymous reporting.[166] A culture of fairness and support has been identified as key issues to improve reporting of medicines incidents in the out of hospital environment.[167]

Manage risks

The ambulance health service should use established risk management systems to identify, monitor, manage and review risks associated with medication management (see **Action 1.10**). It should also:

- Develop processes to manage clinical, workforce and organisational risks
- Record medication safety risks in the organisation's risk management system register
- Use information from patient safety and quality systems to inform and update risk assessments and the risk management system

- Implement systems to assess medication management training needs for the workforce in line with the requirements of **Actions 1.19**, **1.20** and **1.21**
- Monitor, review and report upon medicine-related incidents.
- Use reported outcomes to inform and implement risk reduction strategies
- Seek input from pharmacy services where expert advice or review is required
- Monitor the effectiveness and performance of medication management systems and report findings to members of the workforce, patients and consumers.

Workforce orientation, training and education

Perform a risk assessment of medication management across the ambulance health service to develop a training schedule and to set priorities for members of the workforce.

Identifying medication errors occurring in the out of hospital setting may be more difficult compared to those errors occurring in the hospital context. This can be informed by reviewing:

- Incident management systems
- Consumer and workforce feedback or complaints
- National, state or territory medication safety directives, alerts and information
- Current best practice principles and strategies to reduce risk.

The ambulance health service should:

- Develop or provide access to orientation, training and education resources to meet the needs of the workforce regarding medication management
- Identify individuals with medication management expertise to be involved in orientation, training and education of the workforce
- Where appropriate to the scope of the service, develop and evaluate resources for consumers and their families on quality use of medicines and reducing medicine risk

To support the safe use of medicines, the ambulance health service should train members of the workforce in risk identification, incident management and investigation systems, and quality improvement. Ongoing education might include:

- Information of medication allergies, sign and symptoms of allergic reactions to medications and treatment of allergic reactions to medications and other allergic triggers
- Taking a best possible medication history and reconciling medicines as appropriate for the out of hospital healthcare needs of the patient
- Managing high-risk medicines
- Improving awareness of the factors that contribute to medication errors[166]
- Continual competency in drug calculation skills
- Knowledge of drugs and dose administration across of range of patient cohorts such as paediatrics[181]
- Checking procedures, such as independent double-check[180]
- Documenting known and new allergies and adverse drug reactions
- Systems for reporting medication errors or incidents
- Preparing and administering medicines, including dosing, labelling of injectable medicines, fluids and lines
- The safe use of equipment to administer medicines, such as the use of medication dosing aids, syringes, metred dose inhalers, spacers, cannula ports, infusion devices and pumps.[182]

Examples of evidence

- Policies, procedures and protocols for the safe management and quality use of medicines that are consistent with relevant legislation, state or territory and professional guidelines
- Policies, procedures and protocols for reporting, investigating and managing medication incidents, adverse drug reactions and events and near misses
- Evidence of revisions of policies, procedures and protocols for medication management incorporating updated evidence, risk mitigation strategies and quality improvements
- Documents that detail responsibilities for the medication safety system at all levels of the organisation, including board members, senior executive, managers and the workforce
- Terms of reference for the governance group or committee with responsibility for medication safety
- Position descriptions, duty statements or contracts that outline roles, responsibilities and accountabilities for clinical and organisational medication management activities
- Documentation from committees and other meetings where medication safety issues and incidents are reviewed, and improvement strategies discussed
- Strategic and operational plans detailing the development, implementation and maintenance of the organisation-wide medication safety system
- Examples of improvement activities that have been implemented and evaluated to reduce the risk of adverse medication incidents
- Documented investigations and data analyses of medication incidents, adverse drug reactions and events and near misses from the incident reporting system
- Analysis of sentinel events involving medicines
- Documented process for seeking advice on management of adverse medication incidents
- Reports provided to the committee or group responsible for medication safety and the governing body
- Evidence of medication management audits including workforce compliance with policies and processes
- Documented agreements and correspondence where medication management services are provided by external experts such as a pharmacist
- Orientation manuals, education resources and records of training attendance on medication management, medication safety and quality use of medicines
- Communication material provided to the workforce and consumers on strategies to reduce the risk of medication incidents, or avoiding medicine-related problems
- Feedback from consumers and the workforce on medication safety
- Examples of resources developed and evaluated by consumers and their families to reduce medicine risks.

Applying quality improvement systems

Action 4.02

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

a. **Monitoring the effectiveness and performance of medication management**
b. **Implementing strategies to improve medication management outcomes and associated processes**
c. **Reporting on outcomes for medication management.**

Intent

Quality improvement systems are used to support effective medication management and reduce medicine-related risks.

Reflective questions

- How is the effectiveness and performance of medication management in the ambulance health service monitored and improved?
- How are the outcomes of medication management improvement activities communicated to the governing body, the workforce, patients and other organisations?

Strategies for improvement

The Clinical Governance Standard has specific actions relating to quality improvement systems relevant to this action:

- – **Action 1.08** – quality improvement systems
- – **Action 1.09** – reporting
- – **Action 1.11** – incident management and investigation systems

Monitor effectiveness and performance

Medication safety self-assessments are an important monitoring activity to identify structure, system and communication opportunities to proactively reduce harm and target risk mitigation strategies.

Ambulance health services should use the organisation's quality improvement systems to identify and prioritise the organisational and clinical strategies for medication management. Safe medicine use requires:

- An understanding of the risks and barriers in the medication management pathway (see Figure 4)
- Routine collection and monitoring of data to measure the performance of the medication management pathway
- Processes to identify gaps, implement and evaluate quality improvement strategies
- Mechanisms for learning from medication incidents and identified risks

- Mechanisms to show that the risk reduction strategies in place improve the safety and performance of medication management
- Careful planning when introducing or accessing new technology or digital records, for example, electronic medication management or My Health Record (see **Actions 1.17** and **1.18**).

Self-assessment

Self-assessment can include all or part of the organisation's medication management pathway, with the aim of evaluating both protective and contributing factors for medication errors. This can be supported by reviewing evidence available on safe medication management practices in out of hospital settings.[166, 183]

Where possible, the self-assessment should be performed using multidisciplinary teams and include feedback from consumers. Results should be reviewed and compared with any previous baseline assessments or audits. Areas for self-assessment can include:

- Practices associated with procurement through to storage and destruction of unwanted medicines (including high-risk medicines, see **Action 4.15**)
- Quality of, and access to, medicine-related information resources, decision support tools and documentation (e.g., best possible medication history, see **Action 4.05**)
- Information for patients (see **Actions 4.03**, **4.11** and **4.12**).

Other monitoring actions may include:

- Establishing a list of medicine-related indicators that reflect the ambulance health service's usual range of medicines and their risk
- Auditing compliance with medication safety policies and procedures
- Reviewing practices associated with procurement through to storage and destruction of unwanted medicines (including high-risk medicines, see **Action 4.15**)
- Conducting observation audits to identify barriers to safe medication management
- Assessing the use of technology
- Monitoring the occurrence of, analysing the frequency and causes of, and reporting on, medicine-related incidents, including adverse drug reactions
- Providing access to medicine-related information resources, decision support tools and documentation (e.g., best possible medication history, see **Action 4.05**)
- Reviewing medicine related complaints and incidents
- Reviewing resources and processes to partner with consumers when discussing medication management (see **Actions 4.03**, **4.11** and **4.12**).

Implement quality improvement strategies and report outcomes

Use the ambulance health service's quality improvement systems to identify and prioritise strategies for medication management and use the results to determine the impact of medication safety strategies and identify opportunities for further quality improvement. This might include ensuring that:

- Identified risks are logged in the risk management system
- Responsibilities have been assigned for investigation, evaluation and reporting
- Recommended actions have been implemented and outcomes evaluated and reported
- There is a schedule of medicines management quality improvement activities including clinical audits
- Quality improvement activities and outcomes are reported to the governing body, workforce and consumers.

Examples of evidence

- Policies, procedures and protocols that describe correct, safe and appropriate use of medicines
- A risk register that includes actions to address identified medication management-related risks
- A quality improvement plan that includes actions to address medication management-related issues identified
- Audit of use of policies, procedures and protocols for medication management
- Results of audits of relevant national recommendations and medication safety alerts
- Quality measures and tools developed to evaluate the medication management systems in use
- Results of activities that monitor quality use of medicines indicators and other performance measures of medication management
- Completed risk assessments, registers and action plans related to medication management
- Reports from the incident management and feedback system to identify trends in incident types
- Reports on medication management performance provided to the workforce, medication safety governance committee or group and the governing body
- Documentation from committees and other meetings where reports on medication management performance are reviewed and quality improvement strategies are discussed
- Examples of standardised processes and templates for documentation and communication processes
- Examples of improvement activities to reduce the risks identified in medication management that have been implemented and evaluated
- Feedback from the workforce and consumers on medication quality improvement activities
- Communication material provided to the workforce and consumers on medication safety and safe medication management practices.

Partnering with consumers

Action 4.03

Clinicians use organisational processes from the Partnering with Consumers Standard in medication management to:

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

Intent

Clinicians partner with patients to minimise medicine-related risks.

Reflective questions

- What processes from the **Partnering with Consumers Standard** does the ambulance health service's workforce use to involve patients in planning and making decisions about their medication management?
- What mechanisms does the ambulance health service have in place to monitor the effectiveness of the processes to partner with consumers in medication management?

Strategies for improvement

The **Partnering with Consumers Standard** has specific actions (**Actions 2.03 - 2.10**) related to processes for involving patients in their own care, shared decision making, informed consent and effective communication.

The strategies included in the **Partnering with Consumers Standard** can be used to inform the implementation of actions for minimising medicine-related risks.

Support shared decision making

The ambulance health service should implement processes for involving patients in shared decision making, informed consent and effective communication (**Partnering with Consumers Standard**, see **Actions 2.03–2.10**). This may require referral to a primary health practitioner, such as a general practitioner (GP) or pharmacist, for ongoing support to reduce medicine related risks.

Use processes to partner with patients at key points in the medication management pathway including when:

- Taking a best possible medication history (see **Action 4.05**)
- Documenting a patient's history of medicine allergies and adverse drug reactions (see **Action 4.07**)
- Establishing referral pathways for medication review with a primary care provider for patients identified at risk (see **Action 4.10**)
- Providing information to patients about medicines prior to administration (see **Action 4.11**)
- Providing a list of current medicines at transitions of care (see **Action 4.12**).

Consider the information the patient needs

The ambulance health service should use the strategies outlined in **Action 2.05** to identify and support patients who do not have the capacity to understand the risks of medicine use or make decisions about their care. It should also:

- Develop policies to support the workforce to assess individual health literacy and access language services when providing information about medicine use
- Provide patients and carers with consumer medicines information[184] to support informed choices about their medicines
- Refer to **Action 4.11** for specific strategies relating to the provision of information to patients on their individual medicines needs and risks
- Use techniques to check a consumer's understanding of medicine-related information (see **Action 2.08**).

Examples of evidence

- Policy documents that describe the process for gaining patient consent, or consulting with substitute decision-makers, prior to the administration of medicines
- Feedback from consumers and the workforce on processes for the provision of medicine-related information
- Medicine-related information for the workforce, patients, carers and families that meet the health literacy actions of the **Partnering with Consumers Standard**
- Records of workforce attendance at medication management and shared decision making training sessions
- Examples of improvement activities that have been implemented and evaluated to improve access to, and quality of, information about medicines provided to patients
- Observation of medication management practices
- Examples of clinical documentation that provide evidence of shared decision making about medication management
- Referral pathways for patients to access ongoing medicines support and medication review
- Results of patient experience surveys about medication management.

Medicines scope of clinical practice

Action 4.04

The health service organisation has processes to define and verify the authorisation and scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians.

Intent

Clinicians work within their scope of clinical practice, and have the knowledge, skills, competence and delegated authority to safely manage, use and handle medicines.

Reflective questions

- What processes does the ambulance health service use to ensure that only clinicians with the relevant authority supply, prescribe or administer medicines?
- What processes does the ambulance health service use to ensure that clinicians are competent and operating within their individual scope of clinical practice?
- How does the ambulance health service monitor the effectiveness of its processes for medicines scope of clinical practice?

Strategies for improvement

The **Clinical Governance Standard** has specific actions related to credentialing and scope of clinical practice relevant to this action:

- **Action 1.23** – scope of clinical practice
- **Action 1.24** – credentialing.

Establish processes which ensure only clinicians with the requisite authority prescribe or administer medicines

Develop systems for credentialing and defining scope of clinical practice in line with national, state and territory legislation and the requirements of the Australian Health Practitioner Regulation Agency (Ahpra).[185] A clinicians' scope of clinical practice is likely to be defined by their professional background, qualifications, credentials or authority, acknowledged through a professional board such as the Paramedicine Board of Australia, Ahpra registration or endorsement.

The ambulance health service should develop processes to monitor scope of practice for those with the authority to prescribe and administer medicines, including:

- Mechanisms to monitor compliance through performance management, administrative data and management processes
- Maintaining a log or register for individual positions or professions with authority to prescribe or administer medicines
- Implementing systems for the regular review of qualifications and competence of clinicians that supply, prescribe and administer medicines

- Developing processes for orientation, assessment and supervision of the workforce
- Reviewing organisational policies, procedures and guidelines to ensure regular assessment of qualifications and competence of clinicians to safely prescribe and administer medicines
- Training and competency assessment when new medicines or formulations are introduced or when implementing or updating medication management systems
- Processes for monitoring compliance with scope of clinical practice
- Audit and reporting of the effectiveness of the credentialing and scope of clinical practice processes.

Examples of evidence

- Credentialing and defining scope of clinical practice policies and procedures
- Systems for monitoring workforce compliance with medication management policies, procedures and guidelines
- Position descriptions, duty statements and employment contracts that outline responsibilities, accountabilities and scope of clinical practice for prescribing, supplying and administering or supervising the administration of medicines
- A regularly maintained log or register of clinicians with medication authority that includes details of their health practitioner registration status, any conditions that impact their registration, prescriber number (if applicable) and qualifications
- Maintenance of a secure signature register
- Evidence of contracts for medication management services provided by external providers
- Records of workforce medication authority competency assessments
- Training documents relating to safe prescribing, supply and administration of medicines, and the safe storage and disposal of medicines
- Records of workforce completion of medication management training
- Audits of patients' health care records to assess compliance with medication management policies
- Minutes and agenda items from committees and other meetings where reports on medication incidents and breaches of medication authorisations system are reviewed, discussed and action taken
- A risk register that includes actions to address identified risks
- A quality improvement plan that includes actions to address issues identified
- Examples of improvement activities that increase the effectiveness of the medication authority system
- Consumer and workforce evaluation of medication management training.

Documentation of patient information

A patient's best possible medication history is recorded when commencing an episode of care. The best possible medication history and information relating to medicine allergies and adverse drug reactions should be available to clinicians.

Best possible medication history and medication reconciliation

A best possible medication history (BPMH) is a snapshot of the patient's actual medicines use. This may differ from information contained in healthcare records, discharge summary or medicines lists held by the patient. It is important that the patient (or carer) is actively involved and that there is a formal, systematic process in place for obtaining a BPMH.[182]

Due to the nature of the out of hospital environment, obtaining a BPMH may be challenging and it will be important to work collaboratively with other health care providers involved in a patient's care to develop a BPMH. This can include ensuring a patient's own medicines accompany them to their destination, obtaining copies of recent discharge summaries or obtaining a medication list prepared by a primary care provider or pharmacist.

Medication histories are often incomplete, with medicines, strengths and doses missing, and over the counter and complementary medicines often omitted. Instituting a formal, systematic process for obtaining a BPMH reduces the risk of incomplete information being communicated during transitions of care and is essential for:

- Ensuring continuity of medication management
- Identifying medicine related problems
- Identifying potential medication related discrepancies
- Informing the decision making process
- Optimising use of medicines.

Medicine allergies and adverse drug reactions

Medicine allergies and adverse drug reactions (ADRs) can be classified as:

- Known - those that have been previously experienced by the patient before their episode of care
- New - those that are experienced by patients during their episode of care and have not been previously experienced or documented
- De-labelled – those that are suspected to be or previously were, allergic reactions, however the patient has undergone a drug allergen challenge and has been confirmed not-allergic, therefore the medication is safe to administer.[186]

The administration of contraindicated medicines to patients with a known medicine allergy or previous ADR can be prevented by having mechanisms in place for alerting clinicians who prescribe and administer medicines. Contraindicated means there is a known allergy or ADR. Information on a patient's known medicine allergies and ADRs can be collected on presentation to the ambulance health service and recorded in the patient health record to assist a BPMH. Any new medicine allergies or ADRs should be recorded in the same place.

If there is any doubt about the nature of a medicine allergy, there must be a process for clinicians to ensure ongoing management by the patient's health care provider, including updating the healthcare record and removal of allergy alerts.[187]

Medicine allergies and ADRs are included in the definition of an adverse drug event. If a patient is given a medicine that is contraindicated they are at risk of experiencing preventable harm.[188]

To minimise the risk of preventable harm from adverse drug events, it is critical to ensure that clinicians understand their responsibility to refer to a patient's medicine allergy and ADR history before, or at the point of, decision making when prescribing or administering medicines.

Using the organisation's incident monitoring system, all adverse drug events are expected to be reported. Clinicians are also expected to report new suspected ADRs to the Therapeutic Goods Administration (TGA). This provides important information about possible adverse effects and unintended or unfavourable events associated with a medicine for the TGA's national safety monitoring program (see **Action 4.09**).

Medication reconciliation

Action 4.05

Clinicians take a best possible medication history, which is documented in the healthcare record on presentation or as early as possible in the episode of care.

Intent

Patients and carers are actively involved in taking a best possible medication history as the first step in the process of medication reconciliation.

Reflective questions

- What processes are used by the ambulance health service to obtain and record a best possible medication history (BPMH) in the patient's healthcare record?
- How does the ambulance health service evaluate the quality of patient involvement in the process of obtaining a BPMH?

Strategies for improvement

An ambulance health service should implement processes for obtaining a patient's BPMH as soon as possible during an episode of care. Verification of a person's current medicines or known allergies from other sources may not be possible whilst a person is in the care of the ambulance health service due to the nature of the person's presentation.

Ambulance health services can implement strategies to support the receiving facility by ensuring a patient's own medicines accompany them to their destination, documenting information provided by families or carers, or obtaining copies of recent discharge summaries or a medication list prepared by a primary care provider or pharmacist.

The ambulance health service should also:

- Implement processes for a BPMH to be completed, or the process supervised, by a clinician with the required skills and expertise
- Implement policies, procedures and guidelines for obtaining a BPMH that include:
  - a standardised process
  - the key steps of the process, including accessing information from other health care providers
  - documentation requirements including provision of summaries to primary care providers and My Health Record, if applicable
  - roles, responsibilities and accountabilities
  - training requirements for clinicians
  - involvement of patients and carers (see **Action 4.03**)
- Develop a standardised format for recording the BPMH. This creates 'one source of truth', and acts as an aid to reconciliation during assessment screening, clinical handover and at transitions of care
- Provide orientation, training and education to members of the workforce - learning modules and instructional videos are available from various state, national and international organisations
- Implement and evaluate systems for continuity of medication management at transitions of care.

Examples of evidence

- Policies, procedures and protocols for obtaining and documenting a BPMH
- Standardised templates or forms for documenting a BPMH
- Audit of patient healthcare records for documented BPMH in accordance with published policies and procedures
- Workforce orientation manuals, education resources and records of attendance at training on obtaining and documenting a BPMH
- Feedback from members of the workforce on processes for gathering a BPMH
- Feedback from patients on the process of obtaining a BPMH
- Recommended actions have been implemented and outcomes evaluated and reported.

Action 4.06

Clinicians review a patient's current medication orders against their best possible medication history and the documented treatment plan, and reconcile any discrepancies on presentation and at transitions of care.

Intent

A formal, structured, multidisciplinary and timely process is in place for reconciling medicines against the best possible medication history and treatment plan, which involves patients and carers.

Reflective questions

- What processes does the ambulance health service have in place to ensure that clinicians review their patients' current medication orders against the best possible medication history (BPMH)?
- How and where are discrepancies with a patient's medicines documented and reconciled?
- How are recommendations for a patient's medicines to be reviewed communicated at clinical handover or at transitions of care?
- How does the ambulance health service evaluate its processes for reconciling medicines against the BPMH?

Strategies for improvement

Within the context of out of hospital care, a patients' 'current medication order' will generally be the treatment pathway as determined by the out of hospital clinician and the medicines required within this pathway. The medicines within this pathway are to be reconciled against the *available* BPMH and *available* current medicines lists (see **Actions 4.04** and **4.06**). Ambulance health services should:

- Develop policies, procedures and guidelines to support medication reconciliation. This may include:
  - providing a current medicines list at transitions of care
  - identifying roles, responsibilities and accountabilities
  - outlining requirements for documentation
  - training requirements for clinicians who are responsible for reconciling medicines against an available BPMH and current medicines list
  - processes to involve patients and carers (see **Action 4.03**)
- Use a risk assessment approach to identify and document the types of patients that may require medication reconciliation (see **Action 4.12**).
- Prioritise medication reconciliation in patients who have a higher risk of experiencing medicine-related problems or adverse drug reactions, including those patients who may require additional support with the management of their medicines (see **Actions 4.10** and **4.12**). This may be achieved by referring these patients to a primary care provider for further support.
- Implement a formal structured process to ensure that patients identified at risk, receive appropriate follow up to support medication reconciliation at clinical handover or at transfer of care.

An ambulance health service should develop systems that define scope of clinical practice and assess competence of clinicians to support medication reconciliation. This may include following the patients' treatment pathway and documentation and provision of information to another care provider at transition of, or on completion of an episode of care.

Examples of evidence

- Policies, procedures and protocols that define and prioritise the types of patients who may require medication reconciliation
- Policies, procedures and protocols for the requirements of reconciling medicines in alignment with treatment pathways
- Policies, procedures and protocols for accessing medication histories and medicine lists at the point of care
- Implementation of screening or risk assessment tools
- Completed patient risk assessments
- Standardised templates or forms for documenting the BPMH and medication reconciliation (electronic or paper)
- Policies and processes to support patients at risk to access medication reconciliation via a primary care provider
- Audit of patient healthcare records assessing BPMH against the treatment pathway and referral for medication reconciliation
- Observation of BPMH and discussion of medication reconciliation procedures
- Orientation manuals, education resources and records of clinician attendance at training on processes for reconciling medicines.

Adverse drug reactions

Action 4.07

The health service organisation has processes for documenting a patient's history of medicine allergies and adverse drug reactions in the healthcare record on presentation.

Intent

Medicine-related risks for patients are minimised by documenting and referring to the patient's history of medicine allergies and adverse drug reactions.

Reflective questions

- How does the ambulance health service ensure that a patient's history of medicine allergies and adverse drug reactions (ADRs) is recorded when taking a best possible medication history (BPMH) on presentation?
- How does the ambulance health service ensure that clinicians who prescribe or administer medicines know that a patient has an existing medicine allergy or ADR?
- How does the ambulance health service monitor the effectiveness of its processes to document and refer a patient's history of medicine allergies and ADRs?

Strategies for improvement

The ambulance health service should develop policies, procedures and guidelines for clinicians to elicit and document all known medicine allergies and ADRs in the patient healthcare record (electronic or paper) and on the medication management plan or equivalent. Policies, procedures and guidelines should:

- Identify the clinicians responsible for confirming and recording information on known medicine allergies and ADRs
- Describe requirements for documentation in the patient health care record of known medicine allergies and ADRs
- Describe actions to be taken where verification of information is required
- Describe when it is appropriate to record known allergy or adverse reaction to substances other than medicines such as food
- Consider opportunities that may enable clinicians to elicit ADR information from other health service electronic platforms
- Implement systems to ensure ongoing management by the patient's primary health care provider for appropriate referral to have the medication allergy confirmed
- Ensure that known medicine allergies and ADRs are recorded during the patient journey
- Provide orientation, training and education to clinicians
- Audit compliance with processes for:
  - determining and documenting known medicine allergies and ADRs, including type of reaction and sensitivity
  - referring to a patient's medicine allergy and ADR history before, or at the point of decision making, when prescribing or administering medicines

- Conduct audits of documentation of medicine allergies and ADRs
- Monitor trends relating to medicine allergy incidents and ADRs. If required, implement and assess measures to reduce these types of incidents
- Collate and review audit trends, and provide information to clinicians through medication safety bulletins, at staff meetings, in-service orientation sessions and case reports.

Examples of evidence

- Policies, procedures and protocols for identifying, documenting, managing and reporting known medication allergies and ADRs
- Audit of patient's healthcare records to review documentation of ADRs, including any new allergies
- Audit of the use of ADR alert systems in electronic medicines management software
- Incident management system reports that display types of incidents, including ADRs and medicine allergy-related incidents
- Orientation manuals, education resources and records of clinician attendance at training about recording known medication allergies and reporting ADRs.

Action 4.08

The health service organisation has processes for documenting adverse drug reactions experienced by patients during an episode of care in the healthcare record and in the organisation-wide incident reporting system.

Intent

Medicine allergies and adverse drug reactions experienced by patients while in the ambulance health service are documented in the patient's medicine allergy and adverse drug reactions history and in the incident management and investigation system.

Reflective questions

- What processes does the ambulance health service use to ensure that all medicine allergies and adverse drug reactions (ADRs) experienced by a patient during an episode of care are recorded in the patient's healthcare record?
- How are ADRs reported in the ambulance health service's incident management and investigation system?
- How do clinicians assess that a patient has experienced a side effect or new medicine allergy or ADR?
- What processes are used to ensure that clinicians document a patient's new medicine allergies or ADRs on their medicines list?
- What strategies are in place to support patients and carers to inform or alert clinicians about new allergies or ADRs they suspect they might be experiencing?
- How does the ambulance health service monitor the effectiveness of its processes to document patient medicine allergy and ADR episodes in the patient's existing history and in the incident management and investigation system?

Strategies for improvement

Develop systems for documenting new medicine allergies and ADRs

Implement processes for updating healthcare records and informing a patients' primary health care provider about medicine allergies and ADRs and removal of allergy alerts and the reason, where confirmed. Information on all new medicine allergies and ADRs should be available to clinicians when medicines are being prescribed or administered.

Develop policies and procedures, and provide education and training

Processes for documenting and reporting medicine allergies and ADRs experienced by patients during their episode of care (see **Actions 4.01** and **4.02**) developed by the ambulance health service should:

- Identify the clinician responsible for managing and recording information on side effects and new medicine allergies and ADRs
- Describe requirements for reporting all new medicine allergies and ADRs in the organisation's incident management and investigation system
- Describe processes for informing the patient about all new medicine allergies and ADRs
- Describe processes for communicating all new medicine allergies and ADRs at the conclusion of an episode of care or at transitions of care

- Support the workforce to provide information on new allergies and ADRs to the patients' primary health care provider and the patient's My Health Record
- Incorporate information on new allergies and ADRs is standardised handover documentation
- Include requirements for updating the patient's medicines list (see **Action 4.12**).

The ambulance health service should also identify requirements for new medicine allergies and ADRs to be recorded in the organisation's incident management reporting system, as well as:

- Provide orientation, training and education to the workforce on identifying and documenting medicine side effects, allergy and ADR history
- Provide training and ongoing professional development related to processes for prescribing and administering medicines
- Audit compliance with published policies and requirements for documenting and communicating medicine allergies and ADRs
- Audit health care records on medicine allergies and ADRs
- Report outcomes and trends to members of the workforce
- Utilise results to identify opportunities for improvement
- Provide information on medicine allergies and ADRs through medication safety bulletins, in-service, orientation sessions or case reports.

Examples of evidence

- Policy documents about recording new medicine allergies and ADRs experienced during an episode of care
- Audit results of workforce compliance with policies, procedures, protocols and guidelines for documenting new medicine allergies and ADRs
- Audit results of patient healthcare records for documentation of new medicine allergies and ADRs in places noted in policies, procedures, protocols and guidelines
- Feedback to the workforce about compliance with policies, procedures, protocols and guidelines for documenting existing and new medicine allergies and ADRs
- Results of analysis of incident data relating to existing and new medicine allergies and ADRs
- Screening, clinical handover or transfer tools or templates that include a section to record allergies and ADRs
- Audit of patient's healthcare records where patients have been supported to participate in the reporting of medicine allergies and ADRs during their episode of care
- Examples of quality improvement strategies where recommended actions have been implemented and outcomes evaluated and reported
- Orientation or training documents about documenting patients' new medicine allergies and ADRs.

Action 4.09

The health service organisation has processes for reporting adverse drug reactions experienced by patients to the Therapeutic Goods Administration, in accordance with its requirements.

Intent

All new suspected adverse drug reactions experienced by patients during their episode of care are reported to the Therapeutic Goods Administration (TGA).

Reflective questions

- What processes does the ambulance health service use to report all new suspected adverse drug reactions (ADRs) experienced by patients during an episode of care to the Therapeutic Goods Administration (TGA)?
- What resources, tools or information does the ambulance health service provide to clinicians to encourage the reporting of ADRs?
- How does the ambulance health service use the information and reports about suspected ADRs?

Strategies for improvement

Develop systems to record and report new suspected ADRs to the TGA through the **Australian Adverse Drug Reaction Reporting System**. Within the out of hospital context, this may involve processes to include information for reporting purposes at the conclusion of an episode of care or at transitions of care. To support the process to report all suspected ADRs, the ambulance health service should:

- Consider registration with the **Australian Adverse Drug Reaction Reporting System**
- Provide policies for members of the workforce to report a case of a suspected adverse reaction in association with a medicine (including complementary, over the counter or prescription) or vaccines, together with orientation, training and education
- Develop and implement organisational policies, procedures and guidelines to ensure that all suspected ADRs are reported to the TGA and include information about:
  - roles, responsibilities and accountabilities
  - organisational processes for recording copies of communication with the TGA
  - what to report
  - how to report suspected ADRs
  - how to maintain healthcare records and document a suspected ADR
  - how incidents of suspected ADRs, outcomes and actions for improvement will be reported to the workforce and governing body
- Provide orientation, training and education for members of the workforce on reporting suspected ADRs to the TGA
- Audit compliance with published policies and procedures on reporting suspected ADRs
- Develop and evaluate consumer information about ADRs, including how to recognise and self-report to the TGA

- Disseminate reports on suspected ADRs to the workforce, consumers and relevant governance committees
- Access information on ADRs and medication safety issues by:
  - reviewing the database of Adverse Event Notifications
  - subscribing to the Medicine Safety update email list
  - subscribing to the TGA Safety information email list

Examples of evidence

- Policies, procedures and protocols for identifying, documenting, managing and reporting new suspected ADRs within the ambulance health service to the TGA
- Training and communication to the workforce explaining the process for reporting suspected ADRs to the TGA
- Record of suspected ADR reports submitted to the TGA
- Register of ADRs that includes actions to address the identified risks
- Documentation from committees and other meetings that demonstrate ADRs are reviewed and discussed
- Communication to the workforce and consumers on ADR reports
- Access to tools for reporting ADRs
- Audit reports of health care records
- Patient and carer resources outlining how they can self-report ADRs to the TGA.

Continuity of medication management

A patient's medicines are reviewed, and information is provided to them about their medicines needs. Risks are identified and a list of medicines is provided to the patient and the receiving clinician when handing over care.

Medication review

Medication review is a multidisciplinary responsibility that should be person-centred. It ensures ongoing safe and effective use of medicines at all stages of the medication management pathway, including at the point of prescribing, dispensing and administering a medicine.

For people receiving out of hospital care, the most suitable person to conduct this may be another service provider, such as a primary care provider. Medication review is often considered to be the role of a pharmacist and some aspects of medication review will not be within scope of the ambulance health service.

Where applicable, ambulance health services can contribute to patient safety by ensuring that medicine related information is communicated at completion of an episode of care and at transitions of care. Ambulance health services can contribute to the process of medication review by gathering medications from a person's home or from the person, and ascertaining a best possible medicines history.[170] These are vital steps required for the person's safe onward patient journey.

A well-structured medication review will optimise outcomes and in turn minimise medicine-related problems for patients and can include:[189]

- Prescription review—a technical review of a patient's medicines to identify any anomalies with medicine orders or prescriptions
- Concordance and compliance review—a structured review to consider issues relating to a patient's medicine-taking behaviour (also called review of medicines use)
- Clinical medication review—a structured review of medicines and clinical 'condition' with the patient and/or their carer. An outcome of review could be cessation (or 'de-prescribing') of a medicine.

Medication reviews can be unstructured and opportunistic, and provide a mechanism to partner with patients and their families to optimise medicine use. This can help patients to:

- Be involved in decision making and consider the options, benefits and risks of the proposed treatment
- Make informed choices about their medicines
- Assist in medication reconciliation and prevention of errors by identifying medicine-related problems
- Alert clinicians to suspected ADRs
- Manage their condition and participate in their own care.

Information for patients

The ambulance health service should provide patients and carers with enough information about medicine-related treatment options to ensure the patient and carers understand the treatment options and the benefits and risks. Appropriate education and provision of medicine-related information are essential to encourage safe and effective medicine use and promote adherence to treatment regimens.

Medicines list

Transitions of care can increase risk of medication error.[190] All clinicians have a shared responsibility to ensure that accurate and complete medicine-related information is communicated whenever care is transferred (see **Action 6.07**). When medicine-related information is incomplete or inaccurate this can increase a person's risk of readmission to hospital.[191]

Ambulance health services can contribute to collation of a current medicines list by documenting medicines retrieved from a patient's home and conveying the list to ongoing care providers. There should be processes that enable the workforce to access external services that can provide information about a current medicines list.

Medication review

Action 4.10

The health service organisation has processes:

a. **To perform medication reviews for patients in line with evidence and best practice**
b. **To prioritise medication reviews based on a patient's clinical needs and minimising the risk of medication-related problems**
c. **That specify the requirements for documentation of medication reviews, including actions taken as a result.**

This Action is not applicable for ambulance health services.

See **Advisory AS23/02: Advice on not applicable actions for Ambulance Health Services**.

Where this Action is applicable, refer to the **NSQHS Standards Guide for Hospitals**.

Information for patients

Action 4.11

The health service organisation has processes to support clinicians to provide patients with information about their individual medicines needs and risks.

Intent

Clinicians are supported to provide information to their patients about medicines options, benefits and risks.

Reflective questions

- How does the ambulance health service ensure clinicians inform patients about options for their care, including medicines?
- What information do clinicians provide to patients about the benefits and risks of medicine-related options?
- How does the ambulance health service ensure clinicians gain access to medicine-related information for patients?
- What strategies does the ambulance health service have in place to support patients and carers to raise concerns about medicine-related risks and clarify the information they are provided?
- How does the ambulance health service monitor the effectiveness of the processes to provide information to patients about medicine options, benefits and risks?

Strategies for improvement

The **Partnering with Consumers Standard** **Actions 2.03–2.10** and **Medication Safety Standard** **Action 4.03** include requirements for organisation-wide processes for involving patients in their own care, shared decision-making, informed consent and effective communication relevant to this action.

Providing medicine-related information is a multidisciplinary responsibility. Where an ambulance health service does not possess internal pharmaceutical expertise, development of resources may require external assistance.

The ambulance health service should provide patients and carers with medicine-related information to enable them to make informed choices about their medicines, and to adhere to medicine-related treatment plans (see **Action 4.12**).

Ambulance health services should implement organisational policies, procedures, protocols and guidelines that describe processes for:

- Discussing the benefits and associated risks of medicines and seeking informed consent
- Accessing evidence-based, medicine-related information when treatment options are discussed, such as **consumer medicine information**
- Documenting in the healthcare record information provided to patients and carers about medicines (see **Action 2.04**)
- Providing medicines information to patients and carers
- Providing patients with information about how to identify allergies and report an adverse drug reaction
- Promoting the availability and use of consumer specific medicine-related information, tools and resources to the workforce
- Auditing healthcare records to determine whether the provision of medicine-related information has been documented
- Seeking feedback from consumers and the workforce on medicine-related information.

Examples of evidence

- Policies, procedures and protocols that define the roles, responsibilities and accountabilities of clinicians for informing patients and carers about medication treatment options, benefits and associated risks
- Orientation manuals, education resources and records of attendance about discussing medication treatment options, benefits and associated risks
- Audit of health care records on the types of information provided to patients and carers about medicines
- Reports from incident management or complaints systems regarding medicine-related issues
- Audits of compliance with policies, procedures or protocols
- Results from quality improvement initiates that identify that recommended actions have been implemented and outcomes evaluated and reported
- Results of patient experience surveys on the provision of information about medicines and treatment options.

Provision of medicines list

Action 4.12

The health service organisation has processes to:

a. **Generate a current medicines list and the reasons for any changes**
b. **Distribute the current medicines list to receiving clinicians at transitions of care**
c. **Provide patients on discharge with a current medicines list and the reasons for any changes.**

Intent

Medicine-related problems and risk of patient harm are minimised by maintaining a current medicines list with reasons for any changes, and providing it in a suitable format for clinicians at transfer of care and for patients on discharge.

Reflective questions

- What ambulance health service processes are used by clinicians to contribute to a current medicines list during a patient's episode of care?
- How do clinicians generate a current medicines list and communicate this at transitions of care?
- How is informed patient consent incorporated into the process for sharing the patient's medicines list?
- How does the ambulance health service monitor the processes to manage current medicines list and their use in clinical care?

Strategies for improvement

Continuity of medication management includes generating, maintaining and communicating a current list of medicines and the reasons for changes at clinical handover (see **Actions 6.07** and **6.08**).

It is critical to communicate the patient's current medicines list, along with any medicine-related problems or adverse drug events that have occurred during an episode of care (see **Action 4.06**). A medicine-related problem may include a patient refusing or missing a dose of prescribed medicine.

Incorporate medicines lists at the conclusion of an episode of care and at transitions of care

The ambulance health service should ensure that education of the workforce includes the principles of continuity of medication management.

It should also ensure that policies, procedures and guidelines for clinical handover include communicating issues relating to a patient's medication management during their episode of care, and the roles, responsibilities and accountabilities of clinicians.

The ambulance health service should establish a set of key elements relating to medication management at clinical handover and transitions of care, such as identifying high-risk patients, high-risk medicines, and the priorities for maintaining treatment and achieving patient treatment goals (see **Action 4.03**).

In implementing processes that support clinicians to generate or contribute to a current medicine list (see **Action 4.06**), the ambulance health service should consider including:

- Policies, procedures and protocols for medication management and medication reconciliation that include:
  - roles, responsibilities and accountabilities
  - the minimum information to be documented
  - how and where the list will be accessed
  - managing risks with generating a medicines list
  - the sources of information the ambulance health service will use to generate the medicines list (see **Action 4.05** for obtaining the best possible medication history)
  - how discrepancies will be reconciled
- Develop systems for the provision of a current reconciled medicines list, in a standard format (electronic or paper)
- Provide access to the system that supports medication management in all clinical areas to create 'one source of truth'
- Incorporate the use of medicines lists into clinical handover procedures
- Implement and evaluate systems to ensure effective communication of current medicines lists at transitions of care
- Implement a process to provide patients with a current medicine list. This may require referral to a primary care provider for advice specific to their medicines list and reasons for any recommended changes
- Audit compliance with published policies and processes for documenting current medicines and for maintaining records in a standard format
- Review processes to partner with consumers to:
  - provide current medicines lists to patients and the receiving health professional
  - provide instructions for ongoing care and follow-up requirements
  - obtain informed consent to provide information to other health care professionals
  - provide tailored information for patients and carers that explain the medicines list, its purpose and any changes (see **Action 4.11**).

Examples of evidence

- Policies, procedures and protocols for the generation of medicine lists
- Audit of patient healthcare records that contain a medicine list and documented explanation of changes
- Standardised format for generating medicines lists
- A process for requesting medicines lists from external service providers
- Orientation manuals, education resources and records of clinician attendance at training on generating and updating medicine lists
- Documented evidence in the patient healthcare record of the ambulance health service's contribution to the medicines list
- Documented evidence of processes to gain consent before sharing a patient's medicine list
- Examples of medicines lists including where medicines lists have been tailored to the specific needs of the patient or recipient.

Medication management processes

Health service organisations procure medicines for safety. Clinicians are supported to supply, store, prescribe, dispense, administer, monitor and safely dispose of medicines.

Medication safety strategies and monitoring processes should be adapted to the context of the ambulance health service and extent of medication management activities undertaken. The scope of medication management in out of hospital settings will not include the compounding or manufacturing of medicines.

Many of the risks associated with each part of the medication management pathway can be avoided by using systems and processes that are evidence based. These initiatives focus on addressing the common contributing factors to medication errors, which most commonly include:[192]

- Lack of knowledge of the medicine
- Lack of information about the patient
- Lack of standardised processes[180]
- Slips and memory lapses
- Transcription errors
- Failure in communication
- Lack of patient education
- Poor medicines procurement and distribution practices.

Medication safety initiatives implemented by the ambulance health service should focus on systems and standardisation to reduce unnecessary variation and be supported by tools and resources to improve knowledge and skills. The actions and strategies described in this criterion aim to achieve safe and effective medicines use through:

- Use of best-practice information and decision support tools in clinical decision making
- Compliance and safety in medicines distribution and storage systems
- Identifying high risk areas and embedding processes, practices and tools to reduce risk
- Integration of work practices that underpin safe medication management, such as standardisation, monitoring and risk assessment
- Use of medication safety strategies and tools to create an environment for the optimal communication of medicine-related information.

Actions within this criterion require ambulance health services to:

- Ensure the workforce has access to evidence-based medicine-related information and decision support tools
- Ensure the effectiveness of the supply chain in the safe procurement, delivery and storage of medicines
- Ensure compliance with relevant jurisdictional requirements for maintaining the integrity of medicines, minimising wastage and disposing of medicines appropriately
- Implement strategies for safe and secure storage and selection of medicines, including high-risk medicines.

Information and decision support tools for medicines

Action 4.13

The health service organisation ensures that information and decision support tools for medicines are available to clinicians.

Intent

Medication management is supported by providing relevant, up-to-date and evidence-based medicine-related information and decision-support tools to the clinical workforce.

Reflective questions

- How does the ambulance health service ensure that medicine-related information and decision support tools are up-to-date and available to clinicians at the point of decision making?
- How does the ambulance health service monitor and improve its information and decision support tools for medicines?

Strategies for improvement

Maintain up-to-date and evidence-based medicine-related information and decision support tools

Ambulance health services should maintain a variety of up-to-date and evidence-based medicine-related information and decision support tools and make them available to clinicians.

Decision support includes any functionality or resource that helps clinicians make the most appropriate decisions for patient care and provides guidance (a medicine-related protocol) or incorporates knowledge (an electronic database of medicine–medicine interactions). The use of tailored medication decision support tools can be used to reduce medicine related errors[180] in situations involving high patient acuity, complex patient populations such as paediatrics[193, 194] and where members of the workforce are working in difficult environmental conditions.[195]

Decision support aids may be electronic or in hard copy. They should support all stages of medication administration in a succinct format from the decision to administer, to dose determination and preparation, including dilution and volume of administration.[166, 194] This is particularly important for high-risk or infrequently used medications.[166]

Examples of decision support tools include:

- Formulary information, prescribing requirements and approval systems
- Policy directives, protocols, guidelines and authorised standing orders
- Dosing calculators and electronic medicine-interaction databases
- Reference texts, telephone-based medicines information and advice services
- Guidelines for safe administration of specific medicines, such as administering medicines via enteral tubes
- Access to health care records including My Health Record
- Treatment guidelines and protocols, such as appropriate choice of antimicrobials.

Ambulance health services should:

- Review the organisation's range of medicine-related information and decision support tools, including guidelines and protocols
- Ensure that processes are in place for maintaining up-to-date, evidence-based medicine-related information and decision support tools
- Make available medicine-related information that is mandated by legislation

The ambulance health service should ensure that these processes consider requirements for clinician training and ongoing education. A minimum standard set of medicine-related reference materials could include current versions of:

- **Australian Medicines Handbook (AMH)** and **AMH Children's Dosing Companion**
- **Therapeutic Guidelines**
- **The Australian Immunisation Handbook**
- Australian product information and consumer medicine information, such as **MIMS** or **AusDI**
- Medicine interactions references, such as **Micromedex** or **Stockley's Drug Interactions**
- References on complementary and alternative medicines, such as **MedlinePlus**
- **Australian Injectable Drugs Handbook** or local injectable medicines administration guidelines
- **Don't Rush to Crush** handbook or local guidelines.

Make up-to-date and evidence-based medicine-related information and decision support tools available to clinicians

The ambulance health service should implement systems to ensure the workforce has access to approved, evidence-based medicine-related information and decision support tools at all stages of the medication management pathway. It should also:

- Consider roles, responsibilities and accountabilities for conducting review and approval of medicine related information and reporting to members of the workforce
- Ensure that processes are in place for maintaining up-to-date, evidence-based medicine-related information and decision support tools
- Consider the use of technology to deliver medicine-related information and decision support tools
- Provide workforce orientation, training and education on medicine-related information and decision support tools
- Ensure that the content of medicine-related information and decision support tools are:
  - consistent with evidence-based prescribing and administration of medicines
  - appropriate for the patient case mix, scope of medicines practice and workflows
  - consistent with the organisation's policies, procedures, protocols and guidelines
  - available in several formats to meet the needs and preferences of patients
  - integrated within the ambulance health service's digital systems.

Examples of evidence

- Results of needs assessment to identify up-to-date medicines information resources and decision support tools
- Availability and accessibility of clinical decision support tools
- Evaluation of medicine-related information and decision support tools
- Workforce access to electronic decision support tools
- Communication to the workforce about medicine-related information and decision support tools.

Safe and secure storage and distribution of medicines

Action 4.14

The health service organisation complies with manufacturers' directions, legislation and jurisdictional requirements for the:

a. **Safe and secure storage and distribution of medicines**
b. **Storage of temperature-sensitive medicines and cold chain management**
c. **Disposal of unused, unwanted or expired medicines.**

Intent

Medicines are safely stored and distributed with minimal waste, and disposed of appropriately.

Reflective questions

- What systems does the ambulance health service have in place for the storage and handling of medicines according to manufacturers' directions?
- How does the ambulance health service manage the stability medicines and reduce risks associated with the storage of medicines?
- What processes does the ambulance health service have in place to ensure that only clinicians with the relevant authority have the responsibility to manage and access medicines?
- How does the ambulance health service ensure that processes for medication disposal are consistent with state or territory requirements and the manufacturer's instructions?

Strategies for improvement

Identify and reduce risks

Medicines used in out of hospital settings should be stored in accordance with the manufacturer's guidance. Design and storage of medicines in out of hospital settings may vary and includes portable kit bags, secure medication rooms and safes. Ambulance health services should evaluate processes for storage and disposal of medicines in line with available evidence.[196,166]

Due to the nature of the out of hospital setting, exposure of medicines to extreme environmental conditions can occur. Temperature excursions can be defined as environmental temperatures to which a product may be exposed during transport or long-term storage that exceed the manufacturer's label claim conditions for the product.[197]

Ambulance health services should develop a plan for addressing known and emerging risks relating to medication storage. Emerging literature provides some advice regarding the physicochemical attributes and stability of medicines commonly used by ambulance health services.[198, 199] Advice can be sought from manufacturers on the stability of drug formulations where temperature excursions have occurred.[197, 198] Strategies include:

- Conducting a risk assessment and developing systems for monitoring, storage and use of temperature sensitive medicines[198]
- Implementing systems for reporting and managing temperature excursions

- Implementing policies and processes for safe and secure storage, distribution and disposal of medicines in compliance with legislative requirements
- Implement systems and equipment in accordance with the latest edition of **National Vaccine Storage Guidelines: Strive for 5**[200]
- Establish appropriate governance and oversight to ensure that medicine storage systems are safe, secure and inaccessible to the public (see **Action 4.01)**
- Incorporate factors that reduce opportunity for 'look-alike, sound-alike' selection errors when considering:
  - product procurement, labelling, packaging and storage
  - listing of new medicines in the formulary
  - temporary replacement of a formulary medicine such as when medicine shortages or supply chain interruptions occur
  - design and layout, including workflow and secure access.

Monitor and evaluate processes

- Evaluate the processes for the handling, storage and disposal of medicines
- Utilise results to inform quality improvement initiates to support safe storage, handling and disposal of medicines
- Where risks are identified develop evidence-based strategies to remediate and reduce ongoing risks
- Review compliance with policies, procedures and protocols for handling, storage and disposal of medicines
- Review security, workflow and processes for access to medicine storage areas
- Review incident reports associated with handling, storage and disposal of medications and ensure recommendations for corrective action have been implemented and evaluated
- Implement systems to communicate to the workforce changes to product labelling, packaging or storage requirements.

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

- Implement policies, procedures, protocols and guidelines for disposal of unused, unwanted or expired medicines I line with legislative, health and safety, and state or territory requirements
- Implement and review systems and processes that minimise wastage of medicines
- Monitor usage patterns of medicines to identify underuse or fluctuations of use
- Set up inventory management practices to eliminate wastage of medicines.

Examples of evidence

- Policies, procedures and protocols for the safe and effective storage of medicines including temperature-sensitive and Schedule 8 medicines
- Policies, procedures and protocols for management of cold-chain breaches
- Policies, procedures and protocols for the disposal of unused, unwanted or expired medicines that align with legislative, jurisdictional and manufacturer's requirements
- Completed risk assessment of systems used for distributing/receiving and storing medicines
- Audit of compliance with policies, procedures and protocols for distribution and storage of medicines
- Audit reports of distribution and medicine storage areas, facilities and equipment
- A risk register that includes actions to address identified risks and temperature excursions
- Schedules for maintenance of refrigerators
- Audit of compliance with processes for temperature monitoring of temperature sensitive medicines and vaccines

- An incident register that includes incidents, adverse events and near misses related to temperature excursions
- Records of action taken in response to temperature excursion or cold-chain breaches
- Documentation from committees and other meetings where the risks identified with storage or disposal of medicines are reviewed and discussed
- Examples of improvement activities that have been implemented and evaluated to reduce the risks
- Memorandums, newsletters or other communication material provided to the workforce on safe and secure storage and disposal of unused, unwanted or expired medicines
- Orientation manuals, education resources and records of attendance at workforce training on safe storage and disposal of medicines
- Advice for patients on the safe and appropriate storage and disposal of medicines in the community
- Completed risk assessment and reports of disposal of medicines, including Schedule 8 medicines.

High-risk medicines

Action 4.15

The health service organisation:

a. **Identifies high-risk medicines used within the organisation**

b. **Has a system to store, prescribe and administer high-risk medicines safely**

Intent

Medicine-related risks are minimised by identifying and safely managing processes relating to high-risk medicines.

Reflective questions

- What processes does the ambulance health service have in place to identify medicines that are high risk?
- How does the ambulance health service ensure safe and appropriate storage, prescribing, administration and distribution practices for high-risk medicines?
- How does the ambulance health service monitor the effectiveness of systems to manage high-risk medicines?

Strategies for improvement

Regularly assess use of high-risk medicines

The ambulance health service should set up a structured framework for the monitoring and review of high-risk medicines (see **Action 4.01**). This could include processes for:

- Identifying high-risk medicines and managing the associated risks
- Monitoring and analysis of incident reports and logs
- Monitoring adverse drug reactions (see **Actions 4.07–4.09**)
- Monitoring published literature for safety alerts
- Auditing the use, storage and documentation of high-risk medicines against published policies and procedures
- Developing and implementing evidence-based risk reduction strategies for high-risk medicines.

The ambulance health service should provide training to the workforce on safe prescribing. This could include standardised or specialised charts, using protocols or standard sets, electronic prescribing and dose-calculating tools. The service should also establish quality improvement initiatives to support safe storage, handling and disposal of medicines which may include investigating systems to support:

- Medicine selection, such as using barcode or similar product-scanning technology, or using **Tall Man Lettering**[201]
- Safe procurement practices to address risks such as look-alike packaging for high-risk medicines
- Safe administration including:
  - the appropriate use of equipment such as infusion or administration devices, e.g., oral liquid dispensers
  - line labelling for routes of administration standardised premixed solutions
  - independent double-checks
  - principles of 'timeout'.

Develop and implement evidence-based risk reduction strategies

Ambulance health services should identify and regularly review high-risk medicines and make the list available to clinicians. Useful tools to assist with this include the Institute for Safe Medication Practices' **List of High-Alert Medications in Community/Ambulatory Settings**.[202]

Evidence-based risk reduction strategies might also include:

- Seeking feedback from the workforce on assessing and rating risks for individual high-risk medicines, their class and system risk(s), and how these risks can be mitigated
- Implementing training and ongoing education on medication safety
- Reviewing best available practice such as implementing systems for labelling such as **National Standard for User Applied Labelling of Injectable Medicines, Fluids and Lines**
- Protocols for identifying, reporting and managing adverse drug reactions
- Management of high-risk medicines incidents and jurisdictional requirements

The ambulance health service should use information from quality improvement systems to develop strategies to mitigate medication safety risks (see **Action 4.02**). It should also implement a combination of risk reduction strategies including standardised processes and forms, decision support software or products for medication management.

Monitor, investigate effectiveness and performance

The ambulance health service should audit compliance with published policies and processes to monitor the effectiveness and performance of its high-risk medicine processes. It should also:

- Investigate incidents involving high-risk medicines and implement strategies to mitigate identified risks
- Evaluate risk reduction strategies for high-risk medicines
- Ensure that recommendations from national, state or territory and local policies, alerts, incident reports and audits are actioned
- Provide feedback to the workforce on high-risk medicine related incidents and risk prevention strategies as part of the governance of medication management (see **Actions 4.01** and **4.02**)
- Promote safety awareness of high-risk medicines through regular feedback to clinicians
- Provide information on high-risk medicines to patients and carers.

Examples of evidence

- Policies, procedures and protocols for storing, prescribing, administering and monitoring high-risk medicines
- A list of high-risk medicines used in the ambulance health service
- Completed risk assessments of high-risk medicines
- A risk register that includes actions taken to address identified risks
- Reports of incidents involving high-risk medicines
- Records of feedback from the workforce on the management of high-risk medicines
- Audit results of compliance with policies, procedures, protocols and guidelines for prescribing, administering and monitoring specific high-risk medicines
- Examples of improvement activities that have been implemented and evaluated to reduce the risks of storing, prescribing and administering high-risk medicines
- Documentation from committees and other meetings where the management of high-risk medicines and actions taken are discussed
- Examples of standardisation of high-risk medicines such as
  - standardised dosing protocols, administration guidelines, checking procedures
  - pre-mixed solutions or pre-loaded syringes for injectable high-risk medicines
  - standardised single concentrations of infusions of high-risk medicines
- Memorandums, newsletters or other communication material provided to the workforce on the management of high-risk medicines.

Comprehensive Care Standard

Leaders of a health service organisation set up and maintain systems and processes to support clinicians to deliver comprehensive care. They also set up and maintain systems to prevent and manage specific risks of harm to patients during the delivery of health care. The workforce uses the systems to deliver comprehensive care and manage risk.

Intention of this standard

To ensure that patients receive comprehensive health care that meets their individual needs and considers the impact of their health issues on their life and wellbeing. It also aims to ensure that risks of harm for patients during health care are prevented and managed through targeted strategies.

Criteria

Clinical governance and quality improvement to support comprehensive care

Systems are in place to support clinicians to deliver comprehensive care.

Developing the comprehensive care plan

Integrated screening and assessment processes are used in collaboration with patients, carers and families to develop a goal-directed comprehensive care plan.

Delivering comprehensive care

Safe care is delivered based on the comprehensive care plan, and in partnership with patients, carers and family. Comprehensive care is delivered to patients at the end of life.

Minimising patient harm

Patients at risk of specific harm are identified, and clinicians deliver targeted strategies to prevent and manage harm.

Introduction

The intent of the Comprehensive Care Standard is to ensure that patients receive comprehensive care and that risks of harm for patients during health care are prevented and managed.

Comprehensive care involves teams of health professionals working together and communicating effectively to plan, manage and coordinate care with the patient.[203] It requires ambulance health services to have systems and processes in place to support this, and to foster a collaborative and person-centred culture.[204]

Although this standard refers to actions needed within a single episode of patient care, it is essential that each single episode or period of care is considered as part of the continuum of care for a patient.

Minimising patient harm

Processes for delivering comprehensive care rely upon the key principles of risk screening, goal identification, care coordination and care planning. Screening and triage occur at multiple levels and occasions within an ambulance health care setting, commencing with a request for a service.[205]

Screening outcomes are used to designate priorities and identify optimal care pathways for the patient.[206] Increasingly, ambulance health services play a crucial role in delivering care to those with urgent needs in relation to both acute and chronic medical presentations and those with social and mental health care needs. Ambulance health services play a significant role in transferring people to and from residential aged care facilities(RACF). When compared to the broader elderly population, people from RACF are high-acuity patients with a substantial likelihood of needing hospitalisation, receiving invasive intervention and dying during their admission.[205] Ambulance health services are also often the first (and frequently primary) contact with health services in the event of acute alcohol and other drugs related harms,[207] in addition to acute mental health and self-harm presentations.[208]

Screening and assessment processes should identify risks relating to the population being serviced and enable members of the workforce to identify patients at risk of specific harm to ensure that risks are minimised and managed during an episode of care. These systems will vary and will require a flexible approach to standardisation so that safety and quality systems support implementation and innovation. Ambulance health services should have protocols that clearly outline screening and assessment criteria and identify appropriate care pathways for patients who require referral to other services or health care professionals.

Ambulance health services should implement targeted, best-practice strategies to prevent or minimise the risk of the specific harms identified in this standard. Strategies for managing specific care needs or clinical risks should be documented as part of the screening and assessment process. Screening should be used to identify patients who may be at higher risk of poorer health outcomes or adverse events, with the aim of supporting informed decision making and driving changes in comprehensive care planning and delivering interventions that reduce risks to the patient.

Meaningful implementation of this standard requires attention to the processes for partnering with patients in their own care and for safely managing transitions between episodes of care. This requires that the systems and processes necessary to meet the requirements of this standard also meet the requirements of the **Partnering with Consumers Standard** and the **Communicating for Safety Standard**. This will help to ensure that the organisation's safety and quality systems, policies and processes are integrated, and will reduce duplication of effort.

Out of hospital service provision is an important part of comprehensive care

Ambulance health services provide a range of out of hospital care services including routine patient transportation, conveyance to an emergency department, or another non-emergency service, treat-and-discharge, non- conveyance[28], or referral to another healthcare provider.[209]

Access to up-to-date health information and records can be challenging in the out of hospital environment, particularly outside of usual office hours. This information is vital to inform decisions regarding the most appropriate and safe care pathway for patients.[45] Ambulance health services will

need to implement mechanisms that allow clinicians to collaborate with the wider health sector to access patient health information required to make these decisions. Effective systems can support appropriate patient disposition decisions, reducing the burdening on busy health services and unnecessary attendance at health services for patients.[24]

Whatever the outcome for the patient, ambulance health services are an integrated part of the health system and are uniquely placed to inform comprehensive care planning and contribute to the ongoing patient journey. The contribution that the ambulance health service provides towards comprehensive care planning will depend upon the setting and the service that is being provided and will vary between ambulance health services.

Comprehensive care plans

The specific content of comprehensive care plans will depend on the setting and the service that is being provided.

Comprehensive care plans may be called different things in different ambulance health services. Examples of comprehensive care plans include:

- Clinical pathways for specific interventions
- Integrated care pathways.

The type of plan used, what it includes and how it is used will vary depending on the service context and patient cohort.

Clinical governance and quality improvement to support comprehensive care

Systems are in place to support clinicians to deliver comprehensive care.

Taking an organisation-wide and systematic approach to the delivery of comprehensive care will help to ensure consistent experiences of comprehensive care for patients, and consistent expectations for clinicians and other members of the workforce about how to deliver comprehensive care.

This criterion requires organisation-wide governance, leadership and commitment to support the delivery of comprehensive care and minimise patient harm.

This criterion aligns closely with the **Clinical Governance Standard** and the Partnering with Consumers Standard. To meet this criterion, ambulance health services are required to:

- Integrate clinical governance and apply quality improvement systems
- Apply principles of partnering with consumers, health literacy and shared decision making when developing and implementing organisational processes for comprehensive care and minimising patient harm
- Implement organisational systems and processes to support the effective delivery of comprehensive care and minimise patient harm.

Integrating clinical governance

Action 5.01

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

a. Implementing policies and procedures for comprehensive care

b. Managing risks associated with comprehensive care

c. Identifying training requirements to deliver comprehensive care.

Intent

Safety and quality systems support clinicians in the delivery of comprehensive care and minimising patient harm.

Reflective questions

- How are the ambulance health service's safety and quality systems used to:
  - support implementation of policies, procedures and protocols for the delivery of comprehensive care?
  - identify and manage risks associated with the delivery of comprehensive care including those at transitions of care?
  - identify orientation, training and education requirements for the delivery of comprehensive care?

Strategies for improvement

The **Clinical Governance Standard** has specific actions related to implementing systems to support comprehensive care and minimising patient harm which are related to this action:

- **Action 1.07** – policies and procedures
- **Action 1.10** – risk management systems

Implement governance structures for comprehensive care and minimising patient harm

An ambulance health service should use established safety and quality systems to support policies, procedures, protocols, risk management and orientation, training and education for comprehensive care and minimising patient harm. It should also:

- Use organisation-wide risk management systems to identify, monitor, manage and review risks associated with comprehensive care and minimising patient harm
- Develop policies and procedures that provide guidance on comprehensive care and minimising patient harm including:
  - outlining the roles, responsibilities and accountabilities for identifying if an existing care plan is in place
  - delivering comprehensive care and contributing to and reviewing comprehensive care plans

- using and documenting organisation-wide integrated screening and assessment processes
- planning, and collaborating with the multidisciplinary teams
- communicating screening and assessment findings and agreed goals of care at transitions of care.
- reviewing the safety and quality of end-of-life care
- using processes relating to the specific harms identified in the **'Minimising patient harm'** criterion of this standard.

Manage risks

The ambulance health service should use established risk management systems (see **Action 1.10**) to identify, monitor, manage and review risks associated with comprehensive care. It should also:

- Develop processes to manage clinical, organisational and workplace risks
- Use information to inform quality improvement and the risk management system.

Identify orientation, training and education requirements

To inform the training schedule and to set priorities for workforce training, the ambulance health service should perform a risk assessment. It should also:

- Deliver or provide access to training on comprehensive care and minimising patient harm
- Assess the competency and training needs of the workforce in line with the requirements of **Actions 1.19**, 1.20 and **1.21**
- Train the workforce to effectively use the clinical incident management and investigation system to inform quality improvement and risk management processes.

Examples of evidence

- Policy, procedure and guideline documents that provide guidance on aspects of comprehensive care, including:
  - organisation-wide processes for screening, assessment and transitions of care
  - documentation of screening and assessment findings, the outcome of shared decision making processes and agreed goals of care
  - roles, responsibilities and accountabilities for delivering comprehensive care
  - processes for identifying patients at the end of life and managing their care
  - processes relating to the specific harms identified in the 'minimising patient harm' criterion of this standard
  - processes for managing risks associated with continuity of care at transitions of care
- Documentation of governance structures where reports on planning and delivery of comprehensive care have been discussed
- Committee and meeting records in which planning and delivery of comprehensive care were discussed
- Evidence of how the **Partnering with Consumers Standard** and the **Communicating for Safety Standard** informed decisions about the delivery of comprehensive care
- Examples of approved risk assessment tools
- Audit of workforce compliance with policies, procedures and protocols
- Reports from incident management systems
- Records of quality improvement systems that have been implemented and evaluated in response to identified risks
- Results from patient and carer experience surveys
- Training documents relating to planning and delivering comprehensive care, including care at the end of life, and reducing risks of harm.

Applying quality improvement systems

Action 5.02

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

a. **Monitoring the delivery of comprehensive care**
b. **Implementing strategies to improve the outcomes from comprehensive care and associated processes**
c. **Reporting on delivery of comprehensive care.**

Intent

Quality improvement systems are used to support the delivery of comprehensive care and minimising patient harm.

Reflective questions

- How does the ambulance health service's safety and quality systems:
  - support implementation of policies, procedures and protocols for the delivery of comprehensive care?
  - identify and manage risks associated with the delivery of comprehensive care?
  - identify orientation, training and education requirements for the delivery of comprehensive care?
- How does the ambulance health service communicate the outcomes of improvement activities to the governing body, the workforce and consumers?

Strategies for improvement

The **Clinical Governance Standard** has specific actions relating to health service organisations' quality improvement systems relevant to the delivery of comprehensive care:

- **Action 1.08** – quality improvement systems
- **Action 1.09** – reporting
- **Action 1.11** – incident management and investigation systems.

Monitor effectiveness and performance

The organisation's quality improvement systems can be used to identify and set priorities for the organisational and clinical strategies to deliver comprehensive care and minimise patient harm. The ambulance health service should review, measure and assess these quality improvement systems to ensure they support comprehensive care and minimising patient harm, and include requirements for:

- Audits of documentation on screening and assessment processes
- Evaluation of processes for comprehensive care planning and shared decision making
- Audits of documentation relating to clinical handover of agreed care at transitions of care

- Review of incident management systems relating to failures in screening for risk and comprehensive care planning
- Surveys of consumers and the workforce regarding the systems for providing comprehensive care.

Implement quality improvement strategies

The ambulance health service should use:

- Quality improvement activities that are consistent and measurable across the organisation
- Use the results of organisational risk assessments to identify gaps, plan, and set priorities for areas for investigation or action.

Report outcomes

The ambulance health service should regularly report evaluation findings to the governing body, workforce and patients.

Examples of evidence

- Record of quality improvement activities relating to comprehensive care
- Safety and quality data used to determine risk and priorities for improvement
- Audit results of healthcare records for screening, assessment and shared decision making processes used to develop comprehensive care plans
- Schedules for planned audits associated with delivery of comprehensive care
- Committee or meeting records in which quality performance and improvement strategies for delivery of comprehensive care were discussed
- Results of data analysis of complaints, adverse events and patient outcomes
- Documentation from incident monitoring that captures data relating to delivery of comprehensive care
- Incident management system records and evidence that processes have been reviewed in response to trends in the data
- Audit and reports of workforce compliance with policies and processes for comprehensive care
- Actions taken to manage identified risks associated with delivering comprehensive care
- Reports to the highest level of governance, consumers and the workforce on delivery of comprehensive care, or other documented information showing trends relating to identified risks
- Examples of improvement activities that have been implemented and evaluated to improve teamwork, screening assessment or shared decision making
- Results of consumer and carer experience surveys and actions taken
- Feedback from the workforce on systems for the delivery of care based on patient's identified goals
- Examples of shared decision making in the planning and delivery of comprehensive care
- Communication to the workforce and patients about improvement activities and outcomes
- Observation of clinicians' practice that demonstrates shared decision making in the delivery of comprehensive care
- Examples of risk assessment tools
- Evidence of workforce training and education in systems for the delivery of comprehensive care.

Partnering with consumers

Action 5.03

Clinicians use organisational processes from the Partnering with Consumers Standard when providing comprehensive care to:

a. Actively involve patients in their own care

b. Meet the patient's information needs

c. Share decision making.

Intent

Clinicians partner with patients when providing comprehensive care and minimising patient harm.

Reflective questions

- What processes from the **Partnering with Consumers Standard** do clinicians working for the ambulance health service use to involve patients in shared decision making?
- Is information provided by the ambulance health service about comprehensive care and minimising patient harm tailored to the patients' specific needs and level of health literacy?
- What processes does the ambulance health service have in place to collect and review patient feedback on comprehensive care planning?

Strategies for improvement

The **Partnering with Consumers Standard** has specific actions (**Actions 2.03–2.10**) relating to health service organisations' processes for involving patients in their own care, shared decision-making, informed consent and effective communication.

It is important that ambulance health services implement strategies for partnering with patients in their care, and:

- Implement systems to support the workforce to consider a patient's health literacy when making shared decisions
- Provide information to patients about comprehensive care and minimising patient harm, tailored to their specific needs and level of health literacy[210]
- Use patient experience data to evaluate whether clinicians are actively involving patients in their own care, meeting patient information needs and making shared decisions when providing comprehensive care
- Provide information to patients, carers and families about preventing and or managing pressure injuries (see **Action 5.23**) and falls (see **Action 5.26**)
- Collaborate with patients, carers and families to manage, or minimise risks including:
  - delirium (see **Action 5.30**)
  - self-harm and suicide (see **Action 5.31**)
  - acute behavioural disturbance (see **Action 5.33**).

Examples of evidence

- Audit results of healthcare records that include:
  - patient and carer involvement in screening, assessment and comprehensive care delivery
  - documentation of the patient or substitute decision-maker being involved in care decisions
  - documentation about the outcome of shared decision making processes, such as discussion of risks and benefits, information about patients' goals and preferences
  - a comprehensive care plan based on the outcomes of a shared decision making process
  - patient and carer involvement at completion of an episode of care or at transition of care.
- Results of patient and carer experience surveys and actions taken
- Observation of patients and carers participating in decision making about their care
- Feedback from patients and carers regarding their involvement in care and participation in shared decision making.

Designing systems to deliver comprehensive care

Action 5.04

The health service organisation has systems for comprehensive care that:

a. **Support clinicians to develop, document and communicate comprehensive plans for patients' care and treatment**
b. **Provide care to patients in the setting that best meets their clinical needs**
c. **Ensure timely referral of patients with specialist healthcare needs to relevant services**
d. **Identify, at all times, the clinician with overall accountability for a patient's care.**

Intent

The ambulance health service provides systems to enable and support the delivery of comprehensive care to patients.

Reflective questions

- What systems and processes does the ambulance health service have in place to support the workforce to communicate, deliver and document comprehensive care in the setting that best meets patients' needs?
- How does the ambulance health service ensure the lead clinician is responsible for the episode of care identified?
- How does the ambulance health service ensure the handover of patient's comprehensive care goals and preferences occur at transitions of care?
- What systems and processes are in place in the ambulance health service to ensure disposition decisions or referral pathways are in place for patients identified at risk of harm?

Strategies for improvement

Identifying and developing models of care to support the delivery of comprehensive care to an ambulance health services' patient population will require a flexible approach to standardisation of care, particularly for some patient groups or health services.

Patients accessing out of hospital care may already have a current care plan for an existing condition, such as an advance care directive, asthma, diabetes or anaphylaxis pathway. Provision of care should align with a patient's care plan where one exists and incorporate current best-practice clinical pathways. Collaboration with primary care or other health care providers will be important to facilitate maintaining updated care plans for patients in an ongoing manner. See **Figure 2** for a list of documents that might contain information about an individual's future care preferences.

Ambulance health services should support members of the workforce to systematically review processes, practices and workflow, to identify how to implement comprehensive care in their service context.

Design processes to develop, document and communicate comprehensive care plans

Standardised templates can assist clinicians in goal-setting and comprehensive care planning process, particularly when patients have complex needs. One example of a standardised template for comprehensive care planning is a clinical pathway for the management of a specific clinical condition (such as STEMI).

Clinical pathways can be simple or complex, depending on the nature of the intervention. Care pathways can improve outcomes for patients and improve collaboration and teamwork between different professional groups.[211] However, clinical pathways alone may not meet the needs of patients with complex or multiple health problems. Clinical pathways should include the capacity to document patients' preferences and goals and individualise aspects of care as required.

Ambulance health services should develop and implement alternative comprehensive care planning strategies and tools for patients who are normally managed using a care pathway, but whose care needs cannot be fully addressed with usual care. For example, patients with complex or undetermined conditions, or patients who are receiving concurrent care from multiple medical teams. Some state and territory health departments have developed and endorsed clinical pathways for particular conditions or groups of patients.

Ambulance health services should seek feedback from clinical and consumer groups in designing processes to support the development and use of effective comprehensive care plans. This may include:

- The minimum expectations for the content of comprehensive care plans. See **Implementing the Comprehensive Care Standard: Essential elements for delivering comprehensive care**
- Requirements for contributing to and documenting comprehensive care planning in specific settings or for specific patient populations such as those with complex or multiple health needs[212,213]
- Triggers for review of comprehensive care plans
- Roles, responsibilities and accountabilities for reviewing and updating existing comprehensive care comprehensive care plans
- Processes for supporting shared decision making with patients, carers, families or substitute decision makers (see **Actions 2.06** and **2.07**)
- Standardised, pathways or templates for documenting comprehensive care plans
- Processes for communicating the content of the plan at conclusion of an episode of care or at transitions of care (see **Actions 6.04** and **6.07–6.10**)
- Systems for the workforce to access clinical pathways and external referral processes
- Structured clinical handover systems and documentation to effectively communicate at transitions of care.[214, 215]

Develop processes to ensure that patients receive care in the setting that best meets their needs

Patient flow is complex and can be affected by multiple external variables[216] such as delays in the transfer of patients.[217] When patient flow processes are suboptimal, the timeliness, safety and quality of patient care can be compromised,[45] and impact the workforce at all levels of an organisation.[24]

The ambulance health service should develop patient flow processes to ensure patients receive care that best meets their needs. This might include:

- Processes for escalation of patients that need urgent, or special consideration
- A structure for escalation of, and response to, patient flow issues
- Processes for early recognition of potentially complex patient transportation and timely planning and coordination of care activities
- A process for patient disposition decisions (a recommendation about the final destination for the patient based on triage and clinical assessment).

Ambulance health services should also document the roles, responsibilities and accountabilities of members of the workforce and other key participants in the patient flow process, and:

- Evaluate the patient flow process, this might rely upon collaboration with external health service organisations
- Use data to inform collaborative improvement work.

Establish processes for determining patient disposition decisions and referral processes

The ambulance health service should develop standardised systems for triaging, assessment and determination of patient disposition decisions. It should also provide guidance to members of the workforce related to the scope of the ambulance health service, which might include:

- Primary and secondary triage systems
- Processes for assessment and identifying and allocating the most appropriate care outcome, or mode of transport
- Processes for expediting urgent transfer
- Processes for communicating to usual health care providers or others, in cases of non-transportation
- Processes for referral to support ongoing comprehensive care, such as for
  - safe return to rural or remote health services
  - transfer to residential care facilities, the patient's home, or other health care facility
  - referral for assessment or ongoing care in the community
  - aged care assessments
  - mandatory reporters of child abuse
  - referral to agencies that support people reporting sexual assault or family and intimate partner violence.

Set up processes for identifying the clinician with overall accountability for a patient's care

The ambulance health service should review actions from the **Communicating for Safety Standard** to implement systems to identify the clinician who has overall accountability for a patient's care. This is the person with responsibility for leading and coordinating comprehensive care planning for the patient. Confusion about which clinician has overall accountability for a patient's care can lead to communication issues and delays in clinical decision making.[218,219]

It is important that the ambulance health service:

- Works with clinical teams to develop consistent processes for identifying the clinician with accountability for an individual patients' care
- Identifies roles, responsibilities and accountabilities of clinicians within the team, including escalation of care and access to specialist clinical advice
- Implements systems for members of the workforce to identify the person to whom accountability will be transferred to at transitions, or at completion of an episode of care.

Examples of evidence

- Policies and guidelines that describe roles, responsibilities and accountabilities for:
  - managing patient flow
  - screening and clinical assessment processes
  - updating existing comprehensive care comprehensive care plans
  - developing comprehensive care plans
  - comprehensive care planning, including shared decision making and goal setting
  - triggers for review of comprehensive care plans
  - referral to other services
- Audit of compliance with processes for comprehensive care
- Observation of patients and carers participating in decision making about their care
- Training documents about:
  - shared decision making and goal setting
  - screening and clinical assessment processes for comprehensive care
  - multidisciplinary teamwork and collaboration
  - planning and delivering comprehensive care, including at the end-of-life
  - strategies for minimising risks of harm
- Standardised tools and templates for updating or developing, documenting and communicating comprehensive care plans
- Examples of improvement activities that have been implemented and evaluated
- Feedback from patients and carers regarding their involvement in shared decision making
- Incident management system reports relating to the implementation of comprehensive care plans
- Records of care planning in partnership with patients, carers and families
- Committee or meeting records in which processes for comprehensive care were discussed
- Memorandums of understanding or other agreements with external organisations that outline referral pathways for patients.

Collaboration and teamwork

Action 5.05

The health service organisation has processes to:

a. **Support multidisciplinary collaboration and teamwork**
b. **Define the roles and responsibilities of each clinician working in a team.**

Intent

Clinicians are supported to work in collaborative multidisciplinary teams, and they understand their own roles and responsibilities, and those of other team members.

Reflective questions

- How does multidisciplinary collaboration and teamwork operate within the ambulance health service?
- What systems does the ambulance health service use to support multidisciplinary collaboration and teamwork during an episode of care or at transitions of care?
- How are the roles and responsibilities of each clinician working in a team defined and communicated to team members and the patient?
- How does the ambulance health service monitor and evaluate the effectiveness of its processes to support collaboration and teamwork?

Strategies for improvement

Develop structured processes to support multidisciplinary teamwork and collaboration

To deliver comprehensive care that is safe and continuous, effective communication and teamwork are critical. Ambulance health services will need to develop structured processes to support multidisciplinary teamwork and collaboration. Implement this action with consideration of the requirements of the **Communicating for Safety Standard**.

A substantial proportion of potentially preventable adverse events are underpinned by failures in communication and teamwork.[220, 221] Improvements in multidisciplinary collaboration and teamwork have been associated with outcomes such as reduced length of stay, reduced risk of complications of medical care and reduced risk of surgical complications or death.[222]

Without good continuity or coordination of care and support, many patients, carers and families experience fragmented, poorly integrated care from multiple providers.[223] This is a particular problem for people with chronic or complex conditions, older people in the community, and those in residential aged care facilities (RACFs), who can often experience poor transitions of care. For elderly people, collaborative approaches that support a shared understanding of needs and goals of care can improve communication and transfer of care between hospitals and RACFs or home care providers.[224]

Ambulance health services should:

- Develop structured processes to support multidisciplinary teamwork and collaboration
- Define workforce roles, responsibilities and accountabilities
- Emphasise the importance of effective communication and teamwork in delivering comprehensive care that is safe and continuous.[171, 225]

The ambulance health service should identify evidence based programs and strategies to improve multidisciplinary teamwork.[226] This could include:

- Identifying opportunities for multidisciplinary team communication such as use of the Aged Care Transfer Summary (ACTS)
- Use of communication tools such as IMIST- AMBO[215] (see **Action 6.07**)
- Identifying requirements for documentation and communication at transitions of care and when referring a person to another health care provider
- Seeking feedback from the workforce and key stakeholders about processes for multidisciplinary teamwork and collaboration
- Providing training to the workforce on teamwork and communication.[227-230]

Examples of evidence

- Policy documents that outline structured communication processes and delegated roles, responsibilities and accountabilities
- Meeting records about interdisciplinary membership and collaboration
- Audit of health care records that demonstrate multidisciplinary care provision
- Training and education records on collaboration, multidisciplinary teamwork and communication
- Documented processes for reporting and investigating concerns about failures in communication or collaboration processes
- Observation of handover and team processes to support communication
- Feedback from patients, carers and family members
- Evaluation of multidisciplinary team meetings

Action 5.06

Clinicians work collaboratively to plan and deliver comprehensive care.

Intent

Clinicians work together to plan and deliver comprehensive care in partnership with patients, carers and families.

Reflective questions

- How does the ambulance health service support clinicians to collaborate with each other, external providers, patients, carers and families in planning and delivering comprehensive care?
- What processes does the ambulance health service have in place to ensure relevant intra-agency service providers are included in the planning and delivery of the comprehensive care plan?
- How does the ambulance health service monitor the effectiveness of the partnerships with the external and intra-agency service providers?

Strategies for improvement

Use the **Partnering with Consumers Standard** to guide the development of processes for comprehensive care.

The ambulance health service should support the workforce to use organisational processes and collaborate with patients, carers and families to plan and deliver comprehensive care.

Implement shared decision making

Shared decision making involves discussion and collaboration between a patient and their healthcare provider to reach the most appropriate healthcare decision for that person. Shared decision making supports the provision of safe, appropriate care by identifying essential information for inclusion in comprehensive care planning. This enables patients and their families to make informed decisions based on a shared understanding of the patient's goals of care, and the risks and benefits of clinically appropriate options for diagnostic tests[231], treatments, interventions and care provision.[232, 233]

Use decision support tools

Decision support tools bring together high-quality information about particular conditions.[234] They can be used by consumers and healthcare providers to inform discussions about treatment options, explore consumer's preferences and share decision making.[235]

It is important that the ambulance health service evaluates the use of decision support tools in the out of hospital setting[236], such as those for asthma[237], patient disposition[45], antimicrobial prescribing, risk of violent behaviour[238], **decisional conflict scales**[239], and violence risk assessment tools such as:

- **Centre for Disease Control and Prevention**
- **Domestic Violence Safety Assessment Tools**.

Review the use of decision aids that could support clinicians, patients, carers and families work together. Examples of online tools include:

- **Ottawa Patient decision aids**[240]
- **Decision support tools for consumers**
- Consider using generic decision guides to support people to plan, track and share health-related or social decisions such as the **Ottawa Personal Decision Guide**[241]
- **Ask Share Know** encourages patients to ask three questions about their care.

Strengthen teamwork processes

No single clinician can deliver all aspects of the care that a patient needs. Different clinician groups bring specific expertise and need to work together to provide the complete health care that a patient requires. Interventions to improve teamwork vary, but broadly include:

- Establishing processes that support collaboration and effective teamwork
- Workforce training to increase individual competence of team members
- Defining roles, responsibilities and accountabilities of team members
- Structured communication protocols to support communication between multidisciplinary teams
- Evaluation of workflow to improve structured opportunities for effective teamwork and communication
- Using processes for clinical handover, communicating critical information and documenting information (described in the **Communicating for Safety Standard**) to ensure that clinicians collaborate effectively to plan and deliver comprehensive care.

The ambulance health service should implement processes to support clinicians to understand their own accountabilities in relation to planning and delivering comprehensive care.[242] Strategies may include:

- Identifying clinical opinion leaders and executive leaders to develop and exemplify collaborative practice
- Identifying roles and responsibilities relating to comprehensive care in position descriptions and scope of clinical practice documentation
- Using structured handover and communication tools[243]
- Using checklists to prompt discussion of patient, family and clinical concerns[244]
- Using tools to prompt participation from different professional groups at critical moments
- Identifying accountabilities relating to collaboration and teamwork
- Developing processes to manage issues and feedback relating to multidisciplinary collaboration.
- Seeking feedback from the workforce on communication and collaboration between clinicians and other professional groups.[245-247]

Monitor, analyse and report on system effectiveness

The ambulance health service should develop systems consistent with the requirements of the **Clinical Governance Standard** for reporting and analysing adverse events relating to failures of teamwork and communication, and for ensuring that clinicians are professionally accountable for working collaboratively with patients, carers, families and each other in the planning and delivery of comprehensive care.

Examples of evidence

- Policies, procedures and protocols that support collaboration and teamwork, with clear processes for sharing information
- Position descriptions that outline roles, responsibilities and accountabilities that promote collaborative practice and processes for conflict resolution
- Examples of resources and tools including decision aids
- Examples of activities that have been implemented and evaluated to improve organisation of care delivery routines and workflow
- Observation of collaborative work to plan and deliver care
- Feedback from consumers about how clinicians worked together to deliver care
- Data from patient and carer experience surveys about collaboration and teamwork among clinicians
- Documented evidence of consultation and referral to other services
- Improvements made as a result of feedback on shared decision making.

Developing the comprehensive care plan

Integrated screening and assessment processes are used in collaboration with patients, carers and families to develop a goal-directed comprehensive care plan.

Identifying patients who may be at risk of harm and mitigating risks for those patients is a core part of comprehensive care planning and treatment. The Comprehensive Care Standard requires the use of screening and assessment processes with patients, carers and families. In addition to these general screening and assessment processes, the Standard highlights the need to identify specific risks of harm in the areas of falls, pressure injuries, cognitive impairment, malnutrition, self-harm and suicide, violence, acute behavioural disturbance, and seclusion and restraint.

Ambulance health services provide care and services to a wide range of people in the community, many of whom do not require emergency assistance or transport to an emergency health care facility. In the out of hospital setting, screening and assessment begin with a request for service and are important processes to support triage, patient disposition decisions and care planning.[248]

Following screening and assessment, a range of pathways and clinical guidelines are available to support care decision making. The nature of services provided will determine approaches to screening and assessment. Ambulance health services should investigate the most appropriate triage,[249] screening and assessment tools and referral pathways to support ongoing comprehensive care planning (where required), this may include referral to a primary care provider.[206]

Planning for comprehensive care

Action 5.07

The health service organisation has processes relevant to the patients using the service and the services provided:

a. For integrated and timely screening and assessment

b. That identify the risks of harm in the 'Minimising patient harm' criterion.

Intent

Processes are in place for integrated and timely screening, assessment and risk identification.

Reflective question

How does the ambulance health service ensure that screening and assessment processes used to identify the risks of harm are integrated and timely?

Strategies for improvement

Develop screening processes

Screening is used to identify existing conditions or issues that may predispose a patient to further harm, to identify the level of risk for potential new harms to occur, and to determine what actions should be taken to manage the conditions, issues and risks. Screening should shape the care delivered to a patient.

Systems to support triage of the patient's condition are vital in order to inform appropriate patient disposition decisions and prevent delays in treatment.[24] Examples may include virtual or telephone triage systems and processes, risk stratification and identification of the 'at risk' patient, even though on initial contact the patient is identified as low risk or is identified as being 'well'.[206]

To develop appropriate screening processes, ambulance health services should consider:

- The capacity and type of services that the ambulance health service provides
- The systems used to screen, triage and gather accurate information about the patient
- The risks of harm identified in the **'Minimising patient harm'** criterion of the NSQHS Standards
- Feedback from quality improvement processes

Use this information to work with clinicians and consumers to develop screening and assessment processes that are appropriate to the needs of patients and the clinical service being provided.

Identify expectations about the timing of initial screening and assessment processes, and indications for repeated screening and assessment in relevant policies, procedures and protocols. Processes may vary for different groups of patients in the out of hospital setting.

Integrate screening and assessment

Develop strategies to integrate processes for screening and assessment, establishing:

- Approved tools to screen for common conditions and risks
- Processes for screening and clinical assessment activities
- Processes for the incorporation of patient and carer information to minimise the burden of providing repeated information
- The incorporation of identified risks into comprehensive care planning
- The incorporation of information from multidisciplinary teams
- Formalised communication strategies between members of the workforce and multidisciplinary teams.

Examples of evidence

- Organisational risk profile that details safety and quality risks relevant to the patients, procedures and treatment environments of the service
- Policies, procedures, protocols and guidelines that outline processes for conducting screening and assessment
- Resources and tools developed for screening and assessment
- Workforce access to approved, validated screening tools
- Documented referral pathways, including escalating concerns for identified risks
- Comprehensive care plans that include identified risks
- Workforce orientation manuals, education resources or records of attendance
- Audit results on the use of screening tools
- Patient healthcare records that demonstrate that risk assessments are conducted during an episode of care
- Records that show the use of interpreter services when required
- Quality improvement strategies and actions taken where gaps are identified
- Documents that describe the roles, responsibilities and accountabilities of the workforce in relation to screening and assessment during an episode of care
- Reports from patient safety and quality systems that have been used to improve risk assessment processes.

Action 5.08

The health service organisation has processes to routinely ask patients if they identify as being of Aboriginal and/or Torres Strait Islander origin, and to record this information in administrative and clinical information systems.

Intent

People who identify as being of Aboriginal and/or Torres Strait Islander origin are provided with tailored and culturally appropriate comprehensive care.

Reflective questions

- What processes does the ambulance health service have in place for patients to identify as being of Aboriginal or Torres Strait Islander origin?
- How does the ambulance health service ensure that patient cultural identity information is recorded in administrative and clinical information systems?
- How does the ambulance health service train its workforce to ask about a person's Aboriginal and Torres Strait Islander status?
- How does the ambulance health service monitor the effectiveness of its processes for identification of Aboriginal and Torres Strait Islander status?

Strategies for improvement

Improving identification rates of Aboriginal and Torres Strait Islander peoples in health service organisations has been prioritised as part of the Australian Government's and all state and territory governments' commitment to **Closing the Gap**.

Ambulance health services are required to establish processes to accurately identify and record Aboriginal and Torres Strait Islander status. This information should be routinely recorded in information systems and should be consistent across administrative and clinical information systems.

Identifying a person as being of Aboriginal or Torres Strait Islander origin at the beginning of their care supports the provision of comprehensive, culturally appropriate care.

Develop a policy and protocols on Aboriginal and Torres Strait Islander identification

By partnering with Aboriginal and Torres Strait Islander consumers, the ambulance health service can improve its understanding of reasons why patients declare or choose not to declare their Aboriginal and Torres Strait Islander identity. This will also improve processes for Aboriginal and Torres Strait Islander identification.

The ambulance health service should:

- Develop policies, protocols and processes for confirming Aboriginal and Torres Strait Islander identification status
- Include Aboriginal and Torres Strait Islander identifiers in administrative and clinical datasets
- Train and support the workforce to collect identification information in a culturally appropriate way
- Develop resources in collaboration with Aboriginal and Torres Strait Islander peoples to explain why the question of Aboriginal and Torres Strait Islander identity is being asked
- Implement mechanisms for Aboriginal or Torres Strait Islander status to be transferred to the

clinical information systems and the patient's healthcare record.

Monitor the system for identification of Aboriginal and Torres Strait Islander peoples

- Audit the identification and recording of Aboriginal and Torres Strait Islander status against published policies, procedures and protocols
- Use reported outcome data to identify areas for improvement
- Monitor trends in reporting, healthcare delivery and outcomes for Aboriginal and Torres Strait Islander peoples
- Implement systems to monitor and measure improvements in accuracy and consistency of identification rates, practices and data quality
- Report on the implementation of Aboriginal and Torres Strait Islander identification strategies
- Refer to the **NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health**[18] for additional strategies.

Examples of evidence

- Policy documents, procedures and protocols that outline processes for identifying Aboriginal and Torres Strait Islander patients
- Registration documents on which patients can identify as being of Aboriginal or Torres Strait Islander origin
- Audits of Aboriginal or Torres Strait Islander status documented in the patient healthcare record
- Communication material that provides patients with information about why they will be asked if they identify as being of Aboriginal or Torres Strait Islander origin
- Training documents relating to obtaining information about Aboriginal and Torres Strait Islander patients
- Strategies implemented using the NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health18
- Communication with the workforce and consumers about the importance of identifying Aboriginal and Torres Strait Islander patients
- Meeting minutes and agenda items where asking the question about Aboriginal and Torres Strait Islander patients' status was discussed
- Examples of improvement activities that have been implemented and evaluated
- Reports from patient safety and quality systems
- Examples of resources developed and evaluated by consumers, providing information to consumers.

Action 5.09

Patients are supported to document clear advance care plans.

This Action is not applicable for ambulance health services.

See **Advisory AS23/02: Advice on not applicable actions for Ambulance Health Services**.

Where this Action is applicable, refer to the **NSQHS Standards Guide for Hospitals**.

Screening of risk

Action 5.10

Clinicians use relevant screening processes:

a. **On presentation, during clinical examination and history taking, and when required during care**

b. **To identify cognitive, behavioural, mental and physical conditions, issues, and risks of harm**

c. **To identify social and other circumstances that may compound these risks.**

Intent

Patients receive initial and, if necessary, repeated screening for cognitive, behavioural, mental and physical conditions, issues or risks of harm.

Reflective questions

- What processes does the ambulance health service use for screening patients during an episode of care?
- What systems does the ambulance health service use to identify validated tools for screening for risks of harm?
- How does the ambulance health service workforce apply trauma informed care?
- How does the ambulance health service monitor the effectiveness of its screening processes?

Strategies for improvement

Integrate screening processes in clinical workflow

Identifying patients who are at risk of harm, and mitigating risks for those patients, is a core part of comprehensive care. The purpose of risk screening and assessment is to:

- Gain an understanding of the degree to which a patient might be at risk of harm or poorer outcomes
- Inform decisions about the action(s) required to address identified risks, implement risk mitigation strategies, and escalate care where needed
- Inform comprehensive care planning with the patient.

Ambulance health services should support risk screening and assessment processes that are person-centred and identify:

- The risks of harm that are a priority across the organisation, including those specified in the **NSQHS Standards**[1]
- Organisation-wide processes for risk screening and assessment and the appropriate models of care that mitigate those risks
- A list of approved tools for use in the organisation to assess risk
- When routine screening will occur during an episode of patient care
- Processes for escalating care of patients who are at high risk of experiencing harm
- The role and responsibilities of those who are responsible for screening individual patients

- The process for ensuring that action is taken when conditions or risks are identified through the screening process
- Indications for repeating the screening process
- The processes to monitor and review implementation and impact of risk screening and assessment processes.

Develop and review policies and processes

Ambulance health services should use available data to understand common risks of harm for consumers who use the organisation's services and draw on feedback from clinicians about the usability and effectiveness of screening processes to inform policies and processes. This should include:

- Identifying and evaluating appropriate screening tools for use by the workforce, including screening tools that support telephone triage as well as assessment during face-to-face care
- Implementation of guidelines that describe:
  - how they are selected for use and updated
  - when tools are used
  - how the outcome of screening is documented and communicated
  - what action should be taken after completion and outcome of screening
- Ensuring that updates and changes to screening tools and processes are effectively communicated to clinicians.

Develop orientation, education and training programs

The ambulance health service should provide orientation, training and ongoing education for clinicians to understand their individual roles, responsibilities and accountabilities including:

- When and how to use screening processes and tools
- The application of trauma informed care[250]
- How to partner with patients, carers and families to optimise the identification of relevant information
- What assessments and actions to take when risks of harm are identified
- When to repeat screening processes
- How to provide feedback on screening tools and processes
- Seeking feedback from clinicians and consumers in reviewing the effectiveness of screening processes.

Examples of evidence

- Policy documents that outline processes for conducting screening that identify:
  - when routine screening will occur in an episode of patient care
  - the roles, responsibilities and accountabilities of members of the workforce who screen patients
  - the process for taking action when risks are identified
  - indications for repeating the screening process
- Screening tools that include risks such as social or other history that may increase a patient's risk
- Training documents relating to organisational screening processes such as, syllabus, attendance records and competency assessments
- Communication with clinicians about updates to screening processes
- Availability of approved tools at the point of care
- Observation of clinicians' practice in the use of screening processes
- Audit of the use of approved screening tools in compliance with policies, procedures and protocols
- Audit of processes to escalate care
- Examples of quality improvement actives to improve screening processes
- Reports and committee meeting records where information about screening rates and processes are discussed
- Feedback from patients, carers and the workforce on screening for risk.

Clinical assessment

Action 5.11

Clinicians comprehensively assess the conditions and risks identified through the screening process.

Intent

Patients receive comprehensive assessment to determine their healthcare needs and appropriate treatment options.

Reflective questions

- What processes does the ambulance health service have in place for clinicians to ensure comprehensive assessment of conditions and risks that were identified through the screening process?
- How does the ambulance health service monitor the effectiveness of these processes?

Strategies for improvement

Establish systems that support the workforce to conduct comprehensive assessments

Comprehensive assessment relies on clinicians working with patients, carers and families to understand a patient's current health status and its effect on their life and wellbeing.

In the out of hospital context, different types of clinical assessment may be required during an episode of care, which are often administered by a range of clinicians in the multidisciplinary team. Patients often experience multiple screening processes for different risks, and questions often overlap or are duplicated. This contributes to poorer experiences, confusion and frustration for patients and their carers, and duplication of effort for clinicians.[251]

Use the processes for **communicating critical information** to ensure that assessment findings are effectively documented and communicated between team members and at transitions of care. In the out of hospital context this will often include systems for patient referral for comprehensive assessment of identified risks by another health care provider. Ambulance health services should:

- Establish systems that support the workforce to conduct comprehensive assessments in collaboration with patients, carers, families
- Use approved and validated screening tools that are integrated into clinical assessment processes relevant to specific conditions, context of the service and patient population.

Implement interventions to improve clinical assessment and decision making

A number of interventions to improve clinical assessment skills and diagnostic accuracy can be implemented to improve systems and individual clinical decision making.[252] The **Essential elements for comprehensive care** identifies a set of six essential elements for comprehensive care delivery, which represent different stages or processes that a patient may experience when clinical care is delivered.

To support clinical assessment, ambulance health services can implement a range of systems including:

- The use of decision support tools checklists, algorithms, protocols and clinical pathways
- Orientation, training and education about screening and assessment processes
- Providing systems to capture relevant information from clinical assessment to support for comprehensive care delivery
- Developing processes to seek feedback from members of the workforce to identify gaps and improve systems for screening and comprehensive assessment
- Identifying roles, responsibilities and accountabilities for comprehensive assessment and referral
- Information and support for members of the workforce to partner with patients, carers and primary care providers to identify risks
- Referral pathways for patients identified at risk for comprehensive assessment by another healthcare provider
- How to document outcomes and provide information from comprehensive assessment at transitions of care
- Seeking feedback from consumers on assessment and referral processes.

Examples of evidence

- Policy documents that include:
  - processes for assessing patients' health status
  - identification of risks and actions taken
  - documentation requirements
  - referral and escalation pathways
- Audit results of healthcare records for screening and assessment of risks
- Assessment tools and resources for clinicians
- Training documents relating to clinical assessment and assessment tools
- Standardised templates or forms for communicating critical information identified during assessment
- Observation of the use of standardised assessment processes, tools and resources
- Reports from the incident management system and evidence of actions to improve processes for screening for risk
- Results of workforce and consumer feedback
- Quality improvement initiatives to address identified gaps in assessment of risks and referral processes for further assessment
- Identification and evaluation of referral pathways
- Feedback from patients and carers about assessment and referral processes.

Developing the comprehensive care plan

Action 5.12

Clinicians document the findings of the screening and clinical assessment processes, including any relevant alerts, in the healthcare record.

Intent

Findings of screening and assessment processes are documented accurately and contemporaneously.

Reflective questions

- What systems and processes does the ambulance health service have in place for documenting the findings of screening and assessment processes in the healthcare record?
- What processes does the ambulance health service use to ensure identified risks are communicated to health care providers participating in the patient journey?

Strategies for improvement

This action aligns with the requirements of the **Communicating for Safety Standard**.

Contemporaneously means to record information in the healthcare record as soon as possible after the event that is being documented.

Support the workforce to use and improve documentation processes

The ambulance health service should:

- Involve clinicians in the development of processes for documenting the findings of screening and assessment
- Identify parameters and requirements for documentation in the comprehensive care plan
- Develop or adapt electronic or paper-based tools for documenting findings from screening and clinical assessment
- Provide training to the workforce on screening and assessment processes
- Identify professional roles, responsibilities and accountabilities for documenting the findings of screening and assessment processes
- Identify systems for documenting alerts in the healthcare record and ensuring this information is provided at transitions of care
- Seek feedback from members of the workforce about documentation tools and processes
- Seek feedback from consumers on comprehensive care processes
- Develop strategies to ensure that updates and changes to relevant tools and processes are effectively communicated to clinicians.

Examples of evidence

- Policy documents for recording:
  - findings of screening and clinical assessment processes, risks and alerts in electronic and paper-based systems
  - medical reviews or reassessments and their outcomes
  - changes to the care plan
- Policy and procedure documents that include referral and escalation pathways
- Audit results of healthcare records for the use of a screening and clinical assessment form, and relevant alerts
- Templates and forms for medical review assessment, risk assessment or care variation
- Training records about patient healthcare record documentation, including electronic and paper-based documentation
- Reports from the incident management system about comprehensive care planning and evidence of action to improve processes
- Observation of workforce access to healthcare records at the point of care.

Action 5.13

Clinicians use processes for shared decision making to develop and document a comprehensive and individualised plan that:

a. **Addresses the significance and complexity of the patient's health issues and risks of harm**
b. **Identifies agreed goals and actions for the patient's treatment and care**
c. **Identifies the support people a patient wants involved in communications and decision making about their care**
d. **Commences discharge planning at the beginning of the episode of care**
e. **Includes a plan for referral to follow-up services, if appropriate and available**
f. **Is consistent with best practice and evidence.**

Intent

Clinicians use shared decision-making processes to develop person-centred and goal-directed comprehensive care plans that meet identified patient needs.

Reflective questions

- What processes does the ambulance health service use for shared decision making between clinicians the patient, carer(s) or substitute decisions makers?
- How does the ambulance health service identify the agreed goals of care and then document these?
- How does the ambulance health service monitor the effectiveness of its shared decision making processes?

Strategies for improvement

This action requires clinicians to use the processes described in the:

- **Partnering with Consumers Standard** to work with patients or substitute decision makers to reach shared decisions about the comprehensive care plan
- **Communicating for Safety Standard** to document the comprehensive care plan and communicate the content to other members of the workforce

Ambulance health services play an important role in contributing to ongoing comprehensive care planning by obtaining and communicating information to members of a patient's healthcare team.

Ambulance health services should support clinicians to use shared decision making processes in the context of planning and delivering comprehensive care and communicating effectively throughout the episode of care. The level of detail in a comprehensive care plan should reflect the complexity of the patient's acuity, identified risks of harm and goals of planned care (see **Action 5.04**).

Identify goals of care

Goals of care describe what a patient wants to achieve during an episode of care, within the context of their clinical situation and provides an opportunity for patients to disclose their values and preferences.[253] Identifying goals of care helps to organise and prioritise care activities and contribute to improved satisfaction, quality of life and self-efficacy for patients.[254]

Often patients are in an ambulance health service for a very short period of time. Due to the complexity of the out of hospital environment, or the nature of a person's presentation, it may be challenging to elicit goals of care from every patient. Goals can be aligned with a patients advanced care directive, or other treatment plan agreed between the patient and their primary care provider. See **Figure 2** for information about documents that might contain information about an individual's future care preferences.

Working within a person-centred culture supports effective partnerships between clinicians, patients and their families to support people to get the most out of their care. In the out of hospital setting, identifying goals of care will frequently involve working in collaboration with other multidisciplinary teams, identifying referral pathways and local resources. Goals of care should reflect the input of members of the clinical team, the patient, carers and family.

Sometimes a patient's goals of care may be in conflict with what is possible, particularly when it relates to disposition decisions. For example if a patient requests transfer to a specific facility which is unavailable. A number of principles can be used to support the workforce to identify goals of care including:

- Using information from a patients advance care directive or current care pathway to identify goals of care
- Asking patients what matters to them or what their greatest concerns are in relation to the episode of care
- Seeking feedback on how best to ask the question to identify goals of care
- Supporting the workforce to meet a patient's health literacy and communication needs when discussing goals of care
- Identifying who the patient wants involved in discussions about goals and planning, noting that this will often involve other multidisciplinary teams
- Clarifying roles, responsibilities and accountabilities in achieving goals of care, amongst multidisciplinary teams
- Documenting agreed goals of care in the comprehensive care plan
- Providing information to the receiving clinician or primary care provider about agreed goals of care at transitions of care
- Providing access to training and education to support effective communication, team work and a person-centred approach to care.

There are a range of tools, frameworks and models available which can provide structure to a goal setting conversation between patients and clinicians. Examples include:

- 'What matters to you?'[255]
- **Implementing the Comprehensive Care Standard - Identifying goals of care**[252]

Identify support people

A person-centred healthcare system is one that supports patients to make informed decisions, and successfully manage their own health and care. This includes identifying if a patient has a current care plan and giving patients a choice about who is involved in decision making.[256] To identify the support people a patient wants involved in their care, processes include:

- Asking the patient to identify support people they wish to be involved in communications and decision making about their care
- Allowing the patient to change their nominated support people at any time throughout their care
- Documenting the contact details for a patient's support people in their healthcare record

- Providing access to interpreting services[121]
- Establishing systems to identify substitute decision makers.

Plan for transitions of care

Planning for transitions of care is an important component of delivering comprehensive care. This requires members of the workforce to have access to high-quality, reliable information that supports comprehensive care planning. Some patients can be at higher risk of poor-quality transitions of care due to fragmented referral pathways or gaps in social or medical history.[171]

Ambulance health services should develop policies, procedures and protocols that support safe transitions of care that:

- Define the roles, responsibilities and accountabilities of members of the workforce for planning and managing transitions of care
- Define who is accountable for communication at transitions of care
- Define models of person-centred, team-based care
- Provide orientation, training and education to the workforce on communication between care teams
- Support the workforce to engage with patients and their families and carers to plan for transitions of care
- Include processes to ensure that agreed goals of care are documented and communicated
- Identify the compatibility of electronic information systems for clinicians to access patient data and communicate information during transitions of care.

Seek feedback to improve processes for comprehensive care planning

The ambulance health service should involve the workforce and consumers in reviewing the systems for updating or developing comprehensive care plans and identifying risks of harm. It should also:

- Develop processes for ensuring that updates and changes to comprehensive care planning tools and processes are effectively communicated to clinicians
- Develop and evaluate resources for identifying goals of care
- Seek feedback from the workforce and consumers on identifying goals of care and comprehensive care delivery processes
- Audit and report on workforce compliance with policies and processes for comprehensive care planning
- Monitor the effectiveness and performance of processes for comprehensive care planning and report findings to members of the workforce and patients
- Utilise results to identify opportunities for improvement.

Examples of evidence

- Policies, procedures, protocols, guidelines and/or templates that support the workforce to update or develop comprehensive care plans
- Training documents relating to shared decision making and documenting within comprehensive care plans
- Audit results of comprehensive care plans including identification of the patient's nominated substitute decision-maker, carers and other support people to be involved in care decisions
- Audit results of shared decision making and actions to achieve patient centred goals
- Observation of clinicians practice demonstrating use of organisational processes for shared decision making
- Reports of use of language services
- Feedback from patients and support people on processes for planning for comprehensive care.

Delivering comprehensive care

Safe care is delivered based on the comprehensive care plan, and in partnership with patients, carers and families. Comprehensive care is delivered to patients at the end of life.

This criterion outlines strategies for the delivery of comprehensive care for all patients. It includes specific actions about providing care for patients and addresses care for patients at the end of life.

Using the comprehensive care plan

Action 5.14

The workforce, patients, carers and families work in partnership to:

a. **Use the comprehensive care plan to deliver care**
b. **Monitor the effectiveness of the comprehensive care plan in meeting the goals of care**
c. **Review and update the comprehensive care plan if it is not effective**
d. **Reassess the patient's needs if changes in diagnosis, behaviour, cognition, or mental or physical condition occur.**

Intent

The comprehensive care plan is used to direct the delivery of safe and effective care that aligns with the patient's needs and preferences.

Reflective questions

- What processes does the ambulance health service have in place to ensure that the care delivered is consistent with the patient's comprehensive care plan?
- What processes does the ambulance health service have in place to ensure that the workforce monitors the effectiveness of a patient's care plan, including reviewing and contributing to the plan in collaboration with the patient, carer and family?

Strategies for improvement

Involve patients and carers

The **Partnering with Consumers Standard** includes strategies to ensure that clinicians work in partnership with patients when delivering care.

The **Recognising and Responding to Acute Deterioration Standard** (**Action 8.05**) contains more information about how to reassess the patient's needs when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported.

Collaboration with carers and family is important for the delivery of safe and high-quality care. Involving carers and families in the delivery of care can help to reassure patients, reduce distress and assist in planning for transitions of care.[257] Carers and family members have intimate knowledge of what is 'normal' for a patient, and can detect small changes that may indicate substantial deterioration, or improvement in a patient's condition.[219, 257,258]

Carers may have an official role that goes beyond that of other family members. Accurately identify 'carers' and substitute decision makers to ensure that legal considerations relating to consent and decision making are established.[259,260]

For Aboriginal and Torres Strait Islander peoples, there may be a collective approach to carer responsibilities. Confirming who is responsible for different aspects of care is important for ensuring that carer engagement is effective.

Useful documents that may help to inform and support collaboration with specific groups of carers are available from **Carers Australia**.[93]

Provide orientation, training and education

The ambulance health service should provide orientation, training, and ongoing education for clinicians to identify individual roles, responsibilities and accountabilities in delivering care in accordance with the comprehensive care plan or care pathway. Training might include:

- Guidance on assessment and comprehensive care planning, indications to repeat screening and revise the comprehensive care plan
- Assessing and documenting goals of care.

Examples of evidence

- Policy and procedure documents that describe the requirements for reviewing the effectiveness of the comprehensive care plan
- Audit results of review and updates to comprehensive care plans or clinical pathways following changes to the patient's condition
- Training documents relating to the use of comprehensive care plans, including roles, responsibilities and accountabilities, and how to partner with patients, carers and families to deliver care
- Feedback from patients, carers and families about their inclusion in comprehensive care planning
- Observation of the workforce reviewing and using comprehensive care plans or clinical pathways.

Comprehensive care at the end of life

Ageing populations and increasing preferences to die at home have resulted in a growing demand for community-based palliative and end-of-life care. People often receive care from a range of organisations and multi-disciplinary teams that have different roles and responsibilities for managing palliative and endoflife care. Overall responsibility for coordinating a person's endoflife care and ensuring effective communication and collaboration should be identified.[218]

This guide acknowledges the important role and contribution that ambulance health services play in supporting patient and carer needs and preferences at the end of life. Ambulance health services are frequently required to contribute to the provision of palliative and end-of-life care in community settings and provide an emergency response for urgent palliative and end-of-life care.[261] In such circumstances, ambulance health services will be governed by the scope of the service, medico legal directives and individual state and territory policy frameworks for the provision of palliative and end-of-life care.[262]

The **NSQHS Standards**[1] describe the patient care journey and are designed to be implemented in an integrated way. The intention of the **Clinical Governance Standard** is to ensure that there are systems in place to maintain and improve the reliability, safety and quality of health care for patients, irrespective of the type of care being provided or where it is being delivered. In addition, ambulance health services are required to ensure that the workforce has the right qualifications, skills and supervision to provide safe, high-quality health care to their patients.

Where ambulance health services are supporting palliative and end-of-life care, the role and scope of practice is often related to delivering care that has been *planned by specialist care services* including community health nurses, palliative care specialists and general practitioners. Therefore, the end-of-life actions are considered to be not applicable for ambulance health services.

The National Consensus Statement: essential elements for safe and high-quality end-of-life care[218] describes suggested practice for the provision of end-of-life care in settings where acute care is provided. It is a guiding document designed to inform clinicians and others of recommended practice. The Consensus Statement is not a legal document, and clinicians must continue to be aware of, and abide by, the laws of the jurisdiction in which they practice.[263]

Action 5.15

The health service organisation has processes to identify patients who are at the end of life that are consistent with the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care*.[218]

This Action is not applicable for ambulance health services.

See **Advisory AS23/02: Advice on not applicable actions for Ambulance Health Services**.

Where the Action is applicable, refer to the **NSQHS Standards Guide for Hospitals**.

Action 5.16

The health service organisation providing end-of-life care has processes to provide clinicians with access to specialist palliative care advice.

This Action is not applicable for ambulance health services.

See **Advisory AS23/02: Advice on not applicable actions for Ambulance Health Services**.

Where the Action is applicable, refer to the **NSQHS Standards Guide for Hospitals**.

Action 5.17

The health service organisation has processes to ensure that current advance care plans:

a. **Can be received from patients**
b. **Are documented in the patient's healthcare record.**

This Action is not applicable for ambulance health services.

See **Advisory AS23/02: Advice on not applicable actions for Ambulance Health Services**.

Where the Action is applicable, refer to the **NSQHS Standards Guide for Hospitals**.

Action 5.18

The health service organisation provides access to supervision and support for the workforce providing end-of-life care.

This Action is not applicable for ambulance health services.

See **Advisory AS23/02: Advice on not applicable actions for Ambulance Health Services**.

Where the Action is applicable, refer to the **NSQHS Standards Guide for Hospitals**.

Action 5.19

The health service organisation has processes for routinely reviewing the safety and quality of end-of-life care that is provided against the planned goals of care.

This Action is not applicable for ambulance health services.

See **Advisory AS23/02: Advice on not applicable actions for Ambulance Health Services**.

Where the Action is applicable, refer to the **NSQHS Standards Guide for Hospitals**.

Action 5.20

Clinicians support patients, carers and families to make shared decisions about end-of-life care in accordance with the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care*.[218]

This Action is not applicable for ambulance health services.

See **Advisory AS23/02: Advice on not applicable actions for Ambulance Health Services**.

Where the Action is applicable, refer to the **NSQHS Standards Guide for Hospitals**.

Minimising patient harm

Patients at risk of specific harm are identified, and clinicians deliver targeted strategies to prevent and manage harm.

The screening actions in this standard aim to identify the patients who are at the greatest risk of harm while receiving health care. The specific risks identified in this criterion are areas in which at-risk patients are commonly harmed. Implementing targeted, best-practice strategies can prevent or minimise the risk of these specific harms.

Preventing and managing pressure injuries

Action 5.21

The health service organisation providing services to patients at risk of pressure injuries has systems for pressure injury prevention and wound management that are consistent with best-practice guidelines.

Intent

Evidence-based guidelines are used for wound management and for prevention and care for patients at risk of or with a pressure injury.

Reflective questions

- How does the ambulance health service describe decision making and management processes for preventing pressure injuries and for wound management?
- What processes does the ambulance health service have in place to ensure evidence-based documents and tools for preventing pressure injuries and wound management are current and consistent with best-practice guidelines?
- How does the ambulance health service ensure that the workforce is following best-practice guidelines and tools for the prevention of pressure injuries?

Strategies for improvement

Develop or adapt a wound management system that is based on best-practice guidelines

Ambulance health services should ensure that systems for wound management and preventing pressure injuries are based on best-practice guidelines, such as the Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline.[264] For further information see fact sheet: **NSQHS Standards - Preventing pressure injuries and wound management**.

The ambulance health service should:

- Use information from screening and assessment processes to identify patients at risk of developing pressure injuries (see **Action 5.10**)
- Develop protocols for management of wounds and prevention and treatment of pressure injuries, including requirements for documentation
- Ensure that assessment of wounds and pressure injuries incorporates:
  - the use of a validated risk assessment tool
  - the use of a pressure injury classification system
  - assessment of pain using validated self-reporting tools
- Document and communicate identified risks and treatment at transitions of care to support ongoing comprehensive care by the primary care provider or receiving facility.

Examples of evidence

- Policy documents about wound management and pressure injury prevention that are consistent with best-practice guidelines
- Orientation manuals, education resources and records of workforce attendance on assessing and managing wounds and pressure injuries
- Training and audit of aseptic technique
- Reports from safety and quality systems relating to wound management and pressure injuries
- Audit results of healthcare records for compliance with protocols on management and treatment of wounds and pressure injuries
- Feedback from the workforce and consumers on the wound and pressure injury management system
- Committee and meeting records and feedback to the workforce regarding the wound and pressure injury management
- Observation of wound management performed by the workforce
- Reports of improvement activities related to wound management and the prevention and treatment of pressure injuries.

Action 5.22

Clinicians providing care to patients at risk of developing or with a pressure injury conduct comprehensive skin inspections in accordance with best-practice timeframes and frequency.

Intent

The risk of harm from pressure injuries is minimised by routinely conducting skin inspections.

Reflective questions

- What assessment tools or processes are used by the ambulance health service's workforce to complete skin inspections for at-risk patients?
- What processes does the ambulance health service have in place to ensure that prevention plans for patients at risk of a pressure injury are consistent with best-practice guidelines?

Strategies for improvement

Ensure skin inspections are part of routine patient care

Ambulance health services should develop process to support clinicians to perform skin inspections as comprehensively as possible. It should also:

- Incorporate skin inspections for patients who are screened as being at high risk of pressure injury into routine processes (see **Action 5.11**)
- Document the results of skin inspections, including where pressure injuries are identified (see **Action 5.12**)
- For patients at risk of developing a pressure injury or for those who have an existing pressure injury, document and communicate this information at transitions of care
- Provide the workforce with access to **Prevention and Treatment of Pressure Ulcers: Clinical practice guidelines**.[264]

Examples of evidence

- Policies, procedures and protocols that outline processes for conducting and documenting comprehensive skin assessments
- Orientation manuals, education resources and records of attendance at training by the workforce on conducting and documenting comprehensive skin assessments
- Examples of pressure injury prevention plans
- Demonstration or observation of clinicians accessing risk assessment tools
- Audit of compliance with policies, procedures and protocols relating to skin inspections and management of pressure injuries and wounds
- Observation of patients with preventative aids or equipment
- Reports from review of incidents or complaints regarding wound or pressure injury management and actions taken
- Documentation from committees and other meetings where reports on comprehensive skin assessments are reviewed and discussed
- Feedback to the workforce on comprehensive skin assessments and quality improvement initiatives
- Reports or committee records relating to pressure injury prevention and management systems.

Action 5.23

The health service organisation providing services to patients at risk of pressure injuries ensures that:

a. **Patients, carers and families are provided with information about preventing pressure injuries**
b. **Equipment, devices and products are used in line with best-practice guidelines to prevent and effectively manage pressure injuries.**

Intent

Patients with or at risk of pressure injuries are provided with information and are involved in their pressure injury care, and devices and equipment that minimise the risk of harm are used.

Reflective questions

- What processes does the ambulance health service have in place to ensure that equipment, devices and products are provided to members of the workforce in line with best-practice guidelines to prevent and effectively manage pressure injuries?
- What support does the ambulance health service provide to patients, carers and families about the prevention and management of pressure injuries?
- How does the ambulance health service monitor the effectiveness of its processes to manage the risk of pressure injuries?

Strategies for improvement

Access to products, equipment and devices

The ambulance health service should provide the workforce with access to products, equipment and devices to prevent pressure injuries and reduce harm during an episode of care. It should also:

- Evaluate products, equipment and devices
- Seek feedback from the workforce on products to prevent pressure injuries and reduce harm during an episode of care
- Schedule routine maintenance and cleaning
- Review incident management systems to identify gaps and improve systems to reduce risks of harm from pressure injuries in line with best available evidence.

Provide information to patients and primary health care providers

The ambulance health service should develop referral pathways for people at risk of harm to access ongoing support to prevent and effectively manage pressure injuries. It should also:

- Provide patients, carers and families with information for the prevention and management of pressure injuries, including risk factors and self-care
- Provide systems for risks to be identified at transitions of care
- Evaluate referral pathways and information provided to patients and their families.

Examples of evidence

- Policies, procedures, protocols or guidelines that support the workforce to:
  - access and use equipment, devices and products in line with best-practice guidelines to prevent and effectively manage pressure injuries
  - apply infection prevention and control measures prior to the equipment being re-used (see **Preventing and Controlling Infections Standard**)
  - provide patients, carers and families, at risk of pressure injuries with information to support ongoing care
- Register of equipment for prevention and management of pressure injuries, including maintenance and safety checks
- Guidelines for accessing and use of equipment to prevent and manage pressure injuries
- Education and training for the workforce on the use of equipment and devices for the prevention and management of pressure injuries
- Audit of equipment use against policies and processes for selecting and safe use of equipment and devices
- Review of patient comprehensive care plans about prevention and management of pressure injuries
- Documentation from committees or meetings where reports on pressure injury prevention and management are reviewed and discussed
- Examples of information provided to patients about prevention and management of pressure injuries
- Results of patient and carer feedback on information about pressure injury prevention and management.

Preventing falls and harm from falls

Action 5.24

The health service organisation providing services to patients at risk of falls has systems that are consistent with best-practice guidelines for:

a. **Falls prevention**
b. **Minimising harm from falls**
c. **Post-fall management.**

Intent

Clinical practice for preventing and managing falls is evidence based, and patient risks and harm are minimised.

Reflective question

How does the ambulance health service ensure that falls treatment, care pathways and prevention interventions are consistent with best practice?

Strategies for improvement

In 2020, falls were the leading cause of hospitalised injuries and injury deaths among older Australians (>65 years), making up 77% of all injury hospitalisations and 71% of injury deaths. Aboriginal and Torres Strait Islander peoples are 1.4 times more likely than non-Indigenous Australians to be hospitalised due to a fall injury.[265] A substantial proportion of users of out of hospital services are people over the age of 65[266] who have had a fall.[267]

Provision of care by ambulance health services includes lift assistance and reassurance, education to reduce risks of falls, clinical management of severe injuries, transportation to hospital and referral to other health care providers for further assessment and ongoing support.

Actively support fall prevention programs in the community

Ambulance health services should investigate ways to support fall prevention programs in the community in line with best practice principles. **The Australian Falls Guideline Recommendations and Good Practice Points Guidelines** aim to improve the safety and quality of care for older people in Residential Aged Care Services, Community Care and Australian Hospitals. They provide a nationally consistent approach to preventing falls based on best practice recommendations including: [265]

- Developing referral pathways for assessment by a primary care provider or specialist for people at high risk of falls (e.g., people who fall 2+ times per year, or those with cognitive impairment) 268
- Providing people at increased risk of falls (e.g., people who fall 1+ times per year) with safety education to reduce risks of falls[269]
- Implementing tools for falls screening and assessment
- Supporting the workforce to report falls and evaluating incident management systems relating to falls
- Collaborating or partnering with external organisations, expert bodies and consumers to support the development of policies, processes, services and interventions to prevent falls.

Examples of evidence

- Policies, procedures and protocols for falls prevention and management that are consistent with current evidence-based guidelines
- Examples of tools for falls screening
- Reports relating to falls incidents and improvements implemented and evaluated
- Reports from patient safety and quality systems on falls and falls prevention
- Evidence of pathways to support ongoing assessment and support for people identified at risk of falls
- Documentation from committees and other meetings where reports on compliance with the falls policy framework are reviewed and discussed
- Audit of patient healthcare records to identify management and referral pathways in line with falls prevention and managements policies and procedures
- Reports on falls and falls prevention activities provided to the workforce and consumers
- Orientation, training and education for the workforce on risk screening and falls management.

Action 5.25

The health service organisation providing services to patients at risk of falls ensures that equipment, devices and tools are available to promote safe mobility and manage the risks of falls.

Intent

Patients are provided with equipment and devices to promote safe mobility and reduce harm from falls.

Reflective question

What equipment and devices does the ambulance health service have available for patients to prevent harm from falls or to manage patients who are at risk of falling?

Strategies for improvement

Ambulance health services should utilise a risk management approach to identify equipment and devices to promote safe mobility and reduce harm from falls required for the organisation's patient population. Specialised skills and equipment may be required to support safe access and egress of patients from routine and non-routine conditions and environments.

Where the risk of falls or harm from falls is low, requirements for equipment and devices will be reduced, however it is still important that the ambulance health service consider:

- Training for the workforce on strategies to promote safe mobility and reduce harm from falls
- Ensuring appropriate equipment is available for patients identified at risk of falling
- Provision of appropriate equipment and training to support the workforce to safely lift patients
- Supporting patients who have been provided with equipment and devices to reduce falls in their home environment
- Establishing referral pathways for patients and their carers for ongoing assessment and support in the community
- Providing information to patients and their carers on accessing equipment and devices to prevent falls or harm from falls
- Adjusting chair and stretcher or bed heights
- Ensuring effective brakes on equipment such as stretchers, beds, wheelchairs
- Using safety harnesses and seatbelts
- Using effective lighting
- Reducing clutter and trip hazards
- Stowing and securing equipment in vehicles
- Providing slip-resistant surfaces
- Installing handrails
- Developing a log to register equipment and devices and record their maintenance.

Examples of evidence

- Guidelines for accessing and use of equipment to prevent and manage falls
- Orientation manuals, education resources and records of attendance at training by the workforce in the use of manual handling, equipment and devices for the prevention and management of falls
- Register and maintenance logs of equipment and devices for the prevention and management of falls
- Systems and governance arrangements for review and future procurement of equipment and devices, including templates and examples of equipment evaluation reports
- Reports on falls prevention and management, equipment and resource allocation that promote safe mobility and reduce harm from falls
- Incidents reports relating to falls, including failure of equipment and actions taken to reduce risks
- Referral pathways for people identified at risk for assessment, support and equipment to reduce risks of harm from falls
- Observation of clinicians using the decision making process to identify equipment required.

Action 5.26

Clinicians providing care to patients at risk of falls provide patients, carers and families with information about reducing falls risks and falls prevention strategies.

Intent

Patients, carers and families are provided with information about falls risks and preventing falls.

Reflective question

What information and support does the ambulance health service provide to patients and carers about falls risk and prevention?

Strategies for improvement

Provide information to the patient and their support people

The ambulance health service should involve patients, carers and families in discussions about falls risks and the development of falls prevention and harm minimisation strategies. It should also:

- Provide information to support patients, carers and families understand the falls risks and prevention and management strategies
- Seek feedback from patients, carers and families about the information provided to patients to inform quality improvement
- Provide information about referral pathways for further assessment and support, including how to access equipment and devices to reduce falls and harm from falls
- Implement systems for the workforce to document falls risks at transitions of care

Several states and territories have published resources and guidelines for reducing harm from falls such as:

- **Community Care - Falls Prevention** (NSW Clinical Excellence Commission)
- **Australian and New Zealand Falls Prevention Society** (ANZFPS)
- **Don't fall for it. Falls can be prevented!** (Department of Health and Aged Care)
- **Stay On Your Feet ®** (Queensland Department of Health)
- **Stay On Your Feet®** Falls Prevention Program WA

Examples of evidence

- Information provided to patients and carers or links to resources about falls risks and prevention in the community
- Feedback from consumers about falls risks and preventing falls
- Referral pathways to support patients to access assessment and support in the community
- Audit results of the types of information being provided patients, carers or families about falls risks and prevention strategies
- Results of patient and carer experience surveys, and organisational responses, in relation to information provided about falls risks and falls prevention strategies.

Nutrition and hydration

Action 5.27

The health service organisation that admits patients overnight has systems for the preparation and distribution of food and fluids that include nutrition care plans based on current evidence and best practice.

This Action is not applicable for ambulance health services.

See **Advisory AS23/02: Advice on not applicable actions for Ambulance Health Services**.

Where the Action is applicable, refer to the **NSQHS Standards Guide for Hospitals**.

Action 5.28

The workforce uses the systems for preparation and distribution of food and fluids to:

a. **Meet patients' nutritional needs and requirements**
b. **Monitor the nutritional care of patients at risk**
c. **Identify, and provide access to, nutritional support for patients who cannot meet their nutritional requirements with food alone**
d. **Support patients who require assistance with eating and drinking.**

This Action is not applicable for ambulance health services.

See **Advisory AS23/02: Advice on not applicable actions for Ambulance Health Services**.

Where the Action is applicable, refer to the **NSQHS Standards Guide for Hospitals**.

Preventing delirium and managing cognitive impairment

Cognitive impairment is often associated with dementia and delirium. An increasing number of older people accessing ambulance health services are presenting with cognitive impairment.[248] Both conditions accompany changes in cognition, which may include memory loss, disorientation, language disturbance or perceptual disturbance. [270] This can reduce a person's capacity to provide informed consent, follow instructions and relay vital medical history or symptoms such as pain, impacting the planning and delivery of appropriate health care.[271]

The **Comprehensive Care Standard** actions **5.29** and **5.30** focus on how to develop and use a cognitive impairment system in a health care setting.

The **Recognising and Responding to Acute Deterioration Standard Action 8.05** ensures the health service has processes for recognising and responding to delirium and deteriorating behaviour.

The **NSQHS Standards user guide for health service organisations providing care for patients with cognitive impairment**[129] includes:

- **Other specific actions to consider**
- A number of **resources** to support the implementation of those actions.

Action 5.29

The health service organisation providing services to patients who have cognitive impairment or are at risk of developing delirium has a system for caring for patients with cognitive impairment to:

a. **Incorporate best-practice strategies for early recognition, prevention, treatment and management of cognitive impairment in the care plan, including the Delirium Clinical Care Standard[272] where relevant**
b. **Manage the use of antipsychotics and other psychoactive medicines in accordance with best practice and legislation.**

Intent

A system for caring for cognitive impairment is implemented that minimises the risk of harm for people with cognitive impairment or at risk of developing delirium. The use of antipsychotics and other psychoactive medicines is in line with current best practice and legislation.

Reflective questions

- What processes does the ambulance health service have in place to manage safety and quality issues for patients with, or at risk of, developing cognitive impairment?
- How does the ambulance health service monitor the use of antipsychotics and other psychoactive medicines, and how is feedback provided to clinicians?
- How does the ambulance health service support clinicians to use non-pharmacological approaches in response to behavioural and psychological symptoms of dementia?
- How does the ambulance health service monitor the effectiveness of its system for caring for cognitive impairment?

Strategies for improvement

Implement a system

The ambulance health service should ensure that policies for preventing and responding to acute behavioural disturbance include specific guidance on cognitive impairment. It should also:

- Provide the workforce with access to the current **Delirium Clinical Care Standard**[273]
- Develop a system for early recognition and the provision of high-quality care for patients with cognitive impairment
- Provide the workforce with validated tools, including culturally specific screening tools where available, such as
  - **Kimberley Indigenous Cognitive Assessment** (KICA)
  - **Rowland Universal Dementia Assessment Scale** (RUDAS) (**Action 5.10**)
- Develop pathways for people at risk of harm to seek review and management by their nominated primary care provider.

For all patients with cognitive impairment

The ambulance health service should partner with patients and carers to support early recognition, and obtain information about the patient needs and preferences, and ways to reduce distress.

For all patients with cognitive impairment, the ambulance health service should:

- Assess for delirium where indicated using validated delirium assessment tools (see **Action 8.5**)
- If delirium is detected, refer the patient for further assessment, investigation and follow-up within the scope of the ambulance health service
- Develop an individualised plan, including indications for re-assessment (see **Actions 5.12** and **5.13**)

The ambulance health service should provide training and ongoing education to the workforce on recognition and appropriate management of people with cognitive impairment, including dementia and delirium.[248, 273] It should also:

- Develop policies, procedures and protocols for the workforce to
  - conduct safety assessments
  - effective communication and de-escalation strategies
  - have protocols when behaviour changes present a risk to the patient or others
- Provide relevant information to patients, carers and families in an easy-to-understand format
- Manage medication issues, including:
  - treating pain and reducing sedation
  - providing accurate medicines lists (see **Action 5.12**)
- Manage transitions effectively, including information exchange and transfer of responsibilities between members of the ambulance health service workforce and all relevant health service organisations and care providers (see **Actions 6.07** and **6.08**).

Manage the use of antipsychotic medicines

The ambulance health service should incorporate best practice[274,275] and legislation in the use of antipsychotics and other psychoactive medicines for people with cognitive impairment into policies and procedures. This includes:

- Identifying and treating medical causes such as pain
- Using de-escalation techniques and strategies to reduce distress
- Obtaining information from family or carers about the patient's needs and preferences and ways to reduce distress
- Providing orientation, training and education to the workforce (see **Action 5.30**)
- Avoiding physical restraint and following guidance in **Action 5.35** to minimise restraint
- Obtaining informed consent prior to commencing pharmacological treatment in line with local policies
- Use the lowest appropriate dose for the shortest possible duration, as described in Therapeutic Guidelines: Psychotropic[276]
- Following 'start low, go slow, time limit and review' for pharmacological interventions
- Establishing pathways for review of patients with delirium who have other indications for antipsychotic use, or who have an existing prescription for antipsychotics
- Monitoring and collecting feedback on the use of antipsychotics and other psychoactive medicines.

Examples of evidence

- Policy documents that outline processes for recognising, preventing, treating and managing cognitive impairment, including effectively managing transition of care, that are aligned with **A Better Way to Care: Safe and high-quality care for patients with cognitive impairment**[257] (dementia and delirium) in hospital and the **Delirium Clinical Care Standard**[273]
- Training documents about communicating with, and providing support to, patients with cognitive impairment, and assessing and responding to distress
- Examples of strategies that have been implemented and evaluated to improve the environment for people with cognitive impairment
- Position descriptions that describe the roles and responsibilities of the workforce in the system for caring for cognitive impairment
- Reports of monitoring of antipsychotics and other psychoactive medicines
- Examples of quality improvement activities that have been implemented and evaluated to reduce prescribing of antipsychotics and other psychoactive medicines to patients with cognitive impairment
- Examples of non-pharmacological approaches that have been implemented to respond to behavioural symptoms of dementia
- Consumer information or fact sheets provided to patients, carers and families
- Committee and meeting records that show the ambulance health service's involvement in dementia pathway initiatives

Action 5.30

Clinicians providing care to patients who have cognitive impairment or are at risk of developing delirium use the system for caring for patients with cognitive impairment to:

a. **Recognise, prevent, treat and manage cognitive impairment**
b. **Collaborate with patients, carers and families to understand the patient and implement individualised strategies that minimise any anxiety or distress while they are receiving care.**

Intent

Risks are minimised by undertaking strategies to recognise, prevent, treat and manage cognitive impairment. Clinicians, patients, carers and families work together to minimise anxiety or distress experienced by the person with cognitive impairment.

Reflective questions

- How is the ambulance health service's workforce supported to recognise, prevent, treat and manage cognitive impairment?
- How does the ambulance health service collect and use feedback from patients with cognitive impairment, their carers and families to inform improvement strategies?

Strategies for improvement

Ambulance health services should review national and international programs and best practice recommendations such as:

- **The Royal Commission into Victoria's Mental Health System**
- **Safewards Victoria**
- **Clinical Practice Guidelines for the Appropriate Use of Psychotropic Medications in People Living with Dementia and in Residential Aged Care**
- **Progress Report: Implementation of the Recommendations of the Royal Commission into Aged Care Quality and Safety**

The ambulance health service should provide orientation, training and education for the workforce regarding cognitive impairment including:

- Information about all forms of cognitive impairment[277]
- Use of validated screening and assessment tools
- Use of evidence-based guidelines and referral pathways

The ambulance health service should seek feedback from the workforce and consumers to identify skills gaps and training requirements. It should ensure the workforce has access to relevant tools and resources.

It may be useful for the ambulance health service to liaise with **Dementia Training Australia**[278], **Dementia Support Australia**[279] and **Dementia Australia**[280] in developing its approach to managing cognitive impairment. It could consider implementing evidence-based programs such as **TOP 5**[281] and should seek feedback from patients, carers and families to identify gaps and improve systems for people with cognitive impairment.

Examples of evidence

- Policy documents that describe interventions to prevent and manage delirium for at-risk patients
- Audit results of healthcare records for cognitive screening using validated tools
- Audit results of healthcare records for referral of patients for further assessment
- Communication of screening outcomes to the workforce
- Audit results of communication of screening outcomes at transitions of care
- Training documents that include use of validated screening tools, referral pathways and strategies for reducing distress for people with cognitive impairment
- Consumer information or fact sheets
- Examples of non-pharmacological approaches that have been implemented to respond to behavioural symptoms
- Use of the **Indicator Specification: Delirium Clinical Care Standard**[282]
- Minutes of meetings where care for people with cognitive impairment was discussed
- Carer feedback regarding the management of cognitive impairment support systems.

Predicting, preventing and managing self-harm and suicide

Action 5.31

The health service organisation has systems to support collaboration with patients, carers and families to:

a. **Identify when a patient is at risk of self-harm**
b. **Identify when a patient is at risk of suicide**
c. **Safely and effectively respond to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed.**

Intent

The workforce has the skills and knowledge to engage collaboratively to identify and respond to patients at risk of self-harm or suicide.

Reflective questions

- What strategies does the ambulance health service have in place to ensure that clinicians can identify and manage patients at risk of self-harm or suicide
- How does the ambulance health service ensure that clinicians know how to respond safely and effectively to patients who are distressed, have thoughts of self-harm or suicide, or have self-harmed?
- How do members of the workforce gain access to specialist mental health expertise to provide care to patients who have thoughts of self-harm or suicide, or have self-harmed?
- What processes does the ambulance health service have in place to ensure that the workforce can work collaboratively to provide information about patients at risk of self-harm or suicide at transitions of care?

Strategies for improvement

Strategies for improvement will differ across ambulance health services depending on the scope and type of service provided. Organisations should implement a risk management approach to establish the roles, responsibilities and systems required to support the workforce to respond to patients at risk of self- harm or suicide.[283]

The following strategies and frameworks together are working towards a whole of Australia government response to suicide prevention with an emphasis on promotion, prevention and early intervention:

- The **National Suicide Prevention Strategy** (NSPS)
- **The Fifth National Mental Health and Suicide Prevention Plan (2017)**
- **The Royal Commission into Victoria's Mental Health System: Final Report**
- **Safewards Victoria** identifies and addresses the causes of behaviours in staff and patients that may result in harm, such as violence, self-harm or absconding and reduce the likelihood of this occurring.

- The **Living is for Everyone (LIFE) Framework** provides a practical suite of resources and research finding on how to address the complex issues of suicide and suicide prevention.[284]
- **The National Aboriginal and Torres Strait Islander suicide prevention strategy** comprises a holistic view of mental, physical, cultural and spiritual health.
- **The National LGBTI Mental Health and Suicide Prevention Strategy** outlines effective mental health and suicide prevention strategy for **LGBTI people and communities**.
- **National Mental Health and Wellbeing Pandemic Response Plan** navigates through the COVID-19 pandemic to support the mental health of Australians.

Identify risk of self-harm

The ambulance health service should implement policies, procedures, protocols and processes that support best practice and support the workforce to:

- Identify patients at risk of self-harm
- Triage clinical safety, and
- Provide this information to the receiving facility or primary care provider at transitions of care.

There are several tools for identifying risk, however these have not been validated in the out of hospital setting:

- **Framework for Suicide Risk Assessment and Management** - NSW Health
- **Suicide risk assessment** - Victoria Department of Health
- **Ask Suicide-Screening Questions (ASQ) Toolkit** - National Institute of Mental Health
- **Mental health triage tool**
- Screening Tool for Assessing Risk of Suicide (STARS Protocol)[285] **STARS Training – program facilitated by Griffith University Brisbane**
- **Suicide Assessment Screener** – National Drug and Alcohol Research Centre (NDARC) and University of NSW
- **Suicide Questions Answers and Resources** (SQARE)
- **Self-harm in over 8s: short-term management and prevention of recurrence**[286] - UK National Institute for Health and Care Excellence.

The ambulance health service could investigate systems to gather data on self-harm related behaviours which would provide valuable information and support to national harm reduction programs.[287, 288]

Identify risk of suicide

People who have been treated after a suicide attempt report that the attitudes of members of the healthcare workforce were an important factor determining whether they would disclose suicidal thoughts in the future.[289]

To support the workforce in identifying risk of suicide, the ambulance health service should:

- Review local policies, procedures and protocols to incorporate recovery principles
- Establish relationships with organisations and networks to create pathways for people to access mental health services
- Implement systems for members of the workforce to escalate care
- Implement systems for the workforce to gain access to specialist mental health expertise
- Provide training to the workforce on recognising signs of potential risk for suicide and engaging therapeutically[208]
- Support involvement of people with lived experience and their significant others in reviewing education, training and quality-improvement activities
- Provide access for the workforce to evidence-based tools and programs.

It is important that the ambulance health service adopt a recovery-oriented approach.[290] In the out of hospital setting specific treatment and support immediately after a suicide attempt is likely to be brief but may include:

- Use of tools and resources to support comprehensive psychosocial assessment
- Provision of information regarding support in the community and referral pathways.

Provide support to the workforce

It is widely recognised that first responders are at high risk of developing vicarious trauma, post-traumatic stress[291] and other mental health disorders arising from the traumatic events in which they are involved.[292] Members of the out of hospital workforce spend a great deal of their professional lives dealing with people in urgent need, often providing care to people who are highly distressed in situations where their own safety may also be at risk.[293]

To support the workforce to care for people at risk of harm and suicide, ambulance health services should implement actions from the **Clinical Governance Standard** to provide the workforce with:

- Training and professional development, such as
  - safety and quality roles, responsibilities and accountabilities
  - principles of trauma informed self-care
  - work, health and safety guidelines
- Staff support programs such as Employee Assistance Program (EAP) or similar, clinical supervision and opportunities for debriefing
- Evidence-based strategies and recommendations such as:
  - **The people behind 000: mental health of our first responders**
  - **Answering the call national survey, National Mental Health and Wellbeing Study of Police and Emergency Services**[294]
  - **Fortem Australia**
  - **Australian First Responder Foundation**
  - **Good practice framework for mental health and wellbeing in police and emergency services organisations** - Beyond Blue

Examples of evidence

- Policies, guidelines and processes that outline processes for assessment and screening, treating and referring patients who have self-harmed, or are at risk of self-harm or suicide
- Risk assessment tools for patients at risk of self-harm or suicide
- Professional development and training documents relating to identifying, treating, referring patients at risk of self-harm or suicide, or who have self-harmed
- Workforce orientation, training and ongoing education in the principles of trauma-informed care
- Clinical incident monitoring system that includes information on self-harm and suicide
- Processes for the workforce on monitoring and escalation processes for patients at increased risk
- Audit results of compliance with published policies, procedures and protocols
- Audit results of comprehensive care planning and outcomes of risk screening being communicated at transition of care
- Patient and carer experience surveys for patients at risk of self-harm or suicide.

Action 5.32

The health service organisation ensures that follow-up arrangements are developed, communicated and implemented for people who have harmed themselves or reported suicidal thoughts.

Intent

Adequate follow-up support is arranged and agreed by the nominated participants for when people who have self-harmed or reported suicidal thoughts leave the ambulance health service.

Reflective questions

- What systems does the ambulance health service have in place for appropriate referral or support for people who have harmed themselves or reported suicidal thoughts?
- Does the ambulance health service have any partnerships in place with other agencies to support the transfer of responsibility of care and follow-up?
- How does the ambulance health service identify gaps in referral processes?

Strategies for improvement

Communication at transitions of care

A suicide attempt is the strongest risk factor for subsequent suicide, and the risk for suicide after an attempt is significantly elevated compared to the general population. People who have been provided with appropriate aftercare after a suicide attempt are less likely to have a subsequent suicide attempt.[295] Therefore, every person who has survived a suicide attempt or has presented to a healthcare provider with suicidal behaviours should be proactively provided with aftercare support.

Key components to effective aftercare are identified as timeliness, flexibility, the quality of the human connection established with the person who has attempted suicide and their family or carers.[296] Brief interventions that consist of safety planning, active outreach and a set of low-burden strategies have been found to be effective in reducing repeat suicide attempts.[297]

Strategies will vary depending upon the scope of the ambulance health service and will rely upon establishing partnerships with key stakeholders for providing ongoing support and care. Ambulance health services should:

- Ensure that roles, responsibilities and accountabilities for communicating information about self-harm and suicide risk to ongoing service providers is established
- Establish systems for the workforce to refer people who have harmed themselves or attempted suicide for ongoing care
- Implement systems to identify the primary service or lead clinician that will coordinate ongoing aftercare for the patient
- Develop policies, procedures, protocols and clinical guidelines based upon current best practice for the involvement of families, carers or substitute decision makers
- Develop policies, procedures, protocols and clinical guidelines based upon current best practice for the integration of clinical and non-clinical support
- Identify and establish links and referral pathways with primary care providers or aftercare programs

- Effective follow-up after a suicide attempt can be implemented through a number of avenues, including Beyond Blue's **Way Back Support Service**[298]
- The National Institute for Health and Care Excellence in the United Kingdom has developed guidelines for the longer-term clinical management of self-harm.[299]

Examples of evidence

- Policy documents and clinical guidelines that outline collaborative processes for referring patients at risk of self-harm or suicide, or who have self-harmed to primary health care or other services
- Workforce orientation, training and ongoing education in the principles of trauma-informed care
- Evidence of risk screening and discussions about referral to appropriate services
- Audit results of compliance with published policies, procedures and protocols
- Audit results of comprehensive care planning and referral and support options being discussed with patients and communicated at transition of care
- Feedback from the workforce and consumers on transition and referral pathways.

Predicting, preventing and managing aggression and violence

Action 5.33

The health service organisation has processes to identify and mitigate situations that may precipitate aggression.

Intent

The risk of aggression and violence is minimised by reducing environmental or procedural triggers for aggression.

Reflective questions

- What processes does the ambulance health service have in place to ensure that the workforce can identify situations that may precipitate acute behavioural disturbance?
- What processes does the ambulance health service use to mitigate these situations?
- What features of the ambulance health service environment are used to minimise sources of potential conflict?
- How does the ambulance health service monitor the effectiveness of its processes to predict, prevent and manage aggression and violence?

Strategies for improvement

Clinical Governance Standard Action 1.29 provides information on designing healthcare environments to maximise safety.

Comprehensive Care Standard Action 5.34 provides strategies to reduce the risk of acute behavioural disturbance in individual patients.

Implement strategies to reduce acute behavioural disturbance and reduce the risk of harm[300]

Ambulance health services provide care in a range of settings, in environments that are both unfamiliar and involve high stimulus. Acute behavioural disturbance has been associated with increasing frequency of dementia and acute medical illness associated with an aging population.[301] In the out of hospital environment, patients are often dealing with unfamiliar and stressful experiences including pain and uncertainty, which can increase the risk of acute behavioural disturbance.

Although the design of healthcare environments can contribute to reducing behaviours of concern, it is not always possible to change the environment in ways that reduce these risks. Out of hospital settings with fewer resources may have lower thresholds for managing, escalation and referral of people experiencing acute behavioural disturbance and will often involve medical, legal and ethical decisions.

It will be important for ambulance health services to implement systems to mitigate risks to patients and members of the workforce. This may include guidelines and validated screening tools to support triage and management of agitated patients.[302] It could also include:

- Conducting hazard identification and risk assessment, event reporting, and workplace review of significant events and near-misses
- Identifying risk factors that can trigger acute behavioural disturbance
- Implementing strategies to reduce stressors caused by environmental or procedural factors (where possible)
- Developing, resourcing, implementing, monitoring and evaluating safety processes
- Seeking feedback from the workforce to identify risks and prioritise areas for improvement
- Providing workforce orientation, training and ongoing education in communication and de-escalation techniques
- Identifying models or interventions such as **Safewards** that can be adopted by members of the workforce to recognise potential sources of conflict or 'flashpoints' and implement a range of strategies to reduce risks
- Implementing structured clinical tools to identify patients at higher risk acute behavioural disturbance[303]

Best practice resources available to inform policies on predicting, preventing and managing aggression and violence include:

- **Safety and Security Guidelines for Remote and Isolated Health**[304]
- **Caring for people displaying acute behavioural disturbance Clinical guidance to improve care in emergency settings**[300] workforce training.
- SA Health's **Hazard identification and risk assessment for challenging behaviours**[305]

Examples of evidence

- Policy documents that outline the processes for identifying and mitigating situations that may precipitate acute behavioural disturbance
- Training and education documents about identifying and mitigating situations that may precipitate acute behavioural disturbance
- Audit results of healthcare records about screening for risks of acute behavioural disturbance
- Audit of compliance with published policies, procedures and protocols to reduce risks of acute behavioural disturbance
- Observation of the use of the environment to minimise sources of potential conflict
- Observation of workforce strategies that minimise patient stressors
- Reports from the incident management system relating to acute behavioural disturbance.
- Records of patients, carers or families identifying triggers for acute behavioural disturbance.

Action 5.34

The health service organisation has processes to support collaboration with patients, carers and families to:

a. **Identify patients at risk of becoming aggressive or violent**
b. **Implement de-escalation strategies**
c. **Safely manage aggression, and minimise harm to patients, carers, families and the workforce.**

Intent

Collaborative processes are used to minimise the risk of aggression and violence, and incidents are managed safely when they occur.

Reflective questions

- What processes does the ambulance health service have in place to ensure that the workforce can work collaboratively with people to identify when a person is at risk of acute behavioural disturbance?
- What strategies does the ambulance health service use to support people at risk of acute behavioural disturbance?
- How does the ambulance health service minimise harm from acute behavioural disturbance to patients, carers, families and the workforce?

Strategies for improvement

This action aligns with the:

- Recognising and Responding to Acute Deterioration Standard
- National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state[312]

Implement risk management processes to reduce risks from acute behavioural disturbance[293]

Screening for risk of acute behavioural disturbance is an important and complex task for members of the healthcare workforce.[303] Ambulance health services should implement screening tools and risk management processes that are evidence based and work within the principles of person-centred, trauma informed care.[300]

The ambulance health service should implement systems to monitor for changes in a person's behaviour, cognitive function, perception, physical function or emotional state that may indicate deterioration in mental state that could lead to acute behavioural disturbance. Predictive factors for risk of aggression can include:

- Previous history of aggression or violence
- Use of alcohol or other drug use
- Withdrawal from alcohol or other drug use
- A history of self-harm
- Acute brain injury
- Cognitive impairment.

Support the workforce to use systems to minimise harm from acute behavioural disturbance

The ambulance health service should provide workforce orientation, training and ongoing education in the use of de-escalation strategies.[306] It should also:

- Seek feedback from the workforce and consumers on systems for reducing risk of acute behavioural disturbance
- Monitor the effectiveness and performance of safety and quality systems implemented to reduce risks of acute behavioural disturbance
- Review and report incidents where acute behavioural disturbance has occurred
- Use the organisation's quality improvement systems to identify and prioritise improvements where gaps are identified

Resources available to inform the ambulance health service's approach include:

- **Safer Care Victoria** has developed clinical guidance on caring for people displaying acute behavioural disturbance in emergency settings
- SA Health has developed a set of resources for **Taking care of challenging behaviour**[307]
- **CRANAplus** have developed a number of resources tailored to rural and remote health practice, that can be used to inform rostering practices, policies, procedures, protocols training and behaviours.[306]

Examples of evidence

- Policy documents and clinical guidelines that outline processes for identifying patients at risk of acute behavioural disturbance, and implementing de-escalation strategies
- Training and education documents about de-escalation strategies and safe management of acute behavioural disturbance in patients and other consumers
- Audit results of healthcare records of screening for acute behavioural disturbance in line with published policies and procedures
- Documentation of risks being communicated at transitions of care
- Consumer, carer and family information about the rights and responsibilities of people using the ambulance health service
- Reports from incident management systems on incidents involving acute behavioural disturbance
- Quality improvement activities implemented and evaluated to support systems for reducing risks from acute behavioural disturbance
- Evidence of the availability, operational deployment and use of personal duress alarms for the workforce
- Workforce, patient, carer and family feedback regarding processes for responding to acute behavioural disturbance.

Minimising restrictive practices: restraint

Action 5.35

Where restraint is clinically necessary to prevent harm, the health service organisation has systems that:

a. Minimise and, where possible, eliminate the use of restraint

b. Govern the use of restraint in accordance with legislation

c. Report use of restraint to the governing body.

Intent

Harm relating to the use of restraint is minimised.

Reflective questions

- What strategies does the ambulance health service have in place to minimise the use of restraint?
- Are members of the workforce competent to implement restraint safely?
- How does the ambulance health service ensure that the workforce is aware of safety implications of different forms of physical and mechanical restraint with different patient populations?
- What processes are used to review the use of restraint in the ambulance health service?

Strategies for improvement

Restraint is the restriction of an individual's freedom of movement.[308] It includes mechanical, physical and chemical or pharmacological restraint.

Note that medicines used with the primary intent of relieving a person's pain are not considered chemical restraint, even though they may have sedative side-effects. Definitions and guiding principles for the use of analgesia should be documented in local policies and procedures.

Sedation should not be the first-line treatment for people displaying acute behavioural disturbance, but may be required to prevent serious and imminent harm to the person or others and to facilitate assessment and management of the person's underlying condition.[300] Sedation should be considered in combination with the requirements for **health care rights and informed consent** and **person-centred care**, and in line with state and territory policy and legislative requirements.

Use strategies, tools, resources and training to minimise restraint

Core strategies for ambulance health services to consider in developing local policies and procedures to minimise restraint include:

- Leaders promoting and supporting a positive safety and quality culture
- Use of data to inform practice
- Workforce development
- Use of restraint reduction tools
- Systems to obtain information from carers and families about ways to reduce distress
- Workforce training in de-escalation techniques.

The **National Seclusion and Restraint Project** identifies barriers and a number of strategies for the reduction of seclusion and restraint which may be useful for the ambulance health service.[309]

Develop a policy framework for physical and chemical restraint

The ambulance health service should develop a trauma informed policy framework, guidelines and implementation tools for clinicians relating to the use of restrictive practices. It should also:

- Seek feedback from people with lived experience of mental health conditions in the development of policies and frameworks
- Ensure that members of the workforce are aware of and practice within state or territory legislation
- Provide workforce orientation, training and ongoing education on the use of restrictive practices
- Audit and report on the use of restrictive practices, report variations from published policies[302]
- Support the workforce to report incidents related to the use of restraint
- Seek feedback from the workforce on restraint practices and use feedback to support quality improvement initiatives.

The ambulance health service should review guidelines such as:

- **National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state**[310]
- **Reducing Restrictive Practices** - National Mental Health Commission
- **Caring for people displaying acute behavioural disturbance** - Safer Care Victoria
- **The Mental Health Professional Online Development (MHPOD) Learning Portal**
- **Minimising and, where possible, eliminating the use of seclusion and restraint in people with mental illness** - The Royal Australian and New Zealand College of Psychiatrists.

Examples of evidence

- Policy documents and clinical guidelines on the use of restraint in line with legislation
- Policies, resources and frameworks aimed at minimising, working towards eliminating, the use of seclusion and restraint and a culture which uses seclusion and restraint only as a last resort
- Reports on the use of restraint to the governing body, workforce and consumers
- Training and education documents about the use of restraint and strategies for minimising and, if possible, eliminating the use of restraint
- Evidence of design and use of the environment to minimise the use of restrictive practices
- Evidence of implementation of a systematic approach to minimise restrictive practices
- Communication with the workforce about new or revised policies, procedures and protocols about the use of restraint
- Committee and meeting records where the minimisation and elimination of restraint were discussed
- Audit results that show use of individualised plans to reduce and eliminate the use of restraint
- Communication with patients, carers and families about the use of restraint
- Data about the use of restraint
- Examples of actions taken to reduce the use of restraint.

Minimising restrictive practices: seclusion

Action 5.36

Where seclusion is clinically necessary to prevent harm and is permitted under legislation, the health service organisation has systems that:

a. **Minimise and, where possible, eliminate the use of seclusion**
b. **Govern the use of seclusion in accordance with legislation**
c. **Report use of seclusion to the governing body.**

This Action is not applicable for ambulance health services.

See **Advisory AS23/02: Advice on not applicable actions for Ambulance Health Services**.

Where the Action is applicable, refer to the **NSQHS Standards Guide for Hospitals**.

Communicating for Safety Standard

Leaders of an ambulance health service set up and maintain systems and processes to support effective communication with patients, carers and families; between multidisciplinary teams and clinicians; and across health service organisations. The workforce uses these systems to effectively communicate to ensure safety.

Intention of this standard

To ensure timely, purpose-driven and effective communication and documentation that support continuous, coordinated and safe care for patients.

Criteria

Clinical governance and quality improvement to support effective communication

Systems are in place for effective and coordinated communication that supports the delivery of continuous and safe care for patients.

Correct identification and procedure matching

Systems to maintain the identity of the patient are used to ensure that the patient receives the care intended for them.

Communication at clinical handover

Processes for structured clinical handover are used to effectively communicate about the health care of patients.

Communication of critical information

Systems to effectively communicate critical information and risks when they emerge or change are used to ensure safe patient care.

Documentation of information

Essential information is documented in the healthcare record to ensure patient safety.

Introduction

This standard recognises the importance of effective communication in all health care settings and the essential role that communication plays in supporting safe, coordinated and continuous care.

Communication failures and inadequate or poor documentation of clinical information can result in medication errors, misdiagnosis, inappropriate treatment and poor care outcomes. [311-315] Communication issues are also identified as one of the most common underlying factors in complaints about the Australian healthcare system.[316,317,318]

Clinical handover is a high-risk area for patient safety. Failures in clinical handover have been identified as a major preventable cause of patient harm.[222] Poor communication, documentation gaps or failures in collaborative planning between healthcare providers and those receiving health care, are all issues that can be addressed through effective communication. Communication is a key safety and quality issue and is critical to the delivery of safe patient care.

Factors impacting communication

In out of hospital settings, communication and clinical handover can be impacted by a combination of human and environmental factors. Effective coordination and communication between the control room facility, ambulance health service staff and the receiving facility[319] are vital to support the transfer of information at transitions of care.[320]

Members of the ambulance health services workforce are often required to handover complex information to multiple staff in a time-pressured environment which is frequently impacted by noise, chaos and interruptions.[321]

Standardised processes and tools to support effective communication

A number of barriers have been identified that can impact effective clinical handover in out of hospital settings.[322] Safe delivery of care relies upon effective collaboration,[222] communication[323] and documentation and coordination between all health care providers.[226] Standardising clinical handover processes improves patient safety as critical information is more likely to be transferred and acted upon.[324]

Standardised protocols and tools such as **IMIST-AMBO**[215] have been found to improve the handover process by improving comprehension and retention of information, reducing repetition[324] and handover duration,[215] preventing communication related delays, errors and omissions in patient care. Workforce orientation, training and education in the core competencies of teamwork and effective communication is vital to sustain effective clinical communication, collaboration and teamwork skills.[222]

High-risk areas when communication is critical to patient safety

Actions in this standard focus on three high-risk areas in which communication is critical to patient safety:

- When patient identification and procedure matching should occur
- When all or part of a patient's care is transferred[216]
- When critical information or risks emerge or change throughout the course of care
- Contemporaneous documentation and recording of information that supports the provision and transfer of health care.

Key rinciples of clinical handover include:

- Establishing formal processes for transfer of responsibility for the patient[226]
- Identifying who is responsible for providing and receiving the handover for each team
- Utilising standardised tools and establishing a 'common language' for effective team communication[323]
- Implementing systems for the communication of critical information, alerts or risks (see **Action 6.09**)
- Implementing systems to ensure availability of the healthcare record at transitions of care.[325]

Communication is inherent to patient care, and informal communications will occur throughout care delivery. This standard is not intended to apply to all communications within the ambulance health service. Rather, it aims to ensure that systems and processes are in place at key times when effective clinical communication and documentation are critical to patient safety.

Clinical governance and quality improvement to support effective communication

Systems are in place for effective and coordinated communication that supports the delivery of continuous and safe care for patients.

For systems and processes to work effectively and consistently across a health service organisation, they need to be embedded in the overall governance of the organisation.

This criterion requires organisation-wide governance, leadership and commitment to support effective clinical communication with patients, carers and families; between clinicians and multidisciplinary teams; and across organisations. To meet this criterion, ambulance health services are required to:

- Integrate clinical governance and apply quality improvement systems
- Apply principles of partnering with consumers, health literacy and shared decision making when developing and implementing organisational clinical communication processes
- Implement safety and quality systems and processes to support effective clinical communication during high-risk situations.

Ambulance health services will need to:

- Understand their priorities
- Identify their risks in relation to clinical communications
- Consider how to manage these within their given resources and workforce and organisational structures.

This criterion aligns closely with the **Clinical Governance Standard** and the **Partnering with Consumers Standard**.

Integrating clinical governance

Action 6.01

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

a. Implementing policies and procedures to support effective clinical communication

b. Managing risks associated with clinical communication

c. Identifying training requirements for effective and coordinated clinical communication.

Intent

Safety and quality systems support effective clinical communication.

Reflective questions

- How are the ambulance health service's safety and quality systems used to:
  - support implementation of policies and procedures for effective clinical communication?
  - identify and manage risks associated with clinical communication?
  - identify orientation, training, and education requirements for the delivery of effective clinical communication?
  - monitor effectiveness of policies and procedures for effective clinical governance?

Strategies for improvement

The **Clinical Governance Standard** has specific actions relating to safety and quality systems:

- **Action 1.07** – policies and procedures
- **Action 1.10** – risk management systems
- **Actions 1.19**, **1.20** and **1.21** – education and training.

Ambulance health services should use these and other established safety and quality systems to support policies and procedures, risk management and training for clinical communication.

Implement policies and procedures

The ambulance health service should develop policies procedures and protocols for communicating for safety that outline how organisation-wide systems support effective clinical communication. These might include:

- An organisation-wide strategy that outlines clinical communication processes and integrated structured clinical handover protocols
- Situations when identification, procedure matching, structured clinical handover, communication of critical information and documentation are required (linked to **Actions 6.04** and **6.11**)
- Structured processes that support effective communication, collaboration and teamwork
- Governance and reporting structures linked to safety and quality systems.

Manage risks

The ambulance health service should use established risk management systems to identify, monitor, manage and review risks associated with communicating for safety (see **Action 1.10**). It should consider the types of risks that may be associated with clinical communication, such as:

- Contextual risks, such as noise, interruptions, inadequate space and time
- Informational risks, such as information that is unstructured, incomplete, irrelevant, inaccessible, inaccurate or out of date
- interactional risks, such as failure to design communication processes that are accessible, legible and intelligible to recipients and to which recipients can actively contribute.

The ambulance health service should implement systems for communicating when handover and responsibility for patient care occurs. It should also:

- Implement strategies to streamline communication at handover, reduce transcription errors and decrease repetition of information
- Develop processes to manage clinical risks for different patient populations, such as those transferring to or from Residential Aged Care Facilities or from rural and remote communities
- Use information from safety and quality improvement systems (see **Actions 1.07 to 1.18**) to inform and update risk assessments and the risk management system
- Explore implementation of electronic handover solutions
- Monitor and manage communication risks considering the:
  - potential clinical risks associated with electronic health systems, including hardware and software
  - interaction between non-technical dimensions of healthcare (workflow, policies and personnel) and technical dimensions (software, hardware, content and user interface)[326]
  - patient safety issues related to compatibility of technical dimensions at transitions of care
- Conduct audits of workforce compliance with the clinical communication policies, procedures and protocols
- Provide reports about the use of the organisation's clinical communications protocols to the workforce, the relevant committee and the governing body.

Identify orientation, training and education requirements

The ambulance health service should perform a risk assessment to inform and set priorities for workforce training in effective clinical communication, collaboration and teamwork. It should also:

- Provide orientation, training, and ongoing education about the organisation's clinical communication policies, processes and tools
- Seek feedback to identify gaps and implement and evaluate improvements
- Consider the need to work with external stakeholders to support multidisciplinary training and education initiatives to sustain the implementation of improvement strategies.

Examples of evidence

- Organisation-wide strategy that outlines clinical communication processes
- Policy documents for clinical communication relevant to the ambulance health service's scope and risk profile, including:
  - points of care when communication is required
  - approved communication and clinical handover methods
  - roles and responsibilities for clinical handover
  - how patients, carers and families are engaged in the process
- Observation of clinicians' practice that demonstrates the ambulance health service's clinical communication processes
- Training documents about clinical communication systems and processes
- Committee or meeting records in which clinical communication issues and actions were discussed
- Risk register that identifies clinical communication risks and describes mitigation strategies and risk monitoring
- Reports, investigations and feedback from the incident management and investigation system that identifies incidents, adverse events and near misses relating to clinical communication
- Examples of improvement activities that have been implemented, evaluated and communicated to the workforce, patients, carers and other stakeholders.

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Applying quality improvement systems

Action 6.02

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

a. Monitoring the effectiveness of clinical communication and associated processes

b. Implementing strategies to improve clinical communication and associated processes

c. Reporting on the effectiveness and outcomes of clinical communication processes.

Intent

Quality improvement systems are used to support the effectiveness of clinical communications.

Reflective questions

- How does the ambulance health service continually evaluate and improve the effectiveness of its clinical communication and associated processes?
- Does the incident management system include classification of incidents relating to clinical communication?
- How does the ambulance health service communicate the outcomes of improvement activities to the governing body, the workforce, patients, carers and other organisations?

Strategies for improvement

The **Clinical Governance Standard** has specific actions relating to safety and quality systems:

- **Action 1.08** – quality improvement systems
- **Action 1.09** – reporting
- **Action 1.11** – incident management and investigation systems.

Ambulance health services should use these and other established safety and quality systems to support monitoring, reporting and implementation of qualityimprovement strategies for clinical communications.

Monitor effectiveness of clinical communication

Strategies to improve effective communication require leadership and commitment across the whole organisation, relies on targeted resources and ongoing audit and analysis of results.[222]

The ambulance health service should establish responsibilities and accountabilities for monitoring, evaluation and reporting about systems for clinical communication. This could include:

- Implementing systems and structured processes that support, facilitate and integrate effective communication, collaboration and teamwork across all aspects of health care
- Prioritising at a leadership and organisational level, workforce skills development in effective communication, collaboration and teamwork
- Orientation, training and assessment focused on developing the core competencies for effective clinical communication, collaboration and teamwork.

Monitor effectiveness and performance

Ongoing monitoring and evaluation of clinical communication systems can track changes over time, identify what works well, detect gaps and risks or failures related to communication or clinical handover.

Results from the ambulance health service's safety and quality improvement systems can be used to prioritise improvements, implement and monitor strategies for clinical communications (links to **Actions 1.08** and **1.09**).

Useful guides to measure the effectiveness of clinical communication processes include:

- **Safe Communication**[327] - Quality Improvement Clinic (United Kingdom)
- **OSSIE Guide to Clinical Handover Improvement**[244]

Report outcomes

The ambulance health service should provide feedback from quality improvement systems to committees, consumers and members of the workforce. It should also provide reports to the highest level of governance, consumers and the workforce.

Examples of evidence

- Policy documents that describe the processes for monitoring the organisation-wide clinical communication strategy and incidents and adverse events relating to clinical communication, such as:
  - risk assessment to identify a schedule of audits
  - schedule of reports provided to managers, relevant committees or the governing body
- Risk register that identifies clinical communication risks and describes mitigation strategies and risk monitoring
- Audit results of workforce compliance with policies for clinical communication and associated processes
- Audit results of healthcare records for documentation that critical information has been recorded and acted on
- Quality improvement plan that includes activities to manage risks identified in clinical communication and associated processes
- Committee or meeting records in which clinical communication issues were discussed
- Observation of the workforce using structured communication tools
- Communication with stakeholders, the workforce, patients, carers and families about strategies to improve clinical communication
- Schedule of routine reviews of clinical communication policy documents, and updates in line with changes in best practice, emerging evidence and results of audits and investigations.

Partnering with consumers

Action 6.03

Clinicians use organisational processes from the Partnering with Consumers Standard to effectively communicate with patients, carers and families during high-risk situations to:

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

Intent

Principles of person-centred care, shared decision-making and health literacy inform the way clinicians communicate with patients, carers and families during the key high-risk situations described in the Communicating for Safety Standard.

Reflective questions

- What processes from the Partnering with Consumers Standard do clinicians use to effectively communicate with patients, carers and families during high-risk situations?
- How do members of the workforce involve patients and carers in planning and making decisions about their own care?
- How does the ambulance health service seek feedback from patients about communication during high-risk situations?

Strategies for improvement

The **Partnering with Consumers Standard** has specific actions (**Actions 2.03–2.10**) relating to ambulance health services' processes for involving patients in their own care shared decision making informed consent and effective communication.

Effective clinical communication requires the active participation of patients, carers and families.

Effective clinical communication requires the active participation of patients, carers and families. Ambulance health services should use established processes from the **Partnering with Consumers Standard** when:

- Conducting patient identification and procedure matching
- Performing clinical handover
- Communicating critical information.

The ambulance health service should ensure that communication with, and information provided to, patients, carers and families about assessments, procedures, treatments and care reflect health literacy principles, and are delivered in a way that supports effective partnerships (see **Actions 2.08–2.10**). It should also:

- Implement systems to support people with communication needs, including the provision of 'language services' (see **Action 2.06**)
- Provide patients, carers and families with resources and tools to support communication during high-risk situations
- Implement processes to evaluate patient information and resources for clinical communication (see **Action 2.09**).

Examples of evidence

- Policy documents about clinical communication that include principles of health literacy and shared decision making
- Policy documents that describe mechanisms for consumer involvement in organisation-wide clinical communication strategies
- Meeting records in which consumer input on clinical communication processes was sought, including actions taken
- Training documents about person-centred care, patient partnerships and communication strategies
- Evaluation of workforce skills in communication during high-risk scenarios
- Structured communication processes that include an opportunity for patient, carer and family input
- Records of the use of interpreters and other language support services
- Information for patients and carers about clinical communication processes
- Results of patient experience surveys related to communication
- Examples of improvement activities that have been implemented, evaluated and communicated to the workforce, patients, carers and other stakeholders.

Organisational processes to support effective communication

Action 6.04

The health service organisation has clinical communications processes to support effective communication when:

a. **Identification and procedure matching should occur**

b. **All or part of a patient's care is transferred within the organisation, between multidisciplinary teams, between clinicians or between organisations; and on discharge**

c. **Critical information about a patient's care, including information on risks, emerges or changes.**

Intent

Processes to support effective clinical communication are in place for key high-risk situations, where effective communication with patients, carers and families, and between clinicians and multidisciplinary teams is critical to ensure safe patient care.

Reflective questions

- What processes are in place in the ambulance health service for patient identification, clinical handover and communication of critical information or risks?
- How does the ambulance health service support the workforce to use these processes?
- What has the ambulance health service identified in its service profile as the high-risk situations in which patient identification, and the communication or sharing of information are critical to ensuring safe, continuous patient care?
- How does the ambulance health service evaluate the effectiveness of these processes?

Strategies for improvement

Some states and territories may have mandated tools and approaches for patient identification, procedure matching, clinical handover and communication of critical information. Ambulance health services should comply with relevant state and territory policies, associated by-laws, rules or regulations.

Identify situations when safe communication is required

An ambulance health service should consider the situations when identification, procedure matching or information about a patient's care needs to be communicated or transferred to ensure that the patient receives the right care. This includes communication between the patient, carer and family (if appropriate), between clinicians, multidisciplinary teams and primary health care providers. Situations may include:

- Coordination with the operations centre
- Communication between the control room facility and clinicians, the receiving health service organisation and external health care providers such as primary care providers

- During an episode of care
- When care, treatment or medicine is provided to a patient
- When a patient is undergoing a procedure
- When there is a change of clinician
- During transitions of care
- When a patient is referred to or from another health care provider
- At completion of an episode of care, such as uploading information to My Health Record and providing a summary to a primary care provider.

Review policies and processes

The ambulance health service should have clinical communication policies which describe the processes for patient identification and clinical handover including roles, responsibilities and accountabilities. It should also:

- Establish processes for the inclusion of clinical and contextual information from the patient's carer(s) and family
- Establish processes to ensure that relevant clinical and critical information is communicated in a timely manner at transitions of care.

Seek feedback from members of the workforce and consumers

The ambulance health service should review its identification and procedure matching processes and identify the key points along the patient journey where identification and procedure matching is required. The ambulance health service should:

- Identify high-risk situations and consider strategies to support identification and procedure matching between families, carers, clinicians and multidisciplinary teams
- Investigate clinical incidents, adverse events or near misses to identify failures in communication systems
- Use the results from safety and quality systems to identify gaps in communication systems and implement quality improvement strategies .

Provide resources and tools to facilitate effective communication processes

The ambulance health service should provide information about the policies, processes, resources and tools for communicating during key high-risk situations to all members of the workforce.[328]

The ambulance health service should:

- Provide orientation, training and education and support the workforce to use communication tools
- Provide access to language support services including interpreters.

Consider the role of control-room facility operators and non-clinicians

Control room facility operators and non-clinicians play a critical role in triaging and communicating between ambulance health service staff, patients and receiving health care facilities.

The ambulance health service should implement policies and procedures and provide orientation, training and education that outline the requirements for operators and non-clinicians when they are identifying patients and communicating with clinicians, external agencies (such as notification to external health care organisations and providers), patients, carers and their families.

Support teamwork and effective communication

Patient identification, procedure matching and clinical handover will often involve multiple clinicians or teams. The ambulance health service should consider how teams work and communicate internally, across disciplines and externally with other healthcare facilities.

Given the complexity of out of hospital care, these clinicians and teams may change rapidly depending on the needs of the patient. Teamwork and effective communication are critical in delivering comprehensive care that is safe and continuous. The links between this standard and the Comprehensive Care Standard are important to ensure that safe, comprehensive care is delivered.

Examples of evidence

- Review of organisational process mapping that identifies the situations when patient identification, procedure matching, clinical handover and communication of critical information are required
- A communication policy which describes clinical communication systems and processes
- Policy documents that describe the processes for the transfer of patients from or to residential or health care facilities
- Processes for communication and documentation between members of the workforce, healthcare facilities or healthcare providers
- Policies and processes that support workforce access language support services
- Audit results of healthcare records identifying risk assessments and communication of emerging or critical information
- Risk assessment that identifies situations within the organisation in which identification, procedure matching, structured clinical handover and communication of critical information are required
- Documentation about structured processes for communicating critical information to the responsible clinicians when all or part of care is transferred (e.g., IMST-AMBO[215] or ISBAR)
- Documented processes for communicating critical information
- Standardised and structured templates to support clinical communication
- Evaluation of communication systems including feedback from the workforce and consumers
- Resources and tools to support effective communication
- Reports, investigations and feedback from the incident management and investigation systems that identify clinical incidents, adverse events and near misses relating to patient identification and procedure matching
- Examples of improvement activities that have been implemented, evaluated and communicated to the workforce, patients, carers and other stakeholders.

Correct identification and procedure matching

Systems to maintain the identity of the patient are used to ensure that the patient receives the care intended for them.

Correctly identifying patients and implementing processes to match patients to their intended care are critical to ensuring patient safety and reducing risks of harm. Risks to patient safety can occur at any time during a patient's health care journey if there is a mismatch between a patient and components of their care.

Development of patient identification safety routines for common tasks such as procedure matching, medication management, provision of fluids or blood products and at transitions of care provides a powerful defence against simple mistakes that may cause harm.

In the out of hospital setting, if a patient has no formal source of identification or is confused, unconscious or unable to communicate for themselves, there should be uniform systems for use of default values until verification can occur. When the patient's identity is established, the ambulance health service must ensure that all records are amended in line with jurisdictional requirements.

This criterion does not relate to establishing the legally correct identity of people who choose to use an alias. The criterion is to ensure that a person's declared identity can be matched with any care, therapy, medicine or service that is provided by the ambulance health service.

Correct identification and procedure matching

Action 6.05

The health service organisation:

a. **Defines approved identifiers for patients according to best-practice guidelines**

b. **Requires at least three approved identifiers on registration and admission; when care, medication, therapy and other services are provided; and when clinical handover, transfer or discharge documentation is generated.**

Intent

A comprehensive, organisation-wide system is in place for the reliable and correct identification of patients when care, medicine, therapy and other services are provided or transferred.

Reflective questions

- What processes does the ambulance health service use to ensure consistent and correct identification of patients during an episode of care.
- How does the ambulance health service describe, document and monitor the requirements to use at least three approved patient identifiers?

Strategies for improvement

Develop a patient identification system

An organisation-wide patient identification system is the set of written policies, procedures and protocols that ensure the consistent and correct identification of a patient at any time during an episode of care or course of treatment.

The ambulance health service should define the approved patient identifiers for use in the service, according to best-practice guidelines. Approved patient identifiers are items of information that can be used to identify a patient when care, medicine, therapy or services are provided.

At least three approved patient identifiers are required each time identification occurs. This provides manual or electronic patient identification systems with the best chance to correctly match a patient with their record, without imposing impracticable demands on information gathering. Patient identifiers may include:

- Patient name (family and given names)
- Date of birth
- Gender
- Address (including postcode)
- Healthcare record number
- Individual Healthcare Identifier (IHI) (see **Action 1.17**).

The ambulance health service should specify the data items approved for patient identification for use in the organisation, and use at least three identifiers on the following occasions:

- When matching a patient's identity to care, medicine, therapy or services
- Whenever clinical handover or patient transitions of care occur
- Whenever referral or transfer documentation is generated.

Consider methods of patient identification

Due to the nature of the out of hospital environment, the use of identification bands by the ambulance health service will likely be inappropriate, and alternate methods may be implemented for patient identification and procedure matching.

In some cases, a patient may be unable to communicate or provide a form of formal identification. The ambulance health service should establish systems for the use of default values until verification of a person's identify can occur. Other methods may be required to identify patients such as use of photographic identification (drivers' licence) or identification cards without a photo such as Medicare, Health Care or Pension Concession Card. Consider privacy when adopting a particular method of patient identification.

Standardise patient identification bands (if used)

If the ambulance health service uses patient identification bands, identify where these need to be used within the service and what arrangements are in place for maintaining and checking the identity of people who are not wearing identification bands.

Ensure that patient identification bands are standardised and comply with the **Specifications for a Standard Patient Identification Band**.[329] These specifications apply to bands that have the primary purpose of identifying the patient within the ambulance health service. They do not apply to bands or bracelets that have other purposes, such as triggering an alarm when a patient leaves a certain area. Neither the NSQHS Standards nor the specifications require all people receiving care to wear identification bands.

When disposing of patient identification bands, consider issues relating to maintaining the confidentiality and privacy of patient details.

Assess the use of coloured patient identification bands (if used)

It is recommended that coloured bands are not used to alert clinicians to specific clinical information such as falls risk, allergies or resuscitation status. If it is considered necessary to have a colour system for identifying a known allergy or other known risk, the patient identification band should be red only (see **Specifications for a Standard Patient Identification Band**[329]).

Examples of evidence

- Policy documents for patient identification and procedure matching that:
  - reference best-practice guidelines
  - specify points of care at which patient identification must occur
  - specify the three approved patient identifiers to be used on each occasion
  - require three approved patient identifiers to be recorded in the healthcare record, including the Individual Healthcare Identifier
  - require three approved patient identifiers to be added to all documentation pages, records and reports including pathology, imaging and investigations such as 12 lead ECG
  - stipulate default values until verification can occur
- Policy documents that outline requirements for patient identification using at least three approved patient identifiers for:
  - patient registration
  - provision of an episode of care, therapy or medicines, and all diagnostic activities, including pathology collection, imaging and 12 lead ECG investigations
  - all patient tissue that is separated from the patient (e.g.: amputated body part)
  - clinical handover
  - transitions of care.
- Committee and meeting records that show that information about the performance of patient identification processes is routinely reported and reviewed
- Audit results of correct patient identification, including clinical incidents, adverse events and near misses
- Workforce orientation, training and education on patient identification and procedure matching
- Use of the organisation's quality improvement systems to identify and prioritise improvements for patient identification
- Communication to the workforce about new or revised policy documents or protocols for patient identification.

Action 6.06

The health service organisation specifies the:

a. **Processes to correctly match patients to their care**
b. **Information that should be documented about the process of correctly matching patients to their intended care.**

Intent

Explicit processes are in place to correctly match patients with their intended care, to ensure that the right patient receives the right care.

Reflective questions

- How does the ambulance health service describe the processes for matching a patient to their intended care?
- How does the ambulance health service ensure that the workforce is using these processes?

Strategies for improvement

Develop protocols on how to match a patient to their intended care

The ambulance health service should develop protocols that outline the process of matching a patient to their intended care, tailored to the procedure and organisation. Consider this action alongside other actions in this standard (especially **Actions 6.07** and **6.08**).

Information about a person's identity is critical to ensuring continuous, safe patient care. Unfortunately, patients have reported experiences of 'falling through gaps', 'being forgotten about' or 'having to explain themselves to every professional or service they encounter' where poor-quality transitions of care occur.[330]

Correct identification is especially important at transitions of care where there is an increased risk of information being miscommunicated or lost.[331,332] Frequent transitions of care can increase the risk of poor communication, loss of information and inadequate sharing of information between clinicians and organisations.[226]

Ambulance health services could use the principles of **The WHO Surgical Safety Checklist** to develop procedure-matching protocols within their context.

Support communication among clinicians and with patients and carers

The ambulance health service should support a shared responsibility and understanding amongst members of the workforce of processes to correctly match patients to their care. Communication strategies could include 'making sure', 'double-checking', 'verbalising information' and 'deliberate confirmation' of checklist items with oral validation'.[229] These strategies promote closed-loop communication and allow an opportunity for participants to ask questions or clarify concerns.[229, 333]

Policies should describe requirements for documentation of patient identification and procedure matching. Incorporate patient identification and procedure matching into structured clinical handover processes, involving patients and carers where feasible.

Examples of evidence

- Policies, procedures and protocols that outline:
  - the points during a patient journey when procedure matching is required
  - process for matching patients to their care, including the use of three approved patient identifiers
  - requirements for documentation of patient identification
  - processes where a patient's identification cannot be established or verified
- Standardised templates, checklists or documentation for matching patients to their intended care or transfer
- Audit of documentation for the inclusion of three approved identifiers
- Audit and report on workforce compliance with policies and processes
- Communication material provided to the workforce and patients regarding results of audits on patient identification
- Results of workforce and patient surveys on patient identification and procedure matching
- Training documents and records about processes to correctly match patients to their intended care, therapy or treatment
- A quality improvement plan that includes actions to address gaps
- Examples of improvement activities that have been implemented, evaluated and communicated to the workforce, patients, carers and other stakeholders.

Communication at clinical handover

Processes for structured clinical handover are used to effectively communicate about the health care of patients.

The purpose of clinical handover is to ensure that relevant, accurate and current information about a patient's care is transferred to the right person or people, action is taken (when necessary) and continuity of patient care is maintained. Structured clinical handover has been shown to reduce communication errors within and between health service organisations and members of the workforce. Effective communication during clinical handover can improve the interpretation of vital information,[323] and reduce the time clinicians spend attempting to retrieve and correct information.[334-336] Critical information is more likely to be accurately transferred and acted upon, improving patient safety.[244, 337]

Structured clinical handover at transitions of care

Key principles have been identified to reduce the risk of information being miscommunicated.[338,339] This includes:

- The purpose of the clinical handover
- The structured format and minimum information required
- How responsibility and accountability are transferred[244]
- How patients, carers and families can be involved
- Requirements for documentation.

Multidisciplinary approaches to clinical handover have been identified as important factors in maintaining continuity of care, improving long term health outcomes,[340] and compliance with therapy or recommended follow-up care.[341] This requires effective communication to the patient and their care givers[342], and should include information on disposition outcome, including non-conveyance.[343]

Although standardisation improves the efficiency and effectiveness of clinical handover, there needs to be some flexibility to enable the workforce to respond to emerging information and circumstances.[344] A flexible, standardised approach will provide the structure for handover whilst enabling flexibility depending upon factors including:

- The situation: level of patient acuity, change of clinician and transitions of care
- The method: face-to face, telephone, video, electronic or in writing
- The location: environment, noise or uncontrolled setting
- Who is involved: multidisciplinary team, secondary triage or multiple services.

Defining the minimum information content

The minimum information content for a particular type of handover will depend on the context and the reason for handover. The ambulance health service should be guided by best practice and determine the minimum information content in consultation and collaboration with the patients, carers and members of the workforce.

When defining the minimum information content, consider actions across the NSQHS Standards that require and support communication of relevant information at transitions of care. See Table 1 for a summary of actions that support communication of relevant information at transitions of care.

Table 1: Actions in the NSQHS Standards that support communication of relevant information at transitions of care

Information to be communicated	Actions in the NSQHS Standards
Patient identification	Action 6.05b Action 5.08
Processes for transfer of responsibility and accountability for the patient	Action 6.08
Risks of harm	Action 5.07b Action 5.10 Actions 5.21–5.36 Action 8.06e
Emerging or new critical information (e.g., changes in patient condition, new results, results outstanding or needing follow-up, critical information arising)	Action 6.09 Action 6.10
Diagnosis (provisional or principal), clinical assessment (including any relevant alerts) and current clinical condition (e.g., stable, improving, deteriorating)	Actions 5.11–5.13 Action 6.08b Action 8.05e Action 8.09
Medication history and current medicines list, known allergies and adverse drug reactions	Actions 4.05–4.7 Actions 4.10–4.12
Agreed plan of care and priorities	Action 5.13 Action 5.14
Infectious status (if relevant)	Action 3.09

Engaging patients and carers in clinical handover processes

Engaging patients and their families in clinical handover processes can improve patient care outcomes, prevent adverse events and reduce unscheduled presentations and avoidable readmissions.[345,346] Ambulance health services should provide communication tools and language support to enable those with low health literacy or communication support needs with equal access to clinical handover processes.

To support shared decision making and ensure that patients receive the most appropriate care and treatment, information about the patient's medical history or recent cognitive changes can be obtained from a range of sources. This includes a person's primary care provider, family, carer or substitute decision-maker, healthcare record, advance care plan or recent discharge documentation (see **Actions 5.29** and **5.30**).

Patients and their families can have important insights into a person's condition and circumstances that could impact their ongoing care and needs. Family members may be the first to notice changes in cognition and behaviour assisting in the prompt assessment of delirium248 (see **Actions 8.05** and **8.07**).

Actions under this criterion are closely linked to **Actions 5.05** and **5.06** in the **Comprehensive Care Standard**, which require systems to be in place to support collaboration, teamwork and comprehensive care planning.

Clinical handover

Action 6.07

The health service organisation, in collaboration with clinicians, defines the:

a. **Minimum information content to be communicated at clinical handover, based on best-practice guidelines**
b. **Risks relevant to the service context and the particular needs of patients, carers and families**
c. **Clinicians who are involved in the clinical handover.**

Intent

Accurate and relevant information about a patient's care is communicated and transferred at every clinical handover to ensure safe, high-quality patient care.

Reflective questions

- How does the ambulance health service describe the minimum information content to be communicated at each clinical handover?
- How does the ambulance health service ensure that the workforce is using the structured clinical handover process?
- How does the ambulance health service identify risks relating to the structured clinical handover process?

Strategies for improvement

Engage clinicians in developing the clinical handover process

Ambulance health services should collaborate with clinicians to define the minimum information content to be communicated for each type of clinical handover relevant to the service (see **Action 6.04**). The minimum information required may differ, depending on the type of clinical handover and the situation in which clinical handover is occurring.

It is important to then describe the roles and responsibilities for communicating and receiving information during clinical handovers, including notification to external health care providers. The ambulance health service should also:

- Provide orientation and training to support the workforce in effectively transferring the correct information (see **Action 6.01**)
- Seek feedback on the minimum information required for all handovers and allow this to be adapted and refined to the different contexts in which handovers occur in the organisation.

Implement frameworks for defining minimum information content

Use of structured handover tools can help to provide a framework for communicating the minimum information content for clinical handovers. The IMIST- AMBO framework, presented in **Table 2** below, is an example of a structured clinical framework.[215] These tools are designed to be flexible and adapted to suit workforce environments and the purpose of the handover.

Other examples of tools to help structure handover are:

- ISOBAR: Identify, situation, observations, background, agreed plan, read back
- I PASS the BATON: Introduction, Patient, Assessment, Situation, Safety concerns, Background, Actions, Timing, Ownership, Next
- ISBAR: Identify, Situation, Background, Assessment and Recommendation
- SBAR: Situation, Background, Assessment, Recommendation
- SHARED: Situation, History, Assessment, Risk, Expectation, Documentation.

Table 2: IMIST AMBO framework[215]

I	Identification/ Introduction[347]	Patient name and age/personnel in attendance
M	Mechanism/medical complaint	What is the mechanism of injury or presenting problem?
I	Injuries/information relative to complaint	Patient assessment and history relevant to complaint
S	Signs	Vital signs and GCS
T	Treatment and trends	Interventions and response to treatment
A	Allergies	What is the patient allergic to?
M	Medications	What are the regular medications? Are the medications present?
B	Background	Medical history Characteristics of the scene Social situation Advanced health care directive
O	Other issues	Belongings or valuables Cultural and religious considerations The need for an interpreter or communication support

Examples of evidence

- Policy documents and clinical guidelines for clinical handover that specify the minimum information content to be communicated at each clinical handover
- Structured communication tools that are used to effectively communicate the agreed minimum information content (e.g., IMIST-AMBO, iSoBAR and ISBAR)
- Evidence that clinicians were involved in identifying all points of handover and developing the minimum information content to be communicated at each clinical handover
- Feedback from the workforce on the use of clinical handover policies, procedures or protocols.
- Identification and communication of clinical handover related incidents that have resulted in improvements to the handover processes
- Reports, investigations and feedback from the incident management and investigation system that identifies clinical incidents, adverse events, and near misses relating to clinical handover and associated processes
- A quality improvement plan that includes actions to address issues identified.

Action 6.08

Clinicians use structured clinical handover processes that include:

a. **Preparing and scheduling clinical handover**
b. **Having the relevant information at clinical handover**
c. **Organising relevant clinicians and others to participate in clinical handover**
d. **Being aware of the patient's goals and preferences**
e. **Supporting patients, carers and families to be involved in clinical handover, in accordance with the wishes of the patient**
f. **Ensuring that clinical handover results in the transfer of responsibility and accountability for care.**

Intent

Clinicians use structured clinical handover processes that are consistent with the key principles of clinical handover, to effectively communicate relevant, accurate and up-to-date information about a patient's care to ensure patient safety.

Reflective questions

- How does the ambulance health service describe the structured clinical handover process and who should be involved?
- How is clinical information including patient's goals and preferences obtained and communicated to those involved in clinical handover?
- How does the ambulance health service ensure the clinical handover process supports transfer of responsibility and accountability of care at transitions of care?

Strategies for improvement

Identify a clinical handover framework supported by structured processes

The ambulance health service should document the structured clinical handover processes ensuring that it is consistent with the key principles for clinical handover: It should:

- Include processes for transfer of accountability and responsibility for a patient's care [337]
- Train the workforce to utilise the structured clinical handover framework[324]
- Provide access to structured clinical handover tools
- Support the workforce, patients and carers to provide feedback on use of structured clinical handover processes and tools.

Prepare for and schedule clinical handover

The ambulance health service should evaluate the organisational context and situations when handover takes place, and identify the most appropriate method, timing and frequency for clinical handover:[348] These processes may differ where handover is occurring within the service (via triage systems) and at transitions of care to external health care providers.

The ambulance health service should identify the barriers or factors that may delay or impact clinical handover. Key principles to improve clinical handover include:

- Nominating a leader and all key participants for clinical handovers
- Informing participants of the clinical handover processes and allocating roles
- Implementing structured communication tools, such as **IMIST-AMBO**[215], iSoBAR, SBAR or SHARED, available to the workforce. These tools are designed to be flexible and adaptable to the workforce environment
- Considering the need for multidisciplinary input, including clinical and non-clinical workforce members and carers when appropriate
- Supporting clinicians and the workforce to have situational awareness. This refers to maintaining an awareness of the 'big picture' and thinking ahead to plan and discuss contingencies
- Involving patients, carers and families in handover where possible.

Have relevant information at clinical handover

Implement systems and processes to enable clinicians to obtain the most up-to-date information before handover. In the mobile health environment, this information may include the patient's healthcare record, advance care plans, progress notes, discharge summaries, prepared handover sheets and test results.

This action links to, and is supported by, **Action 1.16** and **Action 6.11**. This action requires organisations to integrate multiple information systems (where they are in use), enable access to the healthcare records at the point of care, and ensure that systems are in place to contemporaneously document relevant information in the healthcare record.

Organise relevant clinicians and others to participate

Effective clinical handover requires all relevant participants to be present before handover begins. The designated leader manages and facilitates the handover. This is usually the role of the most senior clinician present; however this will depend on the handover and it may be more appropriate to designate a clinician who is involved in coordinating a patient's care.

Ensure transfer of responsibility and accountability of care

The key objectives of clinical handover are to maintain continuity of care, transfer professional responsibility and accountability for some, or all aspects of patient care and reduce risk of harm. This requires a clear understanding of who is responsible and who is accountable for a patient's care.[348]

It is important to establish who is responsible for making decisions on a patient's behalf and at what point responsibility for treating the patient ends.[324] There is evidence that gaps in communication may occur due to differing terminology and diverse priorities of different healthcare providers.[323] Unclear responsibility for patients can lead to confusion, waste valuable time and resources, and often lead to adverse patient consequences.[324] These processes can be particularly ambiguous for 'non-critical' patients in emergency departments.[226]

The nature and content of information passed between the ambulance health service and receiving service will vary.[226] Differing terminology can influence how healthcare professionals interrelate and communicate,[349] impacting the exchange of information.[350] Cultural change, training and education is required at all levels of the workforce to ensure high-quality communication at transitions of care.[171]

The importance of ensuring the transfer of responsibility and accountability for patient care should be emphasised in structured communication tools. This may require ambulance health services to:

- Define the roles and responsibilities of the clinicians involved at transitions of care
- Define who is accountable for communication and documentation at transitions of care
- Define when in the patient journey transfer of accountability occurs and in which situations
- Implement processes to clearly document the transfer of responsibility and accountability across the patient's journey
- Ensure patients, carers and families are provided with additional support to understand these processes.

Identify patient's goals and preferences

Action 6.08 should be implemented in alignment with the principles of person-centred care.[97] Ambulance health services should support clinicians to communicate with patients, carers and families so that:

- Patient's goals and preferences are discussed (relevant to the context) during clinical handover (see **Action 5.13**)
- Structured communication tools provide opportunities for patients, carers and families to participate and ask questions
- Information is provided in a way that meets the needs of patients, carers and families and is easy to understand and use
- Patient privacy and confidentiality is maintained at handover and transitions of care.

Examples of evidence

- Policy documents that describe a structured clinical handover process, including the minimum information content to be transferred, roles and responsibilities and how patients and their carers are involved
- Orientation manuals, education resources and records of attendance at training by the workforce on the organisation's protocols for clinical handover
- Audit of compliance with structured clinical handover processes
- Audit results of documentation that demonstrates handover of responsibility for care at transitions of care
- Observations of the workforce using structured clinical handover process
- Information provided to consumers, carers and families that outline their role in clinical handover processes
- Results of patient feedback about their participation in clinical handover
- Results of workforce feedback on clinical handover
- Reports from the quality improvement systems that identify results of improvement activities.

Communication of critical information

Systems to effectively communicate critical information and risks when they emerge or change are used to ensure safe patient care.

When critical information emerges, or there is a risk to patient care, timely communication of this information to the appropriate person(s) is essential to ensuring patient safety and delivery of the right care.

The definition of critical clinical and non-clinical information will depend on the type of services provided and the needs of the patients using the ambulance health service.

This criterion is closely linked to clinical handover (**Action 6.08**) and recognising acute deterioration (**Actions 8.04 –8.13**). It addresses communication gaps by ensuring that organisations have systems and processes in place to support communication of critical communication whenever it emerges or changes.[351]

The type of information and timing of communicating critical information will be dependent upon the patient's acuity, injury or illness and workforce experience.[226]

Documenting information and formal policies and procedures support communication

This standard does not apply to all informal communications. The intention is for ambulance health services to consider and define what critical information means for their service and implement formal processes to ensure that this critical information is communicated whenever it emerges or changes.

In developing processes, consider ways to support closed-loop communication.[352] This is when the person who is communicating the information knows that the message has been received, and there is a response that lets them know that action will be taken to manage the communication need.[353]

Action 6.09

Clinicians and multidisciplinary teams use clinical communication processes to effectively communicate critical information, alerts and risks, in a timely way, when they emerge or change to:

a. **Clinicians who can make decisions about care**

b. **Patients, carers and families, in accordance with the wishes of the patient.**

Intent

Emerging or new critical information, alerts and risks are communicated in a timely manner to clinicians who can make decisions about care, and to the patient, family and carer, to ensure safe patient care.

Reflective questions

- What processes does the ambulance health service use to identify the clinician(s) who can make decisions about care?
- How do clinicians effectively communicate critical information to other clinicians who can make decisions about care, in a timely way?
- How does the ambulance health service monitor and evaluate the processes used for communicating critical information?

Strategies for improvement

Identify critical information

The ambulance health service should define what 'critical information' and 'risks to patient's care' mean for the service context. The nature of critical information depends on multiple factors such as the type of service, patient acuity and identified patient risks.

Review policies for communicating critical information

Ambulance health service policies and processes should indicate:

- Definitions of critical information
- Time frames for communicating critical information
- Roles and responsibilities for communicating and actioning critical information
- Escalation pathways
- Methods of communicating critical information to the responsible clinician or multidisciplinary team
- Requirements for documenting communication of critical information (see **Action 6.11**)
- How critical information is communicated to patients, families and carers.

Use specific strategies and frameworks

Strategies to enable clinicians to communicate critical information will often require ambulance health services to work with external stakeholders to identify and establish processes for communicating critical information. This can be support by:

- Standardised handover protocols and communication strategies[215, 222, 324, 354]
- Establishing agreed communication processes of new critical information within the ambulance health service and between health service organisations or care providers
- Identifying 'a shared common language' and terminology to improve effective multidisciplinary team communication[323]
- Identification of roles, responsibilities and accountabilities for reporting and follow-up of critical information
- Providing workforce orientation, training and education in best-practice principles for communicating critical information, including working within multi-disciplinary teams
- Using the ambulance health service's quality improvement systems to monitor, identify and prioritise improvements for communicating critical information
- Reviewing incidents and complaints relating to communicating critical information
- Seeking feedback from consumers and the workforce on communicating critical information
- Utilising results to identify opportunities for improving systems for communicating critical information.

Examples of evidence

- Policy documents that define critical information, roles and responsibilities for communicating, documenting and actioning critical information
- Protocols for time frames for communicating critical information and processes for escalation
- Standardised templates to support communication of critical information
- Feedback from the workforce and consumers on processes for communication of critical information
- Evidence of communication methods or systems for alerting clinicians when there is a change in a patient's condition, or new critical information is received
- Audit results of workforce compliance with policies relating to communicating critical information
- Examples of improvement activities that have been implemented, evaluated and communicated to the workforce, patients, carers and other stakeholders
- Reports from safety and quality systems regarding the communication of critical information that has resulted in improvements to communication and handover processes.

Action 6.10

The health service organisation ensures that there are communication processes for patients, carers and families to directly communicate critical information and risks about care to clinicians.

Intent

Patients and carers can communicate critical information and risks about their care to clinicians.

Reflective questions

- What processes are in place to support patients and carers to communicate critical information and risks about their care to ambulance health service providers?
- How does the ambulance health service monitor the effectiveness of its communication processes for patients, carers and families?

Strategies for improvement

The ambulance health service should develop and implement processes for patients and carers to communicate critical information and risks about their care. This could include:

- Informing patients, carers and families about what is considered critical information
- Informing patients, carers and families about their role in communicating this information
- Providing access to information or communication tools to support patients, carers and families to communicate critical information.

Examples of evidence

- Policy documents that outline how patients, carers and families are informed about the processes for communicating concerns to clinicians
- Policy and procedures that stipulate how the concerns raised by the patients, carers and families are managed
- Examples of information provided to patients, carers and families about processes for communicating concerns to the clinicians responsible for care
- Resources or tools for patients, carers or families to use to communicate with clinicians
- Patient healthcare records that identify critical information provided by the patient or family and how this information was acted upon
- Feedback from patients about communication of critical information.

Documentation of information

Essential information is documented in the healthcare record to ensure patient safety.

Documentation is an essential component of effective communication. Given the complexity of health care and the fluidity of clinical teams, healthcare records are one of the most important information sources available to clinicians. Undocumented or poorly documented information can result in avoidable hospital admission or harm.[355]

Ambulance health services face additional barriers in obtaining medical and social history from people who are unconscious, intoxicated or otherwise uncooperative.[356]

Examples of documentation

Documentation can be paper based, electronic or a mix of both. For documentation to support the delivery of safe, high-quality care it should:

- 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.[357]

Digital health solutions also come with safety and quality risks

Clinical information systems and technologies play an increasingly important role in documentation in the healthcare system. The introduction of electronic healthcare records in the out of hospital setting can improve communication between primary and secondary care providers, support syndromic disease surveillance[358] and enhance data collection and analysis.[359] However, electronic healthcare records are generally not integrated with other systems and require ongoing strategies to sustain workforce compliance.[360]

Digital health record systems such as laptops or other mobile devices should meet the elements of best practice documentation and support effective clinical communication.

This criterion is supported by actions in the **Clinical Governance Standard** which requires organisations to make the healthcare record available to clinicians at the point of care and support the workforce to maintain an accurate integrated and complete healthcare record. This may require integration of multiple information systems (see **Action 1.16**. Storage and security of records should meet state and territory regulations).

Documentation of information

Action 6.11

The health service organisation has processes to contemporaneously document information in the healthcare record, including:

a. Critical information, alerts and risks

b. Reassessment processes and outcomes

c. Changes to the care plan.

Intent

Relevant, accurate, complete and timely information about a patient's care is documented in the healthcare record to support safe patient care.

Reflective questions

- How does the ambulance health service describe the processes, roles, responsibilities and accountabilities for documentation of information in the healthcare record?
- What processes are in place to ensure that healthcare records are accessible to clinicians?
- How does the ambulance health service protect physical patient records and electronic devices used by off-site clinicians?

Strategies for improvement

The ambulance health service should develop and implement systems to support the contemporaneous documentation of critical information, alerts and risks in the healthcare record. It should also ensure systems and requirements for documentation comply with relevant national, state and territory policies.

Ambulance health service policies and processes to support contemporaneous documentation of information in the healthcare record should describe:

- What needs to be documented
- The format and legal requirements of information being recorded
- Where information should be documented
- Roles, responsibilities and accountabilities relating to documentation
- Processes for transferring information including critical information, between clinicians responsible for care, both internally and externally.

CARE elements

The following **'CARE'** elements[355] provide a useful guide when considering what good written documentation may look like in practice. The elements apply equally to digital information.

Compliant and Complete

- All electronic and written documentation should adhere to approved policies and procedures, including the use of approved abbreviations, patient identification and rules for documentation
- Documentation is complete and current. For example, new or emerging information is recorded, progress notes or care plans are documented during an episode of care and at transitions of care.

Accessible and Accurate

- Paper and electronic documents are available to members of the workforce
- Relevant, up-to-date information is at hand and easy to locate
- The documents consider the needs and capabilities of those who will use the information, including those external to the ambulance health service (deferred accessibility)
- The information recorded correctly reflects the event being documented.

Readable

- Documents are legible and can be understood; electronic and paper forms and checklists should provide enough space so that they can be completed accurately and legibly, and include clear instructions about how they should be completed
- Only approved acronyms and abbreviations should be used.
- Enduring
- Documents should be materially durable and maintained to avoid loss or fading.
- The meaning of the documents is maintained, and be written in a way that provides enough information and justification to explain recommendations and instructions.[348]

Use best practice templates, checklists and forms

The ambulance health service should implement standardised and structured templates, checklists or forms that are based on best practice to support documentation of clinical information.[355] It should also ensure that the workforce has easy access to these resources, and training on how to use standardised forms.

If electronic health systems are implemented to support documentation, the service should consider requirements under the **Clinical Governance Standard** (particularly **Actions 1.16–1.18**), and actions related to managing risks for clinical communication (see **Action 6.01**) and monitoring and reporting incidents (see **Action 1.11**).

Training in the use of documentation systems

The ambulance health service should provide training for the workforce on processes, roles and responsibilities for documenting information, including approved templates and agreed use of abbreviations or standardised language and terminology.

Examples of evidence

- Integrated patient healthcare record, either electronic or paper based, with capacity to incorporate information from multiple sources
- Policy and procedures that specify the organisation's minimum requirements for documenting critical information, risks and alerts
- Policy and procedures for complying with documentation requirements when clinical information systems are not available, either due to planned (upgrades) or unscheduled downtime (internet not available)
- Standardised templates for documentation
- Audit results of compliance with policies for documentation of critical information, risks and alerts
- Training records in the use of the clinical information system
- Examples of improvement activities that have been implemented, evaluated and communicated to the workforce, patients, carers and other stakeholders.

Blood Management Standard

Leaders of an ambulance health service describe, implement and monitor systems to ensure the safe, appropriate, efficient and effective care of patients' own blood, as well as other blood and blood products. The workforce uses the blood product safety systems.

Applicability of actions

The actions in the Blood Management Standard will not be applicable for ambulance health services that do not use blood or blood products.

These services should provide evidence that they do not use, receive, store, collect or transport any of the blood or blood products.

Ambulance health services using blood or blood products should refer to **NSQHS Standards Guide for Hospitals** and **NSQHS Standards Accreditation Workbook** for implementation strategies for blood management and examples of evidence for actions in this standard. The actions in the Blood Management Standard are listed below for information.

The **Blood Management Standard** aims to improve outcomes for patients by identifying risks and using strategies that optimise and conserve a patient's own blood, as well as ensuring that any blood and blood products that patients receive are safe and appropriate.

The standard supports the principles of good patient blood management that provide for clinically appropriate and safe management of patients while avoiding transfusion of blood and blood products, and its associated risks.

Clinical governance and quality improvement to support blood management

Organisation-wide governance and quality improvement systems are used to ensure safe and high-quality care of patients' own blood, and to ensure that blood product requirements are met.

Item		Actions
Integrating clinical governance	7.01	Clinicians use the safety and quality systems from the Clinical Governance Standard when: a. Implementing policies and procedures for blood management b. Managing risks associated with blood management c. Identifying training requirements for blood management

Item		Actions
Applying quality improvement systems	7.02	The health service organisation applies the quality improvement system from the Clinical Governance Standard when: a. Monitoring the performance of the blood management system b. Implementing strategies to improve blood management and associated processes c. Reporting on the outcomes of blood management
	7.03	Clinicians use organisational processes from the Partnering with Consumers Standard when providing safe blood management to: a. Actively involve patients in their own care b. Meet the patient's information needs c. Share decision making

Prescribing and clinical use of blood and blood products

The clinical use of blood and blood products is appropriate, and strategies are used to reduce the risks associated with transfusion.

Item		Actions
Optimising and conserving patients' own blood	7.04	Clinicians use the blood and blood products processes to manage the need for, and minimise the inappropriate use of, blood and blood products by: a. Optimising patients' own red cell mass, haemoglobin and iron stores b. Identifying and managing patients with, or at risk of, bleeding c. Determining the clinical need for blood and blood products, and related risks
Documenting	7.05	Clinicians document decisions relating to blood management, transfusion history and transfusion details in the healthcare record
Prescribing and administering blood and blood products	7.06	The health service organisation supports clinicians to prescribe and administer blood and blood products appropriately, in accordance with national guidelines and national criteria
Reporting adverse blood management events	7.07	The health service organisation uses processes for reporting transfusion-related adverse events, in accordance with national guidelines and criteria
	7.08	The health service organisation participates in haemovigilance activities, in accordance with the national framework

Managing the availability and safety of blood and blood products

Strategies are used to effectively manage the availability and safety of blood and blood products.

Item		Actions
Storing, distributing and tracing blood and blood products	7.09	The health service organisation has processes: a. That comply with manufacturers' directions, legislation, and relevant jurisdictional requirements to store, distribute and handle blood and blood products safely and securely b. To trace blood and blood products from entry into the organisation to transfusion, discard or transfer.
Availability of blood	7.10	The health service organisation has processes to: a. Manage the availability of blood and blood products to meet clinical need b. Eliminate avoidable wastage c. Respond in times of shortage.

Recognising and Responding to Acute Deterioration Standard

Leaders of a health service organisation set up and maintain systems for recognising and responding to acute deterioration. The workforce uses the recognition and response systems.

Intention of this standard

To ensure that a person's acute deterioration is recognised promptly and appropriate action is taken. Acute deterioration includes physiological changes, as well as acute changes in a person's cognition and mental state.

Criteria

Clinical governance and quality improvement to support recognition and response systems

Organisation-wide systems are used to support and promote detection and recognition of acute deterioration, and the response to patients whose condition acutely deteriorates.

Detecting and recognising acute deterioration, and escalating care

Acute deterioration is detected and recognised, and action is taken to escalate care.

Responding to acute deterioration

Appropriate and timely care is provided to patients whose condition is acutely deteriorating.

Introduction

This standard supports the provision of appropriate and timely care to patients whose condition is acutely deteriorating. The standard requires that systems are in place to detect, recognise and respond to acute deterioration in physiological or mental state and applies to patients receiving care from an ambulance health service.

Ambulance health services have evolved around the populations they serve and the resources available. As a result, at an operational level, systems and processes for recognising and responding to clinical deterioration will vary depending upon the environment and clinical context of the patient.[361]

Early identification of deterioration can improve outcomes[362] and reduce the intervention required for patients whose condition deteriorates.[363] Out of hospital escalation of care systems should provide clinicians with the tools to support appropriate timely intervention, escalation for specialised clinical support and disposition decisions for patients who deteriorate very suddenly or severely.[364]

Criteria for escalation will vary depending upon the availability of resources and clinical expertise, role, scope and location of the ambulance health service.[365] Response systems can include algorithms, protocols and pathways specific to the patient's diagnosis such as cardiac arrest, asthma, stroke, anaphylaxis, sepsis,[363] or obstetric and newborn emergencies. Different protocols may be needed for escalation of acute physiological deterioration and escalation for deterioration in a person's mental state.

Early warning scores (EWS) are becoming widespread. These tools are developed to reliably and systematically identify patients who are deteriorating.[366] EWS have the capability of identifying patients:

- With high risk of deterioration and mortality[366]
- Those who need referral to ongoing care
- Those at low risk of deterioration who can be safely managed in the community.[367]

Clinical governance and quality improvement to support recognition and response systems

Organisation-wide systems are used to support and promote detection and recognition of acute deterioration, and the response to patients whose condition acutely deteriorates.

This criterion requires organisation-wide governance, leadership and commitment to support recognition of, and response to, acute deterioration in physiological or mental state.

To meet this criterion, ambulance health services are required to:

- Apply safety and quality systems to support timely and appropriate recognition of, and response to, acute physiological or mental deterioration
- Use quality improvement systems to monitor, review and improve recognition and response systems
- Apply principles of partnering with consumers when designing and implementing systems to recognise and respond to acute physiological or mental deterioration.

This criterion aligns closely with the **Clinical Governance Standard** and the **Partnering with Consumers Standard**.

Integrating clinical governance

Action 8.01

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

a. **Implementing policies and procedures for recognising and responding to acute deterioration**
b. **Managing risks associated with recognising and responding to acute deterioration**
c. **Identifying training requirements for recognising and responding to acute deterioration.**

Intent

Safety and quality systems support clinicians in recognising and responding to acute deterioration.

Reflective questions

- How are the ambulance health service's safety and quality systems used to:
  - support clinicians to recognise and respond to acute deterioration?
  - identify and manage risks associated with recognising and responding to acute deterioration?
  - identify training requirements for recognising and responding to acute deterioration?

Strategies for improvement

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

- **Action 1.07** – policies and procedures
- **Action 1.10** – risk management systems
- **Actions 1.19**, **1.20** and **1.21** – education and training

Implement policies and procedures

The ambulance health service should use established safety and quality systems to support policies and procedures, risk management and training for recognising and responding to acute deterioration. Policies can be developed or adapted at different levels within the organisation. They should provide guidance about aspects of recognising and responding to clinical deterioration, such as:

- Screening and assessment to identify patients likely to deteriorate, and developing or implementing appropriate clinical pathways, monitoring and escalation plans
- Roles, responsibilities and accountabilities of clinicians in recognising and responding to acute deterioration
- Escalation of care processes
- Patient and family escalation processes

- Requirements for documenting the outcome of escalations of care
- Processes to transport and refer patients to appropriate services to definitively manage episodes of acute deterioration in physical or mental state.

Manage risks

The ambulance health service should use established risk management systems (see **Action 1.10**) to identify, monitor, manage and review risks associated with recognising and responding to acute deterioration that align with the requirements of the **Clinical Governance Standard**. It should also:

- Develop processes to manage workforce and organisational risks and clinical risks for the patient populations served
- Use information from safety and quality improvement systems, incident management systems, clinical outcomes and patient experiences to inform and update risk assessments and the risk management system.

Assess orientation, training and education and competency needs

Training should be provided to the workforce on the incident management and investigation system, and the ambulance health service should develop or provide access to training and education resources to meet the needs of the workforce regarding recognising and responding to acute deterioration. See **Actions 1.19**, **1.20** and **1.21**.

The ambulance health service should seek feedback from the workforce to set priorities for education and training in recognising and responding to acute deterioration.

Examples of evidence

- Policies, procedures and guidelines about recognising and responding to acute deterioration and escalation processes
- Observation of clinicians using processes for recognising and responding to acute deterioration and escalation
- Audit of compliance policies and procedures
- A risk management system that includes actions and tools to manage risks
- Audits that demonstrate that appropriate screening and escalation protocols were performed
- Reports from the incident management system relating to recognising and responding to acute deterioration
- Examples of quality improvements initiatives that have been implemented and evaluated
- Mandatory training for recognising and responding to acute deterioration and attendance records of the workforce
- Minutes of meetings where recognising and responding to acute deterioration was discussed.

Applying quality improvement systems

Action 8.02

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

a. **Monitoring recognition and response systems**
b. **Implementing strategies to improve recognition and response systems**
c. **Reporting on effectiveness and outcomes of recognition and response systems.**

Intent

Quality improvement systems are used to support recognition of, and response to, acute deterioration.

Reflective questions

- How are the ambulance health service's recognition and response systems continuously monitored and evaluated?
- How are the outcomes of improvement activities communicated and reported to the governing body, the workforce and consumers?

Strategies for improvement

The **Clinical Governance Standard** has specific actions relating to quality improvement systems relevant to this action:

- **Action 1.08** – quality improvement systems
- **Action 1.09** – reporting
- **Action 1.11** – incident management and investigation systems

Monitor effectiveness and performance

Use the ambulance health service's quality improvement systems to monitor and set priorities for improving the effectiveness of recognition and response systems. This could include:

- Workforce audits in detecting and managing deterioration
- Data from electronic systems such as missed or delayed escalation
- Data collection, evaluation and reporting of recognition and response systems
- Surveys of workforce and patient experiences of using the recognition and response systems.

The Commission has collated a range of resources to assist health service organisations in evaluating systems for recognising and responding to acute physiological deterioration. See the **Recognising and responding to acute physiological deterioration** are of the Commission's website for specifications for quality measures and other tools.

Implement quality improvement strategies

Serious adverse and sentinel events should be reviewed to identify gaps with the performance or use of recognition and response systems. Data from the ambulance health service's quality improvement systems should be used to identify and prioritise strategies for improvement.

A **Guide to Support Implementation** of the **National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration**[363] provides information that can be used to develop, implement, evaluate and improve systems for recognising and responding to acute physiological deterioration. It can be accessed from the Commission's website.

Report outcomes

The ambulance health service should provide regular reports to the governing body and the workforce on the performance of the ambulance health service against its quality improvement strategies. It should also use the data to work with consumers, the workforce, clinical leaders and managers to identify and implement improvements to recognition and response systems.

Examples of evidence

- Policies, procedures and guidelines for monitoring, implementing and reporting on recognition and response systems
- Records that demonstrate appropriate staff have been trained to monitor, implement and report on recognition and response systems
- Quality measures and tools for evaluating the recognition and response systems in use by the workforce
- Regular reports to the highest level of governance and the workforce on evaluation findings
- Quality improvement projects based on investigations of reported incidents
- Workforce survey results and patient and carer experience data relating to recognising and responding to acute deterioration
- Evidence of risk assessment and evaluation processes undertaken when implementing new tools, processes or services as part of the recognition and response systems.

Partnering with consumers

Action 8.03

Clinicians use organisational processes from the Partnering with Consumers Standard when recognising and responding to acute deterioration to:

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

Intent

Clinicians understand the systems for partnering with consumers and use them when recognising and responding to acute deterioration.

Reflective questions

- What processes from the Partnering with Consumers Standard do clinicians use to involve patients in planning and making decisions about recognising and responding to acute deterioration?
- How does the ambulance health service collect feedback from patients about information provided on recognising and responding to acute deterioration?

Strategies for improvement

The **Partnering with Consumers Standard** has specific actions related to processes for involving patients in their own care, shared decision making, informed consent and effective communication (**Actions 2.03 - 2.10**).

These strategies can be used to inform the implementation of actions for recognising and responding to acute deterioration.

Implement effective policies and procedures

The ambulance health service should develop policies and processes for ensuring that informed consent is obtained in a legal, ethical and professional manner. Policies should incorporate:

- Principles on assessing the capacity to consent
- The principles of shared decision making
- Principles for informing patients or substitute decision-makers about the risks, benefits and alternatives of the options available
- Determining patient preferences for treatment
- Documenting patient consent
- Guidance on responding to acute clinical deterioration when a patient lacks the capacity to take part in decision making and a substitute decision-maker is not available.

The ambulance health service should ensure the workforce has access to training on best-practice principles for obtaining informed consent that includes state and territory laws and legislation.

See the **Informed Consent - Fact sheet for clinicians** and **Action 2.04**.

Provide information to patients

Involving patients in their own care, meeting the patient's information needs and shared decision making are all important aspects to support person-centred care. The ambulance health service should:

- Provide information to patients about recognition and response systems that meets their health literacy level and supports them to make decisions
- Ensure that patients are given the opportunity to ask questions and provide feedback.

Examples of evidence

- Policies, procedures and guidelines about informed consent, including with substitute decision-makers
- Records of workforce training on how to partner with consumers where acute deterioration has occurred
- Observation or interviews with clinicians implementing processes for partnering with consumers
- Information resources for patients, carers and families about recognition, response and escalation systems
- Workforce survey results and patient and carer experience data relating to recognising and responding to acute deterioration
- Reports from the incident management system relating to recognising and responding to acute deterioration
- Audit results of shared decision making in relation to recognising and responding to acute deterioration, such as advance care plans, documented goals of care, comprehensive care plans, and documented discussions with patients, carers and families.

Detecting and recognising acute deterioration, and escalating care

Acute deterioration is detected and recognised, and action is taken to escalate care.

Monitoring and tracking changes in vital signs and other observations plays a significant role in detecting acute deterioration. Changes in vital signs can occur both early and late in the deterioration process. Regular measurement and documentation of vital signs and other physiological observations is essential for recognising acute deterioration. Aggregated scoring systems have been shown to offer improved sensitivity to recognising deteriorating patients. Recognition systems should include a graded response to acute deterioration and clearly identified requirements for escalating care.

Systems need to ensure that the most appropriate indicators are monitored and documented for each patient, and that monitoring occurs at the appropriate frequency and for the appropriate duration. In the out of hospital environment, developments in digital technologies enable patient monitoring to be performed and analysed remotely.

Guiding principles to support prompt and reliable recognition of, and response to, physiological deterioration of patients are outlined in the **National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration (third edition)**.[365]

Recognising acute deterioration

Action 8.04

The health service organisation has processes for clinicians to detect acute physiological deterioration that require clinicians to:

a. **Document individualised vital signs monitoring plans**
b. **Monitor patients as required by their individualised monitoring plan**
c. **Graphically document and track changes in agreed observations to detect acute deterioration over time, as appropriate for the patient.**

Intent

Patients with acute physiological deterioration are identified early.

Reflective questions

- What systems does the ambulance health service have in place for monitoring and documenting vital signs and other agreed indicators graphically over time?
- What processes does the ambulance health service use to ensure there is enough equipment to monitor and respond to patient deterioration?
- What systems does the ambulance health service have in place to support clinicians to recognise variations in vital signs and other agreed indicators?
- How does the ambulance health service ensure that clinicians have the skills to monitor patients according to the patient's individualised monitoring plan?

Strategies for improvement

Develop a policy framework for recognising and responding to acute deterioration

Regular measurement and documentation of vital signs and other physiological observations is essential for recognising acute deterioration as changes in vital signs can occur both early and late in the deterioration process.

The ambulance health service should develop recognition and response systems in consideration of local circumstances. The focus of these systems is to ensure that all patients who deteriorate receive an immediate and appropriate treatment response.

The formal policy framework regarding recognition and response systems should identify:

- Governance arrangements including reporting requirements
- Roles, responsibilities and accountabilities for recognition and response systems
- Measurement and documentation of vital signs and other observations
- Tools including standard care pathways, protocols and algorithms based on a provisional diagnosis
- Processes for escalation of care
- Education and training requirements for all clinical staff and rapid response providers
- Evaluation, audit and feedback processes
- Arrangements with external organisations that may be part of the rapid response system.

Policies, procedures and guidelines to support recognition and response systems

Ambulance health service should work with clinicians to design systems for monitoring and responding to patient deterioration. The frequency of monitoring may vary between individual patients and this should be specified in monitoring plans.

The **National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration**[363] identifies key principles which can be applied to all clinical conditions and all patients. Policies should outline:

- Requirements for the measurement and documentation of vital signs and other observations
- Approved variations and modifications for specific groups such as pain and sedation scores, fluid balance, respiratory distress, capillary refill, or pupil size and reactivity, cardiac and end tidal carbon dioxide monitoring (where appropriate)
- How detection of acute physiological deterioration will be assessed and escalated where virtual assessment or remote monitoring of observations are in place.

Develop monitoring plans

Individual monitoring plans (or clinical pathways) should be developed considering the patient's diagnoses, clinical history, goals of care, frequency of monitoring and escalation protocols. Monitoring plans may be included in clinical pathways for specific patient groups who have similar clinical risks and needs. These provide prompts for clinicians to consider whether the monitoring plan meets the needs of each patient, and the capacity for them to review and modify the monitoring plan.

Acute physiological deterioration may be the trigger for recognising that a patient is approaching end of life. In these circumstances, management may differ and should align with the:

- **National consensus statement: Essential elements for safe and high-quality end-of-life care**,[219] and
- **National consensus statement: Essential elements for safe and high-quality paediatric end-of life care**.

Be mindful of special considerations

Special considerations may be needed for patient groups such as those who are at end of life, paediatric patients or patients who have difficulty communicating. In these circumstances other clinical signs and symptoms may be indicative of clinical deterioration such as agitation, behaviour change, breathlessness, nausea, change in skin colour, facial expressions and guarding.

Ensure appropriate skills and equipment

It is important that the ambulance health service provide education on processes for vital sign monitoring, documentation, interpretation of results and escalation protocols. It should:

- Train clinicians to use monitoring equipment
- Audit compliance with policies and processes for documenting and monitoring vital signs
- Seek feedback from the workforce on monitoring equipment and process across the organisation.

Document and track observations

Regardless of the type of system the ambulance health service uses to document vital signs, the system should include:

- The capacity to track changes in observations over time
- The capacity to display and embed alerts
- Thresholds for each observation parameter or combination of parameters that indicate clinical concern
- Information about the response, or action needed when thresholds are reached, or physiological deterioration is identified.

Implement electronic systems for tracking observations

Electronic systems for tracking vital sign observations may be used and may improve the detection of deterioration and escalation of care. When implementing these systems, ambulance health services need to:

- Test usability from both the clinical and human factors perspectives
- Develop strategies for mitigating the risk of human errors associated with issues such as workarounds arising from slow data entry processes, or alarm fatigue from frequent automatic alerts
- Provide orientation, training and education to ensure that electronic systems are used correctly
- Set up processes to evaluate the safety and quality of electronic systems as they are implemented
- Ensure electronic systems are consistent with the principles underlying paper-based processes and protocols
- Seek feedback from the workforce on the capacity and function of electronic systems in use.

Examples of evidence

- Policy documents that align with the **National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration**[363] that describe the minimum requirements for:
  - development and documentation of individualised clinical pathways or monitoring plans
  - frequency of monitoring vital signs or other parameters
  - vital sign documentation
- Training documents about using monitoring equipment, monitoring and documenting vital signs according to individualised clinical pathways or monitoring plans
- Documented protocols that outline monitoring for different patient groups
- Audit results of compliance with monitoring policies, procedures or protocols
- Maintenance logs and checklists for equipment used for monitoring vital signs
- Results of skills and competency evaluation for detecting acute physiological deterioration
- Examples of completed monitoring plans, track-and-trigger observation charts and clinical pathways
- Improvement processes have been implemented and evaluated relating to the detection of acute physiological deterioration.

Action 8.05

The health service organisation has processes for clinicians to recognise acute deterioration in mental state that require clinicians to:

a. **Monitor patients at risk of acute deterioration in mental state, including patients at risk of developing delirium**
b. **Include the person's known early warning signs of deterioration in mental state in their individualised monitoring plan**
c. **Assess possible causes of acute deterioration in mental state, including delirium, when changes in behaviour, cognitive function, perception, physical function or emotional state are observed or reported**
d. **Determine the required level of observation**
e. **Document and communicate observed or reported changes in mental state.**

Intent

Adverse outcomes relating to acute deterioration in a person's mental state are prevented through early recognition and effective response.

Reflective questions

- How does the ambulance health service ensure the workforce identifies patients at high risk of deterioration in mental state or at risk of delirium?
- How does the ambulance health service monitor and evaluate the effectiveness of processes to recognise delirium or acute deterioration in a person's mental state?

Strategies for improvement

Use screening processes to be alert for signs of deterioration in a person's mental state

Screening should be performed to identify people who are at risk of acute deterioration in their mental state, including patients at risk of developing delirium.[273] Use screening processes to identify patients with cognitive impairment or at risk of delirium to trigger strategies to keep the patient safe and minimise potential distress (see **Action 5.29**).

Where screening identifies risk of deterioration in a person's mental state, the ambulance health service should implement processes for patients to be referred or transported for a complete mental state examination to be conducted. Family, neighbours and primary care givers can assist in the early recognition of changes in a person's mental state, including possible delirium.[368, 369]

Members of the ambulance health services workforce must have the skills to initiate an immediate response and escalate their concerns when a person experiences acute deterioration in their mental state. The level of monitoring will be dependent on the context of the service and the risk of acute deterioration in mental state or cognition. Outcomes of screening and risk assessment should be documented in the patient's healthcare record.

Assess observed or reported changes by carers and families

When performing screening or assessment of a person's mental state, it is important to acknowledge family member's non-specific concerns, for example, the person 'is not usually like this'. Delirium can contribute to atypical presentations for other medical conditions in older people. Engagement with carers and families can help maintain safety for the person experiencing deterioration in their mental state while arrangements for specialist intervention are under way.

Use tools and resources

No single tool currently sets out objective criteria for tracking deterioration in a person's mental state equivalent to observation charts for physiological deterioration. Nonetheless, there are parameters that can indicate deterioration in a person's mental state and these can be used to develop individualised monitoring plans in collaboration with the person, their family and carers. These parameters are based on the mental state examination, which is integrated into clinical assessment protocols in most states and territories. Training about mental state examination is available through **Mental Health Professional Online**.

This **Escalation Mapping Template** supports ambulance health services to assess the efficacy of their systems for recognising and responding to signs of deterioration in a person's mental state. The template also supports services to map the alignment of processes to the systemic recognition and response model and to evaluate the effectiveness of their processes.

Use comprehensive care plans to manage patients at risk

If a person has been identified as being at high risk of acute deterioration in their mental state, the ambulance health service should incorporate findings from screening and assessment in development of a comprehensive care plan. It is valuable to incorporate feedback from patients, carers or family members on alerts and recognising signs that indicate a person's mental state is deteriorating.

Examples of evidence

- Policies, procedures and guidelines relating to recognising, documenting and observing acute deterioration in a person's mental state
- Screening and assessment policies and procedures for mental health in line with the **Comprehensive Care Standard**
- Training documents about recognising acute deterioration in mental state and how to incorporate feedback from the patient, carer or family
- Audit results of compliance with the monitoring plan systems for mental state
- Feedback from the workforce and patients on processes for assessing deterioration in mental state and delirium
- Referral pathways and feedback from multidisciplinary teams on processes for patients to access specialist care when deterioration in mental health or delirium has been identified
- Reports from safety and quality systems relating to the deterioration in mental health or delirium
- Improvement processes have been implemented and evaluated relating to systems for the detection in mental health including delirium.

Escalating care

Action 8.06

The health service organisation has protocols that specify criteria for escalating care, including:

a. **Agreed vital sign parameters and other indicators of physiological deterioration**
b. **Agreed indicators of deterioration in mental state**
c. **Agreed parameters and other indicators for calling emergency assistance**
d. **Patient pain or distress that is not able to be managed using available treatment**
e. **Worry or concern in members of the workforce, patients, carers and families about acute deterioration.**

Intent

The ambulance health service has an effective system for escalation of care to minimise risks for patients who are acutely deteriorating.

Reflective questions

- What protocols are used to specify the criteria for escalating care within the ambulance health service?
- How does the ambulance health service monitor the effectiveness of its protocols for escalating care?

Strategies for improvement

Early recognition and effective prompt action of acute physiological deterioration can minimise adverse events such as cardiac arrest and death.[363] Early intervention may also reduce the amount of intervention required to stabilise a patient. The chain of survival concept in out of hospital cardiac arrests has demonstrated improvement in survival rates with early access to medical intervention including defibrillation.[370, 371]

Implement escalation protocols with criteria for escalating care

In collaboration with the workforce, an ambulance health service should develop escalation protocols that outline the organisational response to deterioration of vital signs and other physiological observations.

Escalation protocols can be complex, involving multiple steps and different communication pathways. Consider developing a flow diagram to summarise escalation processes and provide clinicians with a quick reference tool. Escalation protocols should be tailored to the characteristics of the ambulance health service taking into consideration the:

- Size, role and scope of practice
- Patient population, demographics and case mix
- Location, including telemedicine services

- Criteria, parameters and thresholds that indicate acute deterioration
- Action to be taken when deterioration is detected
- Process for calling for help and the expected responses.

Escalation protocols should allow for a graded response commensurate with changes in vital sign observations, physiological measurements or assessments, or other identified deterioration. As early treatment of acute deterioration results in better outcomes, two levels of response are recommended:

- an emergency response
- a treating or on-call team response.

Patients may show signs of clinical deterioration other than those identified in the escalation protocol, and there is evidence that family or clinician worry or concern may precede deterioration in observations.[372] Therefore protocols should include family or clinician worry or concern as a criterion for escalation, and criteria for clinicians to escalate care based on clinical judgement or provisional diagnosis in the absence of other escalation criteria.

Escalation mapping tools have been developed to support health care organisations to evaluate their systems to ensure that trigger thresholds, parameters and responses are safe for use in the population of patients for whom they provide care.

Mapping tools can also be used for developing escalation protocols for deterioration in a person's mental state. Use the signs described in tools such as the mental health triage tool[373] to set thresholds for escalation in response to observed or reported changes in a person's mental state.

Identify indicators of deterioration in a person's mental state

When acute deterioration in a person's mental state occurs, the ambulance health service needs to assess the most appropriate response. Escalation protocols should identify pathways to link to specialist mental health services, including outside normal business hours.

Refer to the **National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state**[312] for guidance on identifying indicators of deterioration in a person's mental state. This resource is intended to be used in conjunction with the **National Consensus Statement: Essential elements for recognising and responding to acute physiological deterioration (third edition)**[365] which describes the essential features of systems for recognising and responding to acute deterioration.

The report **Recognising Signs of Deterioration in a Person's Mental State**[374] identifies five indicators and 28 clusters of signs of deterioration in a person's mental state which may be useful in identifying indicators of deterioration in a person's mental state.

The following tools may assist ambulance health services to set thresholds for escalation in response to observed or reported changes in a person's mental state:

- **Mental State Examination**[375]
- **Australasian Triage Scale**[376]
- **Mental Health Triage Tool**[373].

Develop policies and guidance and provide ongoing training

Develop policies and provide training and ongoing education to guide clinicians in preventing and responding to clinical agitation, aggressive behaviour and violence.

Refer to the **Minimising patient harm** criterion in the **Comprehensive Care Standard** for further detail on:

- Preventing delirium and managing cognitive impairment
- Predicting, preventing and managing self-harm, suicide, aggression and violence
- Minimising restrictive practices.

Provide workforce orientation, training and education on behavioural changes and escalation protocols including:

- Roles, responsibilities and accountabilities
- Causes of behavioural disturbances
- De-escalation strategies
- Principles of trauma informed care
- Maintaining safety of the patient, workforce and bystanders
- The role of sedation.

Examples of evidence

- Policy documents that identify agreed criteria for escalating care
- Triggers for escalation of care and the expected responses
- Documented protocols for escalating care
- Escalation flow diagrams
- Audit results of compliance with escalation protocols
- Feedback from the workforce on escalation protocols
- Resources or tools that help clinicians to use escalation protocols
- Training documents on escalating care
- Reports from the incident management system relating to escalation protocols, including feedback from consumers and the workforce to support improvements.

Action 8.07

The health service organisation has processes for patients, carers or families to directly escalate care.

Intent

Patients, family members and carers can directly escalate care.

Reflective questions

- What processes does the ambulance health service have in place for patients, carers or families to directly escalate care concerns? This might include:
  - when a patient, carer or family contacts triple zero?
  - where a patient has been attended but not transported?
  - when a secondary triage process is completed and an ambulance has not attended?
  - when a patient has been transported and is awaiting assessment at a health care facility?
- How does the ambulance health service communicate the escalating care protocols to patients and their support people?
- How does the ambulance health service monitor and evaluate its processes for patients, carers or families to directly escalate care concerns?

Strategies for improvement

This action links with the intent and strategies outlined in **Actions 6.10 Communicating critical information** and **8.06 Escalating care**.

Use the actions about health literacy from the **Partnering with Consumers Standard** to guide the development of a system for patients, carers and family members to access help when they are concerned that a patient is acutely deteriorating.

Implement escalation protocols for the patient and support people

Escalation protocols should allow for the concerns of the patient, family, carer or other support people to independently trigger an escalation of care. Families and carers will often raise concern about a patient who is 'getting worse', 'not doing as well as expected', 'not improving' or 'not themselves'.

The ambulance health service should provide verbal or written information about how patients, carers and family can escalate their concerns during an episode of care. Several Australian states have established patient, carer and family member escalation systems:

- New South Wales **REACH** program (Recognise, Engage, Act, Call, Help is on its way)[377]
- Queensland's **Ryan's Rule**[378]
- Western Australia's **Aishwarya's CARE Call**
- Victoria 'See Me, Hear Me'[379]

Ensure training of the workforce in these escalation protocols

The ambulance health service should provide training to all members of the workforce including non-clinical members, volunteers and control room facility operators, to ensure that escalation is appropriately managed.

Examples of evidence

- Policies, procedures and guidelines that support patients, carers or families to escalate care
- Training documents about the system for patients, carers and families to directly escalate care
- Information for patients, carers and families outlining how they can directly escalate care
- Evaluation of escalation protocols and improvements implemented
- Feedback from the workforce on patient carer escalation systems
- Incident management system relating to the escalation of care by patients, carers and families occur
- Observation of an escalation system that supports patients, carers and families to directly escalate care.

Action 8.08

The health service organisation provides the workforce with mechanisms to escalate care and call for emergency assistance.

Intent

The ambulance health service has mechanisms for the workforce to escalate care.

Reflective questions

- What mechanisms does the ambulance health service have in place for the workforce to escalate care?
- How does the ambulance health service monitor the effectiveness of the mechanisms for the workforce to escalate care?

Strategies for improvement

Implement mechanisms for the workforce to escalate care

Provide mechanisms to escalate care and call for emergency assistance. In the out of hospital environment, multiple mechanisms may be necessary to allow for different escalation responses for varying types of deterioration. This may include paging systems, dedicated mobile, on-call and emergency telephone numbers, electronic alerting systems and centralised alarms.

Consider the following issues when deciding on the mechanisms to use:

- Maintain consistency and standardise processes to avoid changes in the system at different times of the day or on different days of the week
- Develop processes for maintaining equipment
- Provide backup systems in the event of equipment failure
- Provide training about how to use the mechanisms for escalating care, including new, casual, volunteer and agency members of the workforce.

Examples of evidence

- Policies, procedures and guidelines about escalating care
- Training records in escalation of care protocols
- Resources on escalation protocols
- Audit results of equipment functionality and maintenance
- Audit results of compliance with the mechanisms for escalating care and calling for emergency assistance
- Evidence of investigations into failures of the mechanisms for escalation and emergency assistance calls, and associated quality improvement projects
- Evidence of use of simulation training scenarios
- Evidence of workforce feedback on escalation systems
- Reports from incident management systems relating to the escalation of care.

Action 8.09

The workforce uses the recognition and response systems to escalate care.

Intent

Members of the workforce take prompt action to deal with acute deterioration.

Reflective questions

- How does the ambulance health service ensure that the workforce knows how and when to use the recognition and response systems?
- How does the ambulance health service evaluate the effectiveness of the recognition and response systems to escalate care?

Strategies for improvement

Provide structured and regular training

A skilled and qualified workforce is essential for the provision of safe, appropriate care to patients whose condition is deteriorating. The ambulance health service should provide orientation, training and education for the workforce about the recognition and response systems and their individual roles, responsibilities and accountabilities.

The ambulance health service should use audit and evaluation data to identify trends and potential training gaps, so that training and education can be effectively targeted.

Develop structured communication prompts and tools

Effective escalation of care relies on effective communication. A large amount of information may be communicated to many clinicians when acute deterioration occurs. There are risks to patient safety if information is not comprehensive, relevant or clearly understood.

The ambulance health service should:

- Develop standardised and structured communication prompts and tools for clinicians to use when escalating care
- Provide processes for the workforce to routinely give feedback about their experiences of escalating care and use this information to improve escalation protocols.

See the **Communicating for Safety Standard** and the **Toolkit for Clinical Handover Improvement**[339] for helpful information.

Examples of evidence

- Policies, procedures and guidelines relating to the use of recognition and response systems to escalate care
- Training documents on the use of recognition and response systems to escalate care
- Examples of communication prompts and tools used for escalating care
- Audit results of the use of communication prompts and tools when escalating care
- Quality improvement systems that include analysis of feedback on the workforce's experiences of escalating care to improve escalation protocols
- Patient, carer and family feedback provided on the recognition and response systems.
- Audit results of compliance with the use of recognition and response systems
- Reports on incidents associated with failure of recognition and response systems.

Responding to acute deterioration

Appropriate and timely care is provided to patients whose condition is acutely deteriorating.

Effective monitoring and escalation systems should be complemented by effective response systems which ensure that all patients who acutely deteriorate receive a timely and appropriate response. Response systems between ambulance health services and acute inpatient services and will differ depending upon the location, available resources, clinical workforce skill mix (including volunteer workforce) potential risks, and mitigation strategies (including safe transport).

A comprehensive understanding of the ambulance health service's context will need to be considered when developing policies and procedures.

Response systems will generally include levels of response as part of a graded escalation process. There will be differences in options for response between ambulance health service providers, and even within individual ambulance health services, based on time of day, location and other factors.

Where an ambulance health service operates a control room facility, the development of specific response options in this context will be essential. Response to identified clinical deterioration may include:

- Changes to the requirements and frequency of physiological monitoring
- Changes to the number of staff travelling in the patient compartment or clinician, considering specialist experience and level of experience of clinical care team
- Re-triage and reassessment of service level
- Changes to the referral method, urgency or destination
- Consultation for clinical advice and guidance including telehealth or video conference
- Requests for specialist response for identified need:
  - specialised manual handling or rescue
  - specialised retrieval services (e.g., ECMO, newborn transport services)
  - specialised transport options (e.g., aeromedical).

Responding to deterioration

Action 8.10

The health service organisation has processes that support timely response by clinicians with the skills required to manage episodes of acute deterioration.

Intent

Clinicians have the skills and knowledge to deal with deterioration, as appropriate for their role.

Reflective questions

- How does the ambulance health service ensure that clinicians are competent in the skills required to respond to patients whose condition is acutely deteriorating?
- How does the ambulance health service evaluate the processes for managing acute deterioration?

Strategies for improvement

This action may require varying approaches for people in different roles within the ambulance health service. It applies to the workforce providing the initial response, such as those in a control room facility, and to the response team who bring extra skills to the patient.

Develop systems to ensure that members of the workforce are competent in the skills required to respond to patients whose condition is deteriorating, commensurate to their role and scope of practice.

Some clinicians working in ambulance health care settings will have specialist training to provide advanced clinical procedures and advanced life support, and it may be appropriate to request their attendance to assist in some cases of clinical deterioration. Local processes should identify the person who:

- Is responsible for triaging calls for assistance
- Is responsible for directing and coordinating the response, or multiple activities and treatments needed when providing out of hospital care services
- Is responsible for communicating with the receiving facility or other health professionals
- Is responsible for providing patient care including interventions and therapies
- Is accountable for handing over critical information at transitions of care
- Is responsible for documenting the care provided
- Is responsible for communicating outcomes to the patient, carer and family
- Is responsible for maintenance of emergency equipment, including replenishing used stock and medicines
- Can stand down escalation of care response when appropriate.

Implement training about roles, responsibilities and accountabilities in responding to a patient whose condition is deteriorating

Training needs and priorities should be considered based upon the local context of the ambulance health service. Training about the roles, responsibilities and accountabilities in responding to an episode of acute deterioration may need to be tailored for different roles within the ambulance health service.

A risk assessment approach will ensure the ambulance health service identifies and sets appropriate priorities for orientation, training and education. Clinicians responding to acute deterioration may also require non-clinical skills such as team leadership, closed-loop communication and how to convey bad news.[380]

Examples of evidence

- Policy documents, guidelines and protocols that describe roles, responsibilities and accountabilities in the event of episodes of acute deterioration
- Training documents about actions and interventions in the event of acute deterioration
- Evidence of clinician competency assessment, including through simulation exercises, peer review or formal assessments
- Records indicating that clinicians have met mandatory training and professional development requirements
- Audit of compliance with systems for acute deterioration
- Feedback from members of the workforce on training requirements
- Reports from incident management systems including quality improvement strategies for improving systems for acute deterioration.

Action 8.11

The health service organisation has processes to ensure rapid access at all times to at least one clinician, either on site or in close proximity, who can deliver advanced life support.

Intent

Expert input and assistance is available to manage acute physiological deterioration.

Reflective questions

- What processes does the ambulance health service have in place to ensure that clinicians who are competent in providing advanced life support are available to respond to patients who acutely deteriorate?
- How does the ambulance health service evaluate the effectiveness of its processes to manage acute physiological deterioration?

Strategies for improvement

Implement a system to ensure rapid access to advanced life support for patients who acutely deteriorate.

Ambulance health service response systems should include provision for rapid access to at least one clinician with advanced life support skills for patients who acutely deteriorate. Depending on the size, location and scope of the ambulance health service, this may include systems for rapid referral to the local jurisdictional emergency ambulance services (see **Action 8.06**).

Where the ambulance health service relies on another service provider to provide the advanced life support (e.g., jurisdictional emergency ambulance service), there must be established systems to contact or escalate to the other ambulance health service (see **Action 8.13**).

The ambulance health service should establish systems for assessing transport needs for patients in the event of clinical deterioration. These systems should provide evidence of the decision making process to support members of the ambulance health service's workforce to transport a patient experiencing acute deterioration to a health service provider by the most timely and efficient means.

Ensure clinicians' ongoing competence in advanced life support

If advanced life support is provided by members of the workforce, establish clinicians' competence in advanced life support with evidence of relevant qualifications. The ambulance health service should establish systems to provide evidence of clinicians' ongoing competence in advanced life support and could require the organisation to provide access to formal advanced life supporting training to support clinicians to maintain their skills and competence.[381]

There is broad evidence that advanced life support resuscitation education to health care professionals should be structured, realistic and inclusive of a range of human factors.[382] Further benefits can be gained by providing opportunities for members of escalation teams to train together, and practice using non-technical skills such as leadership, teamwork and communication while managing simulated scenarios of acute deterioration.

Guidelines are provided by the Australian Resuscitation Council (ARC).[383]

Implement appropriate policies, processes and guidelines

The ambulance health service should have policies, processes and guidelines that provide members of the workforce with information on how to manage acute physiological deterioration, including:

- How and when to access advanced life support
- Processes for communication and reporting requirements
- Roles, responsibilities and accountabilities, including where the provision of advanced life support is provided by another agency.

Examples of evidence

- Policies, procedures and guidelines that support the provision of rapid access at all times to at least one clinician who can deliver advanced life support
- Policy documents that describe advanced life support roles, responsibilities and accountabilities
- Rosters of clinicians who can provide advanced life support
- Feedback from members of the workforce regarding systems for advanced life support
- Evidence of qualifications or up-to-date certification for the provision of advanced life support
- Records of ongoing competency assessments for advanced life support
- Training documents about non-technical skills relating to advanced life support, such as teamwork, team leadership and communication
- Equipment logs to ensure maintenance of equipment and medicines used for delivering advanced life support
- Meeting records where systems for advanced life support are discussed
- Reports from incident management systems relating to the delivery of advanced life support.

Action 8.12

The health service organisation has processes to ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated.

Intent

Care for patients whose mental state is deteriorating is escalated safely and effectively.

Reflective questions

- How does the ambulance health service workforce know the processes for escalating care to mental health specialists, including when episodes occur out of normal business hours?
- What partnerships are in place to help patients gain access to mental health services?
- How are patients, carers and families informed about rapid referral to mental health services?
- How does the ambulance health service monitor and evaluate the effectiveness of its processes to ensure rapid referral to mental health services?

Strategies for improvement

The ambulance health service should develop a protocol for escalating care when a person's mental state is deteriorating, in line with mental health legislation and state and territory requirements. This should include designation of roles and responsibilities for members of the workforce, time frames for response and referral pathways to specialist services.

If responding to acute deterioration in a person's mental state is outside the scope of the ambulance health service, develop partnerships with other relevant organisations, including organisations who can provide care outside of normal business hours. Escalation protocols can be tailored taking into account:

- The immediate safety needs of the person
- Potential risks and mitigation strategies, including safe transport
- The available resources, including the clinical workforce skill mix
- How to contact or refer a person to specialist mental health services
- The use of standardised handover and documentation about the person's mental state at transitions of care.

Examples of evidence

- Policies, procedures and guidelines about rapid referral to mental health services for patients whose mental state has acutely deteriorated
- Records that demonstrate the workforce has been trained to instigate rapid referral to mental health services as per policies
- Audit results against policies and processes for rapid referral to appropriate mental health services
- Evidence of use of a behaviour risk assessment and documentation in the patient's healthcare record
- Meeting records where processes for assessing and referral of patients whose mental state has deteriorated is discussed
- Reports from incident management systems relating to the deterioration of mental state and rapid referral to mental health services.

Action 8.13

The health service organisation has processes for rapid referral to services that can provide definitive management of acute physiological deterioration.

Intent

Patients who need other services to resolve the cause of their acute deterioration are rapidly referred to these services.

Reflective questions

- What mechanisms does the ambulance health service have in place to ensure the rapid referral of patients for the management of acute physiological deterioration?
- How does the ambulance health service monitor and improve these mechanisms to ensure they meet the needs of the patient population?

Strategies for improvement

Identify capacity of ambulance health service

Develop processes for rapid referral within the ambulance health service (see **Action 8.06**) and rapid referral to external acute healthcare services. Include processes for triaging and assessing the safe transport of patients. Systems and capacity will vary dependent upon the scope, design, geographical location and workforce skill mix.

Map the common causes of acute deterioration against the ambulance health service's scope and capacity. An example of a service gap may include anaphylaxis. Anaphylaxis is a rare but known occurrence in ambulance health services. Some low acuity patient transport providers of ambulance health services may be unable to provide the necessary advanced life support for patients experiencing anaphylaxis. A system for rapid referral to the local jurisdictional emergency ambulance services would be required to provide effective care for these patients.

Common causes of acute deterioration can be identified using data from the recognition and response systems. These may include common presentations and causes of acute physiological deterioration, such as:[384,361,385,386,387]

- Airway obstruction and respiratory depression associated with issues such as neurological events or opioid or benzodiazepine overdose
- Obstetric and newborn emergencies
- Altered level of consciousness associated with issues such as neurological or toxicology events or delirium
- Respiratory distress associated with issues such as heart failure, sepsis or exacerbations of existing lung disease
- Arrhythmias
- Anaphylaxis
- Hypotension.

To support rapid referral, ambulance health services should:

- Map the causes of acute deterioration against the capacity of the ambulance health service to provide for their definitive management
- Develop systems and guidelines for rapid referral of patients with acute deterioration to other services
- Develop guidelines for episodes of acute deterioration that occur outside normal business hours.

Examples of evidence

- Policies, procedures and guidelines that provide rapid referral to services for the definitive management of acute deterioration
- Records that demonstrate the workforce has been trained to instigate rapid referral to services for the definitive management of acute deterioration
- Audit results of the common causes of deterioration from the recognition and response systems mapped to organisational capacity
- Resources outlining the process such as flowcharts
- Systems to identify and engage with external services that enable rapid referral for definitive management
- Documented processes for the safe transport to other services for definitive management
- Audits of records where a risk assessment of transport is performed
- Evaluation of referral processes and patient outcomes, and evidence of associated quality improvement projects.
- Evidence of meetings with transport providers including other ambulance health service providers, jurisdictional emergency ambulance service or retrieval services
- Use of feedback from patients, families, carers and transport providers to improve rapid referral systems
- Incident management system reports that demonstrate that quality improvement processes have been identified, implemented and monitored relating to the rapid referral of patients.

Glossary

When appropriate, glossary definitions from external sources have been adapted to fit the context of the **NSQHS Standards**

Term	Definition
acute deterioration	physiological, psychological or cognitive changes that may indicate a worsening of the patient's health status; this may occur across hours or days.
ADR	adverse drug reaction
advance care directive	a voluntary, personled document completed and signed by a competent person that focuses on an individual's values and preferences for future care decisions, including their preferred outcomes and care. Advance care directives are recognised by specific legislation (statutory) or under common law (nonstatutory). They come into effect when an individual loses decision making capacity. In some states, these are known as advance health directives.[113]
advance care plan	a document that captures an individual's beliefs, values and preferences in relation to future care decisions, but which does not meet the requirements for statutory or common law recognition due to the person's lack of competency, insufficient decision making capacity or lack of formalities (such as inadequate person identification, signature and date).[113]
advance care planning	a process of planning for future health and personal care whereby the person's values, beliefs and preferences are made known to guide decision making at a future time when that person cannot make or communicate their decisions. Registered and nonregistered health practitioners have a role in advance care planning and require skills to facilitate these conversations effectively. The national quality standards for aged care, general practice and healthcare services all promote advance care planning. Individuals can also choose to engage in advance care planning with people who are not health practitioners, such as friends or family.[113]
advanced life support	the preservation or restoration of life by the establishment and/or maintenance of airway, breathing and circulation using invasive techniques such as defibrillation, advanced airway management, intravenous access and drug therapy.[363]
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.[388] An allergy is a type of adverse drug reaction.
adverse event	n 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.[389] An allergen may be encountered through inhalation, ingestion, injection or skin contact. A medicine allergy is one type of adverse drug reaction.[390]

Term	Definition
ambulance health services	multidisciplinary and bespoke, out of hospital health services that provide a complex range of emergency, urgent and non-urgent clinical care, in a variety of settings, including but not limited to the provision of patient transport to and from health facilities, retrieval and in some cases rescue services.
AMS	antimicrobial stewardship
antimicrobial	a chemical substance that inhibits or destroys bacteria, viruses or fungi, and can be safely administered to humans and animals.[391]
antimicrobial resistance	failure of an antimicrobial to inhibit a microorganism at the antimicrobial concentrations usually achieved over time with standard dosing regimens.[391]
antimicrobial stewardship	a systematic and coordinated approach to optimising antimicrobial use with the goals of improving patient outcomes, ensuring cost effective therapy and reducing adverse consequences of antimicrobial use, including antimicrobial resistance.[392,393,394,395]
approved identifiers	items of information accepted for use in identification, including family and given names, date of birth, sex, address, healthcare record number and Individual Healthcare Identifier. Health service organisations and clinicians are responsible for specifying the approved items for identification and procedure matching. Identifiers such as room or bed number should not be used.
aseptic technique	a technique that aims to prevent microorganisms on hands, surfaces and equipment from being introduced to susceptible sites. Unlike sterile techniques, aseptic technique can be achieved in typical ward and home settings.[396]
assessment	a clinician's evaluation of a disease or condition based on the patient's subjective report of the symptoms and course of the illness or condition, and the clinician's objective findings. These findings include data obtained through laboratory tests, physical examination and medical history; and information reported by carers, family members and other members of the healthcare team. The assessment is an essential element of a comprehensive care plan.[397]
audit (clinical)	a systematic review of clinical care against a predetermined set of criteria.[398]
Australian Charter of Healthcare Rights	specifies the key rights of patients when seeking or receiving healthcare services.[36]
Australian Open Disclosure Framework	endorsed by health ministers in 2013, it provides a framework for health service organisations and clinicians to communicate openly with patients when health care does not go to plan.[34]
best possible medication history	a list of all the medicines a patient is using at presentation. The list includes the name, dose, route and frequency of the medicine, and is documented on a specific form or in a specific place. All prescribed, over-the-counter and complementary medicines should be included. This history is obtained by a trained clinician interviewing the patient (and/or their carer) and is confirmed, where appropriate, by using other sources of medicines information.[399]
best practice	when the diagnosis, treatment or care provided is based on the best available evidence, which is used to achieve the best possible outcomes for patients

Term	Definition
best-practice guidelines	a set of recommended actions that are developed using the best available evidence. They provide clinicians with evidence-informed recommendations that support clinical practice, and guide clinician and patient decisions about appropriate health care in specific clinical practice settings and circumstances.[400]
blood management	a process that improves outcomes for patients by improving their medical and surgical management in ways that boost and conserve their own blood, and ensure that any blood and blood products patients receive are appropriate and safe.
blood products	the products derived from fresh blood – red blood cells and platelets, fresh frozen plasma, cryoprecipitate and cryodepleted plasma, plasma-derived blood products, and recombinant blood products.
BPMH	best possible medication history
business decision making	decision making regarding service planning and management for a health service organisation. It covers the purchase of building finishes, equipment and plant; program maintenance; workforce training for safe handling of equipment and plant; and all issues for which business decisions are taken that might affect the safety and wellbeing of patients, visitors and the workforce.
care pathway	a complex intervention that supports mutual decision making and organisation of care processes for a well-defined group of patients during a well-defined period.[401]
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.[402] State and territory legislation provides further guidance and care responsibilities.
clinical care standards	nationally relevant standards developed by the Australian Commission on Safety and Quality in Health Care, and agreed by health ministers, that identify and define the care people should expect to be offered or receive for specific conditions.
clinical communication	the exchange of information about a person's care that occurs between treating clinicians, patients, carers and families, and other members of a multidisciplinary team. Communication can be through several different channels, including face-to-face meetings, telephone, written notes or other documentation, and electronic means. *See also* 'effective clinical communication', 'clinical communication process'.

Term	Definition
clinical communication process	the method of exchanging information about a person's care. It involves several components and includes the sender (the person who is communicating the information), the receiver (the person receiving the information), the message (the information that is communicated) and the channel of communication. Various channels of communication can be used, including verbal (face to face, over the phone, through Skype), written and electronic.[403] Sending and receipt of the information can occur at the same time, such as verbal communication between two clinicians, or at different times, such as non-verbal communication during which a clinician documents a patient's goals, assessments and comprehensive care plan in the healthcare record, which is later read by another clinician.
clinical governance	an integrated component of corporate governance of health service organisations. It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the ambulance for assuring the delivery of safe, effective and high-quality services. Clinical governance systems provide confidence to the ambulance and the healthcare organisation that systems are in place to deliver safe and high-quality health care.
clinical handover	the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.[404]
clinical information system	a computerised healthcare record and management system that is used by clinicians in healthcare settings. Clinical information systems are typically organisation-wide, have high levels of security and access, and have roles and rights (e.g., prescribing medicines, reviewing laboratory results, administering intravenous fluids) specified for each clinical and administrative user. Clinical information systems enable electronic data entry and data retrieval by clinicians.[405]
clinical leaders	clinicians with management or leadership roles in a health service organisation who can use their position or influence to change behaviour, practice or performance. Examples are directors of clinical services, heads of units and clinical supervisors.
clinician	a healthcare provider, trained as a health professional, including registered and non-registered practitioners. Clinicians may provide care within a health service organisation as an employee, a contractor or a credentialed healthcare provider, or under other working arrangements. They include but are not limited to paramedics, nurses, midwives, medical practitioners, allied health practitioners, technicians, scientists and other clinicians who provide health care, and students providing health care under supervision.
cognitive impairment	deficits in one or more of the areas of memory, communication, attention, thinking and judgement. This can be temporary or permanent. It can affect a person's understanding, their ability to carry out tasks or follow instructions, their recognition of people or objects, how they relate to others and how they interpret the environment. Dementia and delirium are common forms of cognitive impairment seen in hospitalised older patients.[397] Cognitive impairment can also be a result of several other conditions, such as acquired brain injury, a stroke, intellectual disability, licit or illicit drug use, or medicines.

Term	Definition
cold chain management	the system of transporting and storing temperature-sensitive medicines and other therapies, such as blood and blood products, within their defined temperature range at all times, from point of origin (manufacture) to point of administration, to ensure that the integrity of the product is maintained.
communicable	an infection that can be transferred from one person or host to another.
comprehensive care	health care that is based on identified goals for the episode of care. These goals are aligned with the patient's expressed preferences and healthcare needs, consider the impact of the 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 health service organisations. For example, a care or clinical pathway for a specific intervention may be considered a comprehensive care plan.
consumer	a person who has used, or may potentially use, health services, or is a carer for a patient using health services. A healthcare consumer may also act as a consumer representative to provide a consumer perspective, contribute consumer experiences, advocate for the interests of current and potential health service users, and take part in decision making processes.[406]
contemporaneously (documenting information)	recording information in the healthcare record as soon as possible after the event that is being documented.[407]
credentialing	the formal process used by a health service organisation to verify the qualifications, experience, professional standing, competencies and other relevant professional attributes of clinicians, so that the organisation can form a view about the clinician's competence, performance and professional suitability to provide safe, high-quality healthcare services within specific organisational environments.[408]
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.[139]
critical information	information that has a considerable impact on a patient's health, wellbeing or ongoing care (physical or psychological). The availability of critical information may require a clinician to reassess or change a patient's comprehensive care plan.
cultural competency	a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals to enable that system, agency or those professionals to work effectively in cross-cultural situations.[409]

Term	Definition
cultural safety	is determined by Aboriginal and Torres Strait Islander individuals, families and communities. In health care, culturally safe practise is the ongoing critical reflection of knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism. Essential features of cultural safety are individuals and organisations: ▪ Acknowledging colonisation and systemic racism, social, cultural, behavioural and economic factors which impact individual and community health ▪ Acknowledging and addressing individual racism, their own biases, assumptions, stereotypes and prejudices and provide care that is holistic, free of bias and racism ▪ Recognising the importance of self-determined decision-making, partnership and collaboration in healthcare which is driven by the individual, family and community ▪ Fostering a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander peoples and colleagues.
current medicines list	*see* 'medicines list'.
decision support tools	tools that can help clinicians and consumers to draw on available evidence when making clinical decisions. The tools have a number of formats. Some are explicitly designed to enable shared decision making (e.g., decision aids). Others provide some of the information needed for some components of the shared decision making process (e.g., risk calculators, evidence summaries), or provide ways of initiating and structuring conversations about health decisions (e.g., communication frameworks, question prompt lists).[233] *See also* 'shared decision making '.
de-escalation strategies	psychosocial techniques that aim to reduce violent or disruptive behaviour. They are intended to reduce or eliminate the risk of violence during the escalation phase, using verbal and non-verbal communication skills. De-escalation is about establishing rapport to gain the patient's trust, minimising restriction to protect their self-esteem, appearing externally calm and self-aware in the face of aggressive behaviour, and intuitively identifying creative and flexible interventions that will reduce the need for aggression.[306]
definitive management	the treatment plan for a disease or disorder that has been chosen as the best one for the patient after all other choices have been considered.[410]
delirium	an acute disturbance of consciousness, attention, cognition and perception that tends to fluctuate during the day.[411] It is a serious condition that can be prevented in 30–40% of cases, and should be treated promptly and appropriately. Hospitalised older people with existing dementia are at the greatest risk of developing delirium. Delirium can be hyperactive (the person has heightened arousal; or can be restless, agitated and aggressive) or hypoactive (the person is withdrawn, quiet and sleepy).[412]

Term	Definition
deterioration in mental state	a negative change in a person's mood or thinking, marked by a change in behaviour, cognitive function, perception or emotional state. Changes can be gradual or acute; they can be observed by members of the workforce, or reported by the person themself, or their family or carers. Deterioration in a person's mental state can be related to several predisposing or precipitating factors, including mental illness, psychological or existential stress, physiological changes, cognitive impairment (including delirium), intoxication, withdrawal from substances, and responses to social context and environment.
diversity	the varying social, economic and geographic circumstances of consumers who use, or may use, the services of a health service organisation, as well as their cultural backgrounds, disability status, religions, beliefs and practices, languages spoken, sexual orientation, gender identity and gender expression, and sex characteristics.
ECG	electrocardiogram is a quick test to check the heartbeat of a patient.
ECMO	extracorporeal membrane oxygenation is a support strategy for patients with severe respiratory or cardiac failure who are at high risk of death.
effective clinical communication	two-way, coordinated and continuous communication that results in the timely, accurate and appropriate transfer of information. Effective communication is critical to, and supports, the delivery of safe patient care.
emergency assistance	clinical advice or assistance provided when a patient's condition has deteriorated severely. This assistance is provided as part of the rapid response system, and is additional to the care provided by the attending clinician or team.[363]
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.[413]
end-of-life care	includes physical, spiritual and psychosocial assessment, and care and treatment delivered by healthcare workers. It also includes support of families and carers, and care of the patient's body after their death. People are 'approaching the end of life' when they are likely to die within the next 12 months. This includes people whose death is imminent (expected within a few hours or days) and those with: ▪ Advanced, progressive, incurable conditions ▪ General frailty and coexisting conditions which mean that they are expected to die within 12 months ▪ Existing conditions, if they are at risk of dying from a sudden acute crisis in their condition ▪ Lifethreatening acute conditions caused by sudden catastrophic events.
environment	the physical surroundings in which health care is delivered, including the building, fixtures, fittings, and services such as air and water supply. Environment can also include other patients, visitors and the workforce.
episode of care	a phase of treatment. There may be more than one episode of care within the one hospital stay. An episode of care ends when the principal clinical intent changes or when the patient is formally separated from the facility.[414]

Term	Definition
escalation protocol	the protocol that sets out the organisational response required for different levels of abnormal physiological measurements or other observed deterioration. The protocol applies to the care of all patients at all times.[363]
EWS	early warning signs
fall	an event that results in a person coming to rest inadvertently on the ground or floor, or another lower level.[415]
goals of care	clinical and other goals for a patient's episode of care that are determined in the context of a shared decision making process.
governance	the set of relationships and responsibilities established by a health service organisation between its executive, workforce and stakeholders (including patients). Governance incorporates the processes, customs, policy directives, laws and conventions affecting the way an organisation is directed, administered or controlled. Governance arrangements provide the structure for setting the corporate objectives (social, fiscal, legal, human resources) of the organisation and the means to achieve the objectives. They also specify the mechanisms for monitoring performance. Effective governance provides a clear statement of individual accountabilities within the organisation to help align the roles, interests and actions of different participants in the organisation to achieve the organisation's objectives. In the NSQHS Standards, governance includes both corporate and clinical governance.
governing body	a board, chief executive officer, organisation owner, partnership or other highest level of governance (individual or group of individuals) that has ultimate responsibility for strategic and operational decisions affecting safety and quality in a health service organisation.
governing health service organisation	the overarching health service organisation responsible for the ambulance health service. *See* governing body.
guidelines	clinical practice guidelines are systematically developed statements to assist clinician and consumer decisions about appropriate health care for specific circumstances.[416]
haemovigilance	a set of surveillance procedures covering the entire blood transfusion chain, from the donation and processing of blood and its components, to their provision and transfusion to patients, to their follow-up. It includes monitoring, reporting, investigating and analysing adverse events related to the donation, processing and transfusion of blood, as well as development and implementation of recommendations to prevent the occurrence or recurrence of adverse events.[417]
hand hygiene	a general term referring to any action of hand cleansing.
health care	the prevention, treatment and management of illness and injury, and the preservation of mental and physical wellbeing through the services offered by clinicians, such as medical, nursing and allied health professionals.[34]
healthcare-associated infections	infections that are acquired in healthcare facilities (nosocomial infections) or that occur as a result of healthcare interventions (iatrogenic infections). Healthcare-associated infections may manifest after people leave the healthcare facility.[139]

Term	Definition
healthcare record	includes a record of the patient's medical history, treatment notes, observations, correspondence, investigations, test results, photographs, prescription records and medication charts for an episode of care. Information in a healthcare record can be sourced from multiple healthcare organisations.
health literacy	the Australian Commission on Safety and Quality in Health Care separates health literacy into two components – individual health literacy and the health literacy environment. Individual health literacy is the skills, knowledge, motivation and capacity of a consumer to access, understand, appraise and apply information to make effective decisions about health and health care, and take appropriate action. The health literacy environment is the infrastructure, policies, processes, materials, people and relationships that make up the healthcare system, which affect the ways in which consumers access, understand, appraise and apply health-related information and services.[114]
health service organisation	a separately constituted health service that is responsible for implementing clinical governance, administration and financial management of a service unit or service units providing health care at the direction of the governing body. A service unit involves a group of clinicians and others working in a systematic way to deliver health care to patients. It can be in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' homes, ambulance settings, practices and clinicians' rooms.
higher risk (patients at higher risk of harm)	a patient with multiple factors or a few specific factors that result in their being more vulnerable to harm from health care or the healthcare system. Risk factors may include having chronic clinical conditions; having language barriers; being of Aboriginal or Torres Strait Islander background; having low health literacy; being homeless; or being of diverse gender identities and experiences, bodies, relationships and sexualities (diversity in sexualities is currently referred to as lesbian, gay, bisexual, transgender, transsexual, queer, or questioning, and intersex LGBTQI[418]).
high-risk medicines	medicines that have an increased risk of causing significant patient harm or death if they are misused or used in error. High-risk medicines may vary between hospitals and other healthcare settings, depending on the types of medicines used and patients treated. Errors with these medicines are not necessarily more common than with other medicines. Because they have a low margin of safety, the consequences of errors with high-risk medicines can be more devastating.[192,419] At a minimum, the following classes of high-risk medicines should be considered: ▪ Medicines with a narrow therapeutic index ▪ Medicines that present a high risk when other system errors occur, such as administration via the wrong route.
hygienic environment	an environment in which practical prevention and control measures are used to reduce the risk of infection from contamination by microbes.
IHI	individual healthcare identifier
incident (clinical)	an event or circumstance that resulted, or could have resulted, in unintended or unnecessary harm to a patient or consumer; or a complaint, loss or damage. An incident may also be a near miss. *See also* 'near miss'.

Term	Definition
infection	the invasion and reproduction of pathogenic (disease-causing) organisms inside the body. This may cause tissue injury and disease.[420]
informed consent	a process of communication between a patient and clinician about options for treatment, care processes or potential outcomes. This communication results in the patient's authorisation or agreement to undergo a specific intervention or participate in planned care.[421] The communication should ensure that the patient has an understanding of the care they will receive, all the available options and the expected outcomes, including success rates and side effects for each option.[422]
injury	damage to tissues caused by an agent or circumstance.[423]
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.[416] Jurisdictional requirements encompass a number of types of documents from state and territory governments, including legislation, regulations, guidelines, policies, directives and circulars. Terms used for each document may vary by state and territory.
leadership	having a vision of what can be achieved, and then communicating this to others and evolving strategies for realising the vision. Leaders motivate people, and can negotiate for resources and other support to achieve goals.[424]
leave event	occurs when a patient leaves a service before being fully assessed or treated.
local community	the people living in a defined geographic region or from a specific group who receive services from a health service organisation.
mandatory	required by law or mandate in regulation, policy or other directive; compulsory.[179]
medication management	practices used to manage the provision of medicines. Medication management has also been described as a cycle, pathway or system, which is complex and involves a number of different clinicians. The patient is the central focus. The system includes manufacturing, compounding, procuring, dispensing, prescribing, storing, administering, supplying and monitoring the effects of medicines. It also includes decision making, and rules, guidelines, support tools, policies and procedures that are in place to direct the use of medicines.[174]
medication reconciliation	a formal process of obtaining and verifying a complete and accurate list of each patient's current medicines, and matching the medicines the patient should be prescribed to those they are prescribed. Any discrepancies are discussed with the prescriber, and reasons for changes to therapy are documented and communicated when care is transferred. Medication review may form part of the medication reconciliation process.
medication review	a systematic assessment of medication management for an individual patient that aims to optimise the patient's medicines and outcomes of therapy by providing a recommendation or making a change.[425] Medication review may be part of medication reconciliation.

Term	Definition
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.[426]
medicine-related problem	any event involving treatment with a medicine that has a negative effect on a patient's health or prevents a positive outcome. Consideration should be given to disease-specific, laboratory test–specific and patient-specific information. Medicine-related problems include issues with medicines such as: ▪ Underuse ▪ Overuse ▪ Use of inappropriate medicines (including therapeutic duplication) ▪ Adverse drug reactions, including interactions (medicine–medicine, medicine–disease, medicine–nutrient, medicine–laboratory test) ▪ Non-compliance.[427,428]
medicines list	prepared by a clinician, a medicines list contains, at a minimum: ▪ All medicines a patient is taking, including over-the-counter, complementary, prescription and non-prescription medicines; for each medicine, the medicine name, form, strength and directions for use must be included[429] Any medicines that should not be taken by the patient, including those causing allergies and adverse drug reactions; for each allergy or adverse drug reaction, the medicine name, the reaction type and the date on which the reaction was experienced should be included Ideally, a medicines list also includes the intended use (indication) for each medicine. It is expected that the medicines list is updated and correct at the time of transfer (including clinical handover) or when services cease, and that it is tailored to the audience for whom it is intended (that is, patient or clinician).[430]
mental state	*see* deterioration in mental state
minimum information content	the content of information that must be contained and transferred in a particular type of clinical handover. What is included as part of the minimum information content will depend on the context and reason for the handover or communication.[337]
MOU	Memorandum of Understanding
multidisciplinary team	a team including clinicians from multiple disciplines who work together to deliver comprehensive care that deals with as many of the patient's health and other needs as possible. The team may operate under one organisational umbrella or may be from several organisations brought together as a unique team. As a patient's condition changes, the composition of the team may change to reflect the changing clinical and psychosocial needs of the patient.[431] Multidisciplinary care includes interdisciplinary care. (A discipline is a branch of knowledge within the health system.)[432]

Term	Definition
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). Clinicians are able to share health clinical documents to a consumer's My Health Record, according to the consumer's access controls. These may include information on medical history and treatments, diagnoses, medicines and allergies.
national patient identifier	a unique 16-digit number that is used to identify individuals who receive or may receive health care in the Australian healthcare system. Also known as an 'Individual Healthcare Identifier' (IHI).[433]
national provider identifier	a unique 16-digit number that is used to identify individual clinicians or organisations that deliver health care in the Australian healthcare setting. For individuals, it is also known as a 'Healthcare Provider Identifier – Individual' (HPI-I); for organisations, it is also known as a 'Healthcare Provider Identifier – Organisation '(HPI-O).[433]
near miss	an incident or potential incident that was averted and did not cause harm, but had the potential to do so.[434]
non-conveyance	an ambulance deployment as appropriate, where the patient after examination and/or treatment on-scene does not require conveyance with medical personnel and equipment to the healthcare facility.
NSMC	National Standard Medication Chart
nutrition care plan	a plan to meet the nutrition and hydration needs of a patient. The nutrition care plan is developed for the patient after their nutrition and hydration needs have been assessed.
open disclosure	the open discussion that a provider of care or services has with a patient when things go wrong that have harmed or had the potential to cause harm to the patient. This may also involve the patient's family, carers and other support people, when a patient would like them to be involved. It involves an expression of regret by the provider and a factual explanation of what happened, the actual and potential consequences and what steps are being taken to manage this and prevent it happening again.[435]
organisation-wide	intended for use throughout the health service organisation.
orientation	a formal process of informing and training a worker starting in a new position or beginning work for an organisation, which covers the policies, processes and procedures applicable to the organisation.
outcome	the status of an individual, group of people or population that is wholly or partially attributable to an action, agent or circumstance.[423]
paramedicine	is a domain of practice and health profession that specialises across a range of settings including, but not limited to, emergency and primary care. Paramedics work in a variety of clinical settings such as emergency medical services, ambulance services, hospitals and clinics as well as non-clinical roles, such as education, leadership, public health and research.[436]

Term	Definition
partnership	a situation that develops when patients 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 choose. Partnerships can exist in different ways in a health service organisation, including at the level of individual interactions; at the level of a service, department or program; and at the level of the organisation. They can also exist with consumers and groups in the ambulance. Generally, partnerships at all levels are necessary to ensure that the health service organisation is responsive to patient input and needs, although the nature of the activities for these different types of partnership will depend on the context of the health service organisation.
patient	a person or people who are actively receiving health care.
patient disposition decisions	a recommendation about the final destination for the patient, based upon triage and clinical assessment.
person-centred care	an approach to the planning, delivery and evaluation of health care that is founded on mutually beneficial partnerships among clinicians and patients.[437] 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.[97] Also known as 'patient-centred care' or 'consumer-centred care'.
the PICMoRS method	an assessment framework for safety and quality systems. PICMoRS is a mnemonic that stands for: P: Process, I: Improvement strategies, C: Consumer participation, Mo: Monitoring, R: Reporting, S: Safety and quality systems. It incorporates a structured assessment method (the PICMoRS Method), which can be used when interviewing members of the workforce to comprehensively review the processes that make up the safety and quality systems specified in the NSQHS Standards.
point of care	the time and location of an interaction between a patient and a clinician for the purpose of delivering care.
policy	a set of principles that reflect the organisation's mission and direction. All procedures and protocols are linked to a policy statement.
post-discharge surveillance	refers to the monitoring of infection outcomes associated with inpatient admission at a time subsequent to the end of the inpatient admission. For further information see Approaches to Surgical Site Infection Surveillance.[438]
PPE	Personal protective equipment
pressure injuries	injuries of the skin and/or underlying tissue, usually over a bony prominence, caused by unrelieved pressure, friction or shearing. They occur most commonly on the sacrum and heel, but can develop anywhere on the body. Pressure injury is a synonymous term for pressure ulcer.
procedure	the set of instructions to make policies and protocols operational, which are specific to an organisation.
procedure matching	the processes of correctly matching patients to their intended care.
process	a series of actions or steps taken to achieve a particular goal.[439]

Term	Definition
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.
purpose-driven communication	communication in which all the parties involved in the communication process have a shared understanding of why the communication is taking place (e.g., to gather, share, receive or check information), what action needs to be taken and who is responsible for taking that action.
quality improvement	involves the use of a systematic and coordinated approach to solving a problem using specific methods and tools with the aim of bringing about a measurable improvement within a health care setting.[25] Quality improvement activities may be undertaken in sequence, intermittently or continually.
RACF	residential aged care facility
regularly	occurring at recurring intervals. The specific interval for regular review, evaluation, audit or monitoring needs to be determined for each case. In the NSQHS Standards, the interval should be consistent with best practice, risk based, and determined by the subject and nature of the activity.
responsibility and accountability for care	accountability includes the obligation to report and be answerable for consequences. Responsibility is the acknowledgement that a person has to take action that is appropriate to a patient's care needs and the health service organisation.[440]
restraint	the restriction of an individual's freedom of movement by physical or mechanical means.[308]
reusable device	a medical device that is designated by its manufacturer as suitable for reprocessing and reuse.[441, 442]
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.[443]
risk management	the design and implementation of a program to identify and avoid or minimise risks to patients, employees, volunteers, visitors and the organisation.
safety culture	a commitment to safety that permeates all levels of an organisation, from the clinical workforce to executive management. Features commonly include acknowledgement of the high-risk, error-prone nature of an organisation's activities; a blame-free environment in which individuals are able to report errors, clinical incidents, adverse events or near misses without fear of reprimand or punishment; an expectation of collaboration across all areas and levels of an organisation to seek solutions to vulnerabilities; and a willingness of the organisation to direct resources to deal with safety concerns.[11]
scope of clinical practice	the extent of an individual clinician's approved clinical practice within a particular organisation, based on the clinician's skills, knowledge, performance and professional suitability, and the needs and service capability of the organisation.[408]

Term	Definition
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.[444]
seclusion	the confinement of a patient, at any time of the day or night, alone in a room or area from which free exit is prevented.[308]
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.[445]
semi-critical equipment	items that come into contact with mucous membranes or non-intact skin and should be single use or sterilised after each use. If this is not possible, high-level disinfection is the minimum level of reprocessing that is acceptable.[139]
sentinel events	a subset of adverse patient safety events that are wholly preventable and result in serious harm to, or the death of, a patient. The purpose of sentinel event reporting is to ensure public accountability and transparency and drive national improvements in patient safety.
service context	the particular context in which care is delivered. Health service delivery occurs in many different ways, and the service context will depend on the organisation's function, size and organisation of care regarding service delivery mode, location and workforce.[244]
shared decision making	discussion and collaboration between a patient or consumer and their healthcare provider. The process aims to bring together the patient/consumer's values, goals and preferences with the best available evidence about benefits, risks and uncertainties of treatment, in order to reach the most appropriate healthcare decisions for that person.[233]
specialist palliative care	services provided by clinicians who have advance training in palliative care. The role of specialist palliative care services incudes providing direct care to patient with complex palliative care needs, and providing consultation services to support, advise and education non-specialist clinicians who are providing palliative care.[446]
standard	agreed attributes and processes designed to ensure that a product, service or method will perform consistently at a designated level.[423]
standard national terminologies	a structured vocabulary used in clinical practice to accurately describe the care and treatment of patients. Healthcare providers around the world use specialised vocabulary to describe diseases, operations, clinical procedures, findings, treatments and medicines. In Australia, terminologies include SNOMED CT-AU and Australian Medicines Terminology.[447] 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.[441]
structured clinical handover	a structured format used to deliver information (the minimum information content), enabling all participants to know the purpose of the handover, and the information that they are required to know and communicate.[398]

Term	Definition
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.[397]
surveillance	an epidemiological practice that involves monitoring the spread of disease to establish progression patterns. The main roles of surveillance are to predict and observe spread; to provide a measure for strategies that may minimise the harm caused by outbreak, epidemic and pandemic situations; and to increase knowledge of the factors that might contribute to such circumstances.[420] Surveillance can be passive or active.
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 orientation, training and education ▪ 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.
TGA	Therapeutic Goods Administration
timely (communication)	communication of information within a reasonable time frame. This will depend on how important or time critical the information is to a patient's ongoing care or wellbeing, the context in which the service is provided and the clinical acuity of the patient.
timeout	the period immediately before commencing the procedure to undertake a final verification of the patient's identity and the procedure.[448]
traceability	the ability to trace the history, application or location of reusable medical devices. Some professional groups may refer to traceability as 'tracking'.[441]
training	the development of knowledge and skills.
transfusion history	a list of transfusions a patient has had before presentation, including details of any adverse reactions to the transfusion and any special transfusion requirements. The completeness of the history will depend on the availability of information. It is expected that information will be obtained by reviewing any available referral information and interviewing the patient or their carer.
transitions of care	a transition of care is when all or part of a person's health care is transferred between care providers. This may involve transfer of responsibility for some aspects of a person's health care, or all of their health care. It may be temporary - to manage a brief illness, or long term - due to a permanent change in health status. Transitions of care may occur within and between healthcare locations, settings, care delivery types, levels of care and involve a range of health care providers.[449]

Term	Definition
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.[139]
trauma informed care	trauma-informed care is an approach to healthcare service delivery based on an understanding of the ways trauma affects people's lives, their service needs and service usage.[450]
triple zero	Triple Zero (000) is Australia's primary telephone number to call for assistance in life threatening or time critical emergency situations. There are also two secondary emergency call service numbers —**112** (can only be dialled on a mobile phone) and **106** (can only be used with a teletypewriter (TTY) or a device for the deaf). The **Australian Communications and Media Authority regulates and monitors the provision of the Emergency Call Service (ECS)** under Part 8 of the Telecommunications (Consumer Protection and Service Standards) Act 1999.
use-by date	a 'use-by' date is the last date on which the food may be eaten safely, provided it has been stored according to any stated storage conditions and the package is unopened. After this date, the food should not be eaten for health and safety reasons. The 'use-by' date is restricted to foods which need to be eaten within a certain time because of health and safety reasons.[451]
virtual care	any interaction between a patient and clinician, or between clinicians, occurring remotely with the use of information technologies.[452]
workforce	all people working in a health service organisation, including clinicians and any other employed or contracted, locum, agency, student, volunteer or peer workers. The workforce can be members of the health service organisation or medical company representatives providing technical support who have assigned roles and responsibilities for care of, administration of, support of, or involvement with patients in the health service organisation. *See also* 'clinician'.

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