AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Annual Report 2011/12

ISSN 2200-3126

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This annual report is prepared and submitted in accordance with all relevant Acts.

Australian Commission on Safety and Quality in Health Care

ABN 97 250 687 371

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

The Hon. Tanya Plibersek MP
Minister for Health and Ageing
Parliament House
Canberra ACT 2600

Dear Minister

In accordance with the requirements of the *National Health Reform Act 2011* (NHR Act) and in accordance with s. 9 of the *Commonwealth Authorities and Companies Act 1997* (CAC Act) I am pleased to submit to you, for presentation to Parliament, the Annual Report and Financial Statements of the Australian Commission on Safety and Quality in Health Care for the financial year ended 30 June 2012.

The report has been prepared in accordance with the Commonwealth Authorities and Companies Orders (Financial Statements for reporting periods ending on or after 1 July 2010) made by the Finance Minister under the authority of s. 48 of the CAC Act.

This Annual Report has been approved for presentation to you in accordance with a resolution of the Board members of the Australian Commission on Safety and Quality in Health Care.

I commend this report to you.

Yours sincerely

Bill Beerworth
Chair
Australian Commission on Safety and Quality in Health Care

28 September 2012

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CONTENTS

Overview

Millions of Australians use the health system each year and benefit from one of the best health systems in the world. However, as with any system, the health system is not perfect and lapses in the safety and quality of care do occur, for many and varied reasons. The provision of modern health care is very complex. In addition to the highly technical aspects of much of the care, the systems necessary to treat so many people are among the most complex in modern society.

For more than a quarter of a century, it has been increasingly recognised that unintentional harm to people receiving health care is a significant problem for modern healthcare services. A number of studies have investigated the size of the problem in many countries, including Australia, and a conservative but consistent estimate that one person in ten who receives health care is harmed by that care is now well recognised.

In response to this, there is a powerful commitment on the part of the Australian, state and territory governments, health service organisations, individual healthcare providers and consumers to a concerted and coordinated approach to reducing unintentional harm.

'Patient safety' has been defined as 'the reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum' and 'quality of care' has been defined as 'the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge'.[1]

Consumers, healthcare professionals, health services, jurisdictional health departments and the Australian Commission on Safety and Quality in Health Care (the Commission) all play vital roles in improving patient safety and the quality of health care provided.

Initially established in 2006 by the Australian, state and territory governments to lead and coordinate national improvements in safety and quality, the Commission's permanent status was confirmed with the assent of the *National Health Reform Act 2011* (NHR Act). It is now a Commonwealth Authority operating under the requirements of the *Commonwealth Authorities and Companies Act 1997*. The Commission commenced as an independent, statutory authority on 1 July 2011, funded jointly by all governments in Australia.

Under the NHR Act, the Commission's role is to formulate and monitor quality and safety standards, to work with clinicians to identify best practice clinical care and to help ensure the appropriateness of services being delivered in a particular healthcare setting.

Details of the Commission's structure, governance and operations are at Chapter 8 of this report.

'Patient safety' has been defined as 'the reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum' and 'quality of care' has been defined as 'the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge'.

Enabling legislation and functions

The Commission's functions, as specified in the *National Health Reform Act 2011*, are:

a) to promote, support and encourage the implementation of arrangements, programs and initiatives relating to health care safety and quality matters;

b) to collect, analyse, interpret and disseminate information relating to health care safety and quality matters;

c) to advise the Minister about health care safety and quality matters;

d) to publish (whether on the internet or otherwise) reports and papers relating to health care safety and quality matters;

e) to formulate, in writing, standards relating to health care safety and quality matters;

f) to formulate, in writing, guidelines relating to health care safety and quality matters;

g) to formulate, in writing, indicators relating to health care safety and quality matters;

h) to promote, support and encourage the implementation of:
   (i) standards formulated under paragraph (e); and
   (ii) guidelines formulated under paragraph (f);

i) to promote, support and encourage the use of indicators formulated under paragraph (g);

j) to monitor the implementation and impact of:
   (i) standards formulated under paragraph (e); and
   (ii) guidelines formulated under paragraph (f);

k) to advise:
   (i) the Minister; and
   (ii) each participating State/Territory Health Minister;
   about which standards formulated under paragraph (e) are suitable for implementation as national clinical standards;

l) to formulate model national schemes that:
   (i) provide for the accreditation of organisations that provide health care services; and
   (ii) relate to health care safety and quality matters;

m) to consult and co-operate with other persons, organisations and governments on health care safety and quality matters;

n) such functions (if any) as are specified in a written instrument given by the Minister to the Commission Board Chair;

o) to promote, support, encourage, conduct and evaluate training programs for purposes in connection with the performance of any of the Commission's functions;

p) to promote, support, encourage, conduct and evaluate research for purposes in connection with the performance of any of the Commission's functions;

q) to do anything incidental to or conducive to the performance of any of the above functions.

Highlights of 2011/12

The Commission's key achievements in the period 1 July 2011–30 June 2012 included the following.

- ***National Safety and Quality Health Service (NSQHS) Standards***
  One of the Commission's major initiatives has been to develop a set of 10 Safety and Quality Health Service Standards for all Australian health services. These Standards have been endorsed by all Health Ministers as the *National Safety and Quality Health Service (NSQHS) Standards*.

- **A national health service accreditation scheme for Australian hospitals**
  The Australian, state and territory governments have agreed to the National Australian Health Service Safety and Quality Accreditation Scheme for acute health services, day procedure centres and dental practices as developed by the Commission and using the NSQHS Standards.

  Accreditation involves an independent review of health services to assess whether the services meet these pre-defined safety and quality standards.

- **Significant improvement in hand hygiene rates in Australian hospitals**
  A marked improvement in rates has occurred since the beginning of the Commission's National Hand Hygiene Initiative.

  In 2011–12, 75% of hospitals met the agreed benchmark, up from 67% when routine data submission started in 2009.

  The National Hand Hygiene Initiative was recognised as a 'centre of excellence' by the World Health Organization in November 2011.

- **Widespread uptake of Commission's online training**
  This financial year, 6000 healthcare workers used the Commission's online education modules, which focus on improving the prevention and control of infection.

  In addition, the Commission developed a number of new online resources. These include a falls research and practice web-based resource, to enable health services and researchers to access the latest research and practices, and the Clinical Handover Electronic Resource Portal to support clinical handover improvement activities.

- **Seventh International Conference on Rapid Response Systems and Medical Emergency Teams**
  The Commission hosted this conference in Sydney in May 2012. This was the largest of the international conferences held to date on this topic and it was the first time the conference had been held in Australia. It attracted over 500 delegates from 24 countries. Participants' evaluations of the conference were very positive, with 95% of respondents reporting that they were 'satisfied' or 'very satisfied' with the conference, and that their learning needs were met.

- **Communication with thousands of people about safety and quality in health care**
  Each month in 2011/12, approximately 20,000 people visited our web site to access information on the Commission and its work programs. In addition, during 2011/12: over 1700 people participated in online surveys; the Commission received approximately 150 written submissions on its work; over 2800 people attended 28 presentations; and Commission staff made presentations at 17 international and national conferences focussing on safety and quality. Each week, over 1200 people and organisations received *On the Radar*, the Commission's overview of relevant research publications in the area of healthcare safety and quality.
- **Australian Safety and Quality Goals for Health Care**
  In August 2011, the Australian Health Ministers' Advisory Council (AHMAC) asked the Commission to identify a small number of national safety and quality goals—areas that would benefit from a coordinated national approach to improvement.

  The Australian Safety and Quality Goals for Health Care are:

  1. **Safety of care: That people receive health care without experiencing preventable harm**

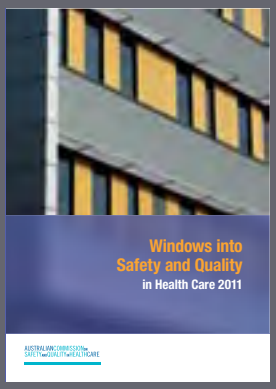
     Initial priorities are in the areas of:
     - 1.1 Medication safety
     - 1.2 Healthcare associated infection
     - 1.3 Recognising and responding to clinical deterioration

  2. **Appropriateness of care: That people receive appropriate, evidence-based care**

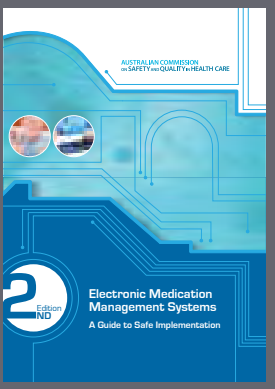
     Initial priorities are:
     - 2.1 Acute coronary syndrome
     - 2.2 Transient ischaemic attack and stroke

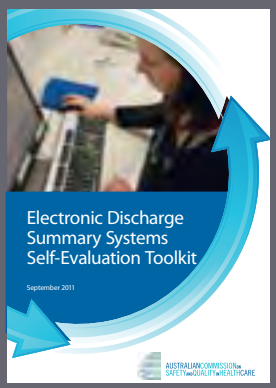
  3. **Partnering with consumers: That there are effective partnerships between consumers and healthcare providers and organisations at levels of healthcare provision, planning and evaluation.**

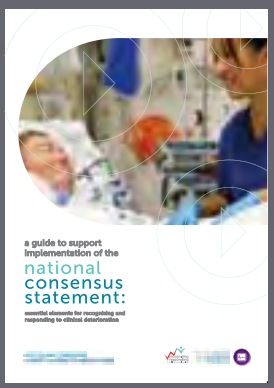
- **National Safety and Quality Data sets**
  This financial year saw the completion of the national safety and quality data set specifications for Australian hospitals. The Core Hospital-Based Outcome Indicators will allow for the generation of key safety and quality information from currently available data, a vital step forward in increasing understanding about the safety of hospital care.
- **Major publications and resources**
  - Safety and Quality Improvement Guides for each of the 10 *National Safety and Quality Health Service Standards*
  - *Windows into Safety and Quality in Health Care 2011*
  - *Patient centred care: Improving safety and quality through partnerships with patients and consumers*
  - The second edition of *Electronic Medication Management Systems: A Guide to Safe Implementation*
  - *Electronic Discharge Summary Systems Self Evaluation Toolkit*
  - *A Guide to Support Implementation of the National Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration*, together with a series of quick start guides and other supporting resources and tools
  - *Implementation Toolkit for Clinical Handover Improvement* and Clinical Handover Electronic Resource Portal
  - Australian Open Disclosure Framework Consultation
  - *Using the Medication Management Plan* online training presentation
  - National set of practice level indicators in primary care
  - Structured laboratory e-request and reporting standards for healthcare associated infections
  - Core outcome indicators for the day procedure sector.

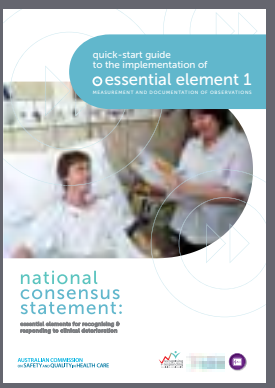

Windows into
Safety and Quality
in Health Care 2011


Patient-centred care:
Improving quality and safety through partnerships with patients and consumers


2nd Edition
Electronic Medication Management Systems
A Guide to Safe Implementation


Electronic Discharge Summary Systems Self-Evaluation Toolkit
September 2011


a guide to support implementation of the
national consensus statement:


quick-start guide to the implementation of
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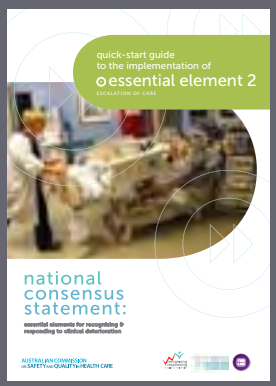
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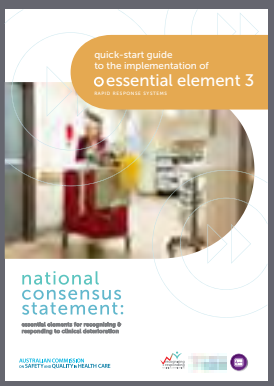
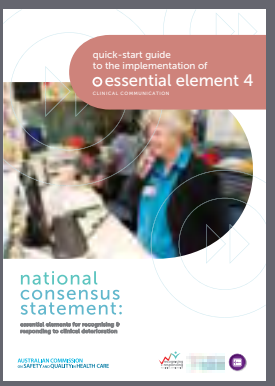
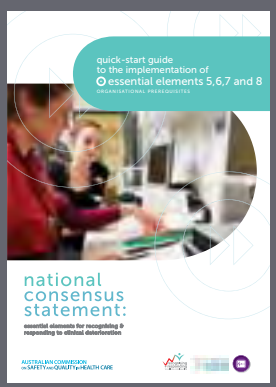

quick-start guide to the implementation of
essential element 3
national consensus statement:


quick-start guide to the implementation of
essential element 4
national consensus statement:


quick-start guide to the implementation of
essential elements 5,6,7 and 8
national consensus statement:


IMPLEMENTATION TOOLKIT
FOR CLINICAL HANDOVER IMPROVEMENT

Message from the Chair

The Australian Commission on Safety and Quality in Health Care (the Commission) commenced life as an independent statutory corporation on 1 July 2011 to promote safety and quality in Australian health care.

It had previously operated in an unincorporated form since 1 January 2006. Its incorporation as an independent statutory body, under the *National Health Reform Act 2011*, was a clear statement by the Australian Government that safety and quality are now a central consideration in the healthcare system.

Applied safety and quality principles greatly reduce resource waste and provide far more efficacious and satisfying outcomes for consumers.

During our first year as an independent statutory authority, the Commission continued work on its existing programs. Foremost have been the development and implementation of the *National Safety and Quality Health Service (NSQHS) Standards* for accreditation and the articulation of a small number of Australian Safety and Quality Goals for Health Care to improve healthcare outcomes and system efficiency and effectiveness.

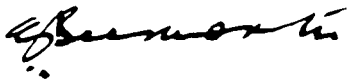
The Commission's statutory functions include the formulation of relevant clinical standards, guidelines and indicators, and we have identified several future initiatives. Since funding is a constraint for any statutory authority, the Commission is developing a strategic plan to prioritise its activities during its first rolling three year work plan.

Dealing with difficult problems across a complex system requires concerted consultation and collaboration with all relevant parties. The Commission accordingly consults widely, and works with a very large number of individuals and organisations.

We were delighted that Professor Debora Picone, AM, was appointed as the first Chief Executive Officer of the newly incorporated Commission. Professor Picone is a highly respected Chief Executive and a leader in public health administration.

The Commission's Board contains distinguished members with rich experience in all facets of the health system. It is also blessed with remarkably capable and dedicated staff who cheerfully produce safety and quality planning and writing of a high intellectual order.

I am honoured to present the Commission's first Annual Report.



Bill Beerworth
Chair
Australian Commission on Safety and Quality in Health Care

28 September 2012

The Commission is developing a strategic plan to prioritise its activities during its first rolling three year work plan.

Bill Beerworth
Chair

Message from the Chief Executive Officer

It has been a busy year for the Australian Commission on Safety and Quality in Health Care. On 1 July 2011 we became an independent, statutory authority under the *National Health Reform Act 2011*, with a defined role agreed by all Australian governments in the National Health Reform Agreement 2011. The Commission has gained a number of new functions and safety and quality challenges to address on a national basis.

I joined the Commission in March 2012 and have been impressed with the remarkable amount of work that has been undertaken by the Commission to improve the safety and quality of health care across Australia.

My predecessor, Bill Lawrence, AM, led the Commission through the organisational changes required for it to become an independent agency, while ensuring that the Commission continued to develop and deliver substantial work programs aimed at improving the safety and quality of Australian health care.

Prior to Bill's appointment as Acting Chief Executive Officer, the organisation was led by Professor Chris Baggoley, who developed many of the key initiatives of the Commission. Professor Baggoley's work in leading the development of national standards will result in a safer healthcare system.

I would like to acknowledge his outstanding contribution to the work of the Commission.

Key work in 2011/12

The development and implementation of the *National Safety and Quality Health Service (NSQHS) Standards* has been a major focus of the Commission's work this financial year. These 10 Standards, developed for use in acute health services, day procedure centres and dental practices, identify the systems and processes that should be in place in key areas that affect large numbers of patients. The NSQHS Standards, and the accompanying national accreditation scheme, were endorsed by state, territory and Australian governments in September 2011. Acute health services and day procedure centres will be accredited using the Standards from January 2013. The Commission has developed a range of resources to assist with implementing these standards.

The Commission has specific work programs in many of the topics covered by the Standards (consumer centred care, healthcare associated infection, medication safety, clinical handover, recognising and responding to clinical deterioration, and falls prevention). In 2011/12, the Commission also reviewed the current *Open Disclosure Standard*, so that the latest research evidence and Australian experience could be incorporated into a revised Standard.

In 2011, the Australian Health Ministers' Advisory Council asked the Commission to identify a small number of national safety and quality goals, which would improve health outcomes and the efficiency and effectiveness of the health system. The Australian Safety and Quality Goals for Health Care have been developed this year.

In undertaking its work, the Commission draws on the best research evidence and consults widely. The extensive participation in the work of the Commission by people throughout Australia—consumers, healthcare experts, healthcare practitioners, managers and policy makers—helps ensure that the work is practically focused to deliver the best results possible.

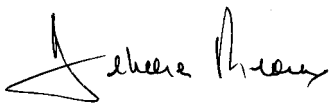
We have also begun to develop a stronger electronic presence. Our web site has undergone a major redesign to improve access to information and publications and we have set up a Twitter account through which we make regular, topical announcements.

Future work

The Commission has a busy 12 months ahead in 2012/13. A major focus will be in providing support for the implementation of the NSQHS Standards and further developing the Australian Health Service Safety and Quality Accreditation Scheme. In addition, we will be identifying and developing clinical care standards in priority areas. The Commission will aim to gain a better understanding of clinical variation and the appropriateness of care delivered in Australia.

I would like to acknowledge the dedication and outstanding commitment shown by our staff. Their efforts and support have ensured we continue to lead and coordinate improvements in safety and quality in health care at a national level and I look forward to continuing to work with them on these matters over the next year.

Finally, I want to acknowledge Health Ministers and Chief Executive Officers, the Department of Health and Ageing, and our Board Chair and Directors for their wisdom, leadership and constant support for the important work of the Commission.



Professor Debora Picone, AM
Chief Executive Officer
Australian Commission on Safety and Quality in Health Care

28 September 2012

A major focus will be in providing support for the implementation of the NSQHS Standards and further developing the Australian Health Service Safety and Quality Accreditation Scheme.

Professor Debora Picone
Chief Executive Officer

The Commission's work

The year 2011/12 saw a transition in the role of the Commission and in the way in which the Commission goes about its work. Since its inception in 2006, the organisation has taken a program-based approach focused on a number of priority programs set by its Commission members, with the agreement of health jurisdictions across the country.

The priority programs that have been the basis of the Commission's work have changed over the past five years as some have been completed and new programs have commenced. During 2011/12 the major programs were:

- National Safety and Quality Health Service Standards and Accreditation
- Clinical Communications
- Consumer Centred Care
- Falls Prevention
- Healthcare Associated Infection
- Information Strategy
- Medication Safety
- National Safety and Quality Goals
- Open Disclosure
- Recognition and Response to Clinical Deterioration.

With the passage of the *National Health Reform Act 2011* (NHR Act), which ratified the Commission as an independent statutory authority, the Commission is now governed by a Board. The Commission's functions are now set by the NHR Act and guided by the National Health Reform Agreement 2011. As a result of these new obligations, the focus of the Commission is now on the following priority areas:

1. National Standards—Health Service and Clinical Standards
2. Formulating national accreditation schemes
3. National data set development
4. Publishing and reporting
5. Knowledge and leadership for safety and quality.

This Annual Report details the work undertaken within the programs of the Commission during the financial year 2011/12 and demonstrates how this work supports the priority functions that will guide the Commission as it begins this new phase of its existence.

The Commission is tasked with overseeing a large and complicated issue: safety and quality in Australian health care.

The focus of the Commission is on the following priority areas:

1. **National Standards**
2. **Formulating national accreditation schemes**
3. **National data set development**
4. **Publishing and reporting**
5. **Knowledge and leadership**

The Australian healthcare system is a complex system involving

thousands

of organisations and millions of individuals.

The Australian healthcare system is a complex system involving thousands of organisations and millions of individuals. The Commission's approach of collaboration, consultation and facilitation has been a key factor in its undoubted success over the past 6 years. It has repeatedly sought the input and assistance of many different people and organisations. Every area of the Commission's work includes involvement of and consultation with consumers, clinicians, governments, funders and other interested parties. This collaboration can take many forms, ranging from advisory and reference groups who provide advice; targeted and public consultations; online surveys; and calls for submissions on discussion papers and proposals; through to other forms of engagement.

The Commission also provides input and advice to other organisations and areas of work. This is done by various means, including participating in consultations, sitting on advisory bodies, and providing written and oral submissions or advice.

All these various forms of consultation and collaboration are reflected throughout this report. All the submissions and reports, and other documentation are available from the Commission's web site: www.safetyandquality.gov.au

National Residential Medication Chart Project engagement

The development of the National Residential Medication Chart (NRMC) started in August 2011 and has been underpinned by extensive engagement. The NRMC is being developed to standardise the processes of prescribing, supplying and administering medicines in residential aged care facilities to reduce medication errors and to allow the direct supply and claiming of PBS/RPBS medicines from a medication chart. Continuing consultation has been integral and has included consumers, the residential aged care sector, relevant experts, professional bodies and governments.

Key groups involved in developing the National Residential Medication Chart include:

- National Residential Medication Chart Reference Group (responsible for overall governance of the project)—consisting of pharmacists, prescribers and medication administrators in residential aged care; people with expertise in clinical, policy and legislative areas; and members of peak national consumer, professional and industry bodies
- First Tier Communications Group—national subject matter and medical software experts, and representatives from professional, industrial, educational, regulatory and monitoring organisations
- a national general communications group—over 300 individuals and groups who have expressed an interest in the project. They receive updates via email and contact the program team if they have questions or ideas≈about the project
- a total of 82 approved providers and 1049 residential aged care facilities involved in the initial national chart analysis
- a total of 735 respondents to two surveys—consisting of 449 staff and managers and 263 approved providers nationally
- residential aged care facilities—involved in the phased implementation in NSW (20) and in on-site visits in Qld (6) and NSW (23)
- peak industrial bodies and their branches
- approved providers who have expressed an interest in the project. These groups meet with the team for information sessions and updates
- institutions with similar needs for a long-term medication chart
- individual academics, researchers and universities with an expressed interest in the project
- attendees at regional information sessions
- user guide development team—consisting of end users who have been active in developing the guidelines for phased implementation.

The NRMC will be ready for use in some residential aged care facilities in New South Wales, as part of a phased implementation, from September 2012.

The NRMC project is being managed by the Australian Commission on Safety and Quality in Health Care and funded by the Department of Health and Ageing under the *Fifth Community Pharmacy Agreement*.

1. National Safety and Quality Health Service Standards

The Commission has developed the *10 National Safety and Quality Health Service (NSQHS) Standards* in consultation with jurisdictions, technical experts, health professionals and consumers. These NSQHS Standards focus on important areas of care that affect large numbers of patients, and identify the systems and practices that health services should have in place to deliver good care.

The first two Standards *(Standard 1 Governance for Safety and Quality in Health Service Organisations and Standard 2 Partnering with Consumers)* provide an overarching framework for systems and processes that support safety and quality improvement. The remaining eight Standards address clinical areas where it is known patient harm occurs and where there are evidence-based strategies that will reduce harm. Each action within the NSQHS Standards is designated as either 'core' (actions which are critical for safety and quality and which all health services should meet), or 'developmental' (actions that health services should be working towards achieving in future). Versions of the Standards have been developed for use in acute health services, day procedure centres and dental services.

National Safety and Quality Health Service Standards

	**Standard 1 Governance for Safety and Quality in Health Service Organisations** describes the quality framework required for health service organisations to implement safe systems. It outlines requirements for systems of governance that actively manage safety and quality risks, and the actions required to support clinical staff to use best practice and for managing performance. It also outlines the kinds of processes that should be in place for incident and complaints management and for patient rights and engagement.
	**Standard 2 Partnering with Consumers** describes the systems and strategies to create a consumer-centred health system by including consumers in the development and design of quality health care. This Standard covers areas such as consumer partnership in designing care, in service planning, measurement and evaluation.

	**Standard 3 Preventing and Controlling Healthcare Associated Infections** describes the systems and strategies to prevent infection of patients within the healthcare system. It also identifies what should be done to minimise the consequences of any infections that do occur. It covers requirements for infection prevention, control and surveillance systems, and what should be done to safely manage patients with infections. It also covers cleaning, disinfection and sterilisation of equipment and health facilities, as well as measures to support safe and appropriate antimicrobial prescribing and good communication about healthcare associated infections with patients and their families.
	**Standard 4 Medication Safety** describes the systems and strategies needed to ensure clinicians safely prescribe, dispense and administer appropriate medicines to informed patients. It covers the governance and systems for medication safety and medication management within health service organisations. It also outlines the requirements for clinicians to inform patients about their medicines including medication options, benefits and risks, to accurately document a patient's medication history, and to provide a complete list of patient's medicines when handing over care to another clinician.
	**Standard 5 Patient Identification and Procedure Matching** describes the systems and strategies required to identify patients and correctly match their identity with the correct treatment.
	**Standard 6 Clinical Handover** describes the systems and strategies required to ensure there is timely, relevant and structured clinical handover whenever responsibility for a patient's care is transferred between healthcare professionals.
	**Standard 7 Blood and Blood Products** describes the systems and strategies for the safe, effective and appropriate management of blood and blood products so the patients receiving blood are safe. It includes actions to ensure that there is proper documentation about which blood products a patient has received, the need for patients and their carers to have good information about risks, benefits and alternatives to blood, and the systems and processes required for blood and blood product safety.
	**Standard 8 Preventing and Managing Pressure Injuries** describes the systems and strategies required to prevent patients developing pressure injuries and best practice management when pressure injuries occur. It includes the need for patients to be screened for risk of developing pressure injuries, as well as actions about prevention, management and communication of information about pressure injuries.
	**Standard 9 Recognising and Responding to Clinical Deterioration in Acute Health Care** describes the systems, strategies and processes to be implemented by health service organisations to respond effectively to patients when their clinical condition deteriorates. It includes descriptions of the recognition and response systems health services should have in place and the actions that need to be taken to ensure that patients whose condition is deteriorating are recognised and appropriate action is taken to escalate care.
	**Standard 10 Preventing Falls and Harm from Falls** describes the systems and strategies to reduce the incidence of patient falls in health service organisations, best practice management when falls do occur and the need for good communication with patients and their carers about risks of falls and plans to prevent falls.

During 2011/12, the Commission refined the NSQHS Standards and piloted a set of draft guides. In total, 63 health services participated in the pilot, representing over 80 rural, regional and metropolitan sites from both the private and the public sectors in each state and territory across Australia. Each site used the draft guides to complete a self-assessment against the NSQHS Standards, and then completed an online survey about their experience with the guide. Follow-up evaluation workshops were held to identify ways to improve the guides and to identify further supports required by health services. The Commission used the feedback it received from this process, and from a separate survey and consultation with small rural health services throughout Australia, to produce a revised set of 10 safety and quality improvement guides. These provide health services with information about strategies to implement changes and quality improvement activities to help meet the NSQHS Standards.

Standards presentations

Commission staff have presented information about the Standards to over 3000 attendees at various organisations, conferences and meetings including:

- ACT Health
- Australian Council on Healthcare Standards, Standards Committee
- Australian Day Hospitals Association Conference
- Australian Health Insurance Association
- Australian Red Cross Blood Service, Annual Transfusion Medicine Update
- BreastScreen Australia
- Cura Day Hospitals
- Dental Health Services Victoria
- Gastroenterological Society of Australia
- Global Mark presentation to surveyors
- Health Issues Centre
- Healthcare Complaints Commissioners
- Medical Affairs Panel, Private Health Care Australia
- Melbourne clinical partners and Deakin University
- Mental Health—Safety and Quality Subcommittee
- National Blood Authority
- NSW Health Directors of Clinical Governance
- Pressure Ulcer Forum and Venous Leg Ulcer Forum
- Quality and Practice Information Session
- Round Table discussion on accreditation
- SA Health on Accreditation Reforms
- Seventh Annual International Conference on Rapid Response Systems and Medical Emergency Teams
- Seventh Health Services and Policy Research Conference
- St Vincent's Health
- Victorian Healthcare Quality Associations Forum
- Videoconference education session, Queensland Health Services
- WA Accreditation Forum
- Western Australian Country Health Service.

75%

of hospitals met the agreed hand hygiene benchmark, up from 67% in 2009.

2. Supporting quality practice and clinical standards

This chapter describes how the Commission has been supporting quality practice and clinical standards in various domains of health care. It includes sections on:

- healthcare associated infection
- medication safety
- clinical handover
- recognising and responding to clinical deterioration, and
- falls prevention.

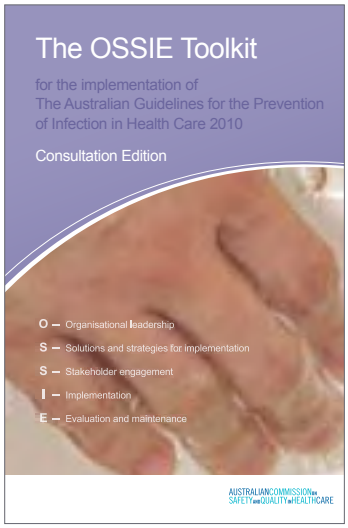
The Commission has undertaken a wide range of activities this financial year to support high quality clinical practice. While the explicit focus on the development of clinical standards is a new one for the Commission, work to date has led to the development of agreed national approaches to a number of clinical areas such as healthcare associated infection and medication safety. The following sections highlight key work in this area.

2.1 Healthcare associated infection

Healthcare associated infections (HAI) are a leading cause of preventable, and sometimes serious, harm. Apart from the pain and suffering caused to patients, healthcare associated infections also have significant resource costs, as they prolong hospital stays and create more work for healthcare staff. The Commission has developed a national approach to reducing healthcare associated infections including strategies for ensuring practices and improvement strategies are sustained.

Australian Infection Control Guidelines: preventing and managing infection in health care

In 2010 the Commission published the *Australian Infection Control Guidelines: preventing and managing infection in health care*. This year the Commission focused on providing healthcare workers with practical advice on ways to implement these guidelines.



People responsible for infection prevention and control within healthcare facilities attended 35 workshops in 25 cities and towns across all states and territories between November 2010 and August 2011. Six workshops were conducted specifically for primary care; seven workshops included videoconferencing to rural and remote areas.

Resources produced by the Commission in 2011/12 included an OSSIE (Organisational leadership, Simple solution development, Stakeholder engagement, Implementation, Evaluation and maintenance) implementation toolkit and a separate companion guide for use in primary care facilities. The Commission also produced consumer factsheets to inform patients, visitors, families and carers about healthcare associated infection and what they can do to limit the spread of infections. There are specific factsheets on infections caused by the methicillin resistant *Staphylococcus aureus*, vancomycin resistant enterococci and *Clostridium difficile*.

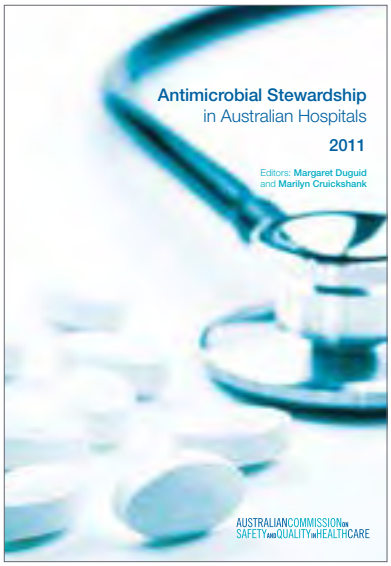
People responsible for infection prevention and control within healthcare facilities attended 35 workshops in 25 cities and towns across all states and territories between November 2010 and August 2011.

National Hand Hygiene Initiative

The hands of healthcare workers are the single most important source of preventable hospital acquired infections. In 2008, Australian Health Ministers endorsed a national program to improve hand hygiene practices of healthcare workers. This National Hand Hygiene Initiative (NHHI) aims to standardise hand hygiene practice (based on the World Health Organization's 5 *Moments for Hand Hygiene*) and to ensure placement of alcohol-based hand rub in every Australian hospital.

Hand Hygiene Australia has been contracted by the Commission to carry out the National Hand Hygiene Initiative. Their team has developed a number of resources which are available to download from its web site www.hha.org.au. These include manuals, online resources and videos. Since 2009, over 300,000 healthcare workers have undertaken the online learning package and approximately 2500 healthcare workers have been trained to audit compliance with correct handwashing procedure.

Hospitals, both public and private in all states and territories, have joined the national initiative to establish standard practices for hand hygiene across the country. This has led to marked improvements in hand hygiene compliance in 629 Australian hospitals—482 public (90–95% of acute public hospital beds) and 147 private (approximately 50% of acute private hospital beds). In the first reporting period of 2011,



the national hand hygiene compliance rate was 69.7% and by the corresponding period in 2012 this figure had increased to 73.9%.

Rates for appropriate hand hygiene are now reported on the MyHospitals web site myhospitals.gov.au. Hospitals submit data three times a year and compliance rates have increased every time data are submitted. The most recent report shows that 75% of healthcare facilities met the national benchmark. The centralised audit database allows for detailed epidemiological analysis of hand hygiene rates.

The NHHI received extensive recognition as a model for national programs at the November 2011 International Conference on Infection Prevention and Control in Geneva, Switzerland, and was named as a centre of excellence by the World Health Organization.

Antimicrobial stewardship

Inappropriate use of antimicrobials leads to the emergence of resistant bacteria, an increase in the risk of patient harm from side effects, infection with multi-resistant bacteria or *Clostridium difficile*, and unnecessary costs.[2-4] The consequences of antimicrobial resistance are now well known—patients with infections due to resistant bacteria experience delayed recovery, treatment failure and even death.[5] When multi-resistant pathogens are prevalent, clinicians are forced to use broader spectrum and usually more expensive agents to treat these seriously ill patients. All of these contribute to increasing healthcare and societal costs.[6]

Antibiotic stewardship programs have been shown to reduce resistance rates, morbidity, mortality and cost. The Commission coordinates a National Antimicrobial Stewardship Network with membership drawn from jurisdictions and the private hospital sector. The network assists with national coordination of antimicrobial stewardship and the development of resources.

Central line associated blood stream infection

Central lines are long flexible tubes that are inserted into a large vein near the heart. They are frequently used in patients who are in intensive care units, to deliver medicines, nutrients, fluids and blood products. Central line associated blood stream infections (CLABSI) are a major cause of mortality and morbidity in Australian hospitals. In 2011/12 the Commission designed and tested a monitoring system for central line associated blood stream infections in intensive care units. The Australian and New Zealand Intensive Care Society has been funded by the Commission for two related projects. The first is to establish a national CLABSI database that will collate surveillance data collected in each jurisdiction, and produce national (de-identified) comparative reports. This information will be available to intensive care unit clinicians, as well as people involved with infection control, and other relevant parties, giving them important feedback on the progress of their work to reduce CLABSI.

The second project is to reduce the rate of CLABSI in Australian intensive care units to less than 1 per 1000 line days. *Central Line Insertion and Maintenance Guidelines* have been produced as part of this project and have been sent to all Australian and New Zealand Intensive Care Society members. A dedicated CLABSI web site www.clabsi.com.au provides all relevant project materials. This includes information about surveillance, the *Central Line Insertion and Maintenance Guidelines*, an insertion checklist and compliance calculator, and a secure discussion forum for clinicians to share their ideas.

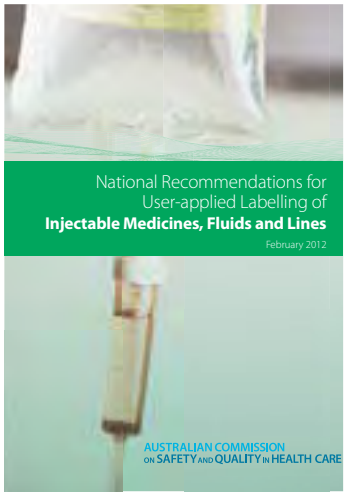
2.2 Medication safety

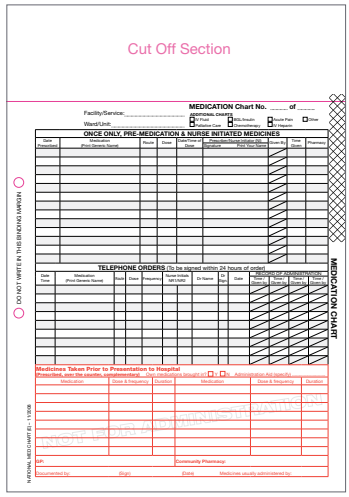
Adverse events arising from the use of medicines can range from a mild allergic reaction to death. Many medication-related adverse events occur because of errors in the way medicines are prescribed, dispensed, administered and monitored—and are potentially preventable. The Commission leads the national effort to reduce patient harm from medicines use. In 2011/12 the Commission's work in this area focused on the following areas:

- standardisation of medication charts and associated procedures used in Australian health services including terminology and abbreviations
- implementation of safer approaches to naming, labelling and packaging medications, and
- initiatives to improve medication reconciliation.

Standardisation of medication charts

In 2011/12 the Commission continued to promote uptake of the *National Inpatient Medication Chart* (NIMC) and related specialist and ancillary charts (including NIMC long stay and paediatric versions). It refined implementation tools and educational materials for these charts and designed and tested a web-based NIMC Audit System. The audit system forms the basis for national auditing and was used successfully in the NIMC 2011 National Audit in which 144 hospitals (including 38 private sites) audited 3634 patients (of whom 31.7% were private patients). A total of 5011 medication charts and 37,817 medication orders were audited. The audit demonstrated improvements in patient safety since the 2006 audit, including a reduction in unclear drug route, name, dose and frequency from 74% of orders to 21.2% and an increase in complete patient identification from 19.8% to 74.9%. Almost all Australian public hospitals are now using the NIMC (or specialist versions) and private hospitals report that over 70% of private hospital beds use the NIMC.





The Commission worked with 19 hospitals to pilot a version of the standard NIMC that incorporates a pre-printed venous thromboembolism risk assessment and a preventative prescribing section. Venous thromboembolism is a major cause of morbidity and mortality in hospitalised patients and many cases are preventable if appropriate prevention is used.

The Commission surveyed and reported on use of the NIMC in acute psychiatric services. Feedback from NIMC users in acute psychiatric services suggested issues with managing medications specific to that therapeutic domain. The survey sought views on specific issues and the report analysed responses and recommended actions—including making available a national clozapine titration chart and developing an educational resource addressing the use of the NIMC in acute psychiatric services. Recommendations will be analysed and responded to throughout 2012/13.

The Commission also published the 2011 version of *Recommendations for Terminology, Abbreviations and Symbols used in the Prescribing and Administration of Medicines*.

Reduction in unclear drug orders from 74% to 21.2% and an increase in complete patient identification from 19.8% to 74.9%.

Naming, labelling and packaging of medications

The Commission has updated its *National Recommendations for User–applied Labelling of Injectable Medicines, Fluids and Lines*. This nationally consistent approach to labelling is helping healthcare professionals correctly identify injectable medicines and fluids and the patients for which they are intended. The Commission has supported 190 health services to implement these labelling recommendations through 16 information sessions with a total of 443 attendees. The Commission is engaging with health services to test the labelling recommendations in specialist areas including:

- perioperative areas (at Calvary Wakefield Hospital, Adelaide)
- intensive care units (at Barwon Health, Royal Hobart Hospital, Tweed Hospital and Royal Prince Alfred Hospital), and
- cardiac catheter laboratories (at St Vincent's Hospital, Melbourne).

Outcomes from these pilots will result in recommendations to specialist areas on implementation of the labelling recommendations in late 2012.

The Commission also updated the *National Tall Man Lettering List* to reduce the risk of drug selection error. Tall Man lettering uses a combination of lower and upper case letters to highlight the differences between look-alike drug names, helping to make them more easily distinguishable. This reduces the risk of medication errors caused by selection of the wrong product in electronic prescribing and dispensing systems or from pharmacy shelves. The *Tall Man Lettering List* has been provided to electronic health software providers for inclusion in medical software. The National E-Health Transition Authority (NEHTA) recently undertook a roadmap survey of the Australian Medicines Terminology, including possible future inclusion of Tall Man lettering. Finally, Standards Australia, through the Health Informatics IT 14 02 Committee, agreed to accept an application for National Tall Man Lettering as a publishable standard, which will ensure its incorporation into future electronic health software.

Medication reconciliation

More than 50% of medication errors occur at transitions of care and the process of medication reconciliation substantially reduces these errors. Medication reconciliation is a formal process of obtaining and verifying a complete and accurate list of each patient's current medicines. This list is compared to the patient's medication orders and any discrepancies are resolved. When care is transferred, such as between hospitals and the community, a current and accurate list of medicines, including reasons for changes, can then be provided to the person taking over the patient's care. The Commission is working to improve the frequency and quality of medication reconciliation both within health services and across the care continuum by providing resources to assist consumers, health professionals and health services.

In 2011/12 the Commission continued to manage the Australian involvement in the World Health Organization's High 5s Medication Reconciliation Project. Thirteen Australian hospitals and health services are taking part in this five-year project. The first phase of the project was the introduction of medication reconciliation for patients 65 years of age and older who are admitted to an inpatient ward from the emergency department. Participating hospitals have demonstrated that an improvement in patient safety is possible through improved medication reconciliation.

Australia has an interesting mix of hospitals participating in the High 5s Project. Some have been conducting medication reconciliation for a number of years while others are just commencing their implementation journey. Consequently, there is considerable variation in the proportion of eligible patients with their medicines reconciled within 24 hours of admission—depending on the stage of implementation, resources available and the spread of the intervention in the organisation. Figure 1 shows aggregated results for November 2010–December 2011. The quality of medication reconciliation is high, with hospitals reporting rates for discrepancies observed after medication reconciliation less than the target of 0.3 discrepancies per patient.

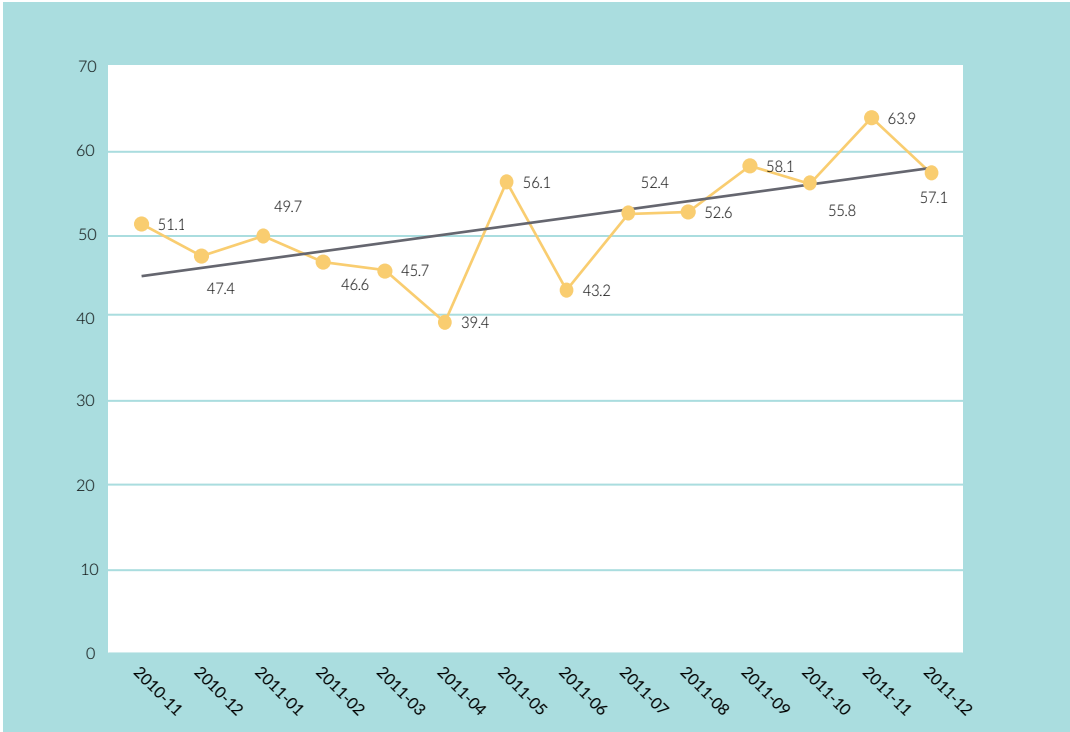


Figure 1 Percentage of patients 65 years and older with medications reconciled within 24 hours of the decision to admit the patient (2010–12)

The Yellow Envelope

The North East Valley Division of General Practice developed the Yellow Envelope as a clinical handover tool, for aged care residents being transferred to emergency departments. The Yellow Envelope is an inexpensive tool that can be used with minimal training, maintains the privacy of the resident as clinical information is not visible externally, is large enough to contain documents and does not need to be retained as part of the health record. The North East Valley Division of General Practice has developed an Envelope template for aged care services. To date 40,225 Envelopes have been printed for use in 274 aged care facilities nationally.

2.3 Clinical handover

Poor or absent clinical handover can have extremely serious consequences for patients compromising the safety and quality of their care. Millions of handovers occur annually in the Australian healthcare system, including when clinicians change shifts, when patients are transferred between wards or health services, or during the process of admission, referral and discharge. In previous years, the Commission funded the National Clinical Handover Pilot Initiative involving 14 public and private sector organisations. These organisations developed and piloted a range of tools for improving handover. This program was externally evaluated in 2010. The evaluation found that the program had significantly increased the evidence base surrounding clinical handover and had created momentum and spread for handover improvement in Australia.

The sustained impact of the clinical handover pilot initiative has been demonstrated in the ongoing sustainability and spread of a number of the tools and processes developed during the project.

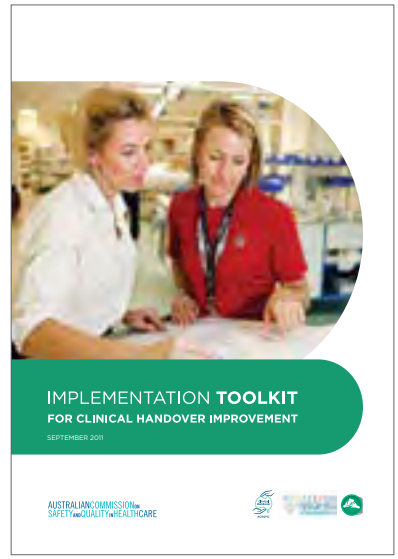
Building on lessons from the National Clinical Handover Pilot Initiative and subsequent evaluation, the Commission continued to develop implementation guidance to promote, support and encourage clinical handover improvement in localised environments and to meet the NSQHS *Standard 6 Clinical Handover*. This work includes:

- development of the *Implementation Toolkit for Clinical Handover Improvement*
- development of the Clinical Handover Electronic Resource Portal, and
- a framework for effective communication during transitions of care.

Development of the *Implementation Toolkit for Clinical Handover Improvement*

The toolkit is a 'how to' guide for managers and clinicians reviewing and implementing local clinical handover processes. The toolkit supports the structured processes and key principles for handover detailed in the *OSSIE Guide to Clinical*

Handover Improvement (produced by the Commission in 2009) and articulated in the National Safety and Quality Health Service *Standard 6 Clinical Handover*. The toolkit is available in electronic format and has been distributed to 1072 health professionals on the clinical handover network. In addition, 640 hard copies of the toolkit have been distributed to health service professionals at national conferences, forums and meetings.

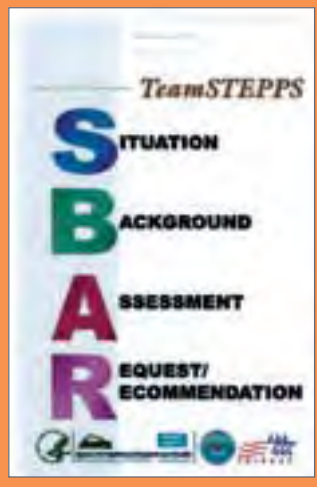


Clinical Handover Electronic Resource Portal

An electronic resource portal was developed to supplement the toolkit and further support clinical handover improvement activities. The aim of the portal is to provide a range of resources, tools, templates and educational materials that are easily modifiable to suit local clinical settings and can be adapted to suit all healthcare settings. The portal is available at www.safetyandquality.gov.au/implementation-toolkit-resource-portal/

Framework for effective communication during transitions of care

This financial year, work was started on developing a framework of the essential elements for effective communication during patient transitions of care. This project builds on and includes elements of effective clinical handover and the lessons from the *Evaluation of the electronic discharge summary systems*. Early outcomes of the work have been developed, refined and communicated in jurisdictional forums, medication safety reference groups and national e-health meetings addressing issues around effective communication at discharge from hospital.



TeamSTEPPS®

TeamSTEPPS® is a teamwork training system that aims to improve communication and team functioning.

TeamSTEPPS® is an example of a pilot project funded by the Commission that has had sustained support and commitment from a state health department with a planned approach for spread across South Australia.

During the project, sites introduced the SBAR (Situation, Background, Assessment, Recommendation) communication tool, followed by briefings (short planning meetings) and huddles (ad hoc planning to re-establish situational awareness). Examples of ongoing sustainability of interventions after the conclusion of the pilot project included:

- sustained use of the SBAR in emergency department medical discharge letters (80% average compliance after 18 months)
- sustained use of SBAR for nursing handover at one country site
- reduction in falls rate (falls per 100 bed days) contributed by use of SBAR in nursing handover in a medical unit.

2.4 Recognising and responding to clinical deterioration

Adverse events which are preventable continue to occur because healthcare professionals fail to recognise clinical deterioration or act on it in a timely way. The Commission has been working since 2008 to help improve the recognition of, and response to, clinical deterioration of patients when they are in hospitals and other acute care facilities.

In 2011/12 the Commission's work in this area has included:

- support for implementation of better recognition and response systems
- help for facilities to evaluate their recognition and response systems, and
- observation and response charts.

Adverse events which are preventable continue to occur because healthcare professionals fail to recognise clinical deterioration or act on it in a timely way.

Better recognition and response systems

The Commission has previously (April 2010) published the *National Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration*. In 2011/12 the Commission developed a comprehensive suite of guides, tools and other resources to support implementation of this national consensus statement by healthcare organisations.

Evaluation of recognition and response systems

The Commission has produced specifications for a series of quality measures to assist health facilities to evaluate and improve their recognition and response systems. Quality measures for recognition and response systems include rates of unexpected in-hospital death, rates of unexpected in-hospital cardio-pulmonary arrest, rates of rapid response activation, and rates of failed escalation with mortality. The Commission has also produced a series of audit tools to help facilities to collect the data required to evaluate some of the different aspects of recognition and response systems.

Observation and response charts

An observation and response chart is a document that allows the recording of patient observations, and specifies the actions to be taken in response to deterioration. The purpose of these charts is to support accurate and timely recognition of clinical deterioration and to prompt action when deterioration is observed. The way in which observation charts are currently designed and used can contribute to both the poor recording of observations and the failure to interpret them correctly. In 2011/12, the Commission produced a series of evidence-based observation and response charts designed according to 'human factors' principles. It also completed a trial of the performance of observation and response charts in a clinical environment. Results will inform the design of the Commission's observation and response charts, and hence those that can be used by hospitals.

2.5 Falls prevention

Falls are a major cause of harm for people receiving health care and for Australians living in residential aged care facilities. In 2008 and 2009, the Commission developed *Preventing Falls and Harm from Falls in Older People: Best Practice Guidelines for Australian Hospitals, Residential Aged Care Facilities and Community Care* along with smaller guidebook versions, fact sheets and an implementation guide. Australian Health Ministers endorsed the falls prevention guidelines in 2009.

The Commission has published the guidelines and support materials on its web site at www.safetyandquality.gov.au/our-work/falls-prevention/ together with links to the latest evidence on falls prevention. The guidelines have been reflected in all state and territory falls prevention policies and similarly in many private health services.

To facilitate and enhance uptake, the Commission managed and underwrote a service for health services and individuals to purchase hard copies of the guidelines and guidebooks. Subsequently, more than 20,000 copies of the guidelines and guidebooks have been purchased.

In addition, the Australian Government Department of Health and Ageing provided each Australian Government-funded residential aged care facility with a free copy of the *Guidebook for Preventing Falls and Harm from Falls in Older People: Australian Residential Aged Care Facilities*.

Adult Deterioration Detection System

The Adult Deterioration Detection System observation and response chart was modified and implemented at Flinders Hospital, in Adelaide, in order to improve the identification and escalation of care for patients who are deteriorating clinically.

Guy Peacock, the Quality and Improvement Manager for the Division of Medicine Cardiac and Critical Care, set up a working group to implement the chart when issues were identified with the timely recognition of, and response to, clinical deterioration. Case reviews of medical emergency team calls found that a large number of patients had not been reviewed by the relevant home team within the 24-hour period prior to the emergency call.

The Adult Deterioration Detection System chart provides formalised triggers and cues for action, which enable the detection of deterioration at an early stage, and clearly articulates what is expected of clinical staff. Guy reports that using the chart has created a lasting change in the way that nursing and medicine work together, which is of real benefit to patients.

In 2011/12, the Commission published a *National Falls Prevention Guidelines Evaluation Strategy* to promote consistent evaluation of the guidelines by health services, jurisdictions and researchers. It was developed in partnership with public and private health services to ensure that evaluation of local falls intervention would contribute to the next review of the falls prevention guidelines by using common data elements.

Also in 2011/12, the Commission started a comprehensive evaluation of the falls prevention guidelines, which will provide:

- quantitative data on the use of guideline recommendations in a sample of 4000 patients on 26 'high falls risk' wards from 7 hospitals in Victoria, New South Wales and Queensland
- qualitative data on clinical staff knowledge and perceptions of the guidelines using a sample of 500 clinical staff from 26 'high falls risk' wards from 7 hospitals in Victoria, New South Wales and Queensland.

The evaluation will report in 2012/13 and will inform a review of the falls prevention guidelines in 2013/14.

3. Accreditation

This chapter describes how the Commission has been working towards accreditation in a number of areas. It includes sections on:

- the Australian Health Service Safety and Quality Accreditation Scheme
- mental health, and
- national arrangements for clinical quality registries.

3.1 Australian Health Service Safety and Quality Accreditation Scheme

The introduction of nationally consistent requirements for accreditation of health services from 2012 will improve safety and quality of care for patients across Australia. In 2006, Health Ministers asked the Commission to develop a national scheme with a set of accompanying Standards. This work, which involved extensive consultation within the health sector, resulted in the Australian Health Service Safety and Quality Accreditation Scheme and the NSQHS Standards (see Chapter 1). In September 2011, state, territory and Australian governments endorsed the accreditation scheme and the NSQHS Standards.

The new model of accreditation has clarified the roles and responsibilities for each of the groups involved in accreditation processes (Figure 2):

- Health Ministers endorse the NSQHS Standards and receive information on the performance of the health system when assessed against the Standards.
- Regulators (state, territory and Australian governments) determine which health services must comply with the NSQHS Standards and receive information about whether health services meet the Standards. If health services do not meet the Standards, regulators decide what further action is necessary.
- Health service organisations put in place the necessary systems and quality improvement measures to meet the NSQHS Standards and engage an approved accrediting agency to verify they meet the Standards.
- Approved accreditation agencies assess health service organisations against the NSQHS Standards and provide relevant information on their findings to health services, regulators and the Commission.
- The Commission develops and maintains the NSQHS Standards, approves accrediting agencies to assess against the Standards, develops tools to help health services implement necessary changes, and reports to Health Ministers on the application and effectiveness of the Standards.

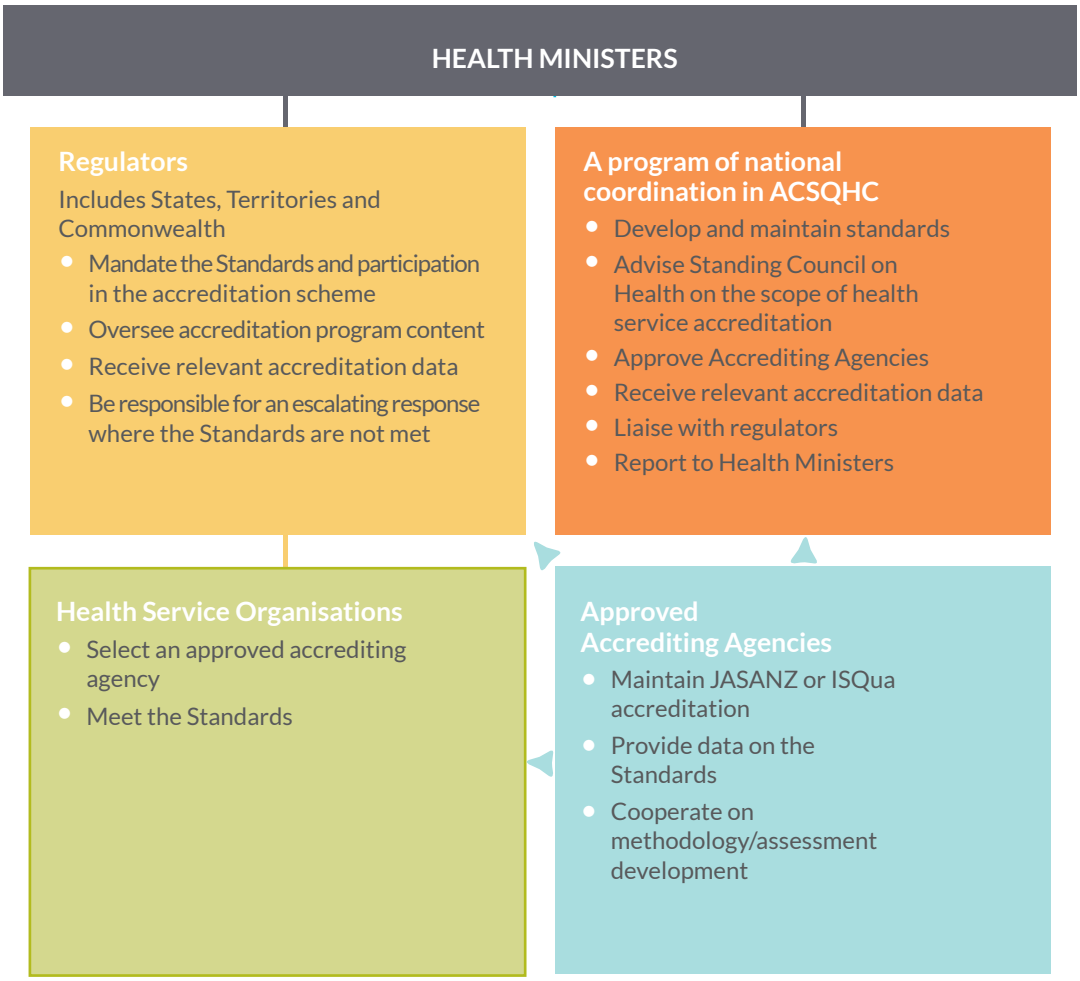


Figure 2 Roles and responsibilities

This financial year, the Commission has produced a series of Safety and Quality Improvement Guides in each of the Standards topic areas and Accreditation Workbooks to support health services put in place the improvements required by the National Safety and Quality Standards and help them identify the evidence they need to demonstrate compliance with each Standard.

A transition period to accreditation of acute health services and day procedure centres against the NSQHS Standards will begin from 1 January 2013. The Commission has also worked with dental practitioners and their professional associations to develop a system for accreditation of private dental practices against the NSQHS Standards. Dental practices will start a voluntary program of accreditation from July 2012.

The Commission is a partner on a research project funded by the Australian Research Council, looking at the effectiveness of accreditation, and evaluating the impact of the accreditation reforms being implemented by the Commission. The research project runs over five years and will report in 2015.

In 2012/13, the Commission will continue to provide national coordination of the accreditation reforms. Working groups were convened for regulators and accrediting agencies to address and coordinate resolution of issues nationally.

Accrediting agencies will be reviewed for approval to assess the NSQHS Standards. Further resources to assist in implementation of the NSQHS Standards will be developed. In addition tools, supports and guidance will be developed for mental health services accredited to both the NSQHS and Mental Health Standards, including an accreditation workbook and audit tools.

Figure 3 Accreditation and quality improvement cycles

3.2 Mental health

In 2011, the Commission began a program of work to incorporate a focus on mental health within its existing programs. Initial areas for this work have included recognising and responding to clinical deterioration, medication safety, and the NSQHS Standards. The mental health team has worked in collaboration with the Department of Health and Ageing and the Safety and Quality Partnerships Sub-Committee to map the NSQHS Standards with the *National Standards for Mental Health Services* (2010). The aim is to reduce duplication by identifying areas where the intent of both sets of standards match. A meeting of jurisdictional, private and non-governmental organisation providers and accreditation agencies was held to consider implementation approaches for both sets of standards.

3.3 Clinical quality registries

Clinical quality registries are secure, standardised information systems which monitor and report:

- the appropriateness of health care (how closely actual care aligns with recommended care), and
- the effectiveness of health care (the degree to which care benefits the patient).

Registry information is used to inform improvements in care by comparing patient outcomes across the healthcare system and assessing performance against standards.

The principal barriers to the development of clinical quality registries in Australia are:

1. data entry (collection) of source data,
2. poor interoperability between clinical information systems,
3. technical systems development and support, and
4. 'data governance' burdens and constraints (restrictions on the disclosure, collection, and use of patient-level data) and
5. funding.

Building on the Commission's Strategic and Operating Principles for Clinical Quality Registries which were endorsed by Health Ministers in 2010, this year the Commission drafted national arrangements for clinical quality registries including a Security Certification Framework, minimum reporting requirements and assessment/accreditation criteria. The Commission also published a suite of technical guidelines for registries.

4. Data set development

This chapter describes how the Commission has been contributing to work to develop data sets so as to collect, collate and analyse information that can be used to better understand and measure improvements in healthcare safety and quality. It includes sections on:

- indicators of safety and quality, and
- health information standards.

One of the core requirements for delivery of safe, high quality care is that it is driven by information. An essential part of this process is that safety and quality data are collected, analysed and fed back to healthcare professionals and to health services so that they can be used to improve care.

4.1 Indicators of safety and quality

The Commission has worked with clinical and data experts to develop standardised, clinically sound national definitions and specifications for the generation of indicators of quality. It has identified six principal domains for developing meaningful patient safety and quality national datasets in Australia and has undertaken work in each of these areas.

(1) Core hospital-based outcome indicators

This year the Commission has produced the final draft set of specifications for a set of core, hospital-based outcome indicators.

(2) Core outcome indicators for day procedure services

This set of outcome indicators published in 2012 builds on the work undertaken to develop hospital-based outcome indicators, and identifies four indicators that could be used by day procedure centres to monitor outcomes of care.

(3) Patient safety reporting for hospitals

The Commission, together with the states and territories, is developing a national patient safety measurement model that will help in the understanding of the rates of hospital adverse event. The Commission has published a taxonomy for classifying the cost of hospital- acquired diagnoses. This will support the review of administrative data to identify significant variance in specific adverse event rates.

(4) Patient experience and patient satisfaction in hospitals

This project involves the development of core common questions for use in hospital patient experience surveys.

(5) Practice level indicators of safety and quality for primary health care

In January 2012, the Commission published its recommended national set of practice level indicators of safety and quality, together with a summary of submissions received, commenting on the content and implementation of the indicator set.

(6) Whole of system indicators

These are population-based indicators of the appropriateness, effectiveness and patient centredness of Australian health care.

4.2 Health information standards

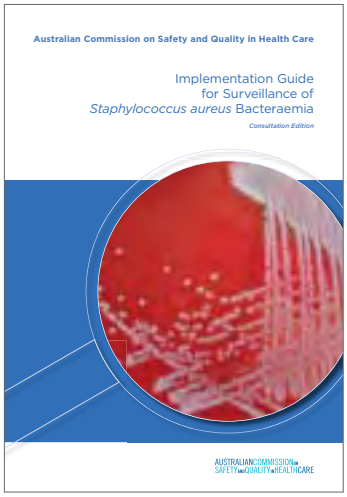
The Commission is involved in two projects aimed at improving national surveillance of healthcare associated infections (HAI) and enhancing clinical management.

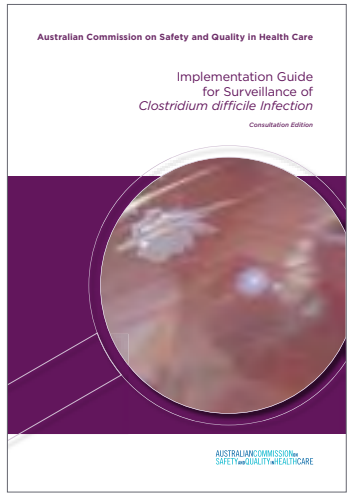
National healthcare associated infection surveillance

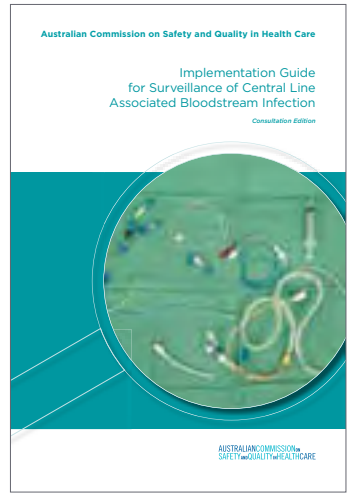
This initiative aims to develop a national surveillance system to monitor and provide feedback on HAI, so that hospital managers and clinicians have information that helps them prevent and manage these infections.

This work is supported by the HAI Surveillance Technical Working Group which has representatives from each of the state-based surveillance units and the Public Health Laboratory Network. The Commission has published national definitions for these infections, data dictionaries and dataset specifications. The Commission has also published a *Consensus statement and core information components for structured microbiology test requesting and reporting of healthcare associated infection*. This means that facilities can collect and share comparable data. Implementation guides to assist with surveillance of these infections are now in their final consultation edition and are available from the Commission's web site www.safetyandquality.gov.au.

An inter-jurisdictional advisory group designed posters for standard precautions, droplet, airborne and contact precautions to standardise messages for staff, patients and visitors. The aim of the signage is to provide consistent messages to patients, healthcare workers and visitors in the variety of healthcare settings across Australia on how to prevent the spread of infection.







E-surveillance of healthcare associated infections

This project supports clinical management and electronic surveillance of healthcare associated infections and other reporting and research. It defines the core information components for structured microbiology requests and reports for healthcare associated infections, in particular healthcare associated *Staphylococcus aureus* bacteraemia; central line associated bloodstream infections; healthcare associated *Clostridium difficile* infection; and surgical site infections. This financial year, the Commission engaged two hospital groups, with their laboratories and surveillance units, to pilot e-surveillance and the core information components.

5. Publishing and reporting

This chapter describes how the Commission has been contributing to the knowledge on healthcare safety and quality through public reporting and publishing. It includes sections on:

- development of resources and tools related to consumer-centred care
- patient–clinician communication
- open disclosure
- *Electronic Discharge Summary Systems Self-evaluation Toolkit*
- *Electronic Medication Management Systems: A Guide*, and
- other publications.

The Commission has developed a large number and range of publications, with more than 200 implementation supports or tools developed and published since its inception. This material is publicly available on the Commission web site, including submissions made to the Commission, submissions made by the Commission, and the evidence that informs the programs and projects, as well as the outputs of the Commission's work with its partners.

The following sections highlight a number of key publications and are followed by a complete list of publications for this financial year.

5.1 Resources and tools related to consumer-centred care

Consumer-centred care is health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers. Different definitions and terminology have been used to describe the concepts in this area but key principles of patient-centred approaches include:

- treating patients, consumers, carers and families with dignity and respect
- encouraging and supporting participation in decision making by patients, consumers, carers and families
- communicating and sharing information with patients, consumers, carers and families
- fostering collaboration with patients, consumers, carers, families and health professionals in program and policy development, and in health service design, delivery and evaluation.

The Commission's work in this area aims to strengthen partnerships between patients, consumers, carers, family members, healthcare providers and healthcare organisations as a means of improving the safety and quality of health care.

Consumer-centred care is health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers.

Raising awareness of consumer-centred care

This year, the Commission finalised a discussion paper: *Patient-centred care: Improving quality and safety through partnerships with patients and consumers*. The paper includes information on the background, context, evidence and impetus for improving quality and safety by giving health care a more patient-centred focus. The paper also provides practical examples, tools, tips and resources that can be used by Australian healthcare organisations to re-orient their systems to a more patient-centred approach. The discussion paper was finalised after considering the content of more than 60 submissions received following public consultation undertaken in 2010 on an earlier version of the paper. Health Ministers agreed to the release of the final discussion paper in August 2011. The paper was distributed via the Commission's patient-centred care network, as well as through key Australian safety and quality conferences such as the 2011 Consumers Reforming Healthcare Conference and the 2011 Great Healthcare Challenge: Achieving Patient Centred Outcomes Conference.

Health literacy

Health literacy is the 'degree to which individuals can obtain, process and understand the basic health information and services they need to make appropriate health decisions'. People with inadequate health literacy have poorer levels of knowledge and understanding about their condition, are less likely to attend appointments, are less adherent to medication regimens and health behaviour advice, make more medication errors, and perform worse at self care activities. It is of concern that studies have shown that approximately 60% of Australians have poor health literacy.

The traditional view of health literacy has been focused on changing the skill levels of the patient or consumer. However, recent research suggests that to effectively make improvements in health literacy it is necessary to look at strategies that focus on activities that minimise the complexity of health care as well as those that focus on improving individual skills. The Commission has undertaken a stocktake of health literacy projects, programs, research and initiatives at local, state and national level. It will use this work to determine where resources should be invested to improve health literacy and which current initiatives could have wider uptake.

5.2 Patient–clinician communication

Work has started on identifying the best ways to improve communication between patients and clinicians across the patient journey. Initial work has included approaches to improve understanding of the patient perspective with the development of audio-visual resources from research about patients' and families' experience of care leading to incident disclosure. The resource—*Using Patient Stories to Improve Patient Safety*—is under development and will inform and support this program of work. In addition, a literature review has been commissioned to identify the essential elements, barriers and challenges and improvement strategies for effective patient–clinician communication. The literature review, due for completion in late 2012, will inform the future development of practical strategies to improve communication in this area.

5.3 Open disclosure

Open disclosure is the open discussion of incidents that result in harm to a patient while receiving health care. The essential elements of open disclosure are outlined in the 2003 national *Open Disclosure Standard* (the Standard).

All jurisdictional open disclosure policies, and many private health service policies, are based on the Standard. A requirement to implement open disclosure is also part of NSQHS *Standard 1 Governance for Safety and Quality in Health Service Organisations*.

The Commission aims to increase the extent, quality and consistency of open disclosure practiced in Australian health services by identifying national barriers to open disclosure and working to reduce them.

In 2011/12, the Commission commenced a review of the Standard. The *Open Disclosure Standard Review Report* analysed and interpreted the latest evidence on, and practice of, open disclosure. Much of the research drawn upon was conducted in Australia. This included Commission-funded independent research published in three peer-reviewed international publications: the *British Medical Journal*, *British Medical Journal Safety and Quality* and the *Joint Commission Journal on Quality and Patient Safety*. The report made over 30 recommendations on how the *Open Disclosure Standard* could be amended to improve the quality and consistency of open disclosure practice.

Open disclosure is the open discussion of incidents that result in harm to a patient while receiving health care.

The resulting draft revised Standard aims to meet the needs of patients, families and carers and of healthcare professionals, facilities and services in relation to open disclosure. It incorporates the latest evidence and research into open disclosure, and builds on Australian experience of implementing and practising open disclosure.

There has been considerable interest in the review from a range of sectors in the Australian healthcare system. The report, draft revised Standard and other materials are available on the Commission's web site at www.safetyandquality.gov.au/our-work/open-disclosure/.

Open disclosure in the Mater Hospital Group

There are many open disclosure success stories in Australia. Mater Health Services Brisbane is among them.

Mater recognises that openly discussing adverse events and near misses with patients and their families is an integral component of Mater's mission and values, and is openly committed to the principles of open disclosure and the promotion of a safety culture that values transparency, honesty and respect.

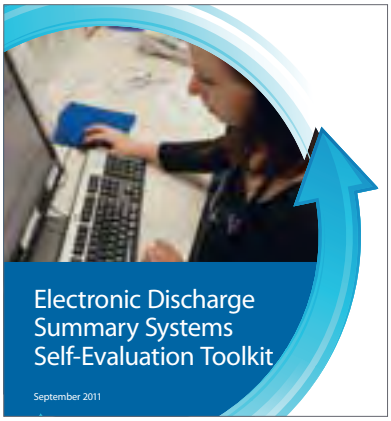
Mater implemented a service-wide Open Disclosure Policy in 2003, complemented by:

- introducing in-house medico-legal and claims management services
- engaging an external contractor to advise on a communications and training package to educate and engage all clinicians in the roll out of open disclosure practice, and clinical incident management.

For the majority of reported clinical incidents at Mater, open disclosure now takes place as a matter of course, initiated by the clinicians involved in patient care.

Mater recognises that ensuring early, honest and comprehensive disclosure with the patient in relation to an event fosters a good rapport with the patient and their family and that this will ultimately have a positive influence on patient clinical care and the rapid resolution of the patient's concerns.

Mater has also received a considerable amount of positive feedback from patients and families on its approach to open disclosure.



5.4 Electronic Discharge Summary Systems Self-evaluation Toolkit

Patients discharged from hospital to the community are at risk of harm due to poor discharge processes, poor communication and differences in information quantity and quality. Introduction of electronic discharge summary systems can improve the timeliness, legibility and consistency of discharge summary contents.

The Commission worked with NEHTA and partner hospitals on projects to ensure electronic discharge summary systems could be implemented safely. A final report on the safety and quality effect of electronic discharge summaries was published in August 2011. It summarised lessons from three sites where electronic discharge summaries had been implemented, including the benefits associated with electronic discharge summaries and potential safety and quality issues. A resource for health services that outlines how to prepare for their own electronic discharge summary system, and how to conduct a self-evaluation, was also published. Since then, the Commission has worked closely with implementing sites to promote uptake and refine the toolkit.

In November 2011, Health Ministers recommended the toolkit be used by Australian hospitals implementing electronic discharge summary systems to improve safety and quality of health care. The toolkit has been recognised and promoted as a resource internationally by leading safety and quality organisations such as the UK National Health Service Institute and US Agency for Healthcare Research and Quality.

5.5 Electronic medication management systems in hospitals

Electronic medication management systems (EMMS) in hospitals have the potential to improve patient safety and quality, but also risk creating new errors if not implemented appropriately. To ensure new systems maximise the safety and quality benefits, the Commission provides advice on the safe implementation of electronic medication management systems in Australian hospitals.

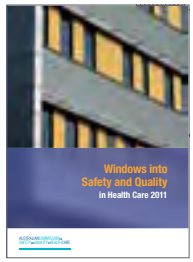
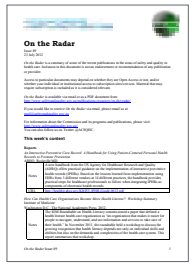
In 2012 the Commission published the second edition of *Electronic Medication Management Systems: A Guide to Safe Implementation* with an accompanying implementation plan. This second edition of the guide has been validated in public and private hospitals; and was informed by a review of international literature, the experiences of previous Australian EMMS hospital implementations and extensive consultation with relevant parties.

In November 2011 Health Ministers recommended that the guide be used by Australian hospitals when implementing electronic medication management systems to improve safety and quality of health care.

5.6 Publications

Over the last financial year, many of the Commission's outputs have been focused on the *National Safety and Quality Health Service Standards* and on supporting implementation of safety and quality initiatives, with other material being developed in other priority areas, including medication safety, clinical deterioration and open disclosure. These are listed below.

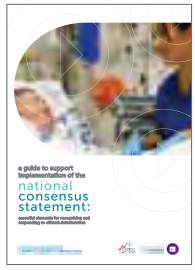
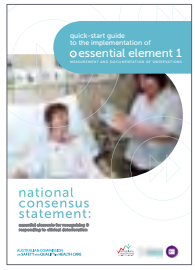
Table 1 Commission publications (2011/12)

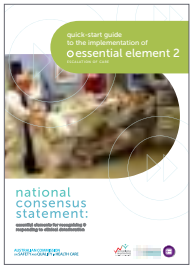
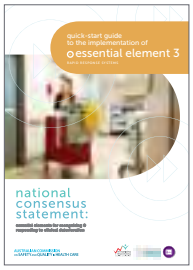
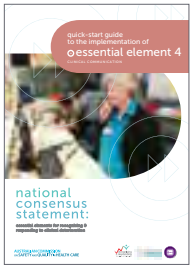
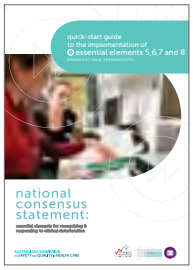
PUBLICATION NAME		DESCRIPTION	AUDIENCE
Windows into Safety and Quality in Health Care 2011		The annual *Windows into Safety and Quality in Health Care* reports provide perspectives on a range of healthcare safety and quality matters in a number of settings.	General
On the Radar		*On the Radar* is a weekly online summary of some of the recent publications in the areas of safety and quality in health care.	Health professionals and health services. More than 1200 individuals and organisations subscribe to the service.

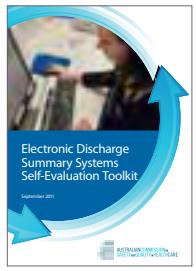
PUBLICATION NAME	DESCRIPTION	AUDIENCE
Standards and accreditation		
National Safety and Quality Health Service Standards:	National healthcare standards to identify the systems and practices that health services should have in place to deliver good care.	Health services
Governance for Safety and Quality in Health Service Organisations		
Partnering with Consumers		
Preventing and Controlling Healthcare Associated Infections		
Medication Safety		
Patient Identification and Procedure Matching		
Clinical Handover		
Blood and Blood Products		
Preventing and Managing Pressure Injuries		
Recognising and Responding to Clinical Deterioration in Acute Health Care		
Preventing Falls and Harm from Falls		
Service-specific guides		
Fact sheets on: *Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme* *National Safety and Quality Health Service (NSQHS) Standards*	Fact sheets	Health services

PUBLICATION NAME		DESCRIPTION	AUDIENCE
Consumer-centred care			
Patient-centred care: Improving quality and safety through partnerships with patients and consumers		Discussion paper	Health service managers, clinicians, policy makers
Assessment of competence in communication of risk		*Medical Journal of Australia—In brief*	Clinicians, primarily medical
Medication safety			
Electronic Medication Management Systems: A Guide to Safe Implementation 2nd Edition		Guide	Managers, clinicians
Electronic Medication Management Systems: Implementation Plan		Template	Managers, clinicians
Electronic Medication Management Systems: Specialist Functions		Guide	Managers, clinicians
Medication Management Plan PowerPoint and Flash presentation		Online training resource	Clinicians

PUBLICATION NAME	DESCRIPTION	AUDIENCE
Medication Safety Update Issue 6	Newsletter	Health professionals and services
National Inpatient Medication Chart Online Training Course (hosted by National Prescribing Service—Better Choices Better Health)	Training	Clinicians
National Inpatient Medication Chart Venous Thromboembolism Prophylaxis Pilot Project Interim Report	Report	Managers, clinicians, clinical governance staff
National Tall Man Lettering Standardisation	Standard	Managers, clinicians, software proprietors
Preventing medication errors by using Tall Man lettering	*Medical Journal of Australia—In brief*	Clinicians, primarily medical
Analysis of Residential Aged Care Facility Medication Charts	Report	Clinicians, aged care providers, consumers, funders
Analysis of Residential Aged Care Facility Staff and Approved Provider Surveys	Report	Clinicians, aged care providers, consumers, funders
Medication Safety Update Issue 7	Newsletter	Health professionals and services
Mistakes can happen with your medicines (joint National Prescribing Service: Better Choices, Better Health and ACSQHC initiative) 	Consumer information	Consumers
National Inpatient Medication Chart and Psychiatric Acute Services Survey Report	Report	Health professionals and services
Revision of existing NIMC and other medication chart support materials including the *NIMC User Guide*, *NIMC Local Management Guidelines*, *Guide to NIMC Auditing* and *Guide to NIMC Audit System*	Guides	Clinicians
Clinical handover		
External Evaluation of National Clinical Handover Initiative Pilot Program	Evaluation report of the Pilot Program, outcomes, impacts, spread and sustainability derived from the 14 funded projects and a 10 step clinical handover implementation checklist	Health sector staff and clinicians

PUBLICATION NAME	DESCRIPTION	AUDIENCE
Implementation Toolkit for Clinical Handover Improvement 	Project management toolkit	Clinicians
Improving clinical handover in Australian hospitals and community settings	*Medical Journal of Australia—In brief*	Clinicians, primarily medical
Electronic Resource Portal Implementation Toolkit for Clinical Handover Improvement	Electronic resources and tools to support clinical handover improvement	Clinicians and managers
Recognising and responding to clinical deterioration		
Clinical deterioration in hospital patients: recognition and response	*Medical Journal of Australia—In brief*	Clinicians, primarily medical
A Guide to Implementation of the National Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration 	Guide	Health service executives, managers, clinicians, educators, policy makers and those with responsibility for quality improvement
Quick start guide to implementing National Safety and Quality Health Service Standard 9 	Guide	Health service executives, managers, clinicians, educators, policy makers and those with responsibility for quality improvement
Quick start guide to the implementation of essential element 1: measurement and documentation of observations 	Guide	Health service executives, managers, clinicians, educators, policy makers and those with responsibility for quality improvement

PUBLICATION NAME		DESCRIPTION	AUDIENCE
Quick start guide to the implementation of essential element 2: escalation of care		Guide	Health service executives, managers, clinicians, educators, policy makers and those with responsibility for quality improvement
Quick start guide to the implementation of essential element 3: rapid response systems		Guide	Health service executives, managers, clinicians, educators, policy makers and those with responsibility for quality improvement
Quick start guide to the implementation of essential element 4: clinical communication		Guide	Health service executives, managers, clinicians, educators, policy makers and those with responsibility for quality improvement
Quick start guide to the implementation of essential elements 5, 6, 7 and 8		Guide	Health service executives, managers, clinicians, educators, policy makers and those with responsibility for quality improvement
Jones DA, Dunbar NJ, Bellomo R. Clinical deterioration in hospital inpatients: the need for another paradigm shift. *Medical Journal of Australia* 2012;196(2):97-100.		Peer reviewed publication	Clinicians, primarily medical
Falls prevention			
Falls Prevention Research web site		Web site	Clinicians, managers
National Falls Prevention Guidelines Evaluation Framework		Framework	Clinicians, health services, aged care providers, consumers

PUBLICATION NAME	DESCRIPTION	AUDIENCE
Open disclosure		
Iedema R, Allen S, Britton K, Piper D, Baker A, Gribich C, et al. Patients' and family members' views on how clinicians enact and how they should enact incident disclosure: The 100 patient stories' qualitative study. *British Medical Journal 2011; 343(d4423).*	Peer reviewed publication ACSQHC-funded research project	Clinicians
Iedema R, Allen S, Sorenson R, Gallagher TH. What prevents incident disclosure, and what can be done to promote it? *Joint Commission Journal on Quality and Patient Safety* 2011;37(9): 409 417.	Peer reviewed publication ACSQHC-funded research project	Clinicians
Australian Open Disclosure Framework consultation draft (the revised Open Disclosure Standard)	Framework	Clinicians and services, consumers, funders, insurers
Iedema R, Allen S, Britton K, Gallagher T. What do patients and relatives know about problems and failures in care? *British Medical Journal Quality and Safety 2012; 21: 198–205.*	Peer reviewed publication ACSQHC-funded research project	Clinicians
Open communication after harmful health care incidents: a way forward	*Medical Journal of Australia—In brief*	Clinicians, primarily medical
Open Disclosure Standard Review Report	Report	Clinicians and services, consumers, funders, insurers
Short Guide to the Open Disclosure Standard Review Report	Report	Clinicians and services, consumers, funders, insurers
Safety in e-health		
Electronic Discharge Summary Systems Self-Evaluation Toolkit 	Pre-implementation and self-evaluation toolkit	Acute health service staff
Safety and Quality Evaluation of Electronic Discharge Summary Systems (Final Report)	Report	Clinicians and services

6. Knowledge and leadership for safety and quality

This chapter describes how the Commission has been contributing to knowledge and leadership on healthcare safety and quality. It includes sections on:

- health professional education
- the Australian Safety and Quality Goals for Health Care
- antimicrobial resistance
- supporting education, training and research, and
- consultations.

The performance of the Commission's functions, and the impact of its work, is dependent on the extent to which it is able to identify quality and safety issues, analyse and identify ways to overcome the barriers and use the enablers to influence change so that the care that is delivered to patients is safe, effective and appropriate. This requires knowledge of the latest research, an appreciation of the perceptions and views of those working within the system, and an understanding of the experiences and wishes of patients, their families and carers.

Staff within the Commission participate in and contribute to a range of research activities related to healthcare quality. The latest international and national publications are scanned each week and summarised in the Commission's publication *On the Radar*, a weekly summary of relevant literature that is subscribed to by more than 1200 individuals and organisations. A reader survey, conducted in late 2011, found that the vast majority of respondents read most issues or every issue; rated it as one of their top three sources; and often forward an item or an issue on to several other people.

The Commission consults and communicates with a wide range of people and organisations so that it can ensure that its work is relevant to consumers, healthcare practitioners and organisations in Australia. Sometimes the Commission's work involves identifying initiatives developed in one state or organisation and ensuring that these can be tailored for use more broadly. At other times, it initiates major pieces of work that have national application.

6.1 Health professional education

In 2011/12 the Commission started to develop a program of activity focusing on the extent to which the knowledge and behaviours required for safe, appropriate and effective care are reflected in the training and assessment of health professionals. One of the general themes that has emerged from widespread consultations has been the need for greater clinical engagement with the quality and safety agenda. Knowledge and competence in key areas relevant to patient safety, and the cues that health professionals receive about the importance of quality and safety from their educational and professional organisations, will be central to successful implementation of the NSQHS Standards and other future quality improvement efforts. Currently, it is not known to what extent educational curricula and assessment processes for health professionals cover core patient safety issues (such as the capacity to work effectively in teams and to contribute towards unit and organisational quality improvement activities) or what level of competence is required at different stages of health professional training.

Planning has started in 2011/12 for a review of the degree to which some of the core competencies required by health professionals—both in the Commission's priority topic areas and more generally for patient safety, quality assurance and quality improvement—are reflected throughout the continuum of undergraduate, postgraduate and specialist training. The Commission will be seeking specific information about the ways in which competency in quality and safety is assessed and the requirements for minimum levels of performance

This review will help to establish a baseline of current practice and to find ways in which the Commission could improve penetration, uptake and impact of its work within the health professional education sector.

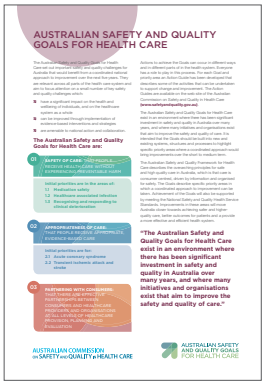
6.2 Australian Safety and Quality Goals for Health Care

The standard of health care in Australia is high, but inconsistent delivery of safe care and inappropriate variation in clinical practice are significant issues. Achieving sustained improvement and consistent standards of safety and quality requires action at all levels of the health system and across the sector. In August 2011, the Australian Health Ministers' Advisory Council (AHMAC) asked the Commission to identify a small number of national safety and quality goals—areas that would benefit from a coordinated national approach to improvement. During 2011/12 the Commission worked with consumers and healthcare experts to identify key safety and quality challenges for Australia over the next five years.

The broad criteria that the Commission and key groups involved considered in developing potential goals were:

- the impact on the health system in terms of issues such as the burden of disease, cost to the system and number of adverse events
- the existence of significant safety and quality problems, such as high levels of preventable harm and significant gaps between evidence and practice
- the existence of a body of work that could be built on to make improvements, with broad agreement about clinical guidelines or other evidence-based strategies
- that the potential goal was amenable to national action at multiple levels of the health system
- the likelihood that improvements would be achieved in a 3–5 year timeframe
- the existence of links to other national priorities
- the potential for the goal to be relevant across disease groups, sectors and settings of care
- the existence of measures, or potential to develop measures, that could be used to monitor progress.

As a result of this work, and public consultation, the Commission prepared a set of goals which have subsequently been endorsed by Health Ministers. The *Australian Safety and Quality Goals for Health Care* are:



1. **Safety of care: That people receive health care without experiencing preventable harm**

Initial priorities are in the areas of:

- 1.1 Medication safety
- 1.2 Healthcare associated infection
- 1.3 Recognising and responding to clinical deterioration

2. **Appropriateness of care: That people receive appropriate, evidence-based care**

Initial priorities are:

- 2.1 Acute coronary syndrome
- 2.2 Transient ischaemic attack and stroke

3. **Partnering with consumers: That there are effective partnerships between consumers and healthcare providers and organisations at levels of healthcare provision, planning and evaluation.**

It is intended that the goals should be integrated into the systems, processes and structures that already exist or are developed to improve the safety and quality of care, including the *National Safety and Quality Health Service Standards*. The value they bring to existing efforts will be to highlight a small number of nationally agreed priorities that can be the basis of coordinated safety and quality improvement action and reporting.

6.3 Antimicrobial resistance

Resistance to antibiotics presents a major challenge to health care as resistant bacteria dramatically decrease the chance of effectively treating infections and increase the risk of complications and death.

There is a growing concern globally about the emergence of antimicrobial resistance. Patients with infections due to resistant bacteria experience delayed recovery, treatment failure, and even death.[3-5] When multi-resistant pathogens are prevalent, clinicians are forced to use broader spectrum and usually more expensive agents to treat seriously ill patients. These effects contribute to increasing healthcare and societal costs.[5]

Resistance to antibiotics presents a major challenge to health care as resistant bacteria dramatically decrease the chance of effectively treating infections and increase the risk of complications and death.

During 2011, the Commission hosted two colloquia on antimicrobial resistance. AHMAC subsequently endorsed the establishment of a new subcommittee to coordinate a national strategy for antimicrobial resistance in Australia. The first major piece of work for the subcommittee is a scoping study and development of a business case for national surveillance of antimicrobial resistance and usage. This study will:

- examine the current surveillance activities of antimicrobial resistance and usage undertaken by the jurisdictions
- examine the current surveillance activities of antimicrobial resistance and usage in other government-funded organisations
- detail gaps in antimicrobial resistance surveillance activities
- report on how reports generated by laboratories might be a practical source of antimicrobial resistance pathology data
- identify opportunities for establishing links between existing reporting activities and provide options for national reporting.

6.4 Supporting education, training and research

The Commission has developed Internet-based training modules and held training workshops to support improvements in medication safety and prevention of healthcare associated infections.

Internet-based training modules

***National Inpatient Medication Chart* online training module**

www.nps.org.au/health_professionals/online_learning/NIMC

Produced in partnership with the National Prescribing Service: Better Choices, Better Health.

Designed for health professionals prescribing, dispensing and administering medications.

In 2010/11, 3743 health professionals and health professional students commenced the course and 2918 (78%) completed the core modules. From 2007/08 to 2010/11, there has been a steady increase in the number of participants (933 to 3743) and the completion rate (54% to 78%).

***Using the National Medication Management Plan* online training presentation**

www.safetyandquality.gov.au/our-work/medication-safety/medication-reconciliation/nmmp/

Designed for health professionals who have responsibility for managing medicines.

Antimicrobial prescribing modules of National Prescribing Curriculum

www.nps.org.au/health_professionals/publications/e-learning/issues/e-learning_february_2012

Produced in partnership with National Prescribing Service: Better Choices, Better Health.

Designed for medical prescribers in their first two years post graduation.

Ten infection prevention and control modules

These modules are available from: www.safetyandquality.gov.au/our-work/healthcare-associated infection/building-clinician-capacity/infection-prevention-and-control-online-modules.

These modules have been designed for healthcare professionals responsible for infection and control, especially those working in small and rural facilities.

Over 9700 health professionals have enrolled to undertake these modules since they were produced in 2010. An additional three modules are now in development. Two of these new modules are designed for use in primary care and dental practice and the third covers antimicrobial stewardship for nurses.

Training workshops

A total of 35 Infection Control Guideline Implementation workshops were presented in 25 cities and towns across all states and territories in Australia. Recognising the significance of local health departments in leading implementation, Director Generals in each state and territory were invited to collaborate. The workshop coordinator liaised with jurisdictional representatives who used relevant local networks to promote the workshops to organisations and individuals. Six workshops were conducted specifically for primary care. Seven workshops included video conferencing to rural and remote areas.

The target audience was people responsible for infection prevention and control practice within a healthcare facility. Over 900 participants attended the various workshops.

Conferences and meetings

The major conference hosted by the Commission this year was the Seventh Annual International Conference on Rapid Response Systems and Medical Emergency Teams. This is the largest international conference in this field. In 2012 it was held in Australia for the first time. The conference was attended by more than 500 delegates and speakers from 24 countries. Evaluations of the conference were overwhelmingly positive, with 95% of respondents reporting that they were satisfied or very satisfied with the conference, and that their learning needs were met.

In addition to this, Commission staff attended, presented papers or workshops, chaired sessions, or otherwise participated in conferences and meetings that involved at least 4000 participants. Participants in these events included consumers, clinicians, healthcare professionals, healthcare executives, researchers, policy advisors and makers, peak bodies, jurisdictions and healthcare providers and organisations.

The 2011/12 conferences or meetings included:

- Australian College of Midwives Biannual National Conference
- Australian General Practice Network Conference/National Network Forum
- Australian Private Hospitals Association, Psychiatric Sub Committee
- Breaking Down the Barriers; Health Literacy, Communication and Health Services
- Building Leadership to Improve Patient-Based Care Meeting
- Conjoint Medical Education Seminar
- The Great Healthcare Challenge Conference
- Guidelines International Network Implementation Workshop
- Health Issue Centre Consumers Reforming Health Care Conference
- High 5s Medication Reconciliation Project Workshop
- International Conference on Rapid Response Systems and Medical Emergency Teams
- International Society for Quality in Health Care
- Lowitja Institute National Conference on Continuous Quality Improvement in Aboriginal and Torres Strait Islander Primary Health Care
- Mental Health Standing Committee Inaugural National Mental Health Recovery Forum
- NEHTA National Definitions Workshop for Continuity of Care
- NEHTA Wave 2 Sites Learning Forum
- NSW Acute Care Health Priority Taskforce Meeting
- Primary Health Care Research and Information Service Conference
- Society of Hospital Pharmacists of Australia National Medicines Management Conference.

The Seventh Annual International Conference on Rapid Response Systems and Medical Emergency Teams was hosted by the Commission this year. It is the largest international conference in the field, attended by more than 500 delegates and speakers from 24 countries.

Engagement in research

Table 2 summarises the research activities that the Commission has been involved with.

Table 2 Commission's engagement in research (2011/12)

RESEARCH	RESEARCH ORGANISATION	BRIEF DESCRIPTION
Are 'potentially preventable hospitalisations' a valid measure of the quality and affordability of primary and community care in Australia?	University of Western Sydney, Sax Institute	This project will investigate the validity of 'potentially preventable hospitalisations' (PPH) as a measure of the quality and affordability of primary and community care in Australia. It will explore relationships between use of primary care services, hospital admissions for PPH diagnoses, and health outcomes and quantify the contributions of person, geographic and service level factors to variations in PPH.
Centre for Research Excellence in Clinical Microsystems	Centre for Research Excellence in Clinical Microsystems	The Centre was established in 2011 for 4 years and is funded by the Australian Primary Health Care Research Institute to address primary healthcare quality, governance, performance and sustainability issues identified within the national health reform agenda. The Centre, incorporating the clinical microsystem approach, will investigate improved models in regional governance and e-health, effective multidisciplinary teamwork, and primary care performance and accountability.
Centre of Research Excellence in E-Health	Centre for Health Informatics (University of NSW)	The Centre will support the design, evaluation and translation of critical e-health interventions, contribute to national policy, focussing on e-health safety, consumer e-health technologies, and next generation evidence-based decision support systems.
Clinical testing of observation and response charts	School of Nursing and Midwifery, University of Technology Sydney	The aim of this project was to examine the use of observation and response charts that were designed according to 'human factors' principles in a clinical environment. The project involved 10 hospitals in 4 states.

COMMISSION ROLE	OUTCOME
Associate Investigator	Research has commenced.
Associate Investigator and National Partner Organisation	Research streams have commenced.
Member of Advisory Committee	5-year NHMRC funding commenced 2012.
Funded the project as part of the Recognising and Responding to Clinical Deterioration Program. Participated in the project reference group and provided guidance on overall strategy.	The project began in early 2011 and finished in June 2012. Results indicate that the charts are appropriate for use in practice. The study identified a number of potential changes to the charts that could increase their utility as clinical tools. These will inform the final versions of the charts. The study also identified the barriers to practice change regarding the recording of observations that will be considered as part of future activities in this program.

RESEARCH	RESEARCH ORGANISATION	BRIEF DESCRIPTION
ECCHO—Effective Clinical Communication in Handover	The project involves a team from University of Technology Sydney, Flinders University, University of Adelaide, University of Melbourne, University of Queensland, Curtin University and health departments from New South Wales, the Australian Capital Territory, South Australia, Western Australia, Victoria and Queensland, who are studying effective and ineffective communication during clinical handovers.	The research team are working with clinicians in hospitals in NSW, ACT, WA and SA to provide a comprehensive description of the types of handovers in Australian hospitals, an improved model for effective handover communication and nationally developed guidelines and policies for clinical handovers
Evaluating the safety of computer decision support systems in general practice	Centre for Health Informatics (University of NSW)	Near real-time identification and classification of patient safety incidents reported by health professionals, using text classification methods to automate incident classification and classify levels of risk
Handover Errors in Radiology	Australian Patient Safety Foundation	Analysis of clinical handover incidents in the radiology setting from clinician reported incident reports
Implementing Falls Prevention Research into Policy and Practice: NHMRC Partnership for Better Health Program	NeuroScience Research Australia (University of NSW)	This 5-year project represents a partnership between key Australian falls prevention researchers, policy makers and technology companies which aims to: a) fill gaps in evidence relating to the prevention of falls in older people b) translate evidence into policy and practice so that health resources can be allocated most efficiently, and c) disseminate evidence to health professionals working with older people, to improve the workforce capacity to prevent falls and associated injuries in the future

COMMISSION ROLE	OUTCOME
National Representative member of National Clinical Advisory Group	3-year Australian Research Council Partnership Grant. Funding commenced 2011.
Associate Investigator	Text classification methods for timely identification of incidents based upon the incident type and risk rating. Measurements of the performance of text classifiers in identifying incident reports and the level of risk associated with the top 10 safety problems in Australian hospitals. A software tool that can monitor specific types of incidents in near real-time across disparate incident reporting systems, and is adaptable in future to other, possibly emerging, incident types.
Commission representative, content expert, analysis and contributor to publication for submission	Research completed in 2011. Paper submitted to peer-reviewed journals.
Partner Organisation providing in kind resourcing. Member of the Program Management Board	Screening and diagnostic tools to identify levels of fall risk and other factors. Understand effectiveness of interventions around fear of falling, use of technologies, etc. Determine adherence to guidelines, disseminate findings and provide resources and knowledge.

RESEARCH	RESEARCH ORGANISATION	BRIEF DESCRIPTION
Listen to me, I really am sick! Understanding patient and family perspectives in triggering responses to medical emergencies	Deakin University	This study will investigate whether patient and family perspectives are treated as evidence of a deteriorating health state whilst in hospital. Recommendations from this study will inform the development of patient-centred strategies to reduce delays in clinician response to physiological deterioration and improve patient safety in hospitals.
Patient-centred care and cultural competence in health care	Health Issues Centre, Australian Institute for Patient and Family Centred Care (Monash University)	The objectives of the study were to: a) describe the international and national evidence on successfully integrating cultural competence and patient-centred care b) identify culturally and linguistically diverse patient and consumers' perceptions and experiences of patient centred care, and c) identify health professional perspectives on culturally responsive patient centred care including strategies to enhance/enable implementation.
Strengthening organisational performance through accreditation research: the ACCREDIT Project	Centre for Clinical Governance Research in Health, Australian Centre for Health Innovation (University of NSW)	A collaboration of 12 inter-related studies with the aims of: a) evaluating current accreditation processes b) analysing the costs and benefits of accreditation c) improving future accreditation via evidence, and d) developing and applying new standards of consumer involvement in accreditation
Evaluating hand hygiene interventions and their ability to reduce healthcare associated infection	Queensland University of Technology	The National Hand Hygiene Initiative (NHHI) is currently being implemented to improve hygiene among healthcare workers. This research will evaluate the NHHI and measure how well the program worked, what factors were important to its success, and whether implementing the program was good value for money.

COMMISSION ROLE	OUTCOME
Linkage Partner Associate Investigators	3-year Australian Research Council Linkage Grant funding from 2012
Funded the project as part of the Consumer Centred Care Program	The project commenced in June 2011 and finished in May 2012. A systematic review about integration of cultural competence and patient centred care has been completed and submitted to the *International Journal for Quality in Health Care*. A final report has been provided to the Commission based on interviews with clinicians and focus groups with members of culturally and linguistically diverse communities. The report contains information about the barriers and facilitators to providing patient centred care to these groups.
Associate Investigator and National Partner Organisation	4 peer-reviewed publications accepted for publication, 12 papers being drafted for peer-reviewed publication, 18 conference presentations accepted or completed.
Policy partner for the NHMRC Partnership Project. Funded $400,000 cash and $19,800 in kind. 2 Associate Investigators, Chair of the Steering Committee	Project in progress. 2200 staff from the largest 50 hospitals surveyed (over 48% of public hospital beds) to assess knowledge and attitudes to hand hygiene. Model of costs identified to assess impact and cost-effectiveness of the National Hand Hygiene Initiative. Hospital infection data sources identified to provide model for change in infection rates after the intervention.

RESEARCH	RESEARCH ORGANISATION	BRIEF DESCRIPTION
Centre for Research Excellence in Reducing Healthcare Associated Infection	Queensland University of Technology	Research areas identified: a) estimating the impact of healthcare associated infection on length of hospital stay and death risk b) clinical effectiveness of infection control interventions c) transmission dynamics of infectious pathogens d) implementation costs of infection reduction at the health system level e) decision making by politicians, bureaucrats and health managers f) emerging pathogens.
Guideline Implementation: Developing collaborative capacity for rapid cycle research and application	University Health Network (Toronto)	An international collaboration to create a network of agencies interested in: a) validating, testing and applying interventions and tools based on the guideline implementability framework b) generating a user-informed research agenda for developing, implementing and evaluating the impact of tools and interventions based on the implementability framework c) enabling rapid cycle real world testing of implementability tools and interventions, and d) accelerating the translation of this new knowledge into guideline development and quality improvement practices. Funded by Canadian Institutes of Health Research.

COMMISSION ROLE	OUTCOME
Health policy partner and a Chief Investigator	Research has commenced.
Member of Steering Committee and Collaborator Committee	Research has commenced.

6.5 Consultations

The Commission consults widely with subject matter experts, peak bodies, jurisdictions, consumers and other relevant individuals and parties. This occurs through a combination of ongoing discussions with key national and other organisations and an extensive and effective network of formal reference and advisory groups. This network links to over 300 clinicians, consumers and other subject matter experts along with jurisdictional representatives. The Commission also undertakes formal consultations on specific issues.

Reference and advisory committees and groups

Table 3 Reference and advisory committees and groups (2011/12)

NAME OF COMMITTEE / ADVISORY GROUP	WHAT DO THEY DO
Inter-Jurisdictional Committee	Provides advice on the process of policy development and facilitating jurisdictional engagement in the work of the Commission. For further details, see Section 8.3.
Private Hospital Sector Committee	Provides advice to the Commission on key safety and quality initiatives from the perspective of the private hospital sector. For further details, see Section 8.5.
Primary Care Committee	Is responsible for facilitating the engagement and uptake of Commission programs in the primary healthcare sector. For further details, see Section 8.5.
Recognising and Responding to Clinical Deterioration Advisory Committee	Provides advice and feedback on program content and direction
Medication Reference Group	Provides strategic advice on medication safety and quality
Health Services Medication Expert Advisory Group	Provides advice on national medication standardisations and other health service-related medication initiatives
Medication Continuity Expert Advisory Group	Provides advice on national initiatives to improve the continuity of medication management and to advise the Commission on its involvement in the WHO High 5s Program

COMPOSITION	CHAIR
9 jurisdictional representatives	Dr Dorothy Jones
13 members who are nominees from the Australian Day Hospital Association, Australian Medical Association, Australian Private Hospital Association, Catholic Health Australia and Private Healthcare Association	Ms Christine Gee
12 members who are nominees from the Australian Dental Association, Australian Medicare Local Alliance, Australian Medical Association, Australian Physiotherapy Association, Community Care, Consumers Health Forum, Department of Health and Ageing, Pharmacy Guild, Royal Australian College of General Practitioners, Royal College of Nursing Australia and the Royal Doctors Association of Australia	Dr Helena Williams
13 plus Commission staff—group includes representatives from quality improvement and patient safety organisations, a consumer, clinical doctors and nurses from intensive care and emergency care backgrounds, educators, researchers and nurse administrators	Ms Alison McMillan
18 members who are subject matter experts and include 1 jurisdictional representative and 1 consumer representative	Professor Lloyd Sansom
16 members who are jurisdictional representatives and subject matter experts	Mr Graham Bedford
17 members who are subject matter experts and includes 1 consumer representative	Dr Paul Kubler

NAME OF COMMITTEE / ADVISORY GROUP	WHAT DO THEY DO
National Residential Medication Chart Reference Group	Provides advice on conduct of the National Residential Medication Chart Project
Anti-coagulation Working Group	Provides advice on anti-coagulation, venous thromboembolism prevention strategies and conduct of the NIMC Venous Thromboembolism Pilot
Labelling Recommendations Reference Group	Provides advice on maintenance and implementation of the *National Recommendations for Labelling of Injectable Medicines, Lines and Labels*
Open Disclosure Advisory Group	Provides advice on the Commission's Open Disclosure Program
Multi-Resistant Gram Negative Taskforce	Develops priorities and recommendations regarding multi-resistant gram negative organism detection, surveillance and containment.
Healthcare Associated Infection Advisory Committee	Provides technical input and expert advice to the Commission regarding healthcare associated infections
Healthcare Associated Infection Implementation Advisory Committee	Provides implementation expertise
Infection control—standardised signage consultation group	Works to develop a suite of nationally standardised Standard and Transmission Based Precautions signs that can be used in healthcare organisations to increase awareness of the workforce and consumers of risks of possible exposure to infectious agents
National Hand Hygiene Advisory Committee	Provides advice, guidance and recommendations on effective implementation of the National Hand Hygiene Initiative
Antimicrobial Stewardship Advisory Committee	Helps establish effective antimicrobial programs across all sectors of the healthcare system
Australian Clinical Quality Registries Advisory Group	Advises on clinical quality registries to improve the quality, consistency and use of clinical registry information
Information Strategy Committee	Guides the implementation of the Commission's information strategy

COMPOSITION	CHAIR
19 members who are subject matter experts and industry representatives and include 2 jurisdictional experts and 1 consumer representative	Dr Penny Flett
12 members who are jurisdictional representatives and subject matter experts from private and public health care	Ms Margaret Duguid
10 members who are subject matter experts and include 2 jurisdictional representatives	Ms Julianne Bryce
11 members who are subject matter experts and include 2 jurisdictional representatives and 1 consumer representative	Ms Christine Gee
14 members who are subject matter experts. The Taskforce has representatives from the Commission, the Australasian Society for Infectious Diseases, the Australasian College on Infection Prevention and Control, Public Health Laboratory Network and Australian Group on Antimicrobial Resistance. There are participants from all states and the Northern Territory	Dr John Ferguson
12 members who are subject matter experts	Dr John Ferguson
14 former members. NB: This committee was stood down in December 2011	Associate Professor Cathryn Murphy
23 members who are jurisdictional representatives	Dr Marilyn Cruickshank
16 members who are a combination of jurisdictional and private hospital representatives and subject matter experts	Ms Veronica Casey
10 members who are subject matter experts	Dr Celia Cooper
12 members who include 5 subject matter experts, 4 organisational nominees, 2 jurisdictional representatives and 1 consumer representative	Professor David Roder
12 members who include 7 subject matter experts, 2 organisational nominees, 1 consumer representative and 1 jurisdictional representative	Professor Vilis Marshall, AC

NAME OF COMMITTEE / ADVISORY GROUP	WHAT DO THEY DO
National Core Indicators Working Party	Provides expert advice and liaison with jurisdictions and the private sector on national core indicators
Accreditation Agency Working Group	Assists the Commission to progress the implementation of the *National Safety and Quality Health Service Standards* as part of the National Accreditation System with accreditation agencies
Accreditation: Day Surgeries Working Group	Assists the Commission to develop a day surgeries guide and supporting documentation for the *National Safety and Quality Health Service Standards*
Accreditation: Dentists Working Group	Assists the Commission to develop a dental services guide and supporting documentation for the *National Safety and Quality Health Service Standards*
Accreditation: Hospitals Working Group	Assists the Commission to develop an acute health services guide and supporting documentation for the *National Safety and Quality Health Service Standards*
Accreditation: Regulators Working Group	Assists the Commission to progress the implementation of the *National Safety and Quality Health Service Standards* as part of the National Accreditation System with regulators

Formal consultations

Table 4 Formal consultations undertaken (2011/12)

TOPIC	METHOD OF CONSULTATION
Australian Safety and Quality Goals for Health Care consultation process	Workshops and submissions
Open Disclosure Standard Review consultation	Consultation forums, online survey, written submissions (opened 1 June 2012)
National Inpatient Medication Chart and Acute Psychiatric Services	Online survey

COMPOSITION	CHAIR
15 members who include 8 jurisdictional representatives, 6 organisational nominees and 1 subject matter expert	Mr Neville Board
19 members who are accrediting agencies representatives	Ms Margaret Banks
4 members who are day surgery representatives. NB: This group has completed its work and has been disbanded	Ms Deanne Day
7 members who are dental practices representatives. NB: This group has completed its work and has been disbanded	Ms Margaret Banks
7 members who are hospital representatives. NB: This group has completed its work and has been disbanded	Ms Margaret Banks
19 members who are jurisdictional representatives plus 1 observer	Ms Margaret Banks

WHAT WAS DONE AND WHERE?	HOW MANY PEOPLE HAD INPUT?
A consultation paper was developed with advice of the Technical Advisory Panel; it was made available for public comment; the 3 goals and 6 priority areas were refined and defined using subject specific experts; and workshops were held across Australia to identify barriers and facilitators and to 'reality check' the direction of the goals	91 submissions, 6 workshops around the nation, 29 experts on a Technical Advisory Panel and additional experts on subject specific technical advisory panels or expert groups
Survey and written submissions invited from 1 June 2012. First consultation forum held in Hobart on 29 June 2012. Other meetings will follow in other state capitals in July and August 2012	14 expected at the Hobart meeting. Currently over 200 invitees to the remaining meetings. Survey still in progress
An online survey of acute psychiatric services was conducted in relation to use of the NIMC and views on it. Results were published on the Commission's web site www.safetyandquality.gov.au/our-work/medication-safety/medication-chart/acute-psychiatric-services-survey/	269 respondents

TOPIC	METHOD OF CONSULTATION
Residential Aged Care Facility Medication Chart Staff Survey	Paper-based survey emailed to residential aged care facilities (RACFs) nationally
Residential Aged Care Facility Medication Chart Staff Survey	Online survey emailed to RACF-approved providers nationally
National Residential Medication Chart (NRMC) Project First Tier Communication Group	Workshop
Infection control	Survey
NSQHS Standards Australian Health Services Safety and Quality Accreditation Scheme	Regular committee meetings
Guides for hospitals, day procedures and dental services for the NSQHS Standards	Piloting processes
Guides for hospitals, day procedures and dental services for the NSQHS Standards	Workshops
Guides for hospitals, day procedures and dental services for the NSQHS Standards	Online survey
NSQHS Standards	Submissions

WHAT WAS DONE AND WHERE?	HOW MANY PEOPLE HAD INPUT?
18 questions in a paper-based format to obtain information from RACF staff on medicines administration in RACFs	449 responses
10 questions in online format to obtain information from approved providers on views on medication chart functions and safety preferences	274 responses
Provided information on the NRMC Project and responded to questions from health professional and industry groups	11
Evaluation of the clinical capacity program to provide direction for future work	721
Bi-monthly teleconferences held with key leaders from accrediting agencies and state and territory health departments to provide input into implementation of the NSQHS Standards and the Australian Health Services Safety and Quality Accreditation Scheme	6 Accrediting Agency Working Group teleconferences held with 19 members 6 Regulators Working Group teleconferences held with 16 members
A pilot of health services was undertaken between October and December 2011. Each health service undertook a self-assessment of their performance to the NSQHS Standards and then completed an evaluation survey. Health services were then invited to participate in a post pilot evaluation workshop	In total, 63 health services participated in the pilot, representing over 80 rural, regional and metropolitan sites from both the private and the public sectors in each state and territory across Australia
A sample of representatives from pilot sites, together with members of the working groups who had prepared the initial draft guides, attended an evaluation workshop to further explore the use of the guides. This was held for day procedure services on 30 November 2011, for dental practices on 2 December 2011 and hospitals on 1 February 2012	Day procedure services: 6 pilot sites 3 working group members Dental practices: 5 pilot sites 4 working group members Hospitals: 25 pilot sites 7 working group members
Evaluation survey with selected health services (hospitals, day procedures, dental services) providing feedback on appropriateness of the format, language and evidence presented in the guides. Feedback was also received on additional resources and support required to assist with the implementation of the NSQHS Standards	71 responses 47 responses (90% response rate)—hospitals 6 responses (100% response rate)—day procedures 5 responses (100% response rate)—dental services
Draft guidelines were made available for public consultation	61 written submissions

External representations

Commission staff also participate in, and represent the Commission in, various international, national/jurisdictional committees, organisations and agencies.

Table 5 External representations by Commission staff (2011/12)

ORGANISATION	COMMITTEE OR GROUP
	National Clinical Handover Advisory Group ECCHO project (Australian Research Council national linkage research project)
Australian Health Ministers' Advisory Council	Clinical, Technical and Ethical Principal Committee
Australian Medical Council	
Australian National University	The Centre of Research Excellence in building quality, governance, performance and sustainability in primary health care—Steering Committee
Australian Patient Safety Foundation	Handover errors in radiology CIG (research project)
Cancer Australia	Cancer Australia Research Data Advisory Group
Cancer Australia and Australian Institute for Health and Welfare	Centre for Monitoring Cancer and Advisory Group
Clinical Deterioration Network, WA	Clinical Deterioration Network, WA
Department of Health and Ageing	National Lead Clinicians Group National Lead Clinicians Group Working Group on Clinical Guidelines Breast Screen Australia Accreditation Review Committee
Department of Health and Ageing / Australian Commission on Safety and Quality in Health Care	Antimicrobial Resistance Surveillance Committee
Fifth Community Pharmacy Agreement (Department of Health and Ageing / Pharmacy Guild of Australia)	Home Medicines Review Hospital Referral Pathway Working Group
Guidelines International Network	Implementation Working Group
Health Workforce Australia	National Competency Framework Expert Reference Group
International Medication Safety Network	Committee
Medical Colleges	Committee of Presidents of Medical Colleges
Mental Health Standing Committee	National Mental Health Standards Implementation Advisory Subcommittee Safety and Quality Partnerships Subcommittee

ORGANISATION	COMMITTEE OR GROUP
National E-Health Transition Authority	Best Practice Implementation Guide Steering Committee, including Acute Care E-Health Implementation BPG Working Group and Primary Care E Health Implementation BPG Working Group Continuity of Care Reference Group Diagnostic Services Reference Group E-Medication Profile Working Group Medication Management Reference Group
National Health and Medical Research Council	
National Health Information Policy Principal Committee (formerly National E-Health and Information Principal Committee)	Data Rationalisation Working Group National Health Information Standards and Statistics Committee Standing Committee on Performance Reporting
National Health Information Standards and Statistics Committee	Patient Experience Information Development Working Group Potentially Preventable Hospitalisations and Potentially Avoidable Deaths (PPH/PAD) Working Group
National Prescribing Service: Better Choices, Better Health	Antibiotic Indicator and Benchmark Study Advisory Group Antibiotic Resistance Reference Group Generic Medicines Advisory Group Prescribing Competencies Framework Expert Reference Group
National Trauma Research Institute	Australian Trauma Quality Improvement Program (AusTQIP)
NSW Health	NSW Health Literacy Network: Develop and implement strategies, actions and activities to support improvement in health literacy in NSW (hosted by NSW Clinical Excellence Commission)
Organisation for Economic Co-operation and Development (OECD)	OECD Health Care Quality Indicators—Patient Experience Sub Group OECD Health Care Quality Indicators Expert Group
Queensland Health	Recognition and Management of the Deteriorating Patient Committee Statewide Clinical Handover Reference Group
Queensland University of Technology	Centre for Research Excellence in Reducing Healthcare Associated Infection Steering Committee Hand Hygiene Evaluation Steering Committee

ORGANISATION	COMMITTEE OR GROUP
Standards Australia	IT 14 02 Health Informatics Committee (Observer)
Therapeutic Goods Administration	Labelling and Packaging Review External Reference Group
Victorian Department of Health	Victorian Quality Council Clinical Leadership Steering Committee
World Health Organization	High 5s Steering Committee

Ministerial advice

During 2011/12, the Commission provided information and advice to Ministers on the issues described below.

Safety in e-health

Health Ministers were provided with: *Electronic Medication Management Systems: A Guide to Safe Implementation for use in Australian Hospitals* and an accompanying Implementation Planning Template; and the *Electronic Discharge Summary Systems Self Evaluation Toolkit* and Evaluation Report. This guide and toolkit were developed in collaboration with the National E-Health Transition Authority, were based on extensive workplace research and widespread consultation, and reflect Australian lead implementation experience.

Ministers supported use of both the guide and the toolkit by Australian hospitals when implementing electronic medication management systems and/or electronic discharge summary systems to improve safety and quality of health care and noted there was potential broader adaptation and application to other health services, as well as residential aged care facilities.

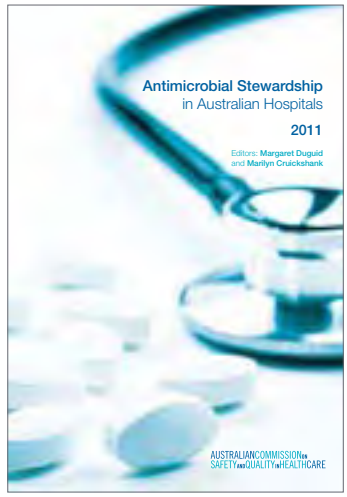
Core, hospital-based outcome indicators

Health Ministers were provided with a progress report on core, hospital-based outcome indicators.

Ministers agreed that the Commission should work with the National Health Performance Authority, Australian Institute of Health and Welfare and the National E-Health and Information Principal Committee of AHMAC to advance the appropriate use of these indicators in the context of national health reforms, noting some concerns over the indicator 'In-hospital mortality rate for heart failure'.

National Hand Hygiene Initiative

Health Ministers were provided with an update on the National Hand Hygiene Initiative and a summary of progress of the national approach to the monitoring of hand hygiene.



Ministers noted that hand hygiene compliance is the single most effective intervention to reduce the risk of healthcare associated infections in hospitals.

Patient-centred care

The *Patient-Centred Care: Improving quality and safety through partnerships with patients and consumers* discussion paper was submitted to Health Ministers in August 2011.

Ministers noted that partnerships between healthcare providers, patients and consumers are an important aspect of the delivery of safe and high-quality care in Australia. There is good evidence that these partnerships have significant benefits for the quality and outcomes of clinical care, the patient experience of care, and the effectiveness of health services. Patient-centred care is also a core principle of the national health reforms.

Ministers agreed to the release of the discussion paper, which provides practical strategies for health services to improve the delivery of health care by taking a more patient-centred approach.

Antimicrobial Stewardship in Australian Hospitals

Health Ministers noted the publication of *Antimicrobial Stewardship in Australian Hospitals*, and the associated implementation strategies for ensuring uptake by healthcare workers. They agreed that antibiotic resistance was a growing issue in Australia and welcomed a national approach to this problem.

Sponsorships

The Commission sponsored 10 events that took place in 2011/12.

Table 6 Commission sponsorships (2011/12)

EVENT	DATE	AMOUNT
International Health Consumer Conference	July 2011	$8,000
Primary Health Care Research Conference	July 2011	$2,750
Australian Day Hospital Association 2011 Conference	July/August 2011	$3,300
Australian Society for Simulation in Health Care	September 2011	$7,300
The Great Healthcare Challenge	October 2011	$50,000
Australian General Practice Network National Forum 2011	November 2011	$4,500
37th Society of Hospital Pharmacists of Australia National Medicines Management Conference	November 2011	$5,000
Conjoint Medical Education Seminar	February 2012	$5,000
Health Informatics Society of Australia 2012 Data Conference	March 2012	$10,000
Lowitja Institute National Conference on Continuous Quality Improvement in Aboriginal and Torres Strait Islander Primary Health Care	May 2012	$6,000

7. Assessment of the safety and quality of health care

This chapter provides an assessment of the safety and quality of health care by examining a number of specific areas of care. It includes discussions of:

- medical practice variation
- medication safety
- healthcare associated infection and hand hygiene
- recognising and responding to clinical deterioration
- partnering with consumers
- stroke, and
- acute coronary syndrome.

Health care is safe when the care that is intended to help patients does not harm them. Quality health care has many dimensions, including being effective, appropriate and patient-centred. Delivery of appropriate and effective care means that services based on scientific knowledge are provided to all who could benefit, and are not provided to those who are not likely to benefit (so that underuse and overuse are both avoided). Patient-centred care is respectful of and responsive to individual patient preferences, needs and values. It ensures that patient values guide all clinical decisions.

Measurement of safety and quality of care, with the capacity to compare the practices and outcomes of similar healthcare providers, is a key driver of action to improve quality. There are, however, several challenges in measuring safety and quality of care. The data gathered about all patients admitted to hospital in Australia provides valuable information about the diagnoses and procedures that patients receive and about broad outcomes such as death and re-admission. However, there is little routinely available information about specific clinical practices and the level of compliance

with guidelines or accepted standards of care. The need for better reporting of health care safety and quality across the spectrum of care underpins the Commission's work in specifying national indicators for inclusion in routine data collections, as well as its work in developing standards for clinical registries.

This report on the safety and quality of healthcare services in Australia this year focuses on some high priority areas where there is the opportunity for coordinated national action to achieve better outcomes for patients and a more effective and efficient health system.

Section 7.1 highlights some concerns about unwarranted clinical variation and provides some information on rates of selected procedures in Australia compared to other OECD (Organisation for Economic Co-operation and Development) countries.

Sections 7.2–7.4 provide some information about areas that were identified as high priorities for improving patient safety. Despite the existence of many evidence-based risk management and harm reduction strategies, many Australians are still experiencing unnecessary harm while receiving health care. As well as the direct impact on patients, this results in increased costs to the healthcare system.

Health care is safe when the care that is intended to help patients does not harm them. Quality health care has many dimensions, including being effective, appropriate and patient-centred.

Delivering care that is patient-centred and focused on partnerships with patients provides many benefits for the patient, provider, organisation and system. One of the main sources of data about partnerships with patients comes from patient experience surveys. **Section 7.5** presents results from three surveys that provide different perspectives of the perceptions of Australians on aspects of the healthcare system.

Ensuring that patients receive best evidence care, and that the right care is provided in the right place at the right time, is a challenge for all health systems. Cardiovascular disease is the leading cause of death and disability in Australia. Strokes and acute coronary syndromes (acute myocardial infarction and angina) are responsible for the majority of the burden of cardiovascular disease.

Section 7.6 presents some of the information gathered through the National Stroke Audit undertaken by the National Stroke Foundation. While a large proportion of patients with stroke do receive recommended care, there are still significant opportunities to increase the percentage of patients who receive treatments of proven effectiveness.

There is good evidence about a number of aspects of care that can improve the mortality and morbidity of people suffering from acute coronary syndromes. **Section 7.7** presents data from a clinical registry of acute coronary events that provides information on effectiveness and appropriateness of care.

A core reason for gathering and reporting data about healthcare safety and quality is so that the information leads to action to reduce unwarranted variation in the care that is provided and to improve patients' experiences and clinical outcomes. This report outlines some of the information that is currently known about patterns of care in key areas. It highlights the need for better clinical data to measure progress towards achieving goals for better care. The Commission's work to increase the focus on indicators of safety and quality of care within national data collections means that in future years the Commission will be able to report more detailed information about the safety and quality performance of Australia's healthcare system.

7.1 Medical practice variation

The existence of widespread variation in clinical practice has been recognised for many decades. In 1938, Glover published a paper in the *Proceedings of the Royal Society of Medicine* describing a tenfold variation in tonsillectomy rates between school districts in England and Wales.[7] Further, it was noted that, at that time, for every death caused by complications of enlarged tonsils there were at least eight deaths caused by tonsillectomy.

Decades later, Dr John Wennberg commenced pioneering, systematic research into small area variation in clinical practice by analysing Medicare data in the United States. One outcome of this research has been the *Dartmouth Atlas of Healthcare*, which has documented small area variation over the past 20 years. Researchers in many countries have now documented widely varying rates in hospital admissions for specific conditions and in the use of particular drugs, diagnostic and surgical procedures.

Variations of this type occur both between countries and within countries to an extent that cannot be explained by patient illnesses or by patient preferences. Higher levels of intervention do not necessarily lead to better health outcomes—they may indicate that some people are receiving treatment which is unlikely to be of benefit and may even be harmful. Lower levels of intervention may mean that people who would benefit from treatment are not receiving it. To get a better understanding of both underuse and overuse of services, and to determine what level of intervention is appropriate, it is necessary to map variations in care, identify the determinants of these medical practice variations and have better information about the outcomes of treatment.

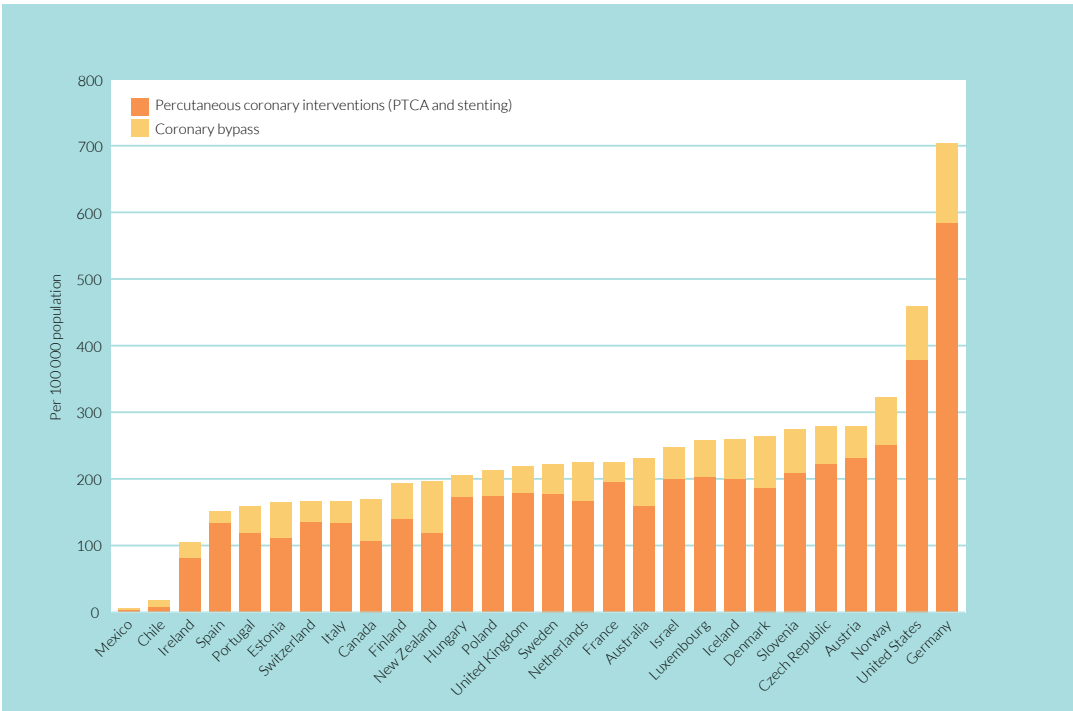


Figure 4 International medical practice variation—Revascularisation procedures (2009)

Notes: Some of the variations across countries are due to different national classifications systems and recording practices.
Source: OECD Health Data 2011

'If all variation were bad, solutions would be easy. The difficulty is in reducing the bad variation, which reflects the limits of professional knowledge and failures in its application, while preserving the good variation that makes care patient centred. When we fail, we provide services to patients who don't need or wouldn't choose them while we withhold the same services from people who do or would, generally making far more costly errors of overuse than of underuse.' [8]

The Health Committee of the OECD has expressed an interest in clinical variation. An expert group meeting was held in early April 2012 to consider the production of an OECD report with a focus on within-country variations. Illustrative examples of variation across OECD countries are shown in Figures 4–6. In none of these examples is it clear which is the 'right rate', if indeed one exists.

'Variations that cannot be attributed to illness or access to care should be interpreted as an indication of variation in professional opinion, and the remedy for that variation ought to be outcomes research.' [9]

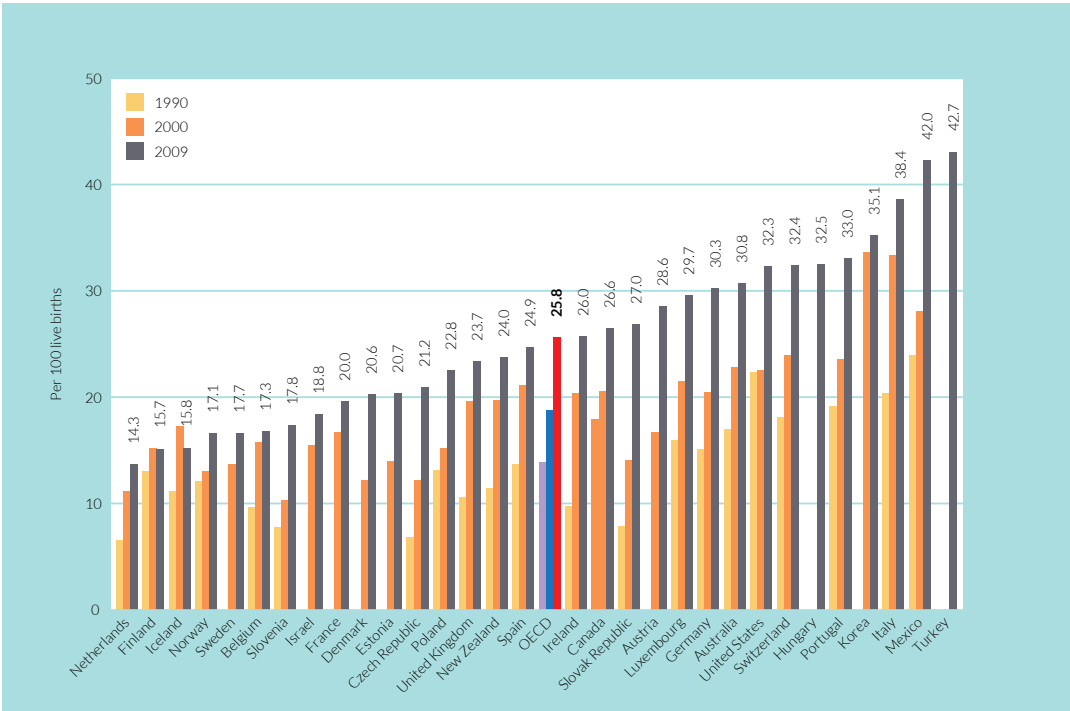


Figure 5 International medical practice variation—Caesarean sections (1990–2009)

Source: OECD Health Data 2011

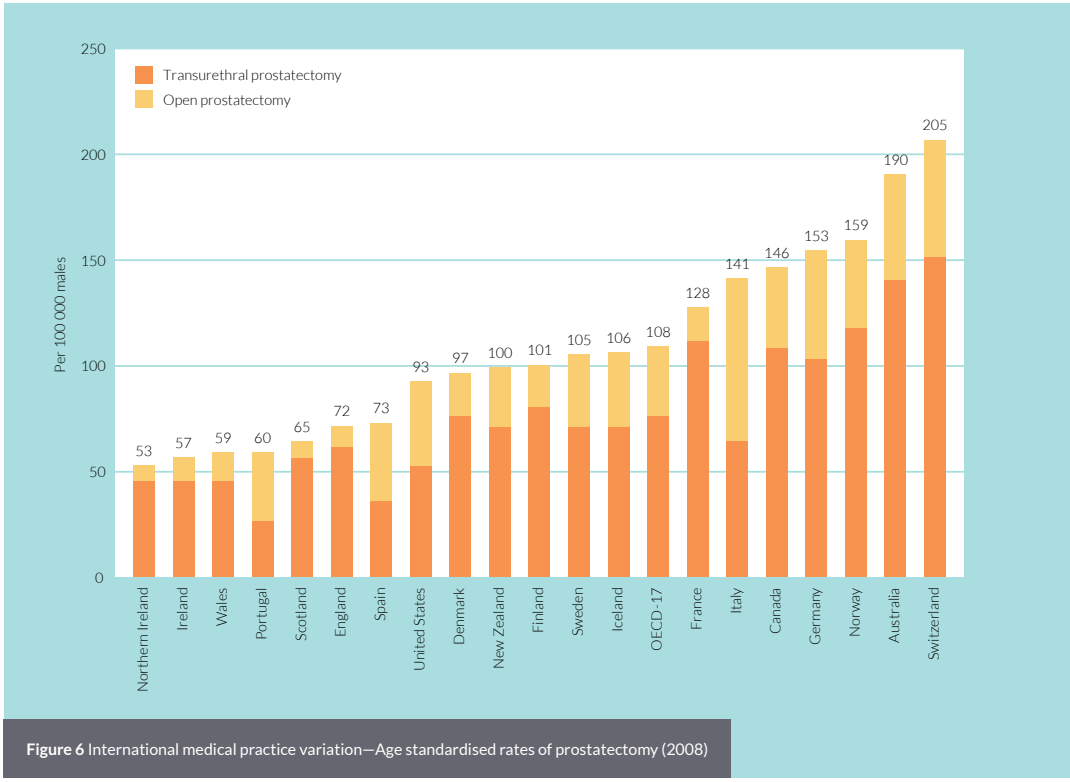


Figure 6 International medical practice variation—Age standardised rates of prostatectomy (2008)

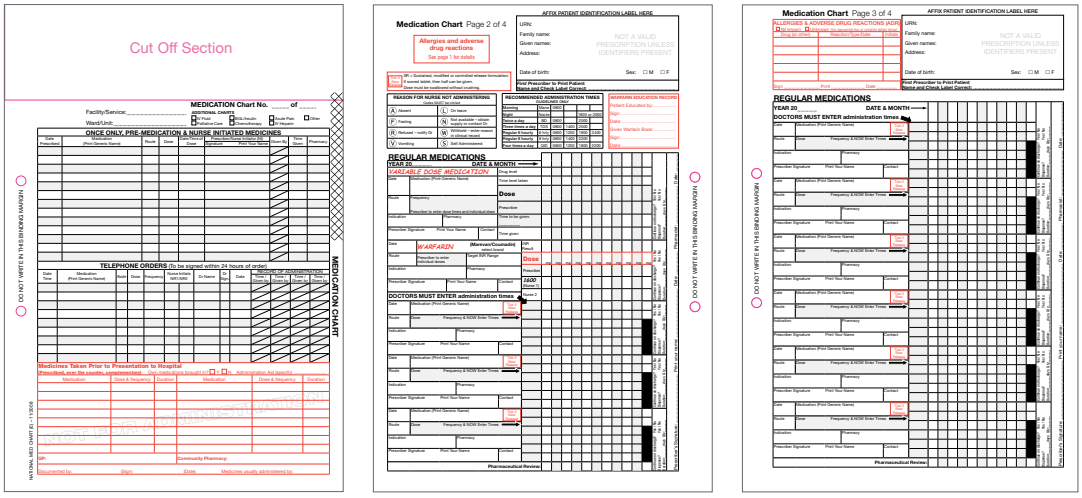
Note: Data for Canada refer to 2004/05; data for the United States refer to 2004.
Source: McPherson et al., OECD Health Working Paper (forthcoming)

Practice variation is of critical interest to consumers, clinicians and policy makers. Documenting the variations that occur within Australia using hospital discharge data as well as information about medical benefits, pharmaceutical benefits, aged care and non-clinical support for aged care and chronic disease is a first step towards understanding why such variations occur. Research into how this variation affects outcomes for patients should be a priority. Such research, accompanied by improved health literacy to inform patient choice, will help identify the 'right rates'.

7.2 Medication safety

Why is it important?

Medication safety has been a strong focus for the Commission and will continue to be an important area for ongoing work. The need for medication safety occurs along the continuum of prescribing, dispensing and administering medications. In 2004, Australian Health Ministers agreed to implement a standardised inpatient medication chart in all Australian public hospitals to reduce harm to patients from medication errors. An initial pilot of the *National Inpatient Medication Chart* (NIMC) was conducted in 2005 in 31 hospitals, and an analysis comparing these hospitals with 22 matched sites showed that hospitals using the NIMC had a significant reduction in prescribing errors and reduced risks of subsequent adverse drug events. The NIMC was subsequently implemented in public hospitals in all jurisdictions, and many private hospitals, during 2006 and 2007.



…hospitals using the NIMC had a significant reduction in prescribing errors and reduced risks of subsequent adverse drug events.

The Commission is charged with supporting NIMC implementation, which it does through an ongoing quality improvement process. This has three main elements:

1. standard arrangements for managing the NIMC locally, including local changes (such as altering the number of days shown for drug administration)
2. agreeing and instituting ongoing improvements to the chart (such as format and layout of medication orders)
3. coordinated national, annual auditing of use of the NIMC safety features.

Health services requested that the Commission annually audit use of the NIMC. Following introduction of the NIMC, most services undertook their own local audit each year. National coordination of the audit means that outcomes can be benchmarked against other services and helps embed this ongoing quality improvement process in local practice. National audit data elements were agreed and regular national auditing began in 2009.

The aims of NIMC national auditing are to:

1. evaluate use of the NIMC and compliance with its safety features
2. recommend changes to ensure the NIMC continues to assist in reducing the risk of harm to patients from medication errors and preventable adverse drug events.

Use of the NIMC safety features acts as a surrogate for the safety of medication management processes in acute care.

Findings

A total of 138 hospitals (including 38 private) from 7 states and territories participated in the NIMC 2011 National Audit from August–November 2011.[a]

All participants in the national audit used the web-based NIMC Audit System, which was developed by the Commission for data submission and reporting. The NIMC Audit System reported on hospital results and benchmarked the results against state, national and peer groups of hospitals.

The NIMC 2011 National Audit included 3634 patients with 5011 medication charts and 37,817 medication orders from 138 hospitals including 38 private sites. Of 3634 patients, 31.7% were private patients.

The results report the level of compliance with NIMC safety features and reduction in prescribing errors in the 2011 audit compared with previous audits.

Table 7 Hospital participation in NIMC 2011 National Audit—By peer group and location

PEER GROUP (AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE CLASSIFICATION)	QLD	WA	SA	NSW	VIC	ACT	NT	TOTAL
Private	16		2	8	11	1		38
Small regional and remote acute (includes non-acute hospitals)	2	6	20	1	3			32
Medium group	1	2	5	3	4			15
Un-peered and other	3	2	6		4			15
Principal referral	3		1	2	5		1	12
Multi-purpose services		9	1					10
Large major cities		1	2		2			5
Specialist women and children	3	1	1					5
Large regional and remote		1			2			3
Psychiatric	1	1						2
Rehabilitation			1					1
Total	29	23	39	14	31	1	1	138

a This report is based on interim analysis of 2011 NIMC National Audit data. The quality of the data has not been checked for consistency and some values may change when the outstanding data files from six hospitals are entered.

Table 8 Hospital participation in NIMC 2011 National Audit—Rate of compliance in selected NIMC safety features

CRITERIA FOR SAFE PRESCRIBING	RATE OF COMPLIANCE (%)			
	2006 POST-NIMC N= 1234*	2009 AUDIT N= 864*	2010 AUDIT N= 2591*	2011 AUDIT N= 3634*
Patient identification completed (all patients)	19.8	31.3	32.8	47.9 ↑
Patients' weight documented — all patients — paediatric patients	19.1	23.1 75.7	24.4 N/A	23.3 N/A
Complete details of previous adverse drug reaction documented	29.4	62.7	77.3	77.9
Clinicians can access *medication history* either via NIMC or Medication Management Plan	9.0	13.1	33.8	27.0 ↓
Medication Management Plan forms with complete Adverse Drug Reaction documentation	N/A	56.0	87.1	90.9 ↑
Indication for warfarin documented	34.3	62.1	70	40.6 ↓
Warfarin education for patients documented	11.0	10.0	12.6	14.9 ↑
Percentage warfarin orders prescribed in warfarin section with target International Normalised Ratio range documented	34.3	69.6	95.7	115.8 (data error)
Medicines prescribed of a similar class (duplication)	0.9	1.6	1.0	1.1
Medicines prescribed by generic name	73.0	80.2	78.8	73.3
Sustained release forms of drugs identified	37.7	46.4	61.3	53.5 ↓
Intermittent medications with administration section boxes blocked correctly	N/A	59.5	78.2	71.9

* N = number of patients N/A = not available

Table 9 Hospital participation in NIMC 2011 National Audit—Examples of reduction in prescribing errors

CRITERIA FOR MISSING, INCORRECT OR UNCLEAR MEDICATION ORDERS	AUDIT RESULTS (%) 2006 POST NIMC N = 15,416 ORDERS	2009 N = 9047 ORDERS	2010 N = 30,005 ORDERS	2011 N = 37,817 ORDERS
Unclear orders for drug name, route, dose and frequency	74.0*	49.4	37.8	21.2 ↓
Unclear drug names prescribed	3.0	7.6	4.0	3.4 ↓
Route errors (missing, unclear, incorrect)	6.5	13.3	10.3	8.4 ↓
Dose errors (missing, unclear, incorrect)	4.3	18.4	14.2	9.7 ↓
– Dose unclear only	N/A	16.4	13.1	8.1 ↓
Regular, PRN, variable frequency errors (missing, unclear, incorrect)	15.5	20.0	19.6	7.5 ↓
– PRN frequency errors only	32.2	35.6	46.2	22.6 ↓
Error prone abbreviations used	N/A	22.6	24.6	17.1 ↓
Indication documented	22.8	14.5	20.2	13.4
Orders ceased correctly	N/A	24.1	49.5	35.5

* based on patient numbers, not orders

Implications

Since its introduction in 2006/07, the NIMC continues to have a variable effect on some aspects of prescribing safety, with a corresponding potential to reduce medication errors and possible adverse drug events. Compared to the 2006 post-pilot audit, there continue to be improvements in a range of prescribing practices that potentially could improve patient safety. Large improvements were seen in documentation of:

- patient identification (19.9% in 2006 to 47.9% in 2011)
- previous adverse drug reactions (29.4% to 77.9%)
- the use of the NIMC or the national Medication Management Plan to document medication histories (9.0% to 27.0%).

Warfarin indication documentation had improved significantly from 34.4% in 2006 to 70.0% in 2010, but declined to 40.6% in 2011. Further investigation of this is required and will consider inter-rater reliability as well as the significant contribution of private hospital data to the 2011 audit, which may reflect different practice amongst prescribers.

The 2011 audit data showed an overall reduction in prescribing error rates compared to earlier audits, although some remain higher than the 2006 audit. This can partly be explained by the introduction of nationally endorsed, unacceptable error-prone abbreviations in 2008 which were not considered as errors in the 2006 audits.[10]

Although there are marked improvements in the use of certain safety features of the NIMC, opportunities for medication errors remain in the clarity and quality of the documentation of prescribing decisions. The high rates of unclear dose, route and frequency errors are of particular concern although reduction of 'as required' frequency errors (from 24.6% in 2010 to 17.1% in 2011) and the use of error-prone abbreviations (from 24.6% in 2010 to 17.1% in 2011) represent significant improvements.

The number of errors relating to undocumented routes and missing doses remained low in 2010 (1.0% and 0.7% respectively). Incorrect route, dose and frequency errors were also low at 0.7%, 0.5% and 0.2% respectively.

Documentation of indications for medication orders at 13.4% represents a decrease from the 2010 figure of 20.2%.

What we don't know

Gaps in our knowledge in this area include:

- how data is used by participating hospitals to improve safety and quality
- the safety culture within which NIMC audits are conducted
- separating error-prone abbreviations from other prescribing errors (such as wrong route, dose and frequency)
- understanding inhibitions on essential prescriber behaviours (providing indications), administrator behaviours (not documenting all drug administrations) and reconcilers (including the availability of pharmacists to review and reconcile orders).

7.3 Healthcare associated infection and hand hygiene

Reduction of harm to people from healthcare associated infections is another area where the Commission has undertaken substantial work. Effective infection control is a high priority for the healthcare system. Good hand hygiene—hand washing or use of an antimicrobial alcohol-based hand rub—is one of the most effective ways to prevent bacteria causing infections being transferred between patients via the hands of healthcare providers. Australia is the only country that audits and reports how often hand hygiene is correctly performed in hospitals. Healthcare associated infection (HAI) is a relatively common complication that mainly occurs in hospitals—about 200,000 HAI occur each year in Australia. It is estimated that 2 million hospital bed days per year are lost due to HAI in Australia. Other burdens associated with HAI include family or community suffering, increased use of healthcare resources for diagnosis and treatment, and the development of antibiotic resistance.

200,000 HAI occur each year in Australia. It is estimated that 2 million hospital bed days per year are lost due to HAI in Australia

National Hand Hygiene Initiative

Hand hygiene is a fundamental action for ensuring patient safety, which should occur in a timely and effective manner in the process of care. The hands of healthcare workers are the single most important source of preventable hospital acquired infections. The National Hand Hygiene Initiative (NHHI) delivers a national hand hygiene culture change program to standardise hand hygiene practice (based on the World Health Organization's *5 Moments for Hand Hygiene*) and to standardise placement of alcohol-based hand rub in every Australian hospital.

The hands of healthcare workers are the single most important source of preventable hospital acquired infections.

Hand Hygiene Australia has been contracted to carry out the NHHI. The team has developed a number of resources, which are available to download from its web site www.hha.org.au. These include manuals, online resources and videos. Over 300,000 healthcare workers have undertaken the online learning package.

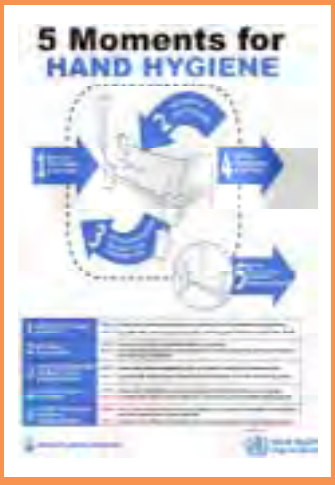
My 5 Moments for Hand Hygiene

Improving hand hygiene among healthcare workers is the single most effective intervention to reduce the risk of hospital associated infections in Australian hospitals.

The World Health Organization's *My 5 Moments for Hand Hygiene* Program is a user focused approach for understanding, training, monitoring and reporting hand hygiene. This approach recommends healthcare workers clean their hands at five critical times:

- before touching a patient
- before clean/ aseptic procedures
- after body fluid exposure/risk
- after touching a patient
- after touching a patient's surroundings.

Adapted from the Hand Hygiene Australia web site www.hha.org.au/home/5-moments-for-hand-hygiene.aspx.



The objectives of the NHHI are to:

- develop reliable indicators for hand hygiene
- accurately measure hand hygiene
- obtain and sustain improvements in hand hygiene compliance rates and reductions in HAI
- make HAI prevention a 'core business' of all healthcare workers.

Hospitals, both public and private in all states and territories, have joined the national program to standardise practice across the country.

The NHHI now has extensive data from over 629 public and private hospitals representing approximately 90–95% of acute Australian public hospital beds and approximately 50% of acute private hospital beds.

There has been a sustained increase in the number of hospitals participating in the NHHI, with clear improvements across all jurisdictions since the commencement of the NHHI (Figure 7).

Over 300,000 healthcare workers have undertaken online education. Approximately 2500 healthcare workers have been trained to audit compliance. Several tertiary education institutions utilise the online educational tools on the Hand Hygiene Australia web site. A marker of education uptake is completion numbers of the Standard Online Learning Package (Figure 8).

Healthcare facilities across Australia in both public and private sector are now consistently applying the '5 Moments' for hand hygiene. Gradual adoption of this simplified concept of when to perform hand hygiene has resulted in a dramatic improvement in compliance rates in these jurisdictions. Further, national hand hygiene compliance rates have increased with every data submission period (Figure 9).

Some groups have a more prominent role in hand hygiene than others. Medical and nursing staff have frequent and invasive contact with patients. Non-compliance with hand hygiene in these groups can have a direct effect on patient safety. Because of the specific tasks they undertake, nursing staff and medical staff are the healthcare workers most frequently required to perform hand hygiene to protect direct inoculation of pathogens into the patient (Moment 2).

The data consistently demonstrates that medical staff have significantly lower rates of hand hygiene compliance than nursing staff. Medical staff only perform hand hygiene 63% of the time in the high risk category Moment 2 (Table 10).

Table 10 Hand hygiene compliance rates for Moment 2 by medical and nursing staff (2011/12)

HEALTHCARE WORKER GROUP	COMPLIANCE RATE
Medical staff	63.4%
Nursing staff	76.5%

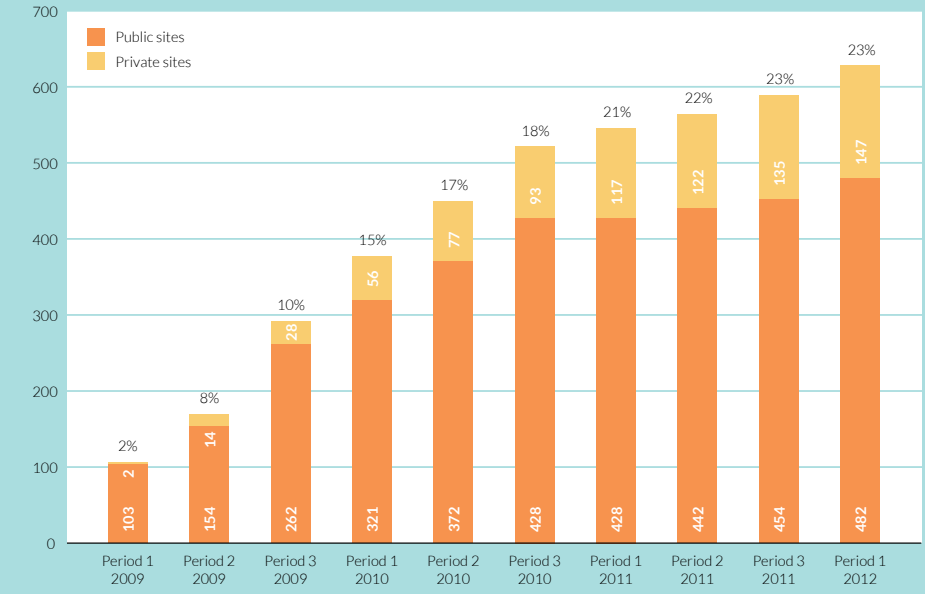


Figure 7 Number of hospitals participating in the National Hand Hygiene Initiative (2009–12)

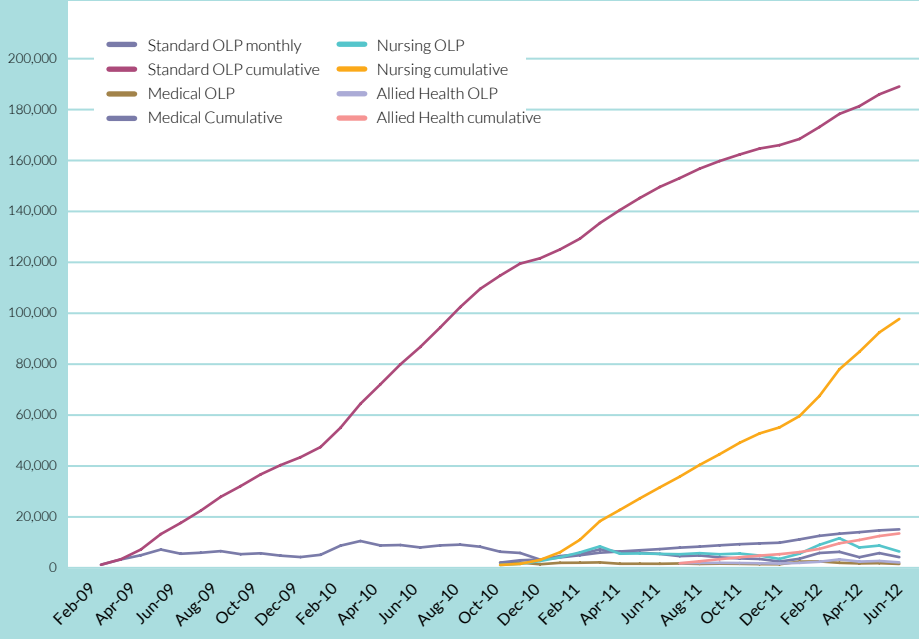


Figure 8 Number of healthcare workers completing the NHHI Standard Online Learning Package (2009–12)

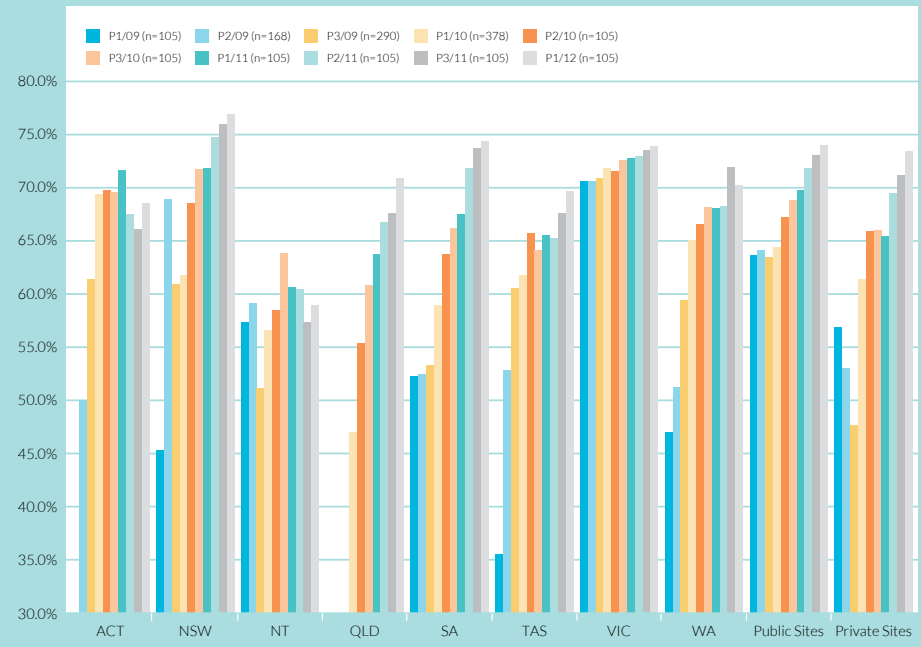


Figure 9 Hand hygiene compliance rates by Moment and location (2011/12)

Figure 10 NHHI compliance rates by nursing and medical staff (2009–12)

Gradual improvements in overall medical and nursing compliance rates can be demonstrated as the NHHI has been taken up by the jurisdictions (Figure 10).

Another important group is domestic staff, who have more contact with the patient's environment rather than the patient. While they are not involved in direct patient care, and so are less likely to directly inoculate patients, they can be responsible for contaminating patients' environments, which can ultimately lead to the transfer of pathogens to patients. Key educational messages for these staff are aimed at performing hand hygiene after they have had contact with patient surroundings before they move into other areas of the hospital (Moment 5).

To deliver this message, Hand Hygiene Australia has developed a specific online learning package targeting domestic staff. This was released in August 2011. At the end of March 2012, over 7100 staff had completed the package.

Comparison with international programs

The NHHI has several unique characteristics that distinguish it from programs in other countries:

- Compliance data is collected by trained and validated auditors. Each auditor has received identical training, and has been required to pass a uniform assessment.
- Each auditor is required to undertake an annual update.
- Data are not accepted from auditors who have not met the above conditions.
- Hospitals are required to submit different amounts of data dependent on the hospital size.
- Data is centrally collated and reported at a national, jurisdictional, network, hospital, ward, and unit level.
- Data on healthcare worker group and type of moments provides flexibility in the analysis process.
- Outlier hospitals can be reviewed by Hand Hygiene Australia staff.
- A review of infection rates is also undertaken to analyse any decrease.

The NHHI received extensive recognition as a model for national programs at the International Conference on Infection Prevention and Control in Geneva, Switzerland (2011). In November 2011, Hand Hygiene Australia was awarded the Hand Hygiene Centre of Excellence award by the World Health Organization, one of only four such awards worldwide, in recognition of the NHHI.

Culture change and sustainability

The NHHI is now becoming embedded in the Australian healthcare culture. This is demonstrated by the fact that:

- many hospitals now require that all new employees undertake the Standard Online Learning Package as part of their orientation program
- Victoria has introduced participation in the NHHI as a performance indicator for Chief Executive Officers
- one large private healthcare group has introduced incentives for hospitals to achieve 70% compliance rates
- hospital-identifiable hand hygiene data is now publicly released on the MyHospitals web site
- data on the MyHospitals web site is collated and analysed by Hand Hygiene Australia prior to it being released. Hand Hygiene Australia undertakes a series of data checks to ensure the quality of data.
- Hand Hygiene Australia is working with the Royal Australasian College of Surgeons to develop an online learning package for surgical trainee applicants. From 2013, all applicants will be required to complete the package as part of the application process.
- Hand Hygiene Australia is working with several universities to embed hand hygiene in the curricula of student healthcare workers.
- some 83% of hand hygiene compliance data comes from hospitals that have greater than 100 beds. However 70% of hospitals submitting data have less than 100 beds. It can be argued that the large, complex hospitals pose the highest risk of infection for patients as they tend to accommodate more vulnerable patients and perform more invasive procedures.

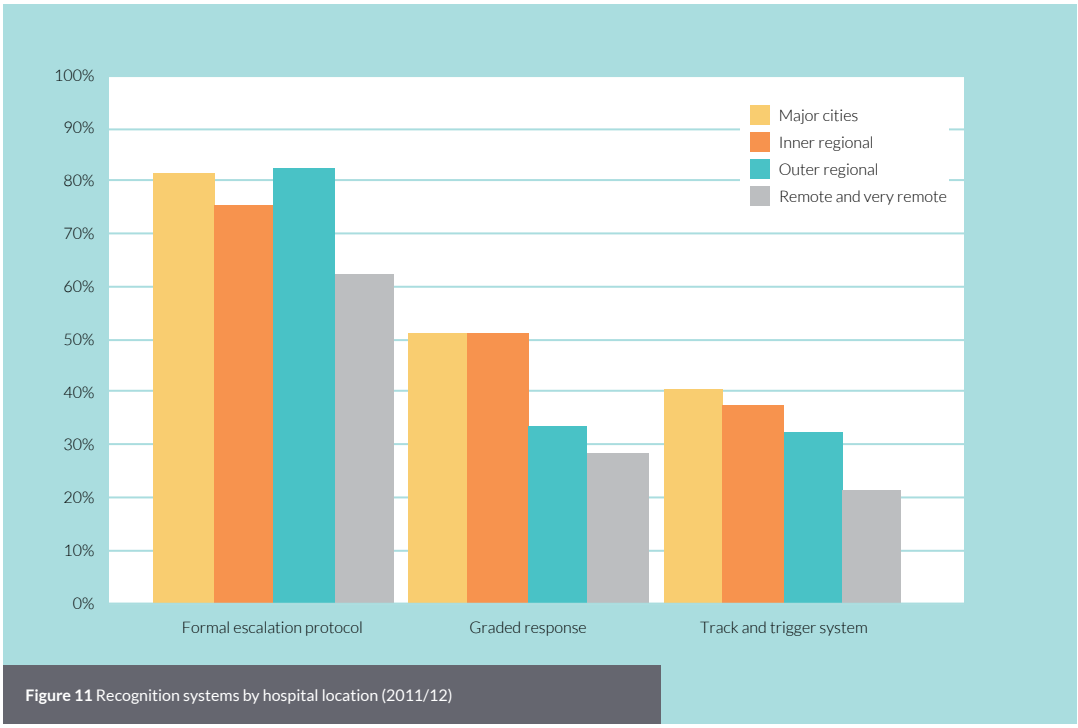


Figure 11 Recognition systems by hospital location (2011/12)

Improvements in auditing methodology in relation to ward selection and the number of Moments submitted, resulting in more meaningful data, will assist in the long-term sustainability of the NHHI.

7.4 Recognising and responding to clinical deterioration

Acute care hospitals have an increasing proportion of patients who have complex problems and who are more likely to be or become seriously ill during their hospital stay.[11] Warning signs often precede serious adverse outcomes such as unexpected death, cardiac arrest and unplanned admission to intensive care.[12-13] The number of patients in hospital with signs of physiological instability and who are at risk of deterioration is significant. A recent Australian point prevalence study across 10 hospitals found that 3% of patients had physiological abnormalities that were sufficient to warrant a call to the medical emergency team (MET) at the time observations were taken, and 5% had fulfilled the criteria for a MET call in the 24 hours prior.[14]

Why is it important?

In-hospital mortality rates for cardiac arrests are approximately 80% and have barely improved in more than 50 years.[15] METs have become one of the most common models for responding to the needs of patients who are deteriorating before a cardiac arrest occurs. They have been shown to decrease rates of in-hospital cardiac arrest in adults and rates of in hospital cardiac arrest and mortality in children.[16]

While the MET has improved outcomes for patients who deteriorate in hospital, there is evidence emerging that even better outcomes may be achieved with a more proactive and pre-emptive approach to recognising and responding to deterioration.[15] Patients who receive MET calls are sick, and have a greater risk of dying in hospital than those who do not require a MET call.[17] By identifying deterioration earlier, hospitals can intervene before a MET is needed, potentially improving outcomes and minimising the interventions needed to stabilise a patient.

Hospitals are complex systems, and a focus on the needs of patients across all parts of this system is needed to ensure that patients whose condition deteriorates, or who are at risk of deterioration, receive appropriate and timely care.[15]

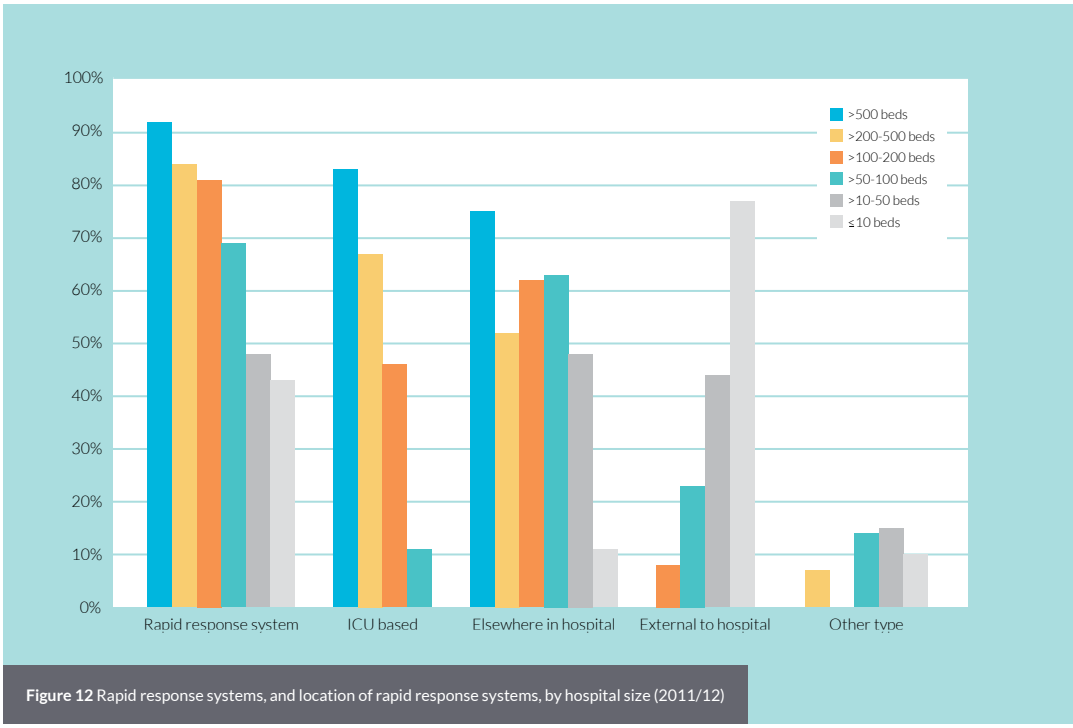


Figure 12 Rapid response systems, and location of rapid response systems, by hospital size (2011/12)

Notes:
Hospitals can have more than one type of rapid response system in place.
Other types of rapid response systems most commonly include transfer of patients to co-located public hospitals or transfer of patients to larger hospitals.

Findings

In 2010 the Commission conducted a national survey of the systems in place for recognising and responding to clinical deterioration (recognition and response systems).[18] Prior to this survey there was very limited information available about the recognition and response systems and practices in place, particularly outside the large public hospitals that have published information on this subject.

Two hundred and seven hospitals (36% of which were private) from all states and territories completed the survey.[b] Sixty two per cent of responding hospitals had less than 100 beds, 52% were outside major cities and 47% did not have an intensive care or high dependency unit.

Most hospitals responding to the survey had policies for the measurement and documentation of observations (77%), protocols to escalate care when a patient's condition deteriorates (77%) and systems to provide a rapid response to manage this deterioration (66%). More sophisticated recognition and response systems were less common: only 47% of hospitals with an escalation protocol included a graded response where different actions are required for different levels of deterioration, and only 36% of hospitals used a track and trigger system to support early identification of deterioration.

Hospitals used a wide variety of different types of rapid response systems for providing emergency assistance to patients whose condition is deteriorating. Over half (55%) of the rapid response systems were not based in intensive care units, with an additional 21% being external to the hospital. Systems based in the emergency department, medical and surgical wards and anaesthetics were mentioned. A number of

b Public hospitals in NSW did not participate in the survey because of the state-wide implementation and parallel evaluation processes being undertaken as part of the Between the Flags program. Between the Flags is a state-wide program that provides a safety net in all NSW public hospitals for recognising and responding to clinical deterioration.

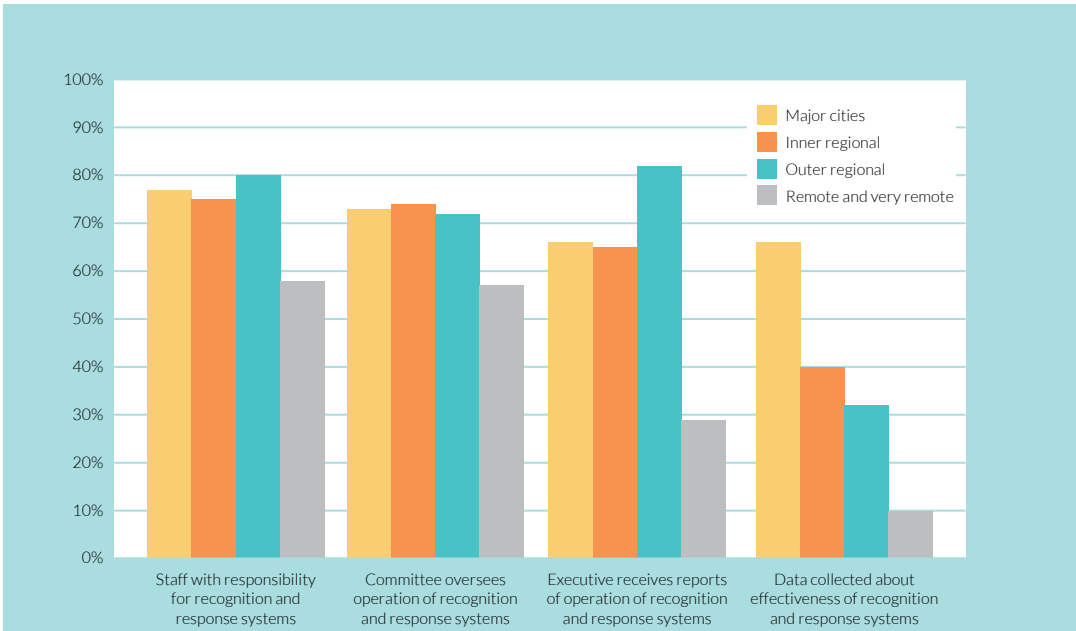


Figure 13 Governance systems by hospital location (2011/12)

systems drew on staff from across the entire hospital. Externally, responses were provided by local general practitioners, ambulance officers, visiting medical officers, retrieval services and co-located public hospitals.

Organisational systems to support the recognition of and response to clinical deterioration were widely reported to be in place. These systems included allocation of staff with responsibility for recognition and response systems (75%), committees to oversee the operation of these systems (71%), processes for reporting on performance to executives (64%) and the provision of relevant training to staff (70%). Less than half of the responding hospitals (47%) reported that they collected data about the effectiveness of their recognition and response systems.

Implications

The survey found generally positive results regarding the presence of basic recognition and response systems in Australian hospitals. The results of the survey varied among hospitals of different size and location. Overall, smaller hospitals, and those in remote areas, tended to be less likely to have formal recognition and response systems in place (Figures 11–13). This trend was found across most of the different types of systems included in this survey, but was particularly noticeable regarding the existence of rapid response systems and organisational systems to support the governance of processes to recognise and respond to clinical deterioration. Smaller and more remote hospitals have fewer staff compared to large metropolitan hospitals, and may have less capacity to put in place these types of systems. In some cases, the need for governance systems such as formal committees may be reduced in these circumstances. However, irrespective of the size or location of the hospital, the presence of a rapid response system, and the existence of processes such as collecting and reporting on performance of rapid response systems would be part of best practice. These findings reinforce the need for more specific information about recognition and response systems tailored for specific settings.

What we don't know

The methodology used for this survey means that it is not possible to generalise the results to make statements about the presence of recognition and response systems in all hospitals in Australia. Nonetheless, this survey has provided new, useful information. This is the first time detailed

information has been presented about the recognition and response systems in place in small rural hospitals.

This survey presents information about the systems in place in a sample of Australian hospitals; it does not provide information about the prevalence of clinical deterioration or the outcomes for patients. A number of measures have been identified as important for evaluation of the quality of recognition and response systems,[19] and more work is needed to develop systems to support the collection and collation of these data nationally.

7.5 Partnering with consumers

Partnerships between patients, consumers, families, carers, healthcare providers and healthcare organisations can exist:[20]

- when care and treatment is provided. These types of partnerships can be developed through the use of shared decision-making strategies, support for self-management and similar approaches.
- when consumers, patients, families and carers provide advice to managers of wards, services, departments or programs of care. These types of partnerships can be seen when people are members of quality improvement and redesign teams.
- when consumers, patients, families and carers are part of organisational governance processes such as boards, and committees on patient safety, quality improvement, ethics and research.

Why is it important?

Delivering care that is patient-centred and focused on partnerships provides benefits for consumers, healthcare providers, organisations and the health system. Evidence is building about the links between a patient-centred approach, good patient experience and high quality health care.[21-25] For example, there is evidence that patient-centred care is associated with: improved clinical outcomes,[26-29] including associations with decreased re-admission rates;[30] decreased healthcare acquired infections;[31-33] improved delivery of preventive care services;[34] reduced length of stay;[32,35] improved adherence to treatment regimens;[36] and improved functional status.[31-32] There is also some evidence that using patient-centred approaches to care can result in reduced hospital costs, over and above any additional costs arising from the provision of patient-centred care.[37]

Findings

One of the main sources of data about partnerships between patients, consumers, healthcare providers and health service organisations comes from patient experience surveys. Presented here are some results from three different surveys, providing different perspectives about the experience of patients and consumers in the health system.

Mapping patient care experiences

Recommendation Two of the Commission's *Patient-centred care: Improving safety and quality through partnerships with patients and consumers* discussion paper proposed that a core set of nationally endorsed patient survey questions be developed to facilitate collation and comparison of patient care experience data in key healthcare settings.

This recommendation has provided the impetus for a national effort to coordinate the collection and reporting of patient experience information. The Commission has led the development of a core set of patient experience survey questions to be used in hospital surveys. This has been negotiated via a multidisciplinary, multi-jurisdictional expert working group, established with the aim of fostering a national approach to patient experience measurement.

The Commission, supported by the working group, mapped similarities and differences in the patient experience surveys used in Australia, and developed a proposal for a core set of common patient experience survey questions. The working group refined and agreed on the core set of questions, which reflect the key patient-centred care domains. The questions are intended to provide a basis for the collation of nationally consistent patient experience data for analysis and comparison. The working group is continuing to progress this work with a core set of questions expected to be agreed by late 2012.

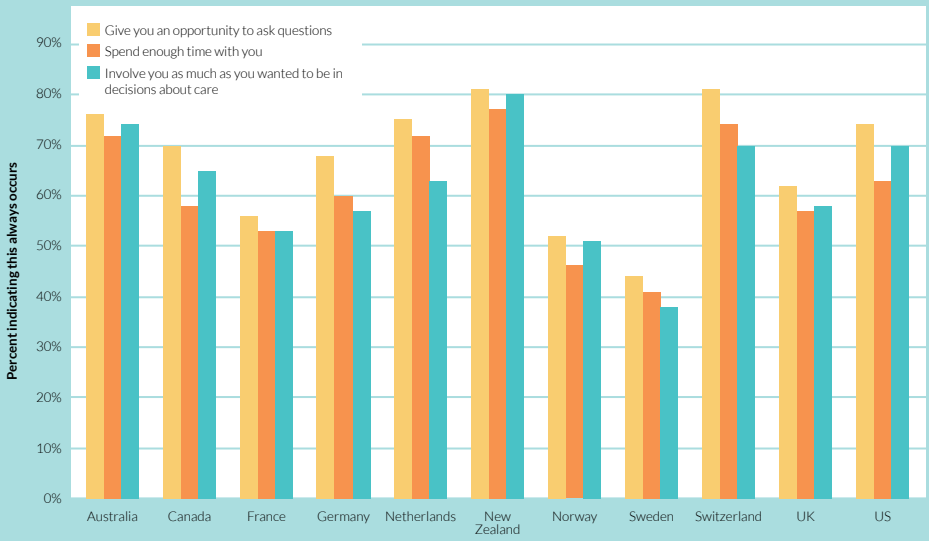


Figure 14 Experience of patients and consumers regarding interactions with healthcare providers, by country (2010)

Source: Commonwealth Fund 2010 International Health Policy Survey

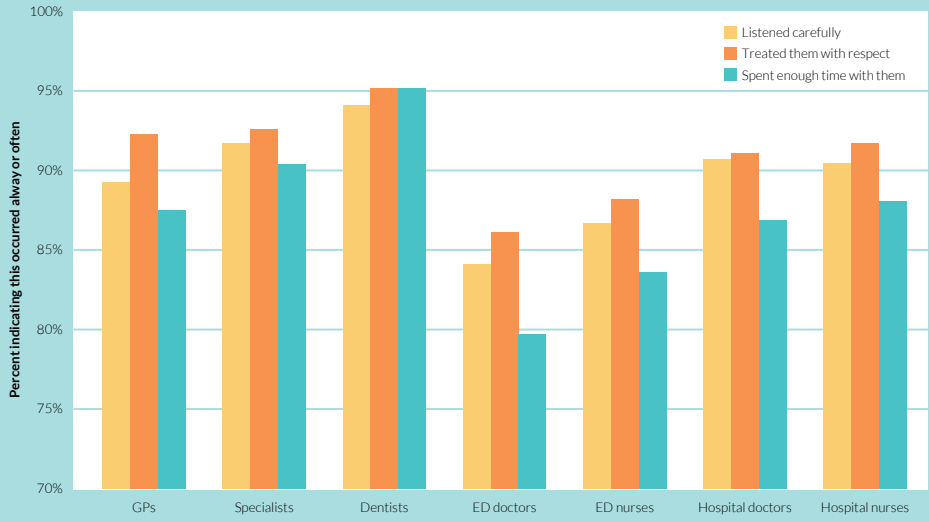


Figure 15 Experience of patients and consumers regarding interactions with healthcare providers, by type of provider (2010–11)

Source: Australian Bureau of Statistics 2010–11 survey of patient experiences in Australia

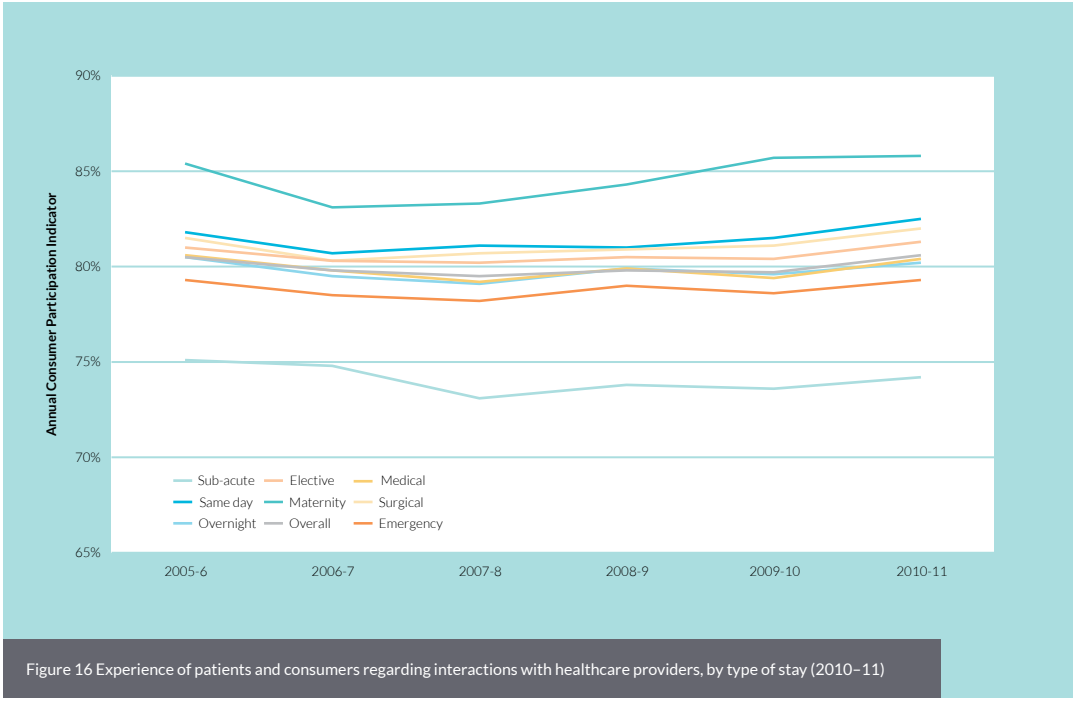


Figure 16 Experience of patients and consumers regarding interactions with healthcare providers, by type of stay (2010–11)

Source: Victorian Patient Satisfaction Monitor 2010–11

The US-based Commonwealth Fund's 2010 International Health Policy Survey is a telephone survey of 19,738 people in 11 countries of whom 3552 were in Australia.[38-39] Australian respondents to this survey reported positive experiences regarding respect for their needs, preferences and values (Figure 14). Over three quarters (76%) reported that when they saw their regular GP, their GP always spent enough time with them and 74% reported that their doctor always involved them as much as they wanted in decisions about care and treatment. Australia performed second or third best for these questions behind New Zealand and Switzerland.

The Australian Bureau of Statistics conducts a Multipurpose Household Survey using interviews, and part of this survey asks questions about patient experiences of health care. In 2011 this involved 26,423 people.[40] People reported positive experiences regarding interactions with health professionals, with around 80% reporting that they always or often felt that the health professionals that they saw listened carefully, showed respect and spent enough time with them. These experiences varied according to the type of health professional that was considered, with the highest ratings for dental professionals (94–95% reporting positive experiences compared to 86–92% for doctors and nurses in the emergency department) (Figure 15). These results may reflect the differences in the way in which care is provided in these settings

Patient experience surveys have been conducted by state and territory health departments for many years, providing a rich source of information, and the potential to track changes over time. One example of these jurisdictional surveys is the Victorian Patient Satisfaction Monitor, a survey of adult inpatients in Victorian public hospitals conducted using mail-out questionnaires, and now accessible for online completion. In 2010/11 responses were received from 28,428 people.[41] A Consumer Participation Index is calculated based on responses to three survey questions about people's perceptions of their opportunity to ask questions, being involved in decisions about care, and the willingness of hospital staff to listen to concerns. There were slight improvements in this index for all stay types in 2010/11, with statistically significant increases for same day, medical, surgical and elective stay types (Figure 16).

Implications

The survey results presented here focus on how people perceive their interaction with their healthcare providers: whether they had enough time, whether they were involved in decision making, if they received enough information, and whether they had the opportunity to ask questions. These issues are important, as high ratings of such interactions are associated with improved adherence to treatment and less diagnostic testing expenditure.[36,42-44] These surveys looked at these issues at different levels—internationally, nationally and within a jurisdiction. However, they all demonstrated similar results: generally positive experiences with the identification of particular areas where improvements could occur. For example, the Australian Bureau of Statistics survey suggests that patient's experiences of communication and involvement in emergency departments were not as positive as other areas, and this could be a potential area of focus for health services.

What we don't know

This information comes only from patient experience surveys, and while the results are positive, the limitations of this methodology need to be recognised. Information from patient experience surveys needs to be interpreted in the light of other qualitative information, such as complaints and narratives from patients and consumers themselves.

Although most states and territories conduct regular surveys of the experience of patients in their health services, at this stage it is not possible to combine these data because of differences in questions and methodology. The results from one state are presented here as an example of the type of information that is collected. The Commission is currently working with the states and territories, the private hospital sector and other interested parties to identify a core common set of questions for patient experience measurement that will support national reporting of these surveys in the future.

This information is focused on one type of partnership only at the individual care level: between patients, consumers and healthcare providers when care is provided. At this stage there is no national way of collecting information about other types of partnerships, such as those that might exist at an organisational or governance level. However, Victoria currently collects this information under its consumer participation standards and indicator reporting in health services' annual Quality of Care Reports. It is anticipated that information that is collected as part of the processes of assessment against the *National Safety and Quality Health Service Standards*, and in particular *Standard 2 Partnering with Consumers*, will contribute to a national understanding of consumer input at these other levels within the healthcare system.

7.6 Stroke

A stroke occurs when a blood vessel to the brain is suddenly blocked by a clot (an ischaemic stroke) or bleeds (a haemorrhagic stroke). This disturbance in the blood supply may result in part of the brain dying, leading to a loss of brain function or impairment in a range of activities including movement, thinking and communication, and may lead to death. Ischaemic and haemorrhagic strokes account for about 80% and 20% of cases, respectively. Although ischaemic strokes are more common, haemorrhagic strokes have a much higher fatality rate.[45]

Risk factors for stroke that cannot be controlled include increasing age, gender (stroke is more common in men) and a family history of stroke. Lifestyle risk factors that can be controlled include high blood pressure, high cholesterol, smoking, poor diet, lack of exercise, being overweight and excess alcohol consumption.[46]

The National Stroke Foundation developed the *Clinical Guidelines for Stroke Management 2010* to provide a series of evidence-based recommendations for the organisation of stroke services, stroke recognition and pre-hospital care, early assessment and diagnosis, acute medical and surgical management, secondary prevention, rehabilitation, managing complications, and community participation and long-term recovery.[47]

Following discharge from hospital, stroke patients should have access to multi-disciplinary, community/home-based rehabilitation and support services such as counselling and respite care, and specialist palliative care if required.[47]

Currently there is no routine data collection available in Australia to measure the quality of care provided to patients with stroke. Information for this Annual Report therefore relies on data published in the *National Stroke Audit of Acute Services 2011*, conducted by the National Stroke Foundation.

Why is it important?

A number of therapies and practices will reduce the risk of stroke for individuals and populations, and many cases of stroke respond well to treatment. A steady decline in stroke mortality began in the early 1970s, and continued to 2008. The standardised death rate for stroke fell from 71.6 deaths per 100,000 population in 1998 to 48.5 deaths per 100,000 in 2008.[49] Declines were greater for ischaemic stroke (about 8% per year) than haemorrhagic stroke (about 2% per year).[45]

However, stroke remains one of Australia's leading causes of death with 8623 people dying of stroke in 2007.[50] In 2007/08, the prevalence of stroke was 346,700 and there were 34,945 hospitalisations associated with a principle diagnosis of stroke.[50]

The National Stroke Foundation estimates the cost burden of stroke to be around $2.14 billion per year.[48]

Findings

The first-hand experiences of people with stroke and their carers suggest that the availability and quality of stroke care in Australia varies.[47]

Evidence-based stroke care, as detailed in the guidelines, is proven to reduce death and disability, and is cost-effective. Stroke care provided in a dedicated stroke unit reduces death and disability by approximately 20% and is cost-effective compared with general ward care.[47] However, evidence-based care is not always provided in clinical practice. It has been reported that 30–40% of patients do not receive treatments that are proven to be effective. In addition, 20–25% of patients receive unnecessary or potentially harmful treatments.[48]

Evidence-based stroke care is proven to reduce death and disability, and is cost-effective.

The biennial National Stroke Audit conducted by the National Stroke Foundation provides an overview of the quality of acute stroke care in Australia by measuring adherence to clinical care recommended in the guidelines and describes variations in stroke services across the country. The audit has been conducted on three occasions in 2007, 2009 and 2011, providing comparative data for that period from the majority of eligible hospitals (184, or 88%).[48]

Since 2007 there has been a significant improvement in the proportion of patients receiving care in a dedicated stroke unit—from 50% in 2007 to 60% in 2009. Over the same period, the proportion of patients with stroke who received brain imaging within 24 hours of arriving at hospital remained high at around 90%. The proportion of patients receiving a swallow screen (to reduce the risk of aspiration pneumonia) before food or drink improved from 50% in 2007 to 64% in 2009. The proportion of patients receiving intravenous thrombolysis—after arriving to hospital within 3 hours of onset of ischaemic stroke—improved (from a low base) of 6% in 2007 to 20% in 2009. The proportion of patients to whom a care plan was provided at discharge from hospital remained relatively low at 50%, down from 53% in 2007.[48]

Measures of effectiveness of patient care are also provided in the 2011 Audit. In hospitals admitting 100 or more patients with stroke per year, patient outcomes are documented for care delivered in hospitals with and without dedicated stroke units. The proportion of patients who either died in hospital or were discharged to an aged care facility was greater in hospitals *without* a stroke unit (30%) than the proportion in hospitals with a stroke unit (21%). Similarly, fewer patients were independent at time of discharge for hospitals without stroke units (37%) than hospitals with stroke units (42%).[48]

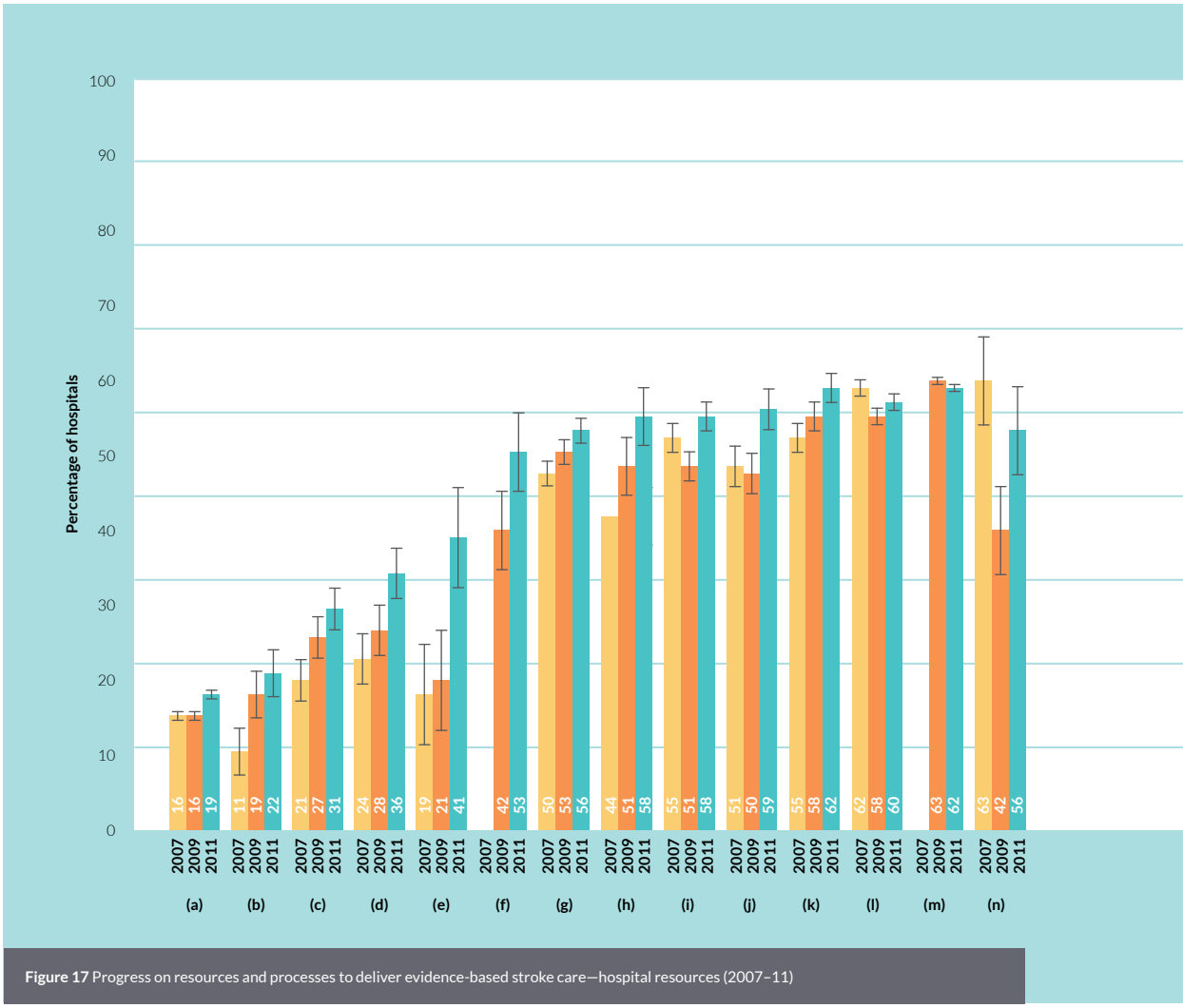


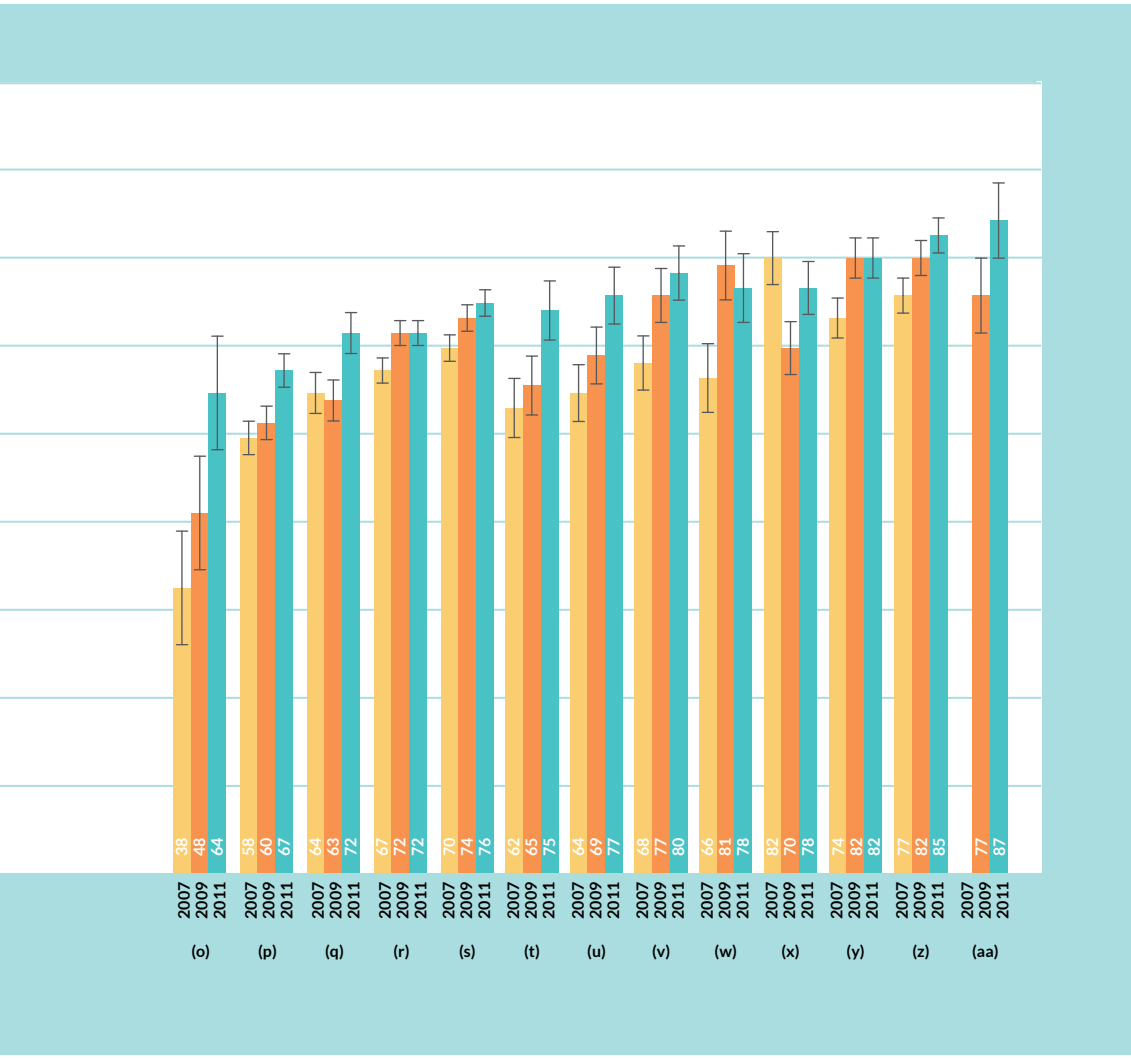
Figure 17 Progress on resources and processes to deliver evidence-based stroke care—hospital resources (2007–11)

Changes in the organisation of stroke care between 2007 and 2011 include an increase in the number of stroke units (54 in 2007 to 74 in 2011) and dedicated stroke beds (391 to 549). The proportion of hospitals that have made specific arrangements for rapid assessment of stroke patients has increased over the period, including ambulance arrangements (19% to 41%) and the development of emergency department protocols for rapid triage (38% to 64%) and transfer to another hospital (44% to 58%). The proportion of hospitals offering thrombolysis increased from 24% in 2007 to 36% in 2011.

Implications

There has been considerable effort across Australia to improve the quality of stroke care. The National Stroke Audit provides evidence that, in many instances, a large proportion of patients with stroke received recommended care as detailed in the guidelines.

However, many of the gaps identified in previous clinical audits remain. The provision of stroke units—with access to thrombolysis—in hospitals with over 100 stroke admissions and the timely access to stroke unit care for patients in regional and rural Australia, is the single most important recommendation. Guidelines indicate that, for this time critical condition, arrangements for rapid assessment of stroke patients, including ambulance arrangements and emergency department protocols for rapid triage and inter-hospital transfer are necessary for effective management.



Source: National Stroke Audit Acute Services — Organisational Survey Report 2011.

254 hospitals were audited in 2007, 206 in 2009, and 188 in 2011

(a) % Hospitals with access to early supported discharge teams

(b) % Hospitals with neurovascular/ transient ischaemic attack clinic

(c) % Hospitals with protocols for routinely reviewing patients with stroke discharged from hospital

(d) % Hospitals offering thrombolysis (rt-PA)

(e) % Hospitals with ambulance arrangements

(f) % Hospitals using a defined pathway for assessing TIA

(g) % Hospitals using care pathways

(h) % Hospitals with ED protocols for transfer of patients to another hospital for care

(i) % Patients who are on a stroke unit (all hospitals)

(j) % Hospitals routinely provide information on community stroke support groups

(k) % Hospitals with access to magnetic resonance imaging (MRI)

(l) % Hospitals routinely providing a discharge care plan

(m) % Hospitals providing routine assessments for all patients needing further rehabilitation

(n) % Hospitals with access to program of continuing education for staff in stroke management

(o) % Hospitals with ED protocols for rapid triage of patients with acute stroke

(p) % Hospitals with access to telehealth for clinical support

(q) % Hospitals routinely providing patient information on stroke

(r) % Hospitals where patients/carers are given details of a hospital contact on transfer from hospital to community

(s) % Hospitals with access to community-based rehabilitation

(t) % Hospitals routinely providing patient information on local community care arrangements

(u) % Hospitals where team routinely meets with family

(v) % Hospitals with access to telehealth for professional development

(w) % Stroke unit hospitals admitting directly to a stroke unit

(x) % Hospitals with regular team meetings

(y) % Hospitals with access to Carotid Doppler

(z) % Hospitals with access to Computerised Tomography (CT) within 24 hours

(aa) % Hospitals offering thrombolysis (rt-PA) on a 24 hour, 7 days per week basis

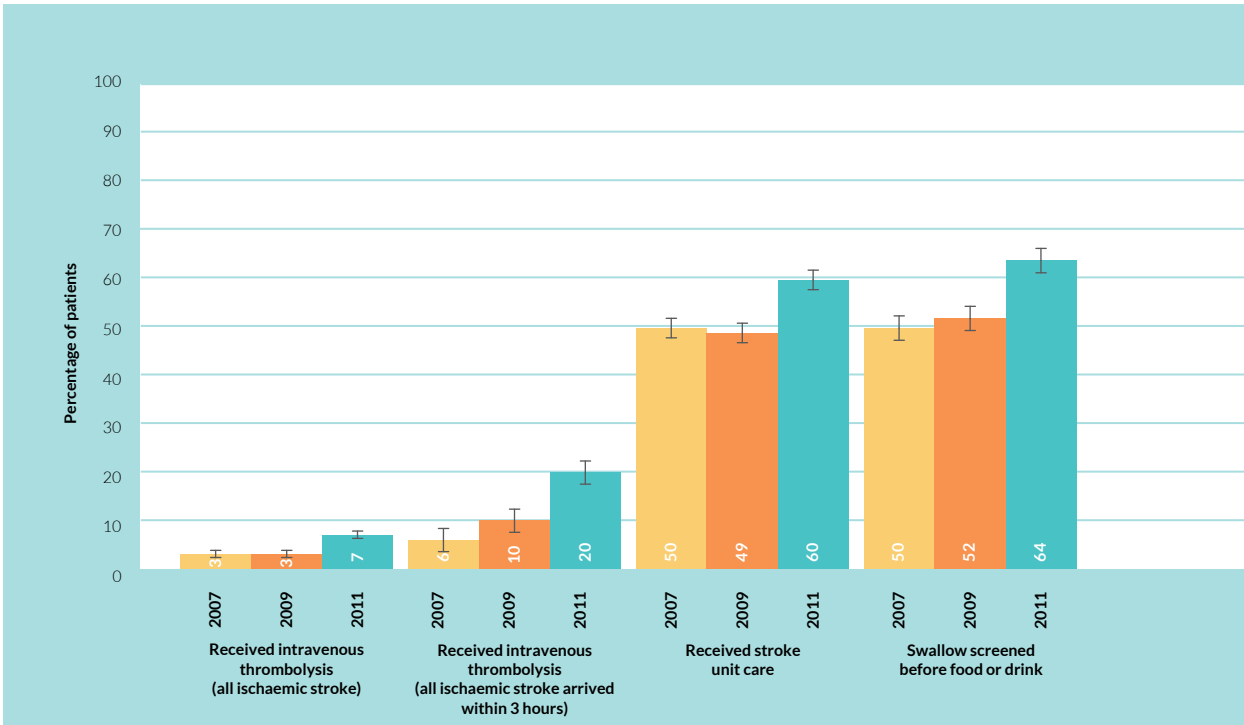


Figure 18 Adherence to guideline-recommended stroke care (2007–11)

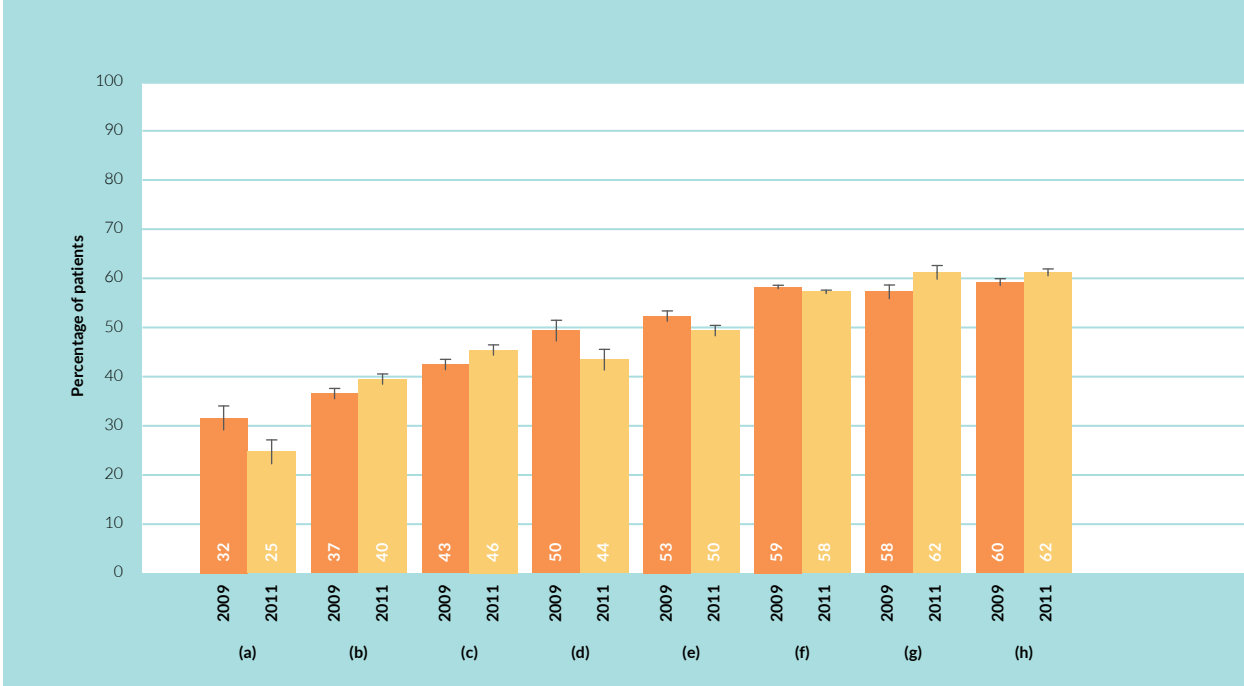
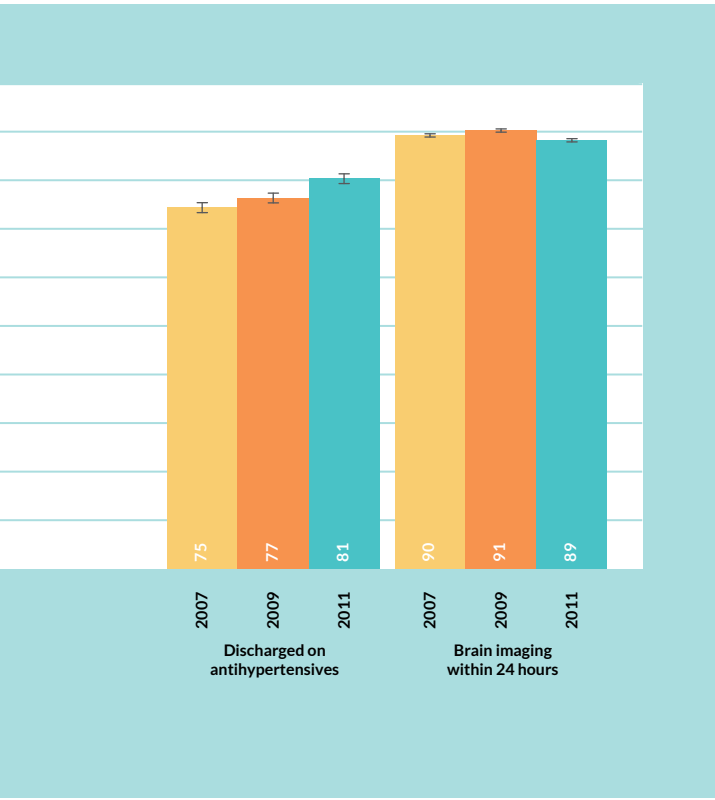
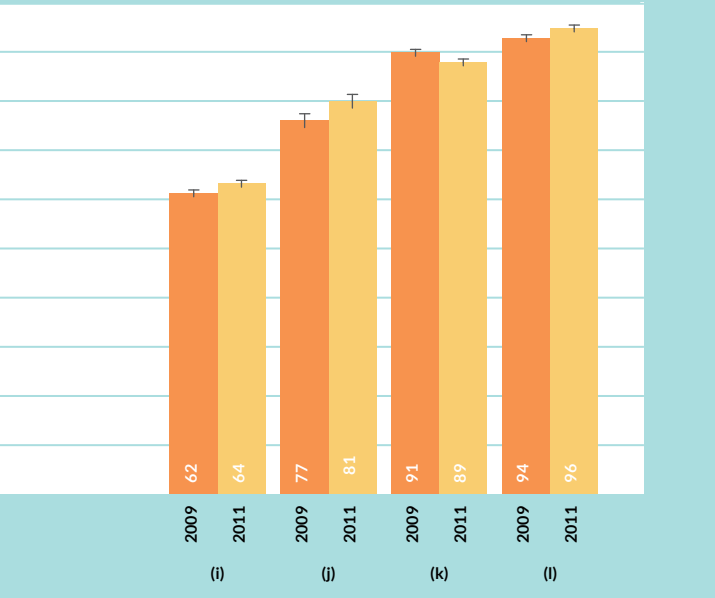


Figure 19 Adherence to guideline-recommended stroke care (2009–11)



Source: National Stroke Audit Acute Services—Clinical Audit Report 2011.
254 hospitals were audited in 2007, 206 in 2009 and 188 in 2011



Source: National Stroke Audit Acute Services – Clinical Audit Report 2011.
206 hospitals were audited in 2009 and 188 in 2011
(a) % Incontinent patients with a continence plan
(b) % Assessed by occupational therapy within 48 hours
(c) % Received behaviour change education
(d) % Received carer training
(e) % Provided with a care plan
(f) % Admitted to a stroke unit on the day of stroke (if admitted to stroke unit)
(g) % Assessed by physiotherapy within 48 hours
(h) % Assessed by speech pathologist within 48 hours
(i) % Given aspirin within 48 hours if ischaemic stroke
(j) % Discharged on antihypertensives
(k) % Received brain imaging within 24 hours
(l) % Discharged on antithrombotics (if ischaemic stroke)

Additionally, processes to support effective discharge planning, ongoing rehabilitation and community follow up are important for achieving optimal health outcomes.

There is an opportunity to elevate these strategies to a national focus to ensure that all patients with stroke receive appropriate, evidence-based care. National clinical standards for stroke care would provide benchmarks of appropriate access to care for patients with stroke.

What we don't know

The National Stroke Audit provides a valuable cross-section of information on the quality of stroke care in Australia every two years. However, there is insufficient longitudinal data available on the appropriateness and effectiveness of stroke care in Australia. Efforts are underway to further develop the Australian Stroke Clinical Registry so that granular information for the entire eligible stroke population could inform specific improvements in stroke care.

7.7 Acute coronary syndrome

Acute coronary syndrome (ACS) refers to the acute coronary artery diseases myocardial infarction and unstable angina. ACS is the result of a sudden blockage of a heart blood vessel, leading to a compromise in blood supply to a portion of heart muscle. Where the compromise is severe enough to lead to injury or death of the heart muscle, the event is termed an acute myocardial infarction (or 'heart attack'). If the blockage is incomplete and not severe enough to cause injury or death of the heart muscle, the event is termed unstable angina. Acute myocardial infarction and unstable angina are sudden, severe and life-threatening events.[51]

The non-modifiable risk factors for ACS include increasing age and having a family history of heart disease. The modifiable risk factors for ACS include smoking (both active smoking and being exposed to second-hand smoke), high blood cholesterol, high blood pressure, diabetes, being physically inactive, being overweight, depression, and insufficient psycho-social support.[52]

Patients with suspected ACS undergo an electrocardiogram and other investigations to determine the nature of the condition and the most appropriate management strategy. There are two major types of acute myocardial infarction, categorised by the appearance of their electrocardiogram traces: ST segment elevation myocardial infarction (STEMI) and non-ST–segment elevation acute coronary syndromes (NSTEACS). This categorisation and the patient's risk profile determine which treatment is indicated.

Coronary angiography is a diagnostic procedure in which dye is injected into the heart's arteries, and an X-ray is taken to see if these arteries are narrowed or blocked.

Following a diagnosis of ACS, there are a number of guideline-recommended methods of restoring blood flow to the heart muscle (reperfusion). These include dissolving the clot by medication and procedures to open the artery. Medical management includes the use of thrombolysis for STEMI, aspirin, beta-blockers, statins, angiotensin-converting enzyme inhibitors or angiotensin receptor blockers, heparin, thienopyridine, glycoprotein receptor agonists and calcium channel blockers.

Indicated procedures include percutaneous coronary intervention (PCI), and coronary artery bypass graft:

- Percutaneous coronary intervention is where a small balloon or other device is fed on a thin tube through the blood vessels to the point of blockage, at which point the balloon is inflated to open the artery. If necessary, a small expandable metal tube called a stent is implanted at the narrowed site to keep the artery open.
- Coronary artery bypass graft is the process of taking a healthy artery or vein from elsewhere in the body and connecting, or grafting, it to the blocked coronary artery. The grafted artery or vein bypasses the blocked portion of the coronary artery.

Currently there is no routine data collection available in Australia to measure the quality of care provided to patients with ACS. Information for this section relies on published analyses of Australian data collected by the Global Registry of Acute Coronary Events (GRACE) over the period 2000–07 and the ACS Prospective Audit over the period November 2005–July 2007, published in the *Medical Journal of Australia*. However, the Cardiac Society of Australia and New Zealand, together with the Heart Foundation and cardiology networks, recently completed the SNAPSHOT ACS audit. SNAPSHOT aims to capture clinical information on every patient admitted to hospital with ACS in Australia and New Zealand over a two-week period. These data will be available in the coming year.

Why is it important?

ACS is often preventable and treatable. Deaths due to acute myocardial infarction declined by 31.3% over the period 1997 (16,525) to 2007 (11,353).[51] However, ACS remains one of Australia's leading causes of death.[53] In 2007/08, ACS accounted for approximately 11,000 deaths and 95,000 hospitalisations in Australia.[51] Despite these declines, death rates in Australia remain higher than those in many other developed countries, indicating the potential for further declines.[45]

Of the hospitalisations, 59% were due to acute myocardial infarction and 41% due to unstable angina.[51] From 1998–2008, the age-standardised separation rates increased by 30.8% for acute myocardial infarction, but decreased by 46.0% for unstable angina.[51] These changes are most likely explained by the improved sensitivity of the troponin blood test used to diagnose acute myocardial infarction in that period.

Access Economics, a private economic analysis company, estimated the associated total economic cost of ACS to Australia in 2009 to be $17.9 billion. Of this, direct healthcare system costs (primarily hospital stays and pharmaceuticals) accounted for around $1.8 billion, indirect costs (primarily lost productivity) accounted for around $3.8 billion, and costs associated with the burden of disease (morbidity and mortality) accounted for around $12.3 billion.[54]

Further, rising levels of obesity and diabetes in an ageing population suggest the number of ACS events in Australia is likely to double by the year 2030.[55]

Findings

Evidence-based care for patients with ACS, as detailed in the *Guidelines for the Management of Acute Coronary Syndromes*,[56] is associated with improved rates of mortality and morbidity.[55,57-58] However, management of ACS in Australia varies and gaps exist between guideline recommended care and actual care.[55]

There is evidence that the sooner a patient is treated for the blockage in their artery, the more positive the outcome.[51] Timely reperfusion is associated with significant outcome benefits.[59] As a result, pre-admission protocols (such as ambulance and emergency department protocols), as well as hospital protocols, are changing with the aim of reducing the time from symptom onset to effective medical intervention.[51] These protocols reflect contemporary 'systems-based' approaches to reducing time to reperfusion.

The most recent time series data for ACS, published in 2011, is an analysis of 8 years of data from 5615 patients in Australia and New Zealand between 2000–07 in the GRACE.[55] The analysis examined measures of appropriateness or care (how close actual care was to guideline-recommended care) and effectiveness of care (outcomes). Regarding the appropriateness of care (Figures 20 and 21), the study demonstrated significant increases in the use of statin therapy, angiotensin-converting enzyme inhibitors or angiotensin receptor blockers, and thienopyridines.[55] Among patients with STEMI, there was an increase in revascularisation with PCI from 36% to 53%, and in-hospital coronary angiography from 61% to 76%.[55] Among patients with NSTEACS, there was an increase in revascularisation with PCI from 20% to 25%.[55]

Regarding effectiveness of care (Figures 22 and 23), the GRACE study demonstrated that heart failure rates declined substantially among STEMI and NSTEACS patients from 21% to 12%, and from 13% to 4%, respectively as did rates of hospital readmission for ischaemic heart disease at 6 months, from 23% to 9% and from 24% to 15% respectively.[55]

Australian-only data is available from analyses of the ACS Prospective Audit between November 2005 and July 2007.[57,59] These data suggest a considerably higher proportion of patients managed with recommended care than in the GRACE study (Figure 24). For example, the proportion of patients receiving PCI in 2006/07 was 71% for STEMI and 34% for NSTEACS.[57] Reperfusion therapy was used in 66.9% of patients with STEMI, and timely reperfusion therapy in 23.1% of patients.[59] Receiving reperfusion therapy of any kind was associated with decreased 12-month mortality and timely reperfusion was associated with a reduction in mortality of 78%.[59] A key conclusion was that timely reperfusion was associated with significant outcome benefits.[59] Furthermore, patients receiving invasive management (revascularisation using PCI or coronary artery bypass graft) experienced a lower rate of late mortality (3.7%) compared with patients treated with pharmacological therapy only (10.1%).[57]

The GRACE data suggest an association with improved uptake of guideline-recommended medical and procedural therapies for ACS in Australia and New Zealand.[55] In particular, invasive cardiac procedures, such as PCI, are becoming more commonly used to treat patients with less severe acute myocardial

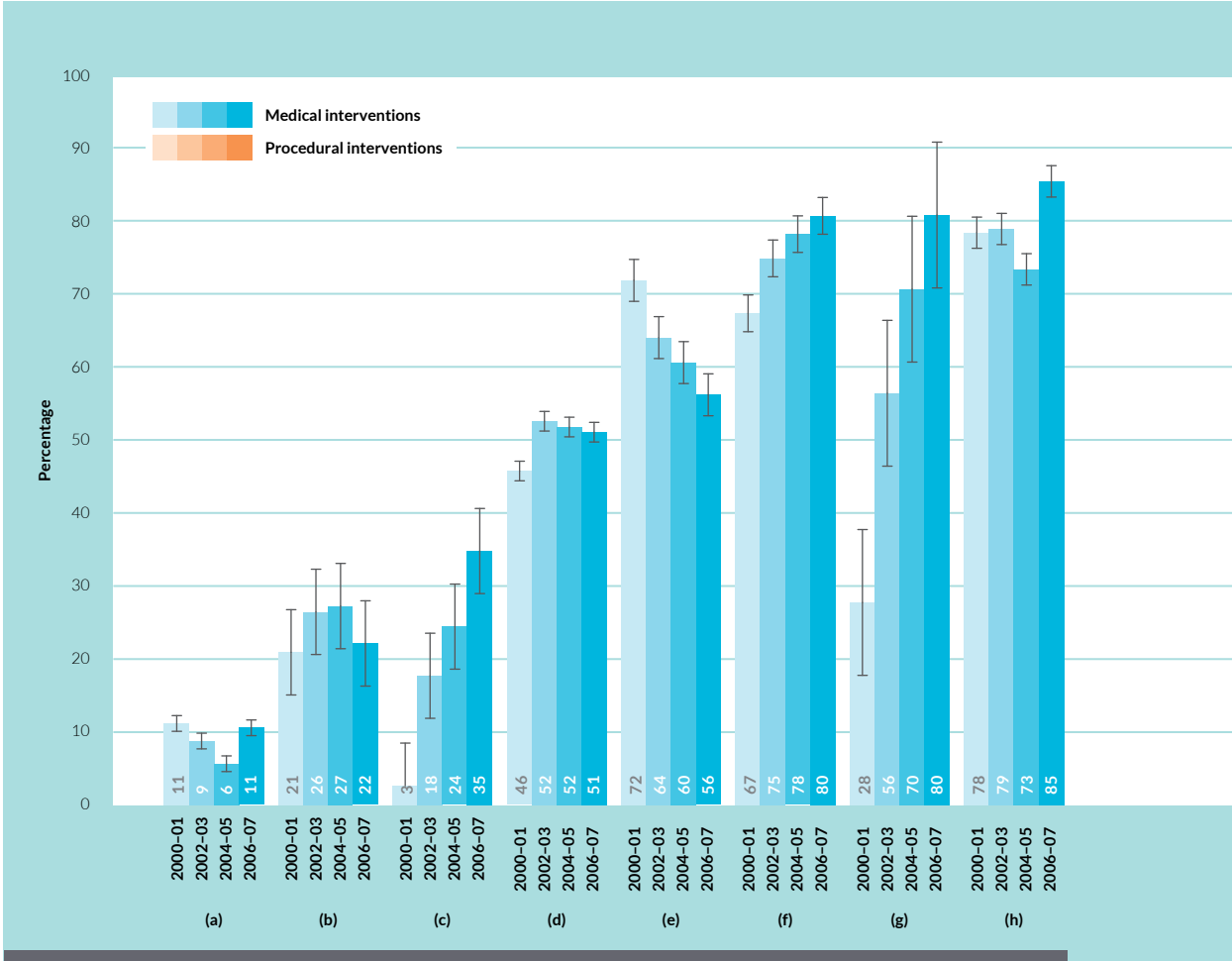
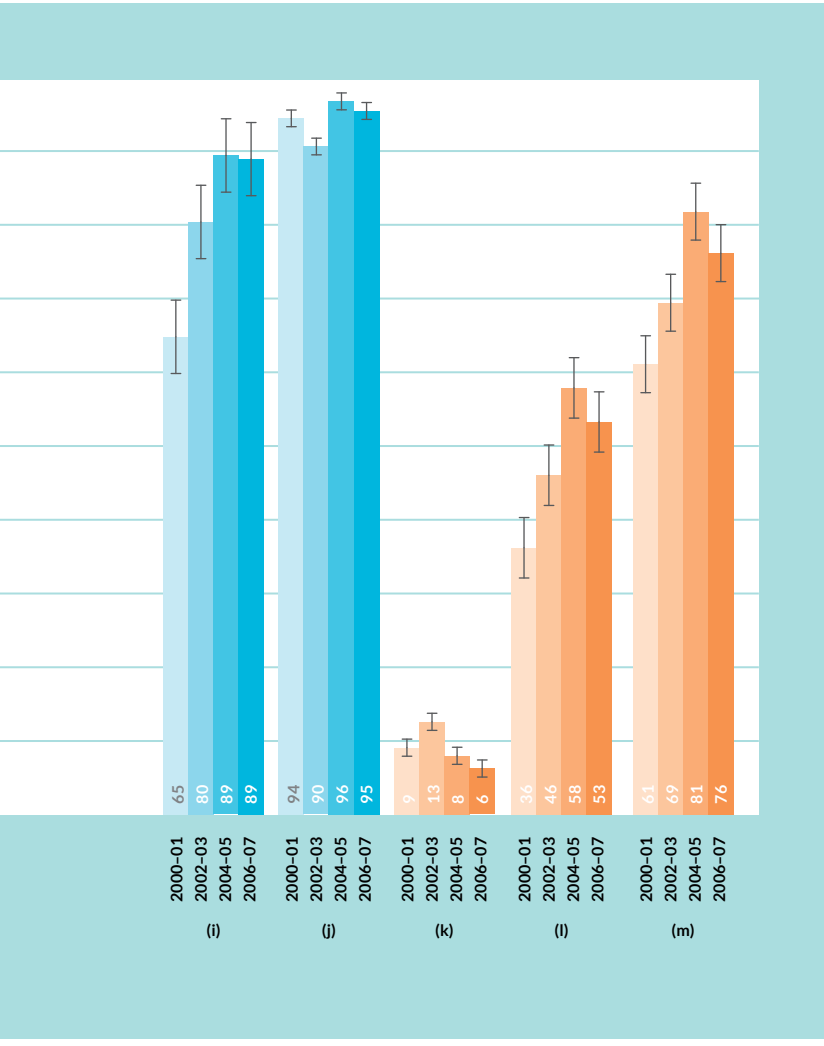


Figure 20 Trends in evidence-based medical and procedural management practices for management of patients with STEMI in Australia and New Zealand (2000–07)

infarction and with unstable angina.[51,57-58] However, Australian use of timely reperfusion for STEMI remains poor and incomplete.[59]

Current guidelines recommend that all patients with ACS be referred to a cardiac rehabilitation program following an acute event.[56] Recent data from the United States and the United Kingdom suggest that secondary prevention therapies have been as significant as acute therapies in achieving the reduction in age-adjusted mortality for coronary heart disease seen over the past two decades.[58]

In 2009 the National Heart Foundation ACS Implementation and Advocacy Working Group published the results of a literature review to identify gaps between guidelines and practice, including evidence for the most effective systems of ACS management. The Working Group provided information on access to rehabilitation and secondary prevention programs and equity of access to appropriate care for geographically isolated and vulnerable communities. Only about 30% of eligible Australian patients access cardiac rehabilitation programs, comparable with findings from overseas, and this has not improved significantly over the past 10 years.[58] The yearly coronary heart disease-related death rate increases with remoteness, from 71.1 per 100,000 population in metropolitan areas to 85.5 in remote Australia.[58] Aboriginal and Torres Strait Islander peoples experience higher mortality rates from coronary heart disease than other Australians.[58]



Source: Aliprandi Costa B, Ranasinghe I, Chow V, Kapila S, Juergens C, Devlin G, et al. Management and outcomes of patients with acute coronary syndromes in Australia and New Zealand, 2000–2007. Medical Journal of Australia;195(3):116 121.

The GRACE cohort analysed 1723 STEMI patients from 11 metropolitan and rural centres in Australia and New Zealand.

(a) Calcium channel blockers
(b) Glycoprotein IIb/IIIa receptor antagonists
(c) Thienopyridine without percutaneous coronary intervention
(d) Total low molecular weight heparin
(e) Unfractionated heparin
(f) Angiotensin-converting enzyme/ Angiotensin receptor blockers
(g) Thienopyridine (total)
(h) ß-blocker (excluding contraindications)
(i) Statin
(j) Aspirin (excluding contraindications)
(k) Coronary artery bypass graft surgery
(l) Percutaneous coronary intervention (all)
(m) Coronary angiography

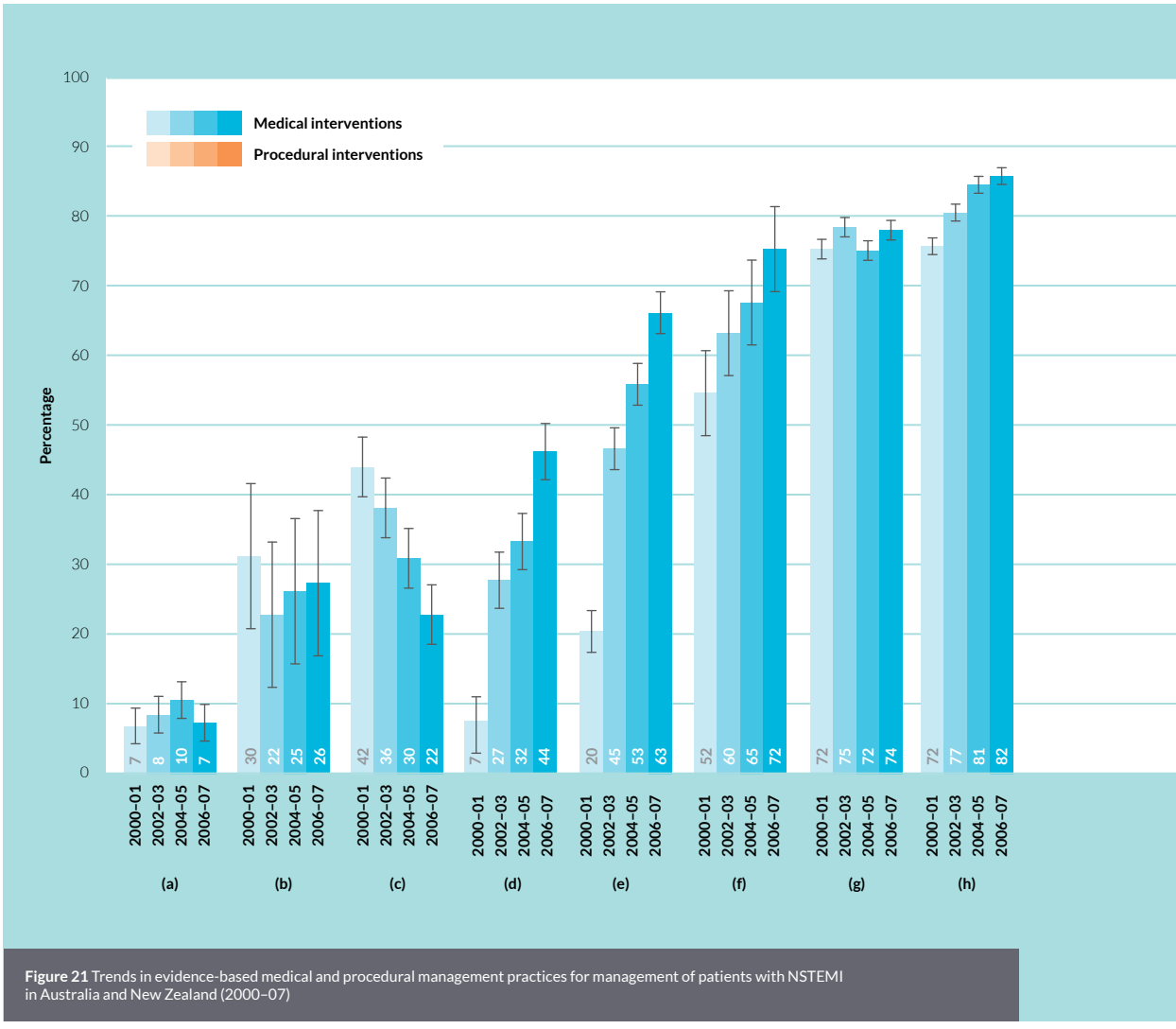


Figure 21 Trends in evidence-based medical and procedural management practices for management of patients with NSTEMI in Australia and New Zealand (2000–07)

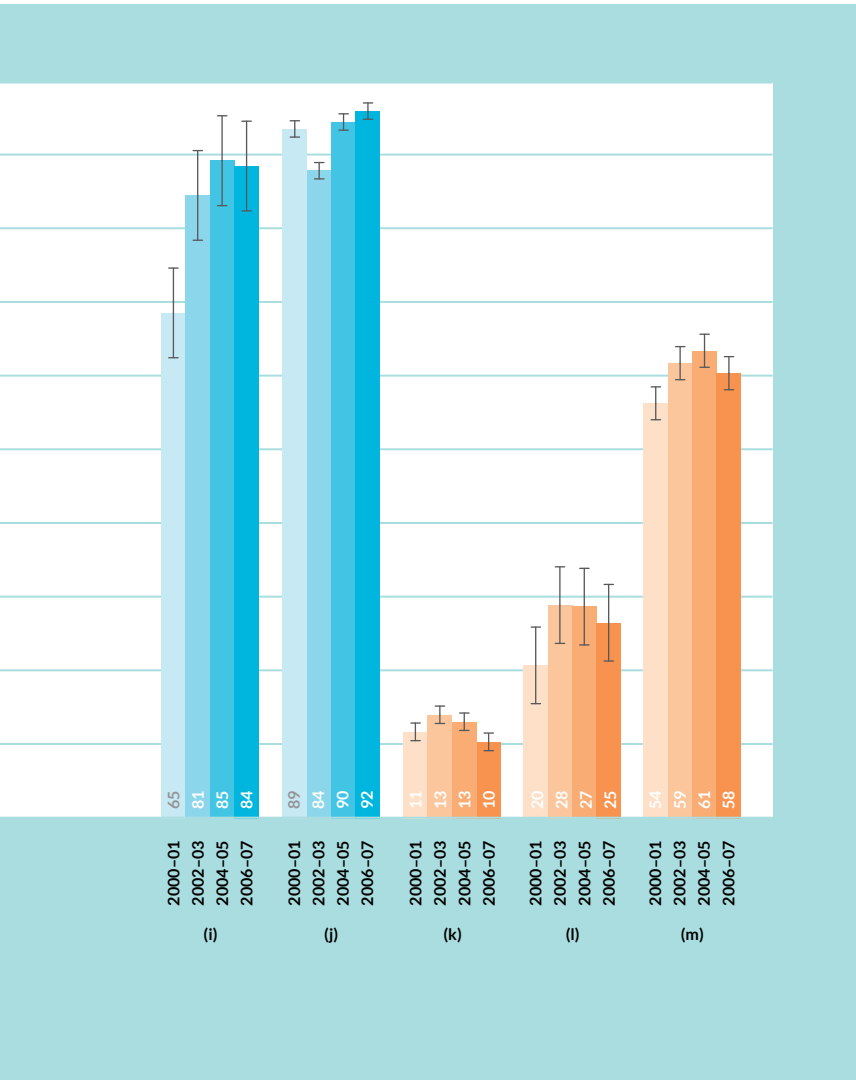
Implications

There has been considerable effort across Australia to improve the quality of ACS care. These efforts have led to improved outcomes for some patients with ACS. The National Heart Foundation ACS Implementation and Advocacy Working Group published recommendations, highlighting priority strategies for translating evidence into practice, on medical and procedural management, rehabilitation and secondary prevention, and equity of access.

There is an opportunity to elevate these strategies to a national focus to ensure that all patients with ACS receive appropriate, evidence-based care. National clinical standards for ACS would provide benchmarks of appropriate access to care for patients with ACS.

What we don't know

There is insufficient information collected over time to measure the appropriateness and effectiveness of care for ACS patients. Further efforts to develop a routine national data collection for ACS could assist with monitoring healthcare quality and informing clinical practice and service provision.



Source: Aliprandi Costa B, Ranasinghe I, Chow V, Kapila S, Juergens C, Devlin G, et al. Management and outcomes of patients with acute coronary syndromes in Australia and New Zealand, 2000–2007. Medical Journal of Australia;195(3):116 121.

The GRACE cohort analysed 1723 STEMI patients from 11 metropolitan and rural centres in Australia and New Zealand.

(a) Calcium channel blockers
(b) Glycoprotein IIb/IIIa receptor antagonists
(c) Thienopyridine without percutaneous coronary intervention
(d) Total low molecular weight heparin
(e) Unfractionated heparin
(f) Angiotensin-converting enzyme/ Angiotensin receptor blockers
(g) Thienopyridine (total)
(h) ß-blocker (excluding contraindications)
(i) Statin
(j) Aspirin (excluding contraindications)
(k) Coronary artery bypass graft surgery
(l) Percutaneous coronary intervention (all)
(m) Coronary angiography

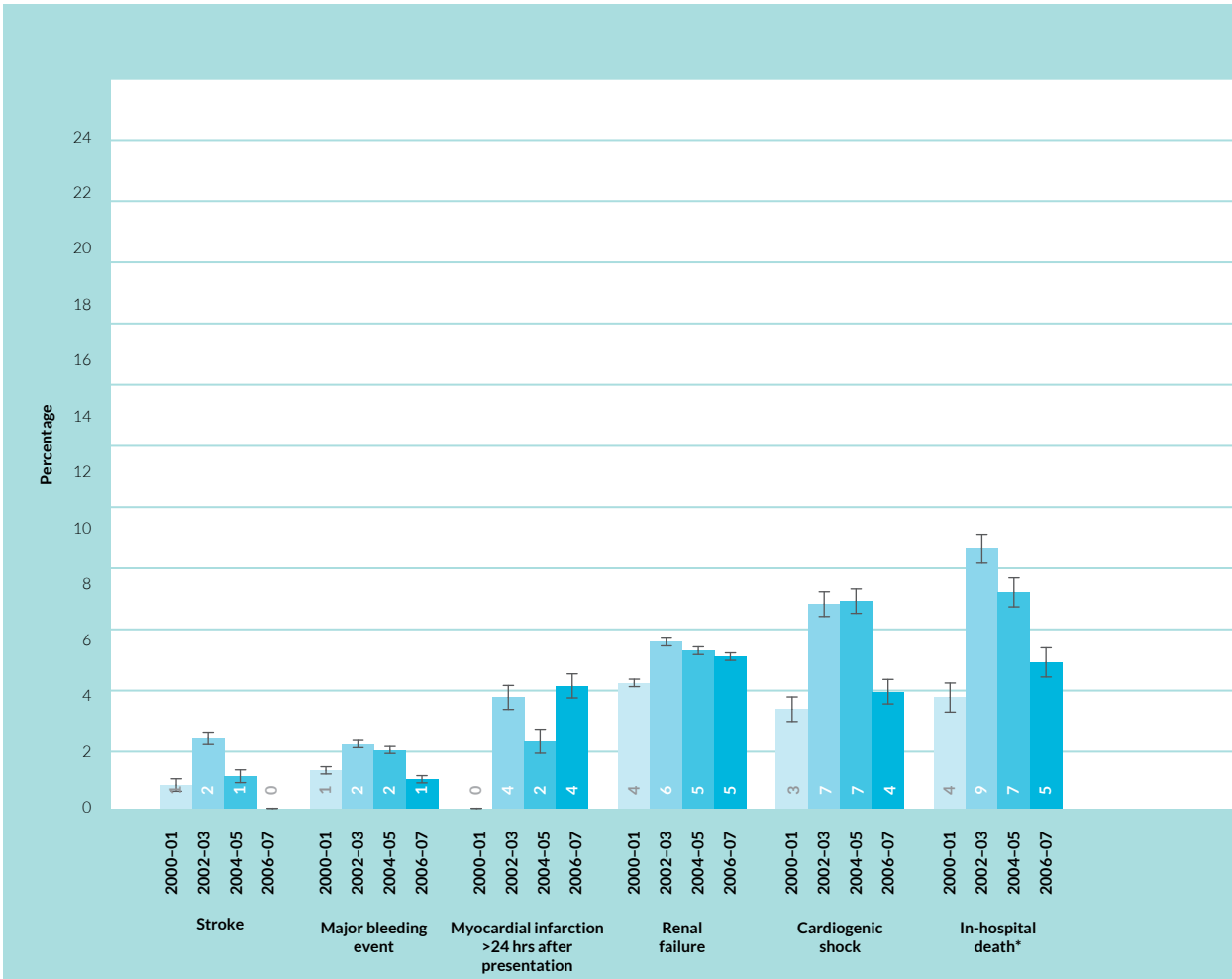


Figure 22 Trends in clinical outcomes for patients with STEMI in Australia and New Zealand (2000–07)

Source: Aliprandi Costa B, Ranasinghe I, Chow V, Kapila S, Juergens C, Devlin G, et al. Management and outcomes of patients with acute coronary syndromes in Australia and New Zealand, 2000 2007. Medical Journal of Australia;195(3):116 121.

The GRACE cohort analysed 1723 STEMI patients from 11 metropolitan and rural centres in Australia and New Zealand

* A consent waiver was introduced in 2002, resulting in the collection of more complete mortality data. Between 2002 and 2007, there was a 3.9% reduction in in hospital deaths (P = 0.04).

** IHD = ischaemic heart disease

21
21
13
12
2
1
0
1
1
2
2
1
4
3
1
3
23
20
14
9
2000–01
2002–03
2004–05
2006–07
Congestive heart failure/pulmonary oedema
Stroke within 6 months from discharge
Myocardial infarction within 6 months from discharge
Death within 6 months from discharge
Readmission for IHD** within 6 months from discharge

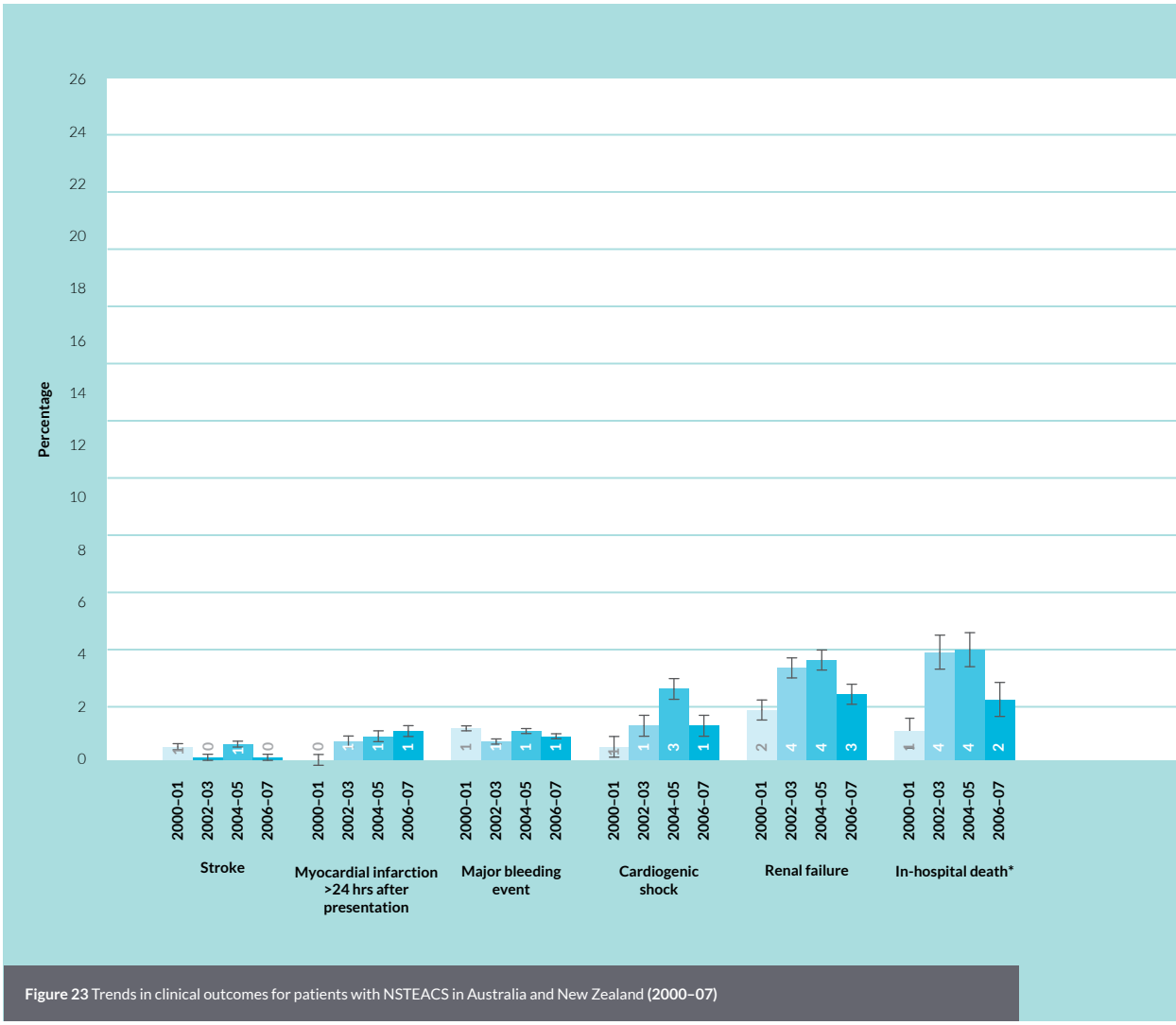


Figure 23 Trends in clinical outcomes for patients with NSTEACS in Australia and New Zealand **(2000–07)**

Source: Aliprandi Costa B, Ranasinghe I, Chow V, Kapila S, Juergens C, Devlin G, et al. Management and outcomes of patients with acute coronary syndromes in Australia and New Zealand, 2000 2007. Medical Journal of Australia;195(3):116 121.

The GRACE cohort analysed 3992 NSTEMI patients from 11 metropolitan and rural centres in Australia and New Zealand

* A consent waiver was introduced in 2002, resulting in the collection of more complete mortality data. Between 2002 and 2007, there was a 1.8% reduction in in hospital deaths (P= 0.04).

** IHD = Ischaemic Heart Disease

13
9
8
4
2
1
1
0
4
4
3
4
6
4
2
3
24
19
16
15
2000–01
2002–03
2004–05
2006–07
Congestive heart failure/pulmonary oedema
Stroke within 6 months from discharge
Myocardial infarction within 6 months from discharge
Death within 6 months from discharge
Readmission for IHD** within 6 months from discharge

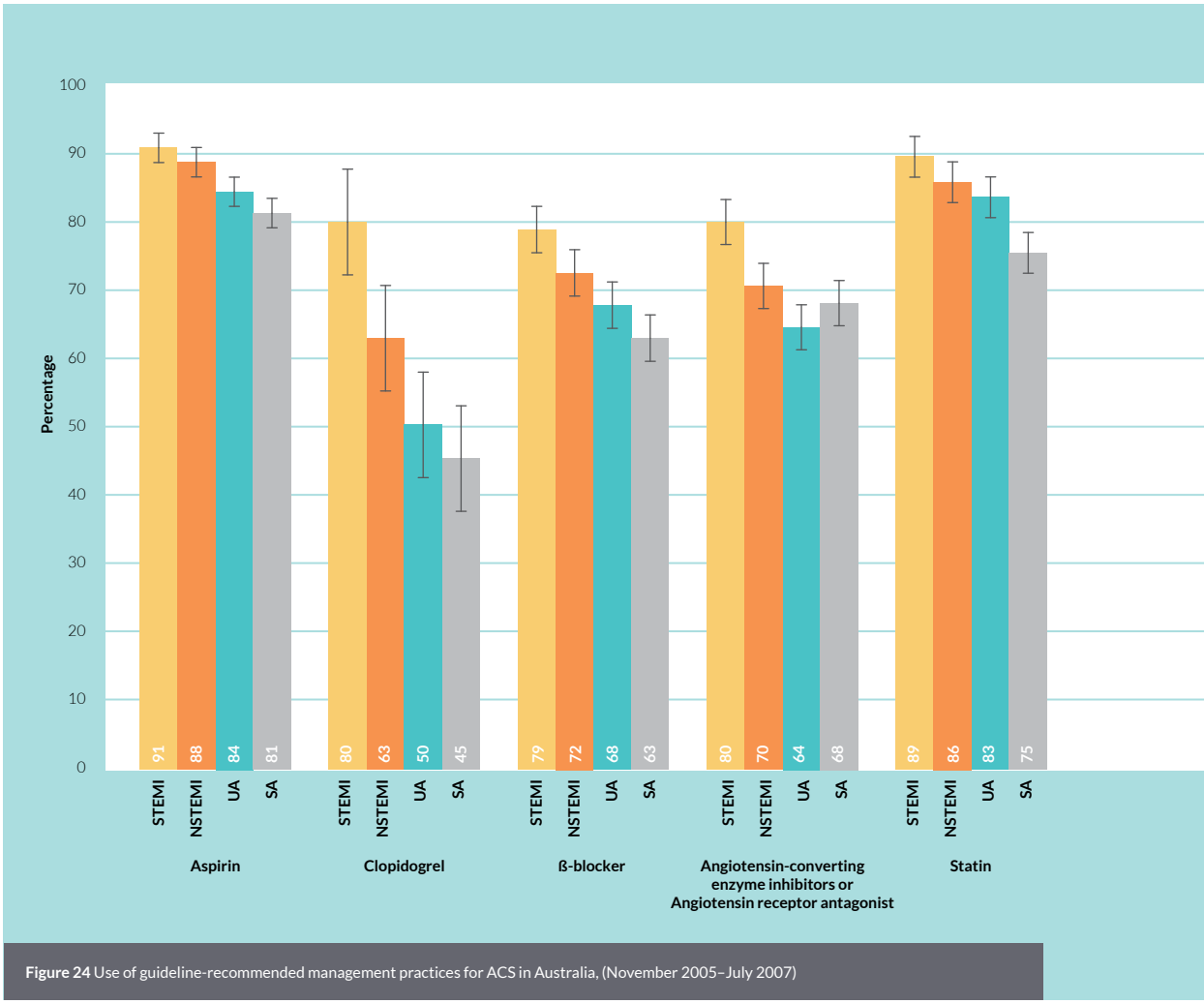


Figure 24 Use of guideline-recommended management practices for ACS in Australia, (November 2005–July 2007)

Source: Chew DP, Amerena JV, Coverdale SG, Rankin JM, Astley CM, Soman A, et al. Invasive management and late clinical outcomes in contemporary Australian management of acute coronary syndromes: observations from the ACACIA registry. Medical Journal of Australia 2008;188(12): Box 3, p.693.

The ACACIA Study enrolled 3402 patients with ACS in 24 metropolitan and 15 non-metropolitan hospitals in Australia.

90
71
45
36
71
34
14
9
95
97
98
100
6
10
7
2
STEMI
NSTEMI
UA
SA
Angiography
Percutaneous coronary intervention (PCI)
Stent (At least one stent among patients undergoing PCI)
Coronary artery bypass graft surgery

8. Corporate governance

8.1 Organisational structure and location of major activities and facilities

The Commission was created by Health Ministers in 2006, and is funded by all governments on a cost-sharing basis, to lead and coordinate healthcare safety and quality improvements in Australia.

In 2011, the Australian Parliament passed the *National Health Reform Act 2011* (the NHR Act) which established the Commission as an independent statutory authority under the *Commonwealth Authorities and Companies Act 1997* (the CAC Act) and specified its functions and governance structure.

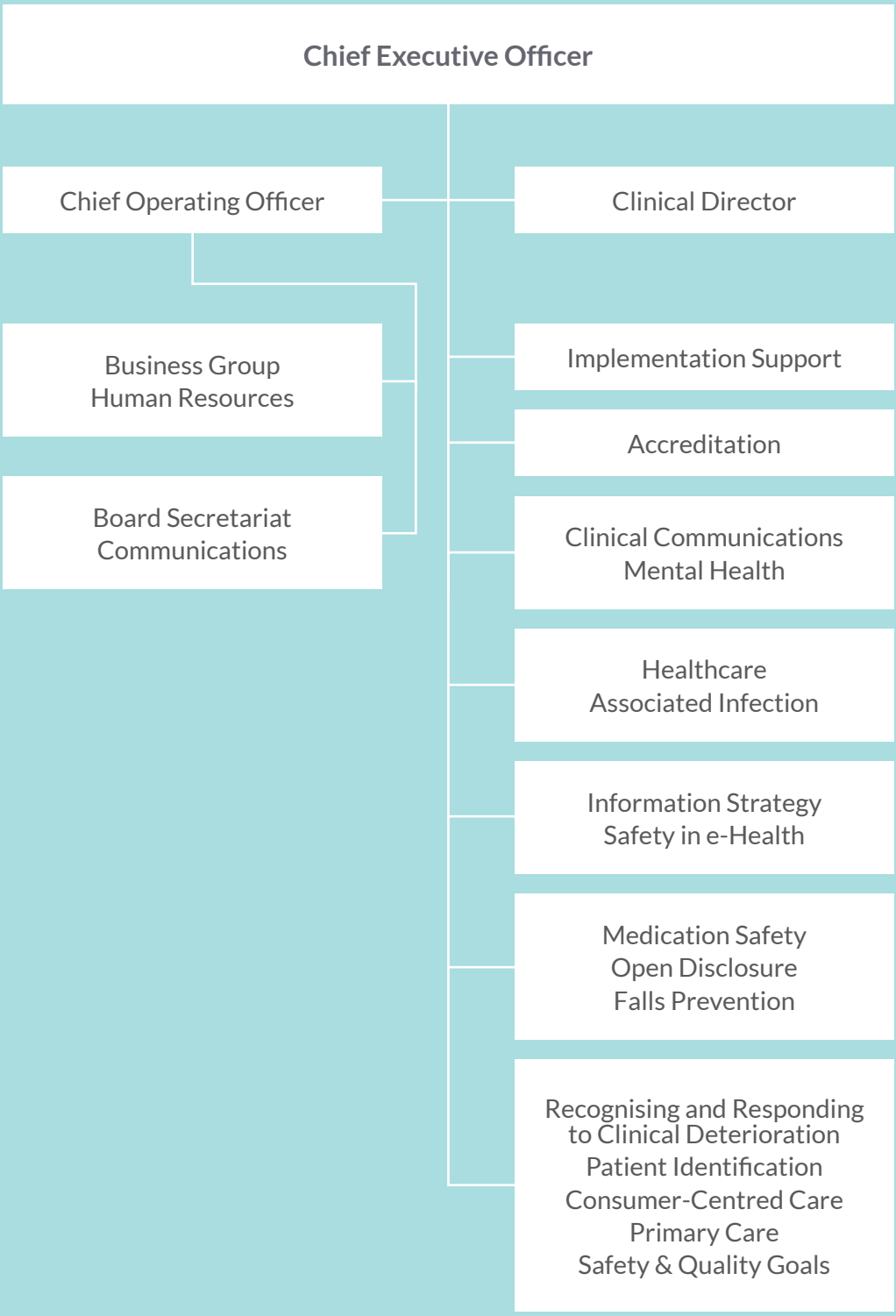
The Commission relates to Health Minsters through the Standing Council on Health and works closely with the Australian, state and territory health departments. This is formalised in the Inter-Jurisdictional Committee, which is made up of senior officials from the Commonwealth Department of Health and Ageing, and each state and territory department or ministry of health.

In addition to its everyday consultation approach, the Commission also has regular and formal contact with the private hospital sector, the primary care sector and the wide range of national organisations involved in e-health, data management and reporting. This is achieved through the Commission's Board Committees.

The Commission also works in close partnership with advisory committees that directly relate to key aspects of individual work programs. These involve relevant groups of people, including consumers and health professionals.

The Commission's office is located in Sydney at Level 7, 1 Oxford Street, Darlinghurst, and is managed on a day-to-day basis by its Chief Executive Officer, Professor Debora Picone, AM.

Organisation chart



8.2 The Commission's Board

The Commission is governed by a Board consisting of a Chair and seven to nine other members. Members of the substantive Commission Board were appointed from 1 April 2012.

Mr William Beerworth (Chair)

Bill Beerworth is an investment banker with a strong background in corporate law. He was educated in Australia and the United States, worked on Wall Street for 3 years and held a number of senior positions in law and banking and finance before establishing Beerworth & Partners Limited over 20 years ago. Beerworth & Partners Limited specialises in corporate strategy, mergers and acquisitions, restructuring and foreign investment.

Bill has been chairman or a director of a number of corporate and advisory boards. He is currently Chairman of the Australian Commission on Safety and Quality in Health Care, RedHill Education Limited and Contango Capital Partners Limited.

He was a member of the Inquiry into the Australian Financial System (the Wallis Inquiry) that proposed the current regulatory architecture of the Australian Financial System. He has been a member of the Australian Competition Tribunal and Chairman of Macquarie Graduate School of Management.

Mr Richard Bowden

Managing Director, Bupa Australia

Richard Bowden has been Managing Director of Bupa Australia for 15 years. He is responsible for ensuring Bupa Australia achieves its strategic ambition of helping members live longer, healthier, happier lives.

He started his career in audit, moved into financial services and has spent most of his career in the private health insurance field. He joined HBA 26 years ago, holding a wide range of executive roles whilst helping HBA evolve and grow throughout changes in both its structure and ownership.

More recently, Richard managed the transition from AXA Asia Pacific ownership to a stand-alone business under the international healthcare company, Bupa.

In 2008, Bupa acquired MBF, and Richard led the integration of the businesses. He has also overseen considerable improvements to healthcare services available to members, with the introduction of Bupa Health Dialog into Australia, and the acquisition of Health Eyewear Pty Limited (Blink Optical) and Peak Fitness Management (Australia) Pty Limited.

In addition to being a Commission Board member, Richard is the President of the Private Healthcare Australia (formerly Australian Health Insurance Association), on the Foundation Board of Very Special Kids, and a director of a number of other Bupa-related companies.

Ms Veronica Casey

Executive Director of Nursing and Midwifery in Metro South Health Service District, and Executive Director of Nursing, Princess Alexandra Hospital, Brisbane

Registered Nurse, Registered Midwife
Bachelor of Nursing
Post Graduate Diploma—Nursing
Masters of Nursing Leadership
Fellow of the College of Nursing Australia

In addition to being a Commission Board member, Veronica is an International Commissioner for the Magnet Program. Princess Alexandra Hospital is the first international Magnet-designated hospital outside of the USA. Veronica is also on the Queensland Regulation Board for Nursing and Midwifery.

Veronica's special interests are in quality and safety, nurse credentialing, models of care, workforce redesign and change management. After 33 years in nursing, her clinical passion remains with chronic disease management.

Professor Chris Brook, PSM

Executive Director, Wellbeing, Integrated Care and Ageing, Victorian Department of Health

Chris Brook is the Executive Director, Wellbeing, Integrated Care and Ageing for the Victorian Department of Health. This role focuses on prevention and population health; Aboriginal health; integrated care—including the primary, sub-acute and hospital diversion programs; aged care; workforce policy and planning in the health sector; and internal departmental human resource functions.

This portfolio is responsible for around $3 billon per annum in expenditure, involving hospitals, residential aged care facilities, community health centres, non-government organisations and local government.

Chris is also the State Health and Medical Commander for Emergency Management.

Chris' original postgraduate training was as a specialist physician but he has subsequently gained specialist qualifications in public health medicine and medical administration.

Chris is a regular attendee at Standing Council on Health and Australian Health Minister's Advisory Council (AHMAC) meetings; a member of the Hospitals Principal Committee of AHMAC; and has extensive policy and management experience in blood and blood products.

In addition to being a Commission Board member, Chris is a former president and an honorary life member of the International Society for Quality in Healthcare, and a Fellow of the Victorian Division of the Institute of Public Administration, Australia. He chairs the Advisory Committee of Deakin University Medical School and is a member of the board of Centre for Evidence in Intervention and Prevention Science. In 2011 Chris was awarded a Public Service Medal.

Ms Christine Gee

Chief Executive Officer, Toowong Private Hospital

Christine Gee has been the Chief Executive Officer of Toowong Private Hospital since 1997. She holds an MBA and her career in public and private acute health care spans over 25 years.

Christine holds a number of Board appointments across local, state and national arenas. She is a past President of the Australian Private Hospitals Association (APHA) and is currently a member of the APHA Board and Chair of the APHA Council, as well as Chair of its Psychiatric Committee. In 2010 she became an inaugural member of the Minter Ellison Health Advisory Board. She is Treasurer of the Private Hospitals Association of Queensland and a member of the Australian Government's Second Tier Advisory Committee. Christine also chairs the National Breast and Ovarian Cancer Centre Implementation Advisory Group and is a member of the Reference Group for the beyondblue National Perinatal Mental Health Program.

Christine has continually emphasised the necessity for private sector inclusion in the development and implementation of national quality and safety initiatives, and was appointed to the former Australian Council for Safety and Quality in Health Care in 2003. In January 2006 Christine was appointed as a Commissioner with the Australian Commission on Safety and Quality in Health Care, and in 2011 she was appointed as a Board member when the Commission was re-established as an independent statutory authority. She continues to Chair the Commission's Private Hospitals Sector Committee and its Open Disclosure Advisory Group.

Christine was awarded a Centenary Medal for distinguished service to the health industry in April 2003. In recognition of her contribution to the viability, growth, quality and achievements of the private hospital sector, she received the 2005 Australian Private Hospitals Association Individual Achievement Award. In November 2007, Christine was the recipient of a special award created in honour of the 20 year association of Baxter Healthcare and the Australian Council on Healthcare Standards that acknowledged an individual for Longstanding Service to Quality in Australian Healthcare.

Professor Jane Halton, PSM

Secretary of the Department of Health and Ageing

Jane Halton is Secretary of the Australian Department of Health and Ageing. She is responsible for all aspects of the operation of the Department, including the provision of advice on and administration of Medicare, the Pharmaceutical Benefits Scheme, aged and community care, population health, regulation of therapeutic goods, plus hospital financing and private health insurance. She also has responsibility for leadership on health security issues, including matters related to bioterrorism.

Jane is a member of the board of the Australian Institute of Health and Welfare and a board member of the National E-Health Transition Authority. She is also on the executive board of the Institute for Health Metrics and Evaluation at the University of Washington and on the Advisory Boards of the Centre for Applied Philosophy and Public Ethics, and the Melbourne Institute advisory board.

Jane is the Chair of the OECD's Health Committee. She was an executive board member on the World Health Organization (WHO) 2004–07 and President of the World Health Assembly (2007), and was Vice-Chair of the executive board 2005–06 and Chair of the WHO Program, Budget and Administration Committee 2005–07. She is currently Chair of the WHO Intergovernmental Meeting on Pandemic Influenza Preparedness.

Prior to her appointment in January 2002 as Secretary of the Department of Health and Ageing, Jane was Executive Co-ordinator, Department of the Prime Minister and Cabinet and was responsible for advising on all aspects of Australian Government social policy including the status of women.

Jane holds an honours degree in Psychology from the Australian National University, is a fellow of the Australian Institute of Management and an honorary fellow of the Australian College of Health Service Executives. She was awarded the Public Service Medal in 2002, and the Centenary Medal in 2003.

Professor Villis Marshall, AC

General Manager, Royal Adelaide Hospital

Professor Villis Marshall is an internationally recognised consultant in urology, educator and researcher.

Following his surgical training and fellowship at the University of Adelaide, he held faculty appointments at the London Hospital Medical College, St Peters Hospital and Royal Adelaide Hospital before serving as Chair of Flinders Medical Centre, Department of Urology for 25 years.

Professor Marshall is a distinguished fellow and past President of the Urological Society of Australasia.

He has received over 50 research grants and numerous invited lectureships from around the world.

In 1999 Professor Marshall received the St John's honour (Bailiff Grand Cross of the Order of St John of Jerusalem, the Order's highest award).

In 2006, Professor Marshall was awarded Companion of the Order of Australia (AC) for service to medicine in urology and kidney disease research.

Mr Russell McGowan

Consumer Board Member

Russell McGowan is a bone marrow transplant survivor who has been active in the healthcare consumer movement since the early 1990s and is now retired from the workforce on health grounds. His working life included teaching, fieldwork, program management and policy development, mainly involving employment, education and training programs for indigenous people.

Russell lives in Canberra and participates in numerous community and consumer healthcare organisations in the Australian Capital Territory (ACT). He retired as President of the Health Care Consumers Association of the ACT after 10 years in that office and was Deputy Chair of the ACT Health Council for some years.

In addition to being a Commission Board member, Russell is a member of the Australian Government's Medical Services Advisory Committee and previously sat on the boards of the Consumers Health Forum of Australia, the Australian Council on Healthcare Standards, the Australian General Practice Network, the Cancer Council of Australia and the National Blood Authority. He is currently focussing his energies on connecting care through the implementation of a personally controlled electronic health record for all Australians, together with continuous quality improvement in healthcare services to ensure better health outcomes for individual consumers and the population as a whole.

Ms Shelly Park

Chief Executive, Southern Health

Southern Health is Victoria's largest public health service and provides health services for over one million people in the south eastern suburbs of Melbourne.

In 2011 Shelly was named as Victorian Telstra Business Woman of the Year.

Prior to her current role, Shelly was the Executive Director of the Monash Sector at Southern Health and the Executive Director of Jessie McPherson Private Hospital. Her previous role was General Manager of Medical and Surgical Services at Christchurch Hospital (New Zealand).

Shelly has a passion for quality and innovation in public hospitals, with a particular emphasis on patient and family-centred care.

She is a graduate of the Australian Institute of Company Directors, a Fellow of the Australian Institute of Management and has studied innovation at The Wharton School, University of Pennsylvania.

Dr Helena Williams

MB BS, FRACGP, Executive Clinical Director of the Southern Adelaide Fleurieu Kangaroo Island Medicare Local and GP

Helena is the Executive Clinical Director of the Southern Adelaide Fleurieu Kangaroo Island Medicare Local, a GP in Blackwood in the Adelaide Hills, and the Presiding Member of the Southern Adelaide Local Health Network.

She has been a board Director of the Cancer Council SA, the Noarlunga Health Service, South Australian Divisions of General Practice, the Australian General Practice Network, and the Southern Adelaide Health Service.

She is also a former member of the South Australian Clinical Senate and the SA Generational Health Review Committee, and in 2009 she was appointed by the Premier of South Australia to the board of The Australian Centre for Social Innovation, on which she served for two years.

Board meeting attendance

BOARD MEMBER	1 JULY 2011	25 JULY 2011	1 SEPT 2011	27 OCT 2011	24 NOV 2011	8 MAR 2012	10 MAY 2012
Bill Beerworth	✓	✓	✓	✓	✓	✓	✓
Richard Bowden	✓	✓	✓	✓		✓	✓
Veronica Casey	✓	✓	✓			✓	✓
Christine Gee	✓	✓	✓		✓	✓	✓
Jane Halton			✓	✓	✓	✓	✓
Russell McGowan	✓	✓	✓	✓	✓	✓	✓
Shelly Park	✓	✓		✓	✓	✓	✓
Helena Williams	✓	✓	✓	✓	✓	✓	✓
Andrew Child[c]		✓	✓	✓	✓	✓	N/A
Tim Smyth[d]	✓	✓	✓	✓	✓	✓	N/A
Chris Brook[e]	N/A	N/A	N/A	N/A	N/A	N/A	✓
Villis Marshall[f]	N/A	N/A	N/A	N/A	N/A	N/A	✓
Total	8	9	9	8	8	10	10

c Term concluded 31 March 2012
d Term concluded 31 March 2012
e Term commenced 1 April 2012
f Term commenced 1 April 2012

8.3 Inter-Jurisdictional Committee

The Inter-Jurisdictional Committee (IJC) is a meeting of safety and quality officials of Australian Government, state and territory governments supported by the Commission, and was created by the Australian Health Minister's Conference (now Standing Council on Health) in 2006. It is responsible for providing advice on the process of policy development and facilitating jurisdictional engagement in the work of the Commission.

The IJC meets at least four times a year.

The role of the IJC includes:

- advising the Commission on the adequacy of the policy development process, in particular the implementation of policies
- ensuring that health departments and ministries are aware of new policy directions and are able to review local systems accordingly
- monitoring national actions to improve patient safety as approved by Health Ministers
- participating in national data collections on safety and quality
- building effective mechanisms within jurisdictions to enable national public reporting.

8.4 Audit and Risk Committee

Chaired by Ms Jennifer Clark, the primary role of the Audit and Risk Committee is to provide the Board with assistance, advice and oversight with respect to the Commission's financial reporting, corporate governance, risk and control and internal and external audit functions. Core responsibilities include:

- monitoring the effectiveness of risk management and internal control frameworks, management policies and key governance processes
- monitoring the Commission's compliance with provisions and requirements of the CAC Act and relevant regulations and helping the authority and its directors to comply with obligations under the CAC Act
- monitoring cost forecasting and collection of information for annual reporting purposes
- reviewing fraud prevention and security related matters
- reviewing operational risks, internal control measures, internal and external audits and reporting
- reviewing any other matter referred to it by the Board or the Chief Executive Officer
- providing a forum for communications between the Board members, the senior managers of the Commission and the internal and external auditors of the Commission.

The Audit and Risk Committee was established in the first half of 2012. Three Board members sit on the Committee — Mr Bill Beerworth, Mr Richard Bowden and Ms Shelly Park.

Audit and Risk Committee attendance 2012

The first meeting of the Committee was held on 8 May 2012. All members attended the meeting.

8.5 Commission Standing Committees

The Commission has a number of standing committees to support and advise on its work.

Primary Care Committee

The Primary Care Committee (PCC) is responsible for facilitating the engagement and uptake of Commission programs in the primary healthcare sector. The Primary Care Committee comprises nominees from the Australian Dental Association, Australian Medicare Local Alliance, Australian Medical Association, Australian Physiotherapy Association, community care sector, Consumers Health Forum, Department of Health and Ageing, Pharmacy Guild, Royal Australian College of General Practitioners, Royal College of Nursing Australia and the Royal Doctors Association of Australia.

The role of the PCC includes:

- assisting in tailoring the Commission's programs to enable their uptake in the primary healthcare sector
- informing the Commission of key safety and quality issues affecting the primary healthcare sector's performance
- providing strategic input and feedback on the Commission's work, including advising on policy development and facilitating primary health sector engagement
- providing leadership to the Commission to implement effective communication mechanisms between health system sectors.

The PCC meets at least four times a year.

Private Hospital Sector Committee

The Private Hospital Sector Committee (PHSC) is responsible for advising the Commission on key safety and quality initiatives from the perspective of the private hospital sector. The PHSC comprises nominees from the Australian Day Hospital Association, Australian Medical Association, Australian Private Hospital Association, Catholic Health Australia and Private Healthcare Australia.

The role of the PHSC includes:

- liaising with the Commission on key safety and quality issues affecting the private hospitals sector
- providing input and feedback on the Commission's work including advising on policy development and facilitating private hospital sector engagement
- working in partnership with the Commission to pursue an agreed safety and quality agenda, including providing feedback on the uptake of safety and quality initiatives
- assisting the Commission to implement effective communication mechanisms between sectors of the health system.

The PHSC meets at least four times a year.

Information Strategy Committee

The Information Strategy Committee (ISC) is responsible for guiding the information strategy for the Commission. The ISC comprises representatives from the Board, Inter-Jurisdictional Committee, Private Hospital Sector Committee, Primary Care Committee, Australian Bureau of Statistics, Australian Institute of Health and Welfare, Department of Health and Ageing, National E-Health and Information Principal Committee, National E-Health Transition Authority, National Health Information Standards and Statistics Committee, National Health Performance Authority, content experts and a consumer representative.

The role of the ISC includes:

- guiding the implementation of the Commission's information strategy
- making recommendations to the Commission
- monitoring and reporting on project progress
- drawing on members' expertise and experience for information strategy implementation.

The ISC meets at least four times a year.

Expert committees, working parties and reference groups

The Commission has established a number of time-limited expert committees, working parties and reference groups to support our projects. These groups allow the Commission to draw on expert knowledge, consult with relevant parties and develop appropriate implementation methods for the sector. For further details, see section 6.5.

8.6 People management

The Commission is committed to establishing a best-practice human resources function, which not only adheres to legislative employment requirements, but also promotes an employer of choice identity.

In the 2011/12 financial period, the Commission underwent a Machinery of Government change, which moved the employment of 47 staff from the Department of Health and Ageing to the Commission. These staff were working on existing health and safety programs and support prior to the move and the Commission is fortunate to have secured the services of this experienced, diverse and talented group of people.

Staffing information

Staff profile

Commission staff profile (30 June 2012)

Total Headcount	47
Male	8
Female	39
Total	**47**
Ongoing	28
Non-ongoing	19
Total	**47**
Part-time	11
Full-time	36
Total	**47**

Staff survey

The Commission understands that staff views and contributions are critical to ensuring that the Commission is an employer of choice. To encourage staff input, the Commission is committed to conducting a comprehensive staff survey every three years, and topical 'pulse' surveys in the two intervening years. The first comprehensive survey was conducted in May 2012, with an 82% participation rate and a 93% overall satisfaction rating—23 percentage points above the small agencies' average for the Australian Public Service. These baseline results were shared with all staff in June 2012 and action plans are to be developed and led by staff for roll-out in 2012/13.

Training and development

As a learning organisation, the Commission is keen to provide opportunities for both individual and organisation-wide professional development. To this end, staff working with the Commission were provided with 28 Continued Professional Development sessions; a tailored Study Support Policy was introduced; and access to Department of Health and Ageing online and face-to-face training was available, which included a comprehensive Australian Public Service induction program. In addition, staff received privacy training, covering staff responsibilities under the Information Privacy Principles.

Carer recognition

The Commission has undertaken to ensure that all personnel have an awareness and understanding of the Statement for Australia's Carers. The Commission's internal human resources policies, so far as they may affect a staff member's caring role, have due regard to the Statement for Australia's Carers.

Workplace agreements

The employment framework for Commission staff is the *Public Service Act 1999*.

On 10 May 2012, in line with the Machinery of Government change, a determination under s. 24(1) of the *Public Service Act 1999* (the Determination) came into effect, providing terms and conditions for all Commission Australian Public Service staff other than Senior Executive staff (SES) and SES equivalents. The Determination is based on the Department of Health and Ageing Enterprise Agreement, which was voted up by staff, including staff working with the Commission, in November 2011.

Negotiation of a Commission Enterprise Agreement will begin in the first half of the 2012/13 financial period.

8.7 Ethics

The Commission's staff are bound by the Australian Public Service Values and Code of Conduct, which apply to all Australian Public Service employees. They provide a clear framework for guiding behaviours and making decisions. Under the Code of Conduct, staff are required to behave at all times in a way which upholds the Australian Public Service Values.

The Commission's staff also have access to the Ethics Advisory Service. The service is available to all Australian Public Service employees who wish to discuss and seek advice on ethical issues that occur in the workplace and make sound decisions around these issues.

8.8 Internal audit arrangements

During 2011/12 the Commission commenced developing an internal audit program to assist the Board, the Audit and Risk Management Committee (see Section 8.4) and Commission management in the effective discharge of their responsibilities relating to risk management and internal control.

8.9 Fraud control

As required under the *Commonwealth Authorities and Companies Act 1997*, the Commission is developing a Fraud Control Plan to manage current and emerging fraud risks faced by the Commission. It is intended for fraud risk assessment to be undertaken regularly to identify and monitor the management of key risks relating to fraud.

8.10 Risk management

The Commission is developing a Risk Management Framework, which will outline key risk management responsibilities and the Commission's overarching approach to risk management. The framework will set the standard and provide a systematic approach to the identification and management of risk. An enterprise risk assessment will be undertaken regularly to identify and monitor the management of key risks in the Commission's ability to deliver against its strategic objectives.

8.11 Compliance Framework

The Commission's Compliance Framework will ensure that external and internal compliance obligations are met, as specified in the relevant legislation, and through the directions of the Board and Chief Executive Officer. The framework will include authorisations, instructions, and operational policies and procedures. The framework is monitored regularly to ensure the Commission's ongoing compliance.

9. Regulatory requirements

9.1 Notification of significant events

Professor Debora Picone, AM, commenced in the position of Chief Executive Officer of the Commission in March 2012.

Professor Picone joined the Commission as a highly respected Chief Executive and leader in public administration, with extensive operating and leadership responsibility in the provision of healthcare services extending from clinical, academic, hospital, Area Health Service, Deputy Director-General and Director-General positions.

9.2 Significant changes in affairs and activities

There have been no significant changes in affairs and activities during the financial year 2011/12, as referred to in s. 15 of the *Commonwealth Authorities and Companies Act 1997*.

9.3 Developments since the end of the financial year

There have been no significant developments since the end of the financial year that have significantly affected the Commission's operations or financial results.

9.4 Judicial decisions and reviews by outside bodies

There have been no judicial decisions or decisions of administrative tribunals that have had, or may have, a significant impact on the operations of the Commission. There have been no reports on the operations of the Commission by the Auditor General (other then the report on the Financial Statements), a Parliamentary Committee or the Commonwealth Ombudsman.

9.5 Ministerial directions

In August 2011, the Australian Health Ministers' Advisory Council asked the Commission to identify a small set of national safety and quality goals and to recommend them to Health Ministers for endorsement.

In response to this request, the Commission undertook a development and consultation process in 2011/12 and has proposed the *Australian Safety and Quality Goals for Health Care*. The goals set out important safety and quality challenges for Australia that would benefit from a coordinated national approach to improvement over the next 5 years.

The proposed goals for 2012–17 are as follows:

1. **Safety of care: That people receive health care without experiencing preventable harm**

Initial priorities are in the areas of:

- 1.1 Medication safety
- 1.2 Healthcare associated infection
- 1.3 Recognising and responding to clinical deterioration

2. **Appropriateness of care: That people receive appropriate, evidence-based care**

Initial priorities are:

- 2.1 Acute coronary syndrome
- 2.2 Transient ischaemic attack and stroke

3. **Partnering with consumers: That there are effective partnerships between consumers and healthcare providers and organisations at all levels of healthcare provision, planning and evaluation.**

9.6. Indemnities and insurance premiums for officers

The Commission has Directors' and Officers' liability insurance with Comcover.

No instances occurred during the 2011/12 financial year where a director or officer of the Commission indemnified or insured an officer/ex-officer of the Commission from any liability incurred by the person as an officer of the Commission.

9.7. Work health and safety

The Commission is committed to providing a positive, safe and healthy work environment for all staff, contractors and members of the public who may be affected by its work.

The Australian Government Solicitor briefed executive staff on their roles and responsibilities under the *Work Health and Safety Act 2011* (WHS Act). Development of policies in line with the new Work Health Safety (WHS) laws has commenced.

Two health and safety representatives received training in March 2012 and a WHS Committee was established. The WHS representatives, with the support of the WHS Committee and the human resources team, took the following actions:

- led a Continued Professional Development session for all staff, providing a high level overview of the new WHS laws
- conducted a thorough review of workplace hazards, and
- instigated actions to address the identified hazards, such as an office storage review, and engagement of an external provider to test and tag all electrical equipment.

As a result of these actions, and the co-operation of all staff, 75% of the identified hazards have been addressed. An action plan is to be developed to address the remaining issues.

All staff completed an online training course that was developed by Comcare and designed to build a worker's knowledge of the WHS Act. In particular it:

- outlined the purpose of the WHS Act
- described the duties as a worker under the WHS Act
- described the duties of others, such as visitors or customers, under the WHS Act
- identified the key parts of the WHS Act that are significant to workers, and
- explained the steps that staff can take to be actively involved in health and safety matters in the workplace.

In addition to the two health and safety representatives, the Commission has four fire wardens, three first aid officers and two workplace harassment contact officers.

Workstation assessments are carried out as part of induction.

The Commission offered influenza vaccinations in May 2012 to all staff and contractors.

There were no reportable work health and safety incidents in the 2011/12 financial period.

9.8. Equal employment opportunity

The Commission is an inclusive organisation that values fairness, equity and diversity consistent with the Australian Public Service Values and Code of Conduct. The Commission is committed to the principles of workplace diversity and equity in employment, which include recognising, respecting, valuing and utilising

individual differences. Comprehensive diversity and harassment policies are being developed to underpin this commitment. The Commission is also developing a Workplace Diversity Program to assist in giving effect to the Australian Public Service Values and to address the removal of employment-related bias. The Workplace Diversity Program will be regularly reviewed and progress against each activity will be measured and reported on an annual basis.

9.9 Freedom of Information

Agencies subject to the *Freedom of Information Act 1982* (FOI Act) are required to publish information to the public as part of the Information Publication Scheme. This requirement is in Part II of the FOI Act and has replaced the former requirement to publish a section 8 statement in an annual report.

A copy of the plan showing what information the Commission publishes in accordance with the Information Publication Scheme requirements is available at www.safetyandquality.gov.au.

9.10 Advertising and market research

All new vacancies with the Commission were advertised in the Australian Public Service Gazette, through the online APS jobs web site www.apsjobs.gov.au. A majority of positions were also advertised on www.seek.com and a small number were advertised in national newspapers.

The Commission used advertising to promote the International Conference on Rapid Response Systems and Medical Emergency Teams held in Sydney in May 2012. An advertisement was placed in *The Lamp* (NSW Nurses Association journal) and promotional material was also disseminated at other conferences.

Media release dissemination was undertaken by Australian Associated Press. In 2011/12 one media release was distributed through Australian Associated Press.

No market research was conducted in 2011/12.

9.11 Ecologically sustainable development

The Commission is dedicated to improving its ecological impact and endeavours to make all of its choices ecologically sustainable.

Commission staff are encouraged to use their personal recycling bin for all recyclable waste. Printer toner cartridges are also recycled.

The office lights operate on a timer and automatically switch off after 8pm.

Our reports are printed on recycled paper stock where possible, and the Commission is looking at using Forest Stewardship Council certified print companies where possible.

Where possible, telephone and video conferences are used to avoid unnecessary travel and minimise carbon emissions.

Environmental risk assessments will be incorporated into all project planning for 2012/13.

9.12 Disability access statement

The Commission is committed to providing full access and opportunity for people with a disability in accordance with the *Disability Discrimination Act 1992*. This commitment will be reinforced in the Commission Diversity Policy, which will specifically refer to creating equal opportunities for people with a disability.

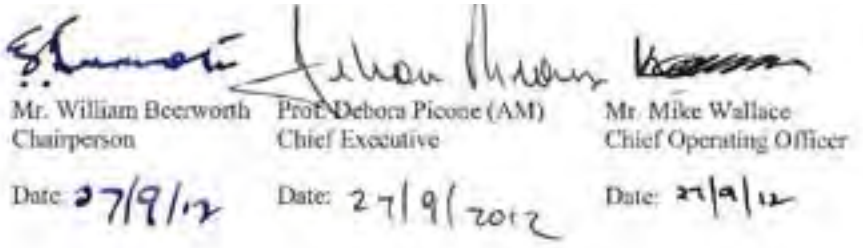
10. Financial statements

Statement by the Directors, Chief Executive and Chief Financial Officer

In our opinion, the attached financial statements for the year ended 30 June 2012 are based on properly maintained financial records and give a true and fair view of the matters required by the Finance Minister's Orders made under the *Commonwealth Authorities and Companies Act 1997*, as amended.

In our opinion, at the date of this statement, there are reasonable grounds to believe that the Authority will be able to pay its debts as and when they become due and payable.

This statement is made in accordance with a resolution of the directors.



Mr. William Beerworth	Prof. Debora Picone (AM)	Mr. Mike Wallace
Chairperson	Chief Executive	Chief Operating Officer
Date: 27/9/12	Date: 27/9/2012	Date: 27/9/12

Australian National Audit Office

INDEPENDENT AUDITOR'S REPORT

To the Minister for Health

I have audited the accompanying financial statements of the Australian Commission on Safety and Quality in Health Care for the year ended 30 June 2012, which comprise: a Statement by the Directors, Chief Executive and Chief Financial Officer; Statement of Comprehensive Income; Balance Sheet; Statement of Changes in Equity; Cash Flow Statement; Schedule of Commitments; and Notes to and forming part of the Financial Statements comprising a Summary of Significant Accounting Policies.

Directors' Responsibility for the Financial Statements

The directors of the Australian Commission on Safety and Quality in Health Care are responsible for the preparation of the financial statements that give a true and fair view in accordance with the Finance Minister's Orders made under the *Commonwealth Authorities and Companies Act 1997*, including the Australian Accounting Standards, and for such internal control as is necessary to enable the preparation of the financial statements that give a true and fair view and are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on the financial statements based on my audit. I have conducted my audit in accordance with the Australian National Audit Office Auditing Standards, which incorporate the Australian Auditing Standards. These auditing standards require that I comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Australian Commission on Safety and Quality in Health Care's preparation of the financial statements that give a true and fair view in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Australian Commission on Safety and Quality in Health Care's internal control. An audit also includes evaluating the appropriateness of the accounting policies used and the reasonableness of accounting estimates made by the directors, as well as evaluating the overall presentation of the financial statements.

GPO Box 707 CANBERRA ACT 2601
19 National Circuit BARTON ACT
Phone (02) 6203 7300 Fax (02) 6203 7777

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Independence

In conducting my audit, I have followed the independence requirements of the Australian National Audit Office, which incorporate the requirements of the Australian accounting profession.

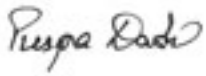
Opinion

In my opinion, the financial statements of the Australian Commission on Safety and Quality in Health Care:

(a) have been prepared in accordance with the Finance Minister's Orders made under the *Commonwealth Authorities and Companies Act 1997*, including the Australian Accounting Standards; and

(b) give a true and fair view of the matters required by the Finance Minister's Orders including the Australian Commission on Safety and Quality in Health Care's financial position as at 30 June 2012 and of its financial performance and cash flows for the year then ended.

Australian National Audit Office



Puspa Dash
Executive Director
Delegate of the Auditor-General

Canberra
27 September 2012

Statement of comprehensive income

FOR THE PERIOD ENDED 30 JUNE 2012

	NOTES	2012 $'000
EXPENSES		
Employee benefits	3A	5,216
Supplier	3B	7,766
Depreciation and amortisation	3C	65
Finance costs	3D	7
Total expenses		13,054
LESS:		
OWN-SOURCE INCOME		
Own-source revenue		
Sale of goods and rendering of services	4A	912
Interest	4B	54
External contributions	4C	5,500
Total own-source revenue		6,466
Net cost of (contribution by) services		6,588
Revenue from Government	4D	5,500
Surplus (deficit)		(1,088)
OTHER COMPREHENSIVE INCOME		
Changes in asset revaluation reserves		8
Total other comprehensive income (loss)		8
Total comprehensive income (loss)		(1,080)
Total comprehensive income (loss) to the Australian Government		(1,080)

The above statement should be read in conjunction with the accompanying notes.

Balance sheet

AS AT 30 JUNE 2012

	NOTES	2012 $'000
ASSETS		
Financial Assets		
Cash and cash equivalents	5A	**11,984**
Trade and other receivables	5B	**2,868**
Total financial assets		**14,852**
Non-Financial Assets		
Land and buildings	6A,B	**235**
Other	6C	**74**
Total non-financial assets		**309**
Total assets		**15,161**
LIABILITIES		
Payables		
Suppliers	7A	**12,879**
Other	7B	**368**
Total payables		**13,247**
Provisions		
Employee provisions	8A	**919**
Other	8B	**239**
Total provisions		**1,158**
Total liabilities		**14,405**
Net assets		**756**
EQUITY		
Parent Entity Interest		
Contributed equity		**1,836**
Reserves		**8**
Retained surplus (accumulated deficit)		**(1,088)**
Total equity		**756**

The above statement should be read in conjunction with the accompanying notes.

Statement of changes in equity

FOR THE PERIOD ENDED 30 JUNE 2012

	RETAINED EARNINGS	ASSET REVALUATION RESERVE	CONTRIBUTED EQUITY	TOTAL EQUITY
	2012 $'000	2012 $'000	2012 $'000	2012 $'000
Opening balance	–	–	–	–
Comprehensive income				
Other comprehensive income	–	8	–	8
Surplus (Deficit) for the period	(1,088)	–	–	(1,088)
Total comprehensive income	(1,088)	8	–	(1,080)
Transactions with owners				
Contributions by owners				
Equity injection	–	–	1,836	1,836
Sub-total transactions with owners	–	–	1,836	1,836
Closing balance as at 30 June	(1,088)	8	1,836	756
Closing balance attributable to the Australian Government	(1,088)	8	1,836	756

The above statement should be read in conjunction with the accompanying notes.

Cash flow statement

FOR THE PERIOD ENDED 30 JUNE 2012

	NOTES	2012 $'000
OPERATING ACTIVITIES		
Cash received		
Receipts from Government		5,060
External contributions		5,500
Sales of goods and rendering of services		586
Interest		21
Total cash received		11,167
Cash used		
Employees		(647)
Suppliers		(372)
Total cash used		(1,019)
Net cash from (used by) operating activities	9	10,148
FINANCING ACTIVITIES		
Cash received		
Contributed equity		1,836
Total cash received		1,836
Net cash from (used by) financing activities		1,836
Net increase (decrease) in cash held		11,984
Cash and cash equivalents at the end of the reporting period	5A	11,984

The above statement should be read in conjunction with the accompanying notes.

Schedule of commitments

AS AT 30 JUNE 2012

	2012 $'000
BY TYPE	
Commitments receivable	
Project Commitments[1]	478
Net GST receivable on commitments	157
Total capital commitments	635
Commitments payable	
Other commitments	
Operating lease[2]	1,425
Other Commitments[3]	321
Total other commitments	1,746
Net commitments by type	(1,111)
BY MATURITY	
Commitments receivable	
One year or less	560
From one to five years	75
Total receivable on commitments	635
Commitments payable	
Operating lease	
One year or less	640
From one to five years	785
Total operating lease commitments payable	1,425
Other commitments	
One year or less	285
From one to five years	36
Total other commitments payable	321
Total commitments payable	1,746
Net commitments by maturity	(1,111)

Note: Commitments are GST inclusive where relevant.

1. Project commitments receivable
   Comprises services committed to be provided by the Commission to the Department of Health and Ageing, under signed agreements, where the Commission has yet to perform the services required.
2. Operating lease commitments payable
   The Commission has committed to a 3 year lease term agreement which commenced in September 2011. The lease is effectively non-cancellable. Lease payments are subject to annual increases or reviews until the end of the lease.
3. Other commitments payable
   Comprises amounts committed under signed agreements where the contracted organisation has yet to perform the services required.

This schedule should be read in conjunction with the accompanying notes.

Table of Contents – Notes

Notes to and forming part of the Financial Statements for the period ended 30 June 2012

Note 1: Summary of Significant Accounting Policies

1.1 Objectives of the entity

The Australian Commission on Safety and Quality in Healthcare (the Commission) is an Australian Government controlled entity. The objective of the Commission is to lead and coordinate health care safety and quality improvements in Australia.

Initially established in 2006 by the Australian, state and territory governments to lead and coordinate national improvements in safety and quality, the Commission's permanent status was confirmed with the assent of the *National Health Reform Act 2011* (NHR Act). It is now a Commonwealth Authority operating under the requirements of the *Commonwealth Authorities and Companies Act 1997*. The Commission commenced as an independent, statutory authority on 1 July 2011, funded jointly by all governments in Australia.

The Commission is structured to meet a single outcome:

To improve safety and quality in healthcare across the health system, including through the development, support for implementation, and monitoring of national clinical safety and quality guidelines and standards.

The continued existence of the Commission in its present form and with its present programs is dependent on Government policy and on continuing funding by Parliament for the Commission's administration and programs.

1.2 Basis of Preparation of the Financial Statements

The financial statements are general purpose financial statements and are required by clause 1(b) of Schedule 1 to the *Commonwealth Authorities and Companies Act 1997*.

The financial statements have been prepared in accordance with:

a) Finance Minister's Orders (FMOs) for reporting periods ending on or after 1 July 2011; and

b) Australian Accounting Standards and Interpretations issued by the Australian Accounting Standards Board (AASB) that apply for the reporting period.

The financial statements have been prepared on an accrual basis and in accordance with the historical cost convention, except for certain assets and liabilities at fair value. Except where stated, no allowance is made for the effect of changing prices on the results or the financial position.

The financial statements are presented in Australian dollars and values are rounded to the nearest thousand dollars unless otherwise specified.

Unless an alternative treatment is specifically required by an accounting standard or the FMOs, assets and liabilities are recognised in the balance sheet when and only when it is probable that future economic benefits will flow to the Commission or a future sacrifice of economic benefits will be required and the amounts of the assets or liabilities can be reliably measured. However, assets and liabilities arising under executor contracts are not recognised unless required by an accounting standard. Liabilities and assets that are unrecognised are reported in the schedule of commitments or the schedule of contingencies.

Unless alternative treatment is specifically required by an Accounting Standard, income and expenses are recognised in the Statement of Comprehensive Income when and only when the flow, consumption or loss of economic benefits has occurred and can be reliably measured.

1.3 Significant Accounting Judgements and Estimates

No accounting assumptions or estimates have been identified that have a significant risk of having a significant impact on the amounts recorded in the financial statements or risk causing a material adjustment to the carrying amounts of assets or liabilities within the next reporting period.

1.4 New Australian Accounting Standards

Adoption of New Australian Accounting Standard Requirements

No Accounting Standard has been adopted earlier than the application date as stated in the standard.

No new standards, revised standards, interpretations or amending standards that were issued prior to the sign off date and are applicable to the current reporting period had a material financial impact on the Commission.

Future Australian Accounting Standard Requirements

New standards, revised standards and interpretations that were issued by the Australian Accounting Standards Board prior to the signing of the statement by chief executive and chief financial officer and are applicable to the future reporting period are not expected to have a material future financial impact.

1.5 Revenue

Revenue from rendering of services is recognised by reference to the stage of completion of contracts at the reporting date. The revenue is recognised when:

a) the amount of revenue, stage of completion and transaction costs incurred can be reliably measured; and

b) the probable economic benefits associated with the transaction will flow to the Commission.

The stage of completion of contracts at the reporting date is determined by reference to surveys of work performed.

Receivables for goods and services, which have 30 day terms, are recognised at the nominal amounts due less any impairment allowance account. Collectability of debts is reviewed at end of the reporting period. Allowances are made when collectability of the debt is no longer probable.

Interest revenue is recognised using the effective interest method as set out in AASB 139 *Financial Instruments: Recognition and Measurement*.

Revenue from Government – CAC Act body payment item

Funding received or receivable from agencies (appropriated to the Department of Health and Ageing as a CAC Act body payment item for payment to the Commission) is recognised as Revenue from Government unless they are in the nature of an equity injection or a loan.

Revenue from Government – Commonwealth Contributions

Commonwealth contributions for specific projects or a contractual agreement. Revenue from rendering of services is recognised by reference to the stage of completion of contracts at the reporting date. The revenue is recognised when:

i) the amount of revenue, stage of completion and transaction costs incurred can be reliably measured; and

ii) the probable economic benefits with the transaction will flow to the Commission.

The stage of completion of contracts at the reporting date is determined by reference to the proportion that costs incurred to date bear to the estimated total costs of the transaction.

External Contributions – States and Territories Contributions

Funding received or receivable from States or Territories. Revenue is recognised in the period to which the Funding is provided and when probable economic benefits with the transactions will flow to the Commission.

Parental Leave Payments Scheme

Amounts received under the Parental Leave Payments Scheme by the Commission not yet paid to employees are presented gross as cash and a liability (payable). The total amount received under this scheme is disclosed as a footnote to the Note 4: Revenue from Government.

1.6 Gains

Resources Received Free of Charge

Resources received free of charge are recognised as gains when, and only when, a fair value can be reliably determined and the services would have been purchased if they had not been donated. Use of those resources is recognised as an expense.

Resources received free of charge are recorded as either revenue or gains depending on their nature.

Contributions of assets at no cost of acquisition or for nominal consideration are recognised as gains at their fair value when the asset qualifies for recognition, unless received from another Government entity as a consequence of a restructuring of administrative arrangements (Refer to Note 1.7).

Sale of Assets

Gains from disposal of assets are recognised when control of the asset has passed to the buyer.

1.7 Transactions with the Government as Owner

Equity Injections

Amounts that are designated as equity injections for a year are recognised directly in contributed equity in that year.

Restructuring of Administrative Arrangements

Net assets received from or relinquished to another Government entity under a restructuring of administrative arrangements are adjusted at their book value directly against contributed equity.

1.8 Employee Benefits

For the period 1 July 2011 to 10 May 2012, staff of the Commission were seconded from the Department of Health and Ageing. Included in employee benefits are amounts paid as reimbursement to the Department of Health and Ageing for employee benefits incurred on the Commission's behalf. On 10 May 2012, the staff seconded from the Department of Health and Ageing became employees of the Commission.

Liabilities for 'short-term employee benefits' (as defined in AASB 119 *Employee Benefits*) and termination benefits due within twelve months of the end of the reporting period are measured at their nominal amounts.

The nominal amount is calculated with regard to the rates expected to be paid on settlement of the liability.

Other long-term employee benefits are measured as net total of the present value of the defined benefit obligation at the end of the reporting period minus the fair value at the end of the reporting period of plan assets (if any) out of which the obligations are to be settled directly.

Leave

The liability for employee benefits includes provision for annual leave and long service leave. No provision has been made for sick leave as all sick leave is non-vesting and the average sick leave taken in future years by employees of the Commission is estimated to be less than the annual entitlement for sick leave.

The leave liabilities are calculated on the basis of employees' remuneration at the estimated salary rates that will be applied at the time the leave is taken, including the Commission's employer superannuation contribution rates to the extent that the leave is likely to be taken during service rather than paid out on termination.

The liability for long service leave is measured at the present value of the estimated future cash flows to be made in respect of all employees at year end. The estimate of the present value of the liability takes into account attrition rates and pay increases through promotion and inflation.

Superannuation

The Commission's staff are members of the Commonwealth Superannuation Scheme (CSS), the Public Sector Superannuation Scheme (PSS), the PSS accumulation plan (PSSap) or other funds.

The CSS and PSS are defined benefit schemes for the Australian Government. The PSSap and other funds are defined contribution schemes.

The liability for defined benefits is recognised in the financial statements of the Australian Government and is settled by the Australian Government in due course. This liability is reported by the Department of Finance and Deregulation as an administered item.

The Commission makes employer contributions to the employees' superannuation scheme at rates determined by an actuary to be sufficient to meet the current cost to the Government. The Commission accounts for the contributions as if they were contributions to defined contribution plans.

The liability for superannuation recognised as at 30 June represents outstanding contributions for the final fortnight of the year.

1.9 Leases

A distinction is made between finance leases and operating leases. Finance leases effectively transfer from the lessor to the lessee substantially all the risks and rewards incidental to ownership of leased assets. An operating lease is a lease that is not a finance lease. In operating leases, the lessor effectively retains substantially all such risks and benefits.

Operating lease payments are expensed on a straight-line basis which is representative of the pattern of benefits derived from the leased assets.

The Commission did not have any finance leases during the year.

1.10 Borrowing Costs

All borrowing costs are expensed as incurred.

1.11 Cash

Cash is recognised at its nominal amount. Cash and cash equivalents includes:

a) cash on hand; and

b) demand deposits in bank accounts with an original maturity of 3 months or less that are readily convertible to known amounts of cash and subject to insignificant risk of changes in value.

1.12 Financial Assets

The Commission classifies its financial assets as loans and receivables.

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition. Financial assets are recognised and derecognised upon trade date. The Commission only held loans and receivables.

Loans and Receivables

Trade receivables, loans and other receivables that have fixed or determinable payments that are not quoted in an active market are classified as 'loans and receivables'. Loans and receivables are measured at amortised cost using the effective interest method less impairment. Interest is recognised by applying the effective interest rate.

The Commission has no contingent assets and liabilities. Hence, a Schedule of Contingencies has not been prepared.

Impairment of Financial Assets

Financial assets are assessed for impairment at the end of each reporting period.

If there is objective evidence that an impairment loss has been incurred for loans and receivables or held to maturity investments held at amortised cost, the amount of the loss is measured as the difference between the asset's carrying amount and the present value of estimated future cash flows discounted at the asset's original effective interest rate. The carrying amount is reduced by way of an allowance account. The loss is recognised in the Statement of Comprehensive Income.

1.13 Financial Liabilities

Financial liabilities are classified as either financial liabilities 'at fair value through profit or loss' or other financial liabilities. Financial liabilities are recognised and derecognised upon 'trade date'.

The Commission only incurred other financial liabilities. These consist of trade creditors and accruals and other payables. Other financial liabilities are recognised at their nominal amount, being the amounts the Commission expects the liabilities to be settled. Liabilities are recognised to the extent that the goods or services have been received (and irrespective of having been invoiced).

1.14 Contingent Liabilities and Contingent Assets

Contingent liabilities and contingent assets are not recognised in the balance sheet but are reported in the relevant schedules and notes. They may arise from uncertainty as to the existence of a liability or asset or represent an asset or liability in respect of which the amount cannot be reliably measured. Contingent assets are disclosed when settlement is probable but not virtually certain and contingent liabilities are disclosed when settlement is greater than remote.

The Commission has no contingent assets and liabilities. Hence, a Schedule of Contingencies has not been prepared.

1.15 Acquisition of Assets

Assets are recorded at cost on acquisition except as stated below. The cost of acquisition includes the fair value of assets transferred in exchange and liabilities undertaken. Financial assets are initially measured at their fair value plus transaction costs where appropriate.

Assets acquired at no cost, or for nominal consideration, are initially recognised as assets and income at their fair value at the date of acquisition, unless acquired as a consequence of restructuring of administrative arrangements. In the latter case, assets are initially recognised as contributions by owners at the amounts at which they were recognised in the transferor's accounts immediately prior to the restructuring.

1.16 Property, Plant and Equipment

Asset Recognition Threshold

Purchases of property, plant and equipment are recognised initially at cost in the balance sheet, except for purchases of leasehold improvements costing less than $10,000 and for all other purchased of property, plant and equipment costing less than $2,000, which are expensed in the year of acquisition (other than where they form part of a group of similar items which are significant in total).

The Commission did not have any property, plant and equipment other than leasehold improvements.

The initial cost of an asset includes an estimate of the cost of dismantling and removing the item and restoring the site on which it is located. This is particularly relevant to 'make good' provisions in property taken up by the Commission where there exists an obligation to restore the leased premises to the condition they were in prior to fitout. These costs are included in the value of the Commission's leasehold improvements with a corresponding provision for the 'make good' recognised.

Revaluations

Fair values for each class of asset are determined as shown below:

ASSET CLASS	FAIR VALUE MEASURED AT
Leasehold improvements	Depreciated replacement cost

Following initial recognition at cost, property, plant and equipment are carried at fair value less subsequent accumulated depreciation and accumulated impairment losses. Valuations are conducted to ensure that the carrying amounts of assets do not differ materially from the assets' fair values as at the reporting date. The regularity of independent valuations will depend upon the volatility of movements in market values for the relevant assets.

Revaluation adjustments are made on a class basis. Any revaluation increment is credited to equity under the heading of asset revaluation reserve except to the extent that it reversed a previous revaluation decrement of the same asset class that was previously recognised in the surplus/deficit. Revaluation decrements for a class of assets are recognised directly in the surplus/deficit except to the extent that they reversed a previous revaluation increment for that class.

Any accumulated depreciation as at the revaluation date is eliminated against the gross carrying amount of the asset and the asset restated to the revalued amount.

Depreciation

Depreciable property, plant and equipment assets are written-off to their estimated residual values over their estimated useful lives to the Commission using, in all cases, the straight-line method of depreciation.

Depreciation rates (useful lives), residual values and methods are reviewed at each reporting date and necessary adjustments are recognised in the current, or current and future reporting periods, as appropriate.

Depreciation rates applying to each class of depreciable asset are based on the following useful lives:

	2012
Leasehold improvements	Lease term

Impairment

All assets were assessed for impairment at 30 June 2012. Where indications of impairment exist, the asset's recoverable amount is estimated and an impairment adjustment made if the asset's recoverable amount is less than its carrying amount.

The recoverable amount of an asset is the higher of its fair value less costs to sell and its value in use. Value in use is the present value of the future cash flows expected to be derived from the asset. Where the future economic benefit of an asset is not primarily dependent on the asset's ability to generate future cash flows, and the asset would be replaced if the Commisison were deprived of the asset, its value in use is taken to be its depreciated replacement cost.

Derecognition

An item of property, plant and equipment is derecognised upon disposal or when no further future economic benefits are expected from its use or disposal.

1.17 Intangibles

Intangibles comprise internally developed and purchased software for internal use. These assets are carried at cost less accumulated amortisation and accumulated impairment losses.

Intangibles are recognised initially at cost in the balance sheet, except for purchases costing less than $100,000, which are expensed in the year of acquisition.

Intangibles are amortised on a straight-line basis over its anticipated useful life.

The Commission did not hold any intangible assets as at 30 June 2012.

1.18 Taxation

The Commission is exempt from all forms of taxation, except for Fringe Benefits Tax and Goods and Services Tax.

Revenues, expenses and assets are recognised net of GST except:

i) where the amount of GST incurred is not recoverable from the Australian Taxation Office; and

ii) for receivables and payables.

Note 2: Events After the Reporting Period

No matters or circumstances have arisen since the end of the financial year which significantly affected or may affect the operations of the Commission, the results of these operations or the state of affairs of the Commission in subsequent years.

Note 3: Expenses

	2012 $'000
Note 3A: Employee Benefits	
Wages and salaries	3,910
Superannuation:	
Defined contribution plans	484
Defined benefit plans	138
Leave and other entitlements	647
Other employee benefits	37
Total employee benefits	5,216
Note 3B: Suppliers	
Goods and services	
Consultants	55
Contractors	4,579
Travel	529
Information and communication	384
Printing and postage	395
Other	1,089
Total goods and services	7,031
Goods and services are made up of:	
Provision of goods – external parties	662
Rendering of services – related entities	387
Rendering of services – external parties	5,982
Total goods and services	7,031
Other supplier expenses	
Operating lease rentals – related entities:	
Sublease	674
Workers compensation expenses	61
Total other supplier expenses	735
Total supplier expenses	7,766
Note 3C: Depreciation and Amortisation	
Depreciation:	
Land and buildings	65
Total depreciation	65
Note 3D: Finance Costs	
Unwinding of discount	7
Total finance costs	7

The unwinding of discount relates to make good on lease relating to the period 8 September 2011 to 30 June 2012.

Note 4: Income

	2012 $'000
OWN-SOURCE REVENUE	
Note 4A: Sale of Goods and Rendering of Services	
Rendering of services – related parties	500
Rendering of services – external parties	412
Total sale of goods and rendering of services	912
Note 4B: Interest	
Deposits	54
Total interest	54
Note 4C: External Contributions	
States and Territories contributions	5,500
Total external contributions	5,500
REVENUE FROM GOVERNMENT	
Note 4D: Revenue from Government*	
Department of Health and Ageing:	
CAC Act body payment item	5,500
Total revenue from Government	5,500

* The Commission did not receive any funding under the Paid Parental Leave Scheme in 2012.

Note 5: Financial Assets

	2012 $'000
Note 5A: Cash and Cash Equivalents	
Cash on hand or on deposit	11,984
Total cash and cash equivalents	11,984
Note 5B: Trade and Other Receivables	
Good and Services:	
Goods and services – external parties	368
Total receivables for goods and services	368
Department of Health and Ageing	
Receivable	1,378
Total receivable from Department of Health and Ageing	1,378
Other receivables:	
GST receivable from the Australian Taxation Office	1,055
Interest – external parties	33
Other – related entities	30
Other – external parties	4
Total other receivables	1,122
Total trade and other receivables (gross)	2,868
Less impairment allowance account:	
Goods and services	–
Total impairment allowance account	–
Total trade and other receivables (net)	2,868
Receivables are expected to be recovered in:	
No more than 12 months	2,868
More than 12 months	–
Total trade and other receivables (net)	2,868

No receivables were overdue or impaired at 30 June 2012.

Note 6: Non-Financial Assets

	2012 $'000
Note 6A: Land and Buildings	
Fair value	300
Accumulated depreciation	(65)
Total land and buildings	235

No indicators of impairment were found for land and buildings.

No land or buildings were expected to be sold or disposed of within the next 12 months.

The Commission did not have any property, plant and equipment other than leasehold improvements.

Revaluations of non-financial assets

All revaluations are conducted in accordance with the revaluation policy stated at Note 1.

	2012 $'000
Note 6B: Reconciliation of the opening and closing balances of land and buildings	
As at 1 July 2011	
Gross book value	–
Accumulated depreciation and impairment	–
Net book value 1 July 2011	–
Additions:	
By make good	300
Depreciation expense	(65)
Net book value 30 June 2012	235
Net book value as of 30 June 2012 represented by:	
Gross book value	300
Accumulated depreciation	(65)
	235

Note 6C: Other Non-Financial Assets	
Prepayments	74
Total other non-financial assets	74
Total other non-financial assets – are expected to be recovered in:	
No more than 12 months	74
More than 12 months	–
Total other non-financial assets	74

No indicators of impairment were found for other non-financial assets.

Note 7: Payables

	2012 $'000
Note 7A: Suppliers	
Trade creditors and accruals	12,879
Total supplier payables	12,879
Supplier payables expected to be settled within 12 months:	
Related entities - Department of Health and Ageing	11,740
Related entities - Other	112
External parties	1,027
Total	12,879

Settlement is usually made within 30 days.

Note 7B: Other Payables	
Salaries and wages	196
Superannuation	26
Unearned income	80
GST payable to ATO	62
Other	4
Total other payables	368

All other payables are expected to be settled in no more than 12 months.

Note 8: Provisions

	2012 $'000
Note 8A: Employee Provisions	
Leave	919
Total employee provisions	919
Employee provisions are expected to be settled in:	
No more than 12 months	668
More than 12 months	251
Total employee provisions	919
Note 8B: Other Provisions	
Provision for restoration obligations	239
Total other provisions	239
Other provisions are expected to be settled in:	
No more than 12 months	–
More than 12 months	239
Total other provisions	239

	PROVISION FOR RESTORATION $'000
Carrying amount 1 July 2011	–
Provisions made	240
Amounts recognised in other comprehensive income	(8)
Unwinding of discount or change in discount rate	7
Closing balance 30 June 2012	239

The rental agreement relating to the Commission's premises contains provisions requiring the restoration of the premises to their original condition at the conclusion of the rental agreement term. The Commission has made a provision to reflect the present value of this obligation.

Note 9: Cash Flow Reconciliation

	2012 $'000
Reconciliation of cash and cash equivalents as per Balance Sheet to Cash Flow Statement	
Cash and cash equivalents as per:	
Cash flow statement	11,984
Balance sheet	11,984
Difference	–
Reconciliation of net cost of services to net cash from operating activities:	
Net cost of services	(6,588)
Add revenue from Government	5,500
Adjustments for non-cash items	
Depreciation and amortisation	65
Movements in operating recognised in equity	8
Capitalisation of accruals not classified as operating	(300)
Changes in assets / liabilities	
(Increase) / decrease in net receivables	(2,868)
(Increase) / decrease in prepayments	(74)
Increase / (decrease) in employee provisions	919
Increase / (decrease) in supplier payables	12,879
Increase / (decrease) in other payables	368
Increase / (decrease) in other provisions	239
Net cash from (used by) operating activities	10,148

Note 10: Contingent Assets and Liabilities

Quantifiable Contingencies

As at 30 June 2012, the Commission has no quantifiable contingencies.

Unquantifiable Contingencies

As at 30 June 2012, the Commission has no unquantifiable contingencies.

Significant Remote Contingencies

As at 30 June 2012, the Commission has no material remote contingencies.

Note 11: Directors Remuneration

The number of non-executive directors of the Commission included in these figures are shown below in the relevant remuneration bands:

	2012 $'000
$0 to $29,999*	12
Total	12
Total remuneration received or due and receivable by directors of the Commission	61,763

* 5 directors included in this band waived their right or were not eligible to receive remuneration during 2011-12.

Remuneration of executive directors is included in Note 13: Senior Executive Remuneration.

Note 12: Related Party Disclosures

The directors of the Commission during the year were:

	COMMENCED	CEASED
Bill Beerworth (Chair)	1/07/2011	
Richard Bowden	1/07/2011	
Professor Chris Brook PSM	1/04/2012	
Veronica Casey	1/07/2011	
Dr Andrew Child	1/07/2011	31/03/2012
Christine Gee	1/07/2011	
Professor Jane Halton PSM	1/07/2011	
Professor Villis Marshall AC	1/04/2012	
Russell McGowan	1/07/2011	
Shelly Park	1/07/2011	
Dr Tim Smyth	1/07/2011	31/03/2012
Dr Helena Williams	1/07/2011	

The aggregate remuneration of directors is disclosed in Note 11.

Transactions with directors of director related entities

There are no loans to the directors, or director related entities.

Several directors of the Commission hold directorships with other organisations. All transactions between the Commission and organisations with a director common to the Commission, or any dealings between the Commission and directors individually, are conducted using commercial and arms-length principles.

Transactions with related parties

Transactions between related parties are on normal commercial terms and conditions unless otherwise stated.

Note 13: Senior Executive Remuneration

Note 13A: Senior executive remuneration expenses for the reporting period

	2012 $
Short-term employee benefits	
Salary	600,000
Annual leave accrued	56,176
Performance bonuses	14,976
Total short-term employee benefits	671,152
Post-employment benefits	
Superannuation (post-employment benefits)	110,751
Total post-employment benefits	110,751
Other long-term benefits	
Long service leave (long term benefits)	58,173
Total other long-term benefits	58,173
Termination benefits	–
Total	840,076

1. Note 13A is prepared on an accruals basis (therefore the performance bonus expenses disclosed above may differ from the cash `Bonus paid' in Note 13B).
2. Note 13A excludes acting arrangements and part-year service where remuneration expensed for a senior executive was less than $150,000.

Note 13B: Average Annual Reportable Remuneration Paid to Substantive Senior Executives During the Reporting Period

		2012				
AVERAGE ANNUAL REPORTABLE REMUNERATION[1]	SENIOR EXECUTIVES NO.	REPORTABLE SALARY[2] $	CONTRIBUTED SUPER-ANNUATION[3] $	REPORTABLE ALLOWANCES[4] $	BONUS PAID[5] $	TOTAL
Total remuneration (including part-time arrangements):						
less than $150,000	2	64,593	5,681	–	–	70,274
$210,000 to $239,999	1	198,923	26,075	–	14,976	239,974
$240,000 to $269,999	1	210,862	32,473	–	–	243,335
$360,000 to $389,999	1	313,589	53,102	1,126	–	367,817
Total	5					

Notes:

1. This table reports substantive senior executives who received remuneration during the reporting period. Each row is an averaged figure based on headcount for individuals in the band.
2. 'Reportable salary' includes the following:
   a) gross payments (less any bonuses paid, which are separated out and disclosed in the 'bonus paid' column);
   b) reportable fringe benefits (at the net amount prior to 'grossing up' to account for tax benefits); and
   c) exempt foreign employment income.
3. The 'contributed superannuation' amount is the average actual superannuation contributions paid to senior executives in that reportable remuneration band during the reporting period, including any salary sacrificed amounts, as per the individuals' payslips.
4. 'Reportable allowances' are the average actual allowances paid as per the 'total allowances' line on individuals' payment summaries.
5. 'Bonus paid' represents average actual bonuses paid during the reporting period in that reportable remuneration band. The 'bonus paid' within a particular band may vary between financial years due to various factors such as individuals commencing with or leaving the Commission during the financial year.
6. Various salary sacrifice arrangements were available to senior executives including superannuation, motor vehicle and expense payment fringe benefits. Salary sacrifice benefits are reported in the 'reportable salary' column, excluding salary sacrificed superannuation, which is reported in the 'contributed superannuation' column.

Note 13C: Other Highly Paid Staff

AVERAGE ANNUAL REPORTABLE REMUNERATION[1]	STAFF NO.	REPORTABLE SALARY[2] $	CONTRIBUTED SUPER-ANNUATION[3] $	REPORTABLE ALLOWANCES[4] $	BONUS PAID[5] $	TOTAL
Total remuneration (including part-time arrangements):						
$150,000 to $179,999	3	123,023	34,455	301	9,794	167,573
$180,000 to $209,999	1	154,338	26,614	220	18,470	199,642
$210,000 to $239,999	2	161,720	48,235	1,139	17,829	228,923
Total	6					

Notes:

1. This table reports staff:
   a) who were employed by the Commission during the reporting period;
   b) whose reportable remuneration was $150,000 or more for the financial period; and
   c) were not required to be disclosed in Tables A, B or director disclosures.
   Each row is an averaged figure based on headcount for individuals in the band.
2. 'Reportable salary' includes the following:
   a) gross payments (less any bonuses paid, which are separated out and disclosed in the 'bonus paid' column);
   b) reportable fringe benefits (at the net amount prior to 'grossing up' to account for tax benefits); and
   c) exempt foreign employment income (nil paid by the Commission during the year).
3. The 'contributed superannuation' amount is the average actual superannuation contributions paid to senior executives in that reportable remuneration band during the reporting period, including any salary sacrificed amounts, as per the individuals' payslips.
4. 'Reportable allowances' are the average actual allowances paid as per the 'total allowances' line on individuals' payment summaries.
5. 'Bonus paid' represents average actual bonuses paid during the reporting period in that reportable remuneration band. The 'bonus paid' within a particular band may vary between financial years due to various factors such as individuals commencing with or leaving the Commission during the financial year.
6. Various salary sacrifice arrangements were available to other highly paid staff including superannuation, motor vehicle and expense payment fringe benefits. Salary sacrifice benefits are reported in the 'reportable salary' column, excluding salary sacrificed superannuation, which is reported in the 'contributed superannuation' column.

Note 14: Remuneration of Auditors

	2012 $'000
Financial statement audit services were provided to the Commission by the Australian National Audit Office (ANAO).	
Value of the services provided	
Financial statement audit services	
Australian National Audit Office	50
	50

No other services were provided by the ANAO.

Note 15: Financial Instruments

	2012 $'000
Note 15A: Categories of financial instruments	
Financial assets	
Loans and receivables:	
Cash on hand or on deposit	11,984
Trade and other receivables	1813
Total	13,797
Carrying amount of financial assets	13,797
Financial liabilities	
At amortised cost:	
Trade creditors and accruals	
Suppliers	12,879
Total	12,879
Carrying amount of financial liabilities	12,879

Note 15B: Net income and expense from financial assets

Loans and receivables	
Interest revenue	54
Net gain/(loss) loans and receivables	54
Net gain/(loss) from financial assets	54

Note 15C: Fair value of financial instruments

	CARRYING AMOUNT 2012 $'000
Financial assets	
Loans and receivables:	
Cash and cash equivalents	11,984
Trade and other receivables	1,813
Total	13,797
Carrying amount of financial assets	13,797
Financial liabilities	
At amortised cost:	
Suppliers	12,879
Total	12,879
Carrying amount of financial liabilities	12,879

There are no potential differences between the carrying amounts and fair values of financial assets and liabilities.

Note 15D: Credit risk

The Commission was exposed to minimal credit risk as loans and receivables were cash and trade receivables. The maximum exposure to credit risk was the risk that arises from potential default of a debtor. This amount was equal to the total amount of trade receivables (2012: $1,813,000).

The Commission manages its debtors by undertaking recovery processes for those receivables which are considered to be overdue. The risk of overdue debts arising is minimised through the implementation of credit assessments on potential customers.

The Commission holds no collateral to mitigate against credit risk.

The credit quality of financial instruments not past due or individually determined as impaired:

	NOT PAST DUE NOR IMPAIRED	PAST DUE OR IMPAIRED
	2012 $'000	2012 $'000
Cash and cash equivalents	11,984	–
Trade and other receivables	1,813	–
Total	13,797	–

Note 15E: Liquidity risk

The Commission's financial liabilities comprise trade creditors, research project creditors, and other payables. The exposure to liquidity risk is based on the notion that the Commission will encounter difficulty in meeting its obligations on its financial liabilities. This is highly unlikely due to Government and State and Territory funding, the Commission's ability to draw down on cash reserves, and internal policies and procedures put in place to ensure there are appropriate resources to meet its financial obligations.

The Commission manages liquidity risk by ensuring all financial liabilities are paid in accordance with terms and conditions on demand. In addition, the Commission has no past experience of defaults in its current and prior forms.

Maturities for financial liabilities 2012:

	ON DEMAND	WITHIN 1 YEAR	TOTAL
	2012 $'000	2012 $'000	2012 $'000
Other financial liabilities			
Suppliers	–	12,879	12,879
Total	–	12,879	12,879

Note 15F: Market risk

The Commission holds basic financial instruments that do not expose the Commission to certain market risks, such as 'currency risk' or 'other price risk'.

The only interest-bearing items on the balance sheet were the cash and cash equivalents, which bear interest at prevailing bank interest rates. Their values do not fluctuate due to changes in the market interest rate.

Note 16: Financial Assets Reconciliation

	NOTES	2012 $'000
Financial assets		
Total financial assets as per balance sheet		14,852
Less: non-financial instrument components:		
Other receivables	5B	1,055
Total non-financial instruments components		1,055
Total non-financial assets as per financial instruments note		13,797

Note 17: Compensation and Debt Relief

No payments were made during the reporting period.

Note 18: Reporting of Outcomes

Note 18A: Net Cost of Outcome Delivery

The Commission is structured to meet one outcome:

To improve safety and quality in healthcare across the health system, including through the development, support for implementation, and monitoring of national clinical safety and quality guidelines and standards.

	OUTCOME 1
	2012 $'000
Expenses	
Departmental	13,054
Income from non-government sector	
Sale of goods and rendering of services	912
Interest	54
External contributions	5,500
Total income from non-government sector	6,466
Net cost of outcome delivery	6,588

The primary statements of these financial statements represent the Major Classes of Departmental Expense, Income, Assets and Liabilities by Outcome, as required by the FMOs. Accordingly these tables are not repeated in note 18.

11. Acronyms and abbreviations

ACS	Acute coronary syndrome
ACSQHC	Australian Commission on Safety and Quality in Health Care
AHMAC	Australian Health Ministers' Advisory Council
ARC	Australian Research Council
CAC Act	*Commonwealth Authorities and Companies Act 1997*
CLABSI	Central line associated blood stream infection
DoHA	Department of Health and Ageing
EMMS	Electronic Medication Management Systems
GRACE	Global Registry of Acute Coronary Events
HAI	Healthcare associated infection
HHA	Hand Hygiene Australia
IJC	Inter-Jurisdictional Committee
ISC	Information Strategy Committee
MET	Medical emergency team
NEHTA	National E-Health Transition Authority
NHHI	National Hand Hygiene Initiative
NHMRC	National Health and Medical Research Council
NHR Act	*National Health Reform Act 2011*
NIMC	National Inpatient Medication Chart
NRMC	National Residential Medication Chart
NSQHS	National Safety and Quality Health Service
NSTEACS	Non-ST-segment-elevation acute coronary syndromes
OECD	Organisation for Economic Co-operation and Development

OSSIE	Organisational leadership, Simple solution development, Stakeholder engagement, Implementation, Evaluation and maintenance
PBS	Pharmaceutical Benefits Scheme
PCC	Primary Care Committee
PCI	Percutaneous coronary intervention
PHSC	Private Hospital Sector Committee
PRN	pro re nata (as needed)
RACF	Residential aged care facility
STEMI	ST-segment-elevation myocardial infarction
WHS	Work Health Safety

12. Glossary

Accreditation: A status that is conferred on an organisation or an individual when they have been assessed as having met particular standards. The two conditions for accreditation are an explicit definition of quality (i.e. standards) and an independent review process aimed at identifying the level of congruence between practices and quality standards.[60]

Acute healthcare facility: A hospital or other healthcare facility providing healthcare services to patients for short periods of acute illness, injury or recovery.

Adverse event: An incident in which harm resulted to a person receiving health care.

Antimicrobial: A chemical substance that inhibits or destroys bacteria, viruses and fungi, including yeasts or moulds. [3]

Antimicrobial stewardship: A program implemented in a health service organisation to reduce the risks associated with increasing microbial resistance and to extend the effectiveness of antimicrobial treatments. Antimicrobial stewardship may incorporate a broad range of strategies including the monitoring and review of antimicrobial use.[3]

Clinical communication: An exchange of information that occurs between treating clinicians. Communication can be formal (when a message conforms to a predetermined structure for example in a health record or stored electronic data) or informal (when the structure of the message is determined solely by the relevant parties; for example, a face-to-face or telephone conversation).[61]

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.[62]

Clinical practice guidelines: Clinical practice guidelines are 'systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific circumstances'.[63]

Clinical workforce: The nursing, medical and allied health workforce who provide patient care and students who provide patient care under supervision. This may also include laboratory scientists.[64]

Clinician: A healthcare provider, trained as a health professional. Clinicians include registered and non-registered practitioners, or a team of health professionals providing health care who spend the majority of their time providing direct clinical care.

Consumer (health): Patients and potential patients, carers and organisations representing consumers' interests.[65]

Consumer-centred care: A consumer-centred approach to care involves treating consumers and/or carers with dignity and respect, communicating and sharing information between consumers and/or carers and healthcare providers, encouraging and supporting participation in decision making, and fostering collaboration with consumers and/or carers and healthcare organisations in the planning, design, delivery and evaluation of health care. Internationally, the terms patient-based, person-centred, relationship-based, patient-centred or patient and family-centred care are also used.

Core hospital-based outcome indicators (CHBOI): A succinct set of indicators that hospitals routinely monitor and review. These hospital-based outcome indicators can be generated by jurisdictions or private hospital ownership groups, which hold the source data, and reported back to provider facilities.

Data set: A collection of data elements which are collected as a set.

Data set specifications: A data set specification specifies a group of data elements and the conditions under which this group is collected. A data set specification can define the sequence in which data elements are included, whether they are mandatory, what verification rules should be employed and the characteristics of the collection (e.g. its scope).

Electronic Medication Management Systems (EMMS): Can enable prescribing, supplying, administering and reconciling of medicines to be completed electronically.

Fall: An event that results in a person coming to rest inadvertently on the ground or floor or another lower level.[66]

Hand hygiene: A general term referring to any action of hand cleansing.

Health care: Services provided to individuals or communities to promote, maintain, monitor, or restore health. Health care is not limited to medical care and includes self-care.

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.[67]

Health service organisation: A separately constituted health service that is responsible for the clinical governance, administration and financial management of a service unit(s) providing health care. A service unit involves a grouping of clinicians and others working in a systematic way to deliver health care to patients and can be in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' homes, community settings, practices and clinicians' rooms.

Hospital: A healthcare facility licensed by the respective regulator as a hospital or declared as a hospital.

Infection: The invasion and reproduction of pathogenic or disease-causing organisms inside the body. This may cause tissue injury and disease.[3]

Infection control or infection control measures: Actions to prevent the spread of pathogens between people in a healthcare setting. Examples of infection control measures include targeted healthcare associated infection surveillance, infectious disease monitoring, hand hygiene and personal protective equipment.[3]

Jurisdictions: State and territory governments

Medication: The use of medicine for therapy or for diagnosis, its interaction with the patient and its effect.

Medication chart: A chart used by an authorised prescriber to record medication and treatment orders, and by nursing staff to record and monitor the administration of such medicines and treatment.

Medication error: Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient or consumer.[68]

Medication reconciliation: The process of obtaining, verifying and documenting an accurate list of a patient's current medications on admission and comparing this list to the admission, transfer, and/or discharge medication orders to identify and resolve discrepancies. At the end of the episode of care the verified information is transferred to the next care provider.

Medicine: A chemical substance given with the intention of preventing, diagnosing, curing, controlling or alleviating disease, or otherwise improving the physical or mental welfare of people. Prescription, non-prescription and complementary medicines, irrespective of their administration route, are included.[69]

Monitor: To check, supervise, observe critically, or record the progress of an activity, action or system on a regular basis in order to identify and/or track change.

National Hand Hygiene Initiative (NHHI): An initiative to develop a national approach to improving hand hygiene and monitor its effectiveness.

National Residential Medication Chart: The medication chart or set of standard elements for a medication chart developed by the Commission and which permits PBS prescribers to prescribe and eligible approved suppliers to claim for eligible PBS/RPBS medicines under this initiative. It also sets out required fields for safe use of medicines in residential aged care facilities.

National Safety and Quality Health Service (NSQHS) Standards: Ten Standards were developed by the Australian Commission on Safety and Quality in Health Care in consultation and collaboration with jurisdictions, technical experts and a wide range of relevant people, including health professionals and patients. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure minimum standards of safety and quality are met, and a quality improvement mechanism that allows health services to realise aspirational or developmental goals.

Open disclosure: An open discussion with a patient about an incident(s) that resulted in harm to that patient while receiving health care. The criteria of open disclosure are an expression of regret and a factual explanation of what happened, the potential consequences and the steps taken to manage the event and prevent recurrence.[70]

Patient: A person receiving health care. Synonyms for 'patient' include consumer and client.

Patient safety: The reduction of risk of unnecessary harm associated with health care to an acceptable minimum.

Point of care: The time and location where an interaction between a patient and clinician occurs for the purpose of delivering care.

Practice level indicators: Indicators designed for voluntary inclusion in quality improvement strategies at the local practice or service level, and are intended for local use by organisations and individuals providing primary healthcare services.

Pressure injuries: These are localised to the skin and/or underlying tissue, usually over a bony prominence and caused by unrelieved pressure, friction or shearing. Pressure injuries occur most commonly on the sacrum and heel but can develop anywhere on the body. Pressure injury is a synonymous term for pressure ulcer.

Quality of care: The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Rapid response system: The system for providing emergency assistance to patients whose condition is deteriorating. The system includes the clinical team or individual providing emergency assistance, and may include on-site and off-site personnel.[71]

Recognition and response systems: Formal systems that help workforce promptly and reliably recognise patients who are clinically deteriorating, and appropriately respond to stabilise the patient.[71]

Residential aged care facility: This is the term used to describe a residential aged care facility operated by an approved provider. It replaces the older terms 'nursing home' and 'hostel'.

Standard: Agreed attributes and processes designed to ensure that a product, service or method will perform consistently at a designated level.

Surveillance data: Disease surveillance is an epidemiological practice by which the spread of disease is monitored in order to establish patterns of progression. The main role of disease surveillance is to predict, observe and minimise the harm caused by outbreak, epidemic and pandemic situations, as well as increase our knowledge as to what factors might contribute to such circumstances.

13. Index

14. List of requirements

The list below, based on the Report of Operations Schedule of the Commonwealth Authorities and Companies (Report of Operations) Orders 2011, summarises the Commission's compliance with essential Annual Report reporting requirements.

TOPIC	REQUIREMENT MET	COMMENT	PAGE NO.
Preliminaries			
Director's sign off	Yes	Letter of transmittal	1
Subsidiaries included	Not relevant		N/A
Exemptions (if approved)	Not relevant		N/A
Legislation/objectives/functions	Yes		6
Operational			
Name of Minister in financial year	Yes		1
Ministerial directions	Yes		133
Organisational			
Organisational structure and locations	Yes		118
Corporate Governance			
Directors: names/meetings/attendances/ executive or non-executive	Yes		116–123
Board committees (including Audit) and attendance	Yes		124–125
Related Entity Transactions	Yes		154
Key activity and changes affecting ACSQHC			
Key activities and changes that have affected ACSQHC	Yes		129
Reviews			
Judicial decisions and administrative tribunals	Yes		129

TOPIC	REQUIREMENT MET	COMMENT	PAGE NO.
Report of operations and future prospects			
Significant changes during 2010–11	Yes		129
Risks, opportunities and strategies	Yes		127
Community Service Obligations	Not relevant		N/A
Information that is commercially prejudicial	Not relevant		N/A
Performance			
Assessment of the performance of each of the Commission's functions	Yes	*National Health Reform Act 2011*	14–79
Assessment of the impact of the performance of each of the Commission's functions	Yes	*National Health Reform Act 2011*	14–79
Assessment of the safety of healthcare services provided	Yes	*National Health Reform Act 2011*	80–117
Financial results			
Reports—Auditor General, Parliamentary Committee, Ombudsman	Yes		133
Financial statements	Yes		132
Miscellaneous			
Glossary	Yes		162
Index of Annual Report requirements	Yes		168
Complies with Parliament Presentation and Printing Standards	Yes		N/A

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LIST OF TABLES

LIST OF FIGURES

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