

# Australian Safety and Quality Framework for Health Care

Putting the Framework into action: Getting started



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## Contents

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### Principle: **Consumer centred**

**Area for action: 1.4** Provide care that respects and is sensitive to different cultures 2

**Area for action: 1.5** Involve consumers, patients and carers in planning for safety and quality 3

**Area for action: 1.9** If something goes wrong, openly inform and support the patient 4

### Principle: **Driven by information**

**Area for action: 2.2** Collecting and analysing safety and quality data to improve care 5

**Area for action: 2.3** Learn from patients' and carers' experiences 6

### Principle: **Organised for safety**

**Areas for action: 3.3** Managers and clinical leaders take action for safety, and **3.8** Take action to prevent or minimise harm from healthcare errors 7

**Area for action: 3.7** Design and operate facilities, equipment and work processes for safety 8

**Australian Safety and Quality Framework for Health Care** 9

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## Putting the Framework into action: Getting started

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### What is the Framework?

The Australian Safety and Quality Framework for Health Care describes a vision for safe and high-quality care for all Australians, and sets out the actions needed to achieve this vision. The Framework specifies three core principles for safe and high-quality care. These are that care is **consumer centred, driven by information,** and **organised for safety.** Health Ministers endorsed the Australian Safety and Quality Framework for Health Care in 2010.

The Framework provides 21 areas for action that all people in the health system can take to improve the safety and quality of care provided in all healthcare settings over the next decade. The Framework should:

- be used as the basis of strategic and operational safety and quality plans
- provide a mechanism for refocusing current safety and quality improvement activities and designing goals for health service improvement
- be used as a guide for reviewing investments and research in safety and quality, and
- promote discussion with consumers, clinicians, managers, researchers and policy makers about how they might best form partnerships to improve safety and quality.

### Who is this document for?

Everyone who works in health has a part to play in creating a safe and high-quality healthcare system. This document has been prepared specially for those who have a **governance role within the health system.** This includes roles with responsibility for setting strategic direction, and overseeing the delivery of health care by health services, hospitals or regional healthcare organisations. You may be a chief or senior executive, trustee or board member of a health service with a background in a clinical or non-clinical area. You may also be the owner of a private practice delivering specialist, general practice or allied health services.

### How can you put the Framework into action?

You should use the Framework in a way that suits your needs and circumstances. This will vary depending on your role and responsibilities, and the nature of your organisation. Irrespective of the specific nature of your position, you have a leadership role and share overall responsibility for the safety and quality of health services delivered to patients and consumers by your organisation or health service. In this role, you are likely to be involved in setting strategic direction and ensuring that the resources and operational supports are available to achieve the strategic plan. The Framework will support this work.

This ‘Getting started’ document will help you to start putting the Framework into action. It highlights several of the Framework’s 21 areas of action that particularly apply to senior executives, board members and those with a governance role and describes some examples of activities to help you. The Framework, including all 21 areas for action by people in the health system, is published in full on the final page of this document.

This document is supported by the website of the Australian Commission on Safety and Quality in Health Care. This website contains up-to-date resources, tools, and links on all of the safety and quality issues covered in the Framework. The Commission will develop and publish further papers to support the application of the Framework and specific areas of action within it.

‘Getting started’ documents have also been developed for managers, the health care team and people who work in policy development roles so that everyone can work towards common goals in developing a safe and high-quality healthcare system.

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AREA FOR ACTION: **1.4** Provide care that respects and is sensitive to different cultures

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Miscommunication between health professionals and patients who speak a different language or come from a different cultural background is common and is associated with poor health outcomes. Consumers tell us that a fundamental aspect of consumer centred care is their capacity to understand the information that is being given to them and the health care worker's capacity to understand the questions and concerns of each patient and family member.

The basic requirement for effective and respectful communication is to provide information to a patient that makes sense to them in the context of their cultural background and in a language that they can understand.

Each patient's clinical situation will vary, and while pre-prepared information translated into different languages can be a valuable tool to assist with communication, the need for a dynamic, interpreter-supported conversation will remain. Early recognition of the language needs of particular patients can allow healthcare workers to plan ahead for specific opportunities

to have a conversation with patients and families. Although use of interpreters is straightforward in concept, it is well recognised that timely availability of interpreters to simplify this two-way communication is difficult to achieve for a wide variety of reasons.

In order for any health service to be more prepared to communicate effectively and appropriately with its patients, it is important to know the cultural and language distribution of the particular patient population. Using that knowledge, information about routine clinical and administrative matters can be developed, pre-printed and made available at key locations within the organisation. This preparation is essential to making effective and appropriate communication the normal way of working.

You also need to acknowledge the cultural diversity of your clinical and non-clinical workforce and ensure mechanisms and processes are established that take these differences into account.

**As a senior executive or board member, you should:**

- 1** Ensure that the values of your health service reflect the need to provide care that is respectful and sensitive to the needs of different cultures.
- 2** Understand the nature of the population that uses your health service, including the most common cultural and language groups.
- 3** Ensure that interpreter services are available based on demand and in line with best practice. Protocols and policies need to be developed to support routine use of these services.



Links to tools, resources, and literature relating to these topics are available at [www.safetyandquality.gov.au](http://www.safetyandquality.gov.au)

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**AREA FOR ACTION:** **1.5** **Involve consumers, patients and carers  
in planning for safety and quality**

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Evidence increasingly shows that health systems are safer when consumers, patients and carers are involved in the design and delivery. When healthcare administrators, providers, patients and families work in partnership, quality and safety and operational outcomes improve, costs decrease, and provider and patient satisfaction increases.

Consumers and patients have experiences and perspectives as users of health services that are invaluable when brought to planning and improvement activities. Structured, prospective involvement of patients, carers and consumers within the governance arrangements of your organisation will enhance the understanding of consumers' desires and priorities in all aspects of planning and care delivery. Options include involving consumers, patients and carers in committees and advisory groups, redesign of care processes, and the development of new programs and facilities.

Successful and positive engagement can be difficult to achieve and requires executive and organisational support to actively seek and support partnerships with interested individuals and consumer groups. Leaders play an essential role in setting the health service culture so that the workforce recognise the value patients, families and carers bring to organisational and safety and quality planning.

**As a senior executive or board member, you should:**

- 1** Ensure that partnerships with consumers, patients, and carers are reflected in the values of the organisation. You have a role in clearly articulating these values throughout your health service.
- 2** Actively seek to involve patients, carers and consumers in planning for safety and quality. This may be as members of committees and advisory groups, advisors for process redesign work, or participants in planning groups for new facilities.
- 3** Ensure that your clinical and non-clinical workforce has the capacity to actively and positively engage with consumers, patients and carers. This may require education and organisational change processes across the health service.



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AREA FOR ACTION: **1.9** If something goes wrong, openly inform  
and support the patient

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Evidence from multiple health systems across the world over the past 15-20 years has demonstrated that around 10% of patients admitted to a hospital will suffer an adverse event. While the incidence of such events in the sub-acute and primary healthcare settings is not yet known, we do know that adverse events occur in these settings that are associated with unnecessary harm to the patient.

Patients, carers and other healthcare consumers have made it clear that if something goes wrong during their care, the first thing they want is to be told about it promptly with as much information as is known at that stage. They want to know what is being done to minimise any harm that may come from the adverse event, how the incident is being investigated, and, perhaps most importantly, what is being done to prevent such an incident from happening again.

In addition to the ethical imperative that this places on the health professional to give prompt and full information to the person inadvertently harmed, there are good reasons for supporting

the practice of openly informing and supporting patients when something goes wrong. Being open, honest and truthful is the basis for the essential relationship of trust that patients have with their health providers and the facilities in which they are treated. Patients must be openly informed of harmful incidents in order to make decisions about further treatment and future consent. A well designed open disclosure approach will also provide them with emotional and practical support throughout the episode.

Open disclosure can help health professionals understand how harm has occurred and to learn from it. Importantly, it can also assist them overcome any trauma they may suffer as a result of the incident.

A comprehensive open disclosure process therefore supports both patients and healthcare workers through difficult and traumatic circumstances and optimises the opportunity to learn from the, albeit unwanted, experience. A learning, rather than a blaming, culture makes for safer and higher quality care.

### As a senior executive or board member, you should:

- 1 Ensure that a formal open disclosure process exists within your health service that aligns with the National Open Disclosure Standard.
- 2 Ensure that your workforce is supported to effectively participate in the open disclosure process. This may require a commitment to the provision of resources or training.
- 3 Ensure that resources are also available to inform and support patients, their families and carers when things go wrong.



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**AREA FOR ACTION:** **2.2** Collecting and analysing safety and quality data to improve care

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An essential part of improving the safety and quality of care provided to patients is the gathering, analysis and use of information regarding clinical performance. All types of healthcare organisations should have a clearly defined set of safety and quality information that is gathered and consolidated into meaningful indicators for clinicians, managers and the executive.

Your role in this process will vary depending on the position you hold. You share overall responsibility for the safety and quality of care delivered in your organisation and need to understand the information that is collected about safety and quality so that you can monitor performance over time.

**As a senior executive or board member, you should:**

- 1** Ensure that there is a safety and quality reporting framework within your organisation. This framework should specify the data items that are collected, how they are collected, and how the information is used.
- 2** Review the information provided to you about the safety and quality performance of your organisation, and monitor changes in performance over time.
- 3** Ensure that action is taken within the health service to address issues identified from the safety and quality performance data.

In addition, you should look at how your health service can be involved in national, state and territory, and other data collection activities, such as national clinical quality registries and reporting against nationally agreed indicators. Such activities provide information about how your health service compares to other similar types of health services, and allows your health service to contribute to larger efforts to improve safety and quality.



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AREA FOR ACTION: **2.3** Learn from patients' and carers' experiences

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Information about the safety and quality of care provided within the health system should not be limited to data about processes and clinical outcomes. An understanding of the actual experience of patients being treated is essential for an accurate appreciation of overall safety and quality of care. The 'real life' experience of patients and carers provides a unique perspective. If taken together with information that comes from clinical and other data generated within a health service, it provides a more accurate picture of safety and quality performance.

Understanding the experience of patients and carers is best achieved by using a variety of approaches. Some of these are "passive" approaches that rely on recording, collating and reporting of comments and complaints made across the organisation. Other, more active, approaches should also be used to seek the views of consumers, patients, families and carers in an ongoing way. These approaches include the use of regular, standard and formal mechanisms such as surveys or focus groups.

**As a senior executive or board member, you should:**

- 1** Ensure that there are formal systems in place to collect information from consumers, patients and carers about their experiences in your health service. These systems need to include mechanisms for review and use of this information by executives, managers and clinicians.
- 2** Consider these experiences when setting and reviewing the strategic direction of the organisation. This may require reviewing the results of patient experience surveys, examining trends and issues identified in complaints, and involving consumers, patients and carers in planning discussions.
- 3** Explore ways that you can directly obtain feedback from patients and carers about their experiences. Options may include executive walkarounds and starting each board meeting with a story or presentation from a patient.



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**AREAS FOR ACTION:** **3.3** Managers and clinical leaders take action for safety, and  
**3.8** Take action to prevent or minimise harm from healthcare errors

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The principles of clinical governance, which have been in place in health care for more than a decade, clearly recognise the responsibilities of individual executives, managers and clinicians for the safety and quality of care being provided to patients. The other major development associated with this concept is the recognition that the ways in which health systems are organised is the main determinant of patient safety. This means that senior executives and board members have both the responsibility and the mechanisms for improving patient safety and quality of care within their own organisations.

The growing day-to-day pressures on everyone working in health, combined with a historical health care focus on financial and activity performance, has meant that it can be difficult for the clinical and non-clinical workforce to find the time and the energy to focus on safety and quality improvements. A key role for senior executives and board members is to make it clear that the priority of improving performance in patient safety and quality is equally as important as improving activity and financial performance, a concept often referred to as the ‘triple bottom line’. This means modelling behaviour that reflects this reality as well as making sure that organisational priorities and mechanisms are structured to support this activity.

**As a senior executive or board member, you should:**

- 1** Accept shared personal responsibility for the quality and safety of clinical care provided within your organisation.
- 2** Ensure that your health service has an effective clinical governance framework in place. This framework should include information about your organisation’s quality assurance and improvement systems, how performance will be measured, and how errors and complaints will be managed.
- 3** Provide leadership to establish, support and maintain a culture within your health service that is focussed on learning and improving, rather than on blaming. The clinical and non-clinical workforce need to be supported and encouraged to be involved in quality activities and to have their efforts recognised when they do this.

In addition, you should ensure that mechanisms have been established and maintained to help anyone take immediate action to prevent harm occurring to patients. You should also show leadership in encouraging and supporting your workforce to report any event or circumstance that could have resulted, or did result, in unnecessary harm to a patient.



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**AREA FOR ACTION:** **3.7** Design and operate facilities, equipment and work processes for safety

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Organisational processes and systems can sometimes contribute to poor quality care and compromise patient safety. The inevitability of human error within complex, stressful and technically demanding situations is well recognised in many fields, including health care. The recognition of this fact and the use of risk reduction principles in the design of work processes, equipment, and even in facility design is growing. While error analysis and quality improvement are extremely important for producing safer and higher quality health environments, these approaches are essentially reactive.

One proactive approach that is becoming more common in patient safety is 'human factors'. The human factors approach examines the interactions between people and other elements of a system. These other elements could encompass an environment, a building, a device or machine, a form, a software application or other person or organisation. Human factors approaches examine patient safety risks and known errors that can occur at these interfaces. Having knowledge of these high risks means that healthcare equipment and facility design can consciously support patient safety and quality by incorporating mechanisms to reduce the risk of human error. The increasing use of these approaches to health care is beginning to provide benefits for patient safety and quality activity.

**As a senior executive or board member, you should:**

- 1** Be aware of human factors approaches in health care, and how they can be applied to identify risks and improve safety.
- 2** Whenever possible, introduce these concepts into the design and/or refurbishment of your facilities.
- 3** Support your managers to use these approaches and information in the design of standard operating procedures for existing and new equipment and procedures.



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Safe, high-quality health is always:	What it means for me as a consumer or patient:	Areas for action by people in the health system:
<p><b>1 CONSUMER CENTRED</b></p> <p>This means:</p> <p>Providing care that is easy for patients to get when they need it.</p> <p>Making sure that healthcare staff respect and respond to patient choices, needs and values.</p> <p>Forming partnerships between patients, their family, carers and healthcare providers.</p> <p>Ensuring that patients and carers report positive experiences of health care.</p>	<p>I can get high-quality care when I need it.</p> <hr/> <p>I have information I can understand. It helps me to make decisions about my health care.</p> <p>I can help to make my care safe.</p> <hr/> <p>My health care is well organised. The doctors, nurses and managers all work together. I feel safe and well cared for.</p> <hr/> <p>I know my healthcare rights.</p> <hr/> <p>If something goes wrong, my healthcare team look after me. I receive an apology and a full explanation of what happened.</p>	<p><b>1.1</b> Develop methods and models to help patients get health services when they need them.</p> <hr/> <p><b>1.2</b> Increase health literacy.</p> <p><b>1.3</b> Partner with consumers, patients, families and carers to share decision making about their care.</p> <p><b>1.4</b> Provide care that respects and is sensitive to different cultures.</p> <p><b>1.5</b> Involve consumers, patients and carers in planning for safety and quality.</p> <hr/> <p><b>1.6</b> Improve continuity of care.</p> <p><b>1.7</b> Minimise risks at handover.</p> <hr/> <p><b>1.8</b> Promote healthcare rights.</p> <hr/> <p><b>1.9</b> If something goes wrong, openly inform and support the patient.</p>
<p><b>2 DRIVEN BY INFORMATION</b></p> <p>This means:</p> <p>Using up-to-date knowledge and evidence to guide decisions about care.</p> <p>Safety and quality data are collected, analysed and fed back for improvement.</p> <p>Taking action to improve patients' experiences.</p>	<p>My care is based on the best knowledge and evidence.</p> <hr/> <p>The outcome of my treatment and my experiences are used to help improve care.</p>	<p><b>2.1</b> Use agreed guidelines to reduce inappropriate variation in the delivery of care.</p> <hr/> <p><b>2.2</b> Collect and analyse safety and quality data to improve care.</p> <hr/> <p><b>2.3</b> Learn from patients' and carers' experiences.</p> <p><b>2.4</b> Encourage and apply research that will improve safety and quality.</p>
<p><b>3 ORGANISED FOR SAFETY</b></p> <p>This means making safety a central feature of how healthcare facilities are run, how staff work and how funding is organised.</p>	<p>I know that the healthcare team, managers and governments all take my safety seriously.</p> <hr/> <p>The health system is designed to provide safe, high-quality care for me, my family and my carers.</p> <hr/> <p>When something goes wrong, actions are taken to prevent it happening to someone else.</p>	<p><b>3.1</b> Health staff take action for safety.</p> <p><b>3.2</b> Health professionals take action for safety.</p> <p><b>3.3</b> Managers and clinical leaders take action for safety.</p> <p><b>3.4</b> Governments take action for safety.</p> <p><b>3.5</b> Ensure funding models are designed to support safety and quality.</p> <p><b>3.6</b> Support, implement and evaluate e-health.</p> <p><b>3.7</b> Design and operate facilities, equipment and work processes for safety.</p> <hr/> <p><b>3.8</b> Take action to prevent or minimise harm from healthcare errors.</p>

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