AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Accreditation outcome results and evidence of implementation of the National Safety and Quality Health Service (NSQHS) Standards

NSQHS STANDARDS

A better way to care

November 2012

DOCUMENT INFORMATION

This document specifies the information to be collected on accreditation outcome results and evidence of implementation of the National Safety and Quality Health Service (NSQHS) Standards.

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Table of contents

Introduction

Purpose

The purpose of this document is twofold. First, it specifies the information to be reported by accreditation agencies on the outcome of each accreditation process for all health services being assessed in an accreditation process to the National Safety and Quality Health Services (NSQHS) Standards. Second, the document specifies the evidence required for health services to demonstrate implementation of the National Safety and Quality Health Service (NSQHS) Standards[1].

Accreditation outcomes information will be generated by accreditation agencies. This information will be reported for health service assessments that have been finalised from 2013. It will include information on health services that were awarded accreditation to the NSQHS Standards, and on those that did not meet accreditation requirements.

The safety and quality information required as a part of this process is being collected by health services as part of the process of implementing the NSQHS Standards or for nationally mandated data collections. Health services are to provide this information to accrediting agencies as part of their assessment process at each accreditation event.

Accrediting agencies are to provide this information in the specified format to regulators (as required), and to the Australian Commission on Safety and Quality in Health Care, as part of their routine quarterly data submissions.

Information collected from health services will be used to assess the impact of the NSQHS Standards on the safety and quality of care provided nationally. Reports will be prepared for Health Ministers and jurisdictions. Hospital level data will not be reported publicly.

The reports are to be provided in an electronic format, compliant with the formatting specified in this document.

Context

Accreditation Outcome Results

The results of an accreditation process, that include information on the health service being accredited, as well as the outcome of each accreditation event. They information collected represent the output of processes of assessment.

Evidence of NSQHS Standards Implementation

Information on implementation of the NSQHS Standards is to be provided by each health service organisation to its approved accrediting agency as part of the accreditation assessment process.

National reporting requirements

This document references and builds on existing national hospital reporting requirements. These include the:

A. *Performance and Accountability Framework* (PAF)[2]

B. *Report on Government Services* (ROGS)[3] and *National Agreement Performance Information 2010-11: National Healthcare Agreement*[4]

C. *National Safety and Quality Health Service Standards*[1]

D. *MyHospitals* website.[5]

A. The *Performance and Accountability Framework* (PAF)

"*The August 2011 Council of Australian Governments (COAG) National Health Reform Agreement (NHRA) outlined COAG's objectives for national health reform, including:*

- *improving performance reporting through the establishment of the National Health Performance Authority (the Authority); and*
- *improving accountability through the Performance and Accountability Framework (the Framework).*

The NHRA builds on the Heads of Agreement – National Health Reform agreed by COAG in February 2011…A robust performance reporting framework is critical to ensuring extensive information is available for patients and clients, health providers, and health system managers.

The Framework will underpin reporting across three domains – equity, effectiveness and efficiency of service delivery in health care. By publicly and transparently reporting on these domains of health system performance, the Framework will help to drive improvements in health system delivery and hence the achievement of broader health system objectives."[2]

The PAF specifies a series of performance indicators to be reported at hospital, Local Hospital Network (LHN), and Medicare Local levels. The Performance and Accountability Framework – *Initial indicators for hospitals and Local Hospital Networks* - includes:[2]

6.2.1 Effectiveness – safety and quality

6.2.1.1 Hospital standardised mortality ratio

6.2.1.2 Death in low-mortality diagnostic related groups

6.2.1.3 In-hospital mortality rates for:

- acute myocardial infarction
- heart failure
- stroke

- fractured neck of femur
- pneumonia.

6.2.2.1 Measures of the patient experience with hospital services

6.2.1.5 Healthcare associated *Staphylococcus aureus* (including MRSA) bacteraemia.

6.2.1.6 Healthcare associated *Clostridium difficile* infections. (CDI)

***B. Report on Government Services* (ROGS) and *National Agreement Performance Information 2010-11: National Healthcare Agreement* (Productivity Commission)**

The *Health* section of the annual *Report on Government Services* (ROGS) includes reports on public hospitals, primary and community health, and management of mental health.[3]

C. National Safety and Quality Health Service Standards

The National Safety and Quality Health Service Standards require health service organisations to undertake a range of audits as part of ongoing monitoring of their performance and quality improvement processes. The information collected from a number of these audit processes are to be provided to accrediting agencies and routinely reported to the Commission.

D. The *MyHospitals* website

The *MyHospitals* website (www.myhospitals.gov.au) is operated by the Australian institute of Health and Welfare (AIHW) on behalf of the National Health Performance Authority. *MyHospitals* presents information on hospitals throughout Australia and how they compare against national and State and Territory data, including:

- hospital profile
- services offered
- number of admissions
- waiting times for emergency departments and elective surgery
- safety and quality, including rates of *Staphylococcus aureus* bacteraemia and hand hygiene compliance
- cancer services
- cancer surgery waiting times.

MyHospitals is based on the latest available information provided to the Australian Institute of Health and Welfare by state and territory health departments for public hospitals, and by private hospitals that have elected to be included.

Reference period

The period for which data is recorded by accrediting agencies is known as the “reference period”. The reference period is a 12 month period that is either the full calendar year or financial year immediately preceding the accreditation assessment event, which ever is the most recent. Health service organisations nominate the reference period and need to provide details of this period for each of the data items in their reports to accrediting agencies. The reference period is to be the same for all data items.

Key references

Australian Commission on Safety and Quality in Health Care 2011, *National Safety and Quality Health Service Standards*, ACSQHC, Sydney.[1]

Australian Commission on Safety and Quality in Health Care 2012, *Safety and Quality Improvement Guide* [Various, one relating to each Standard], ACSQHC, Sydney.[6-15]

National Health Performance Authority 2012, *Performance and Accountability Framework*. NHPA, Sydney.[2]

Accreditation Assessment Records

Each accreditation assessment performed by an accrediting agency will consist of the following components.

Components

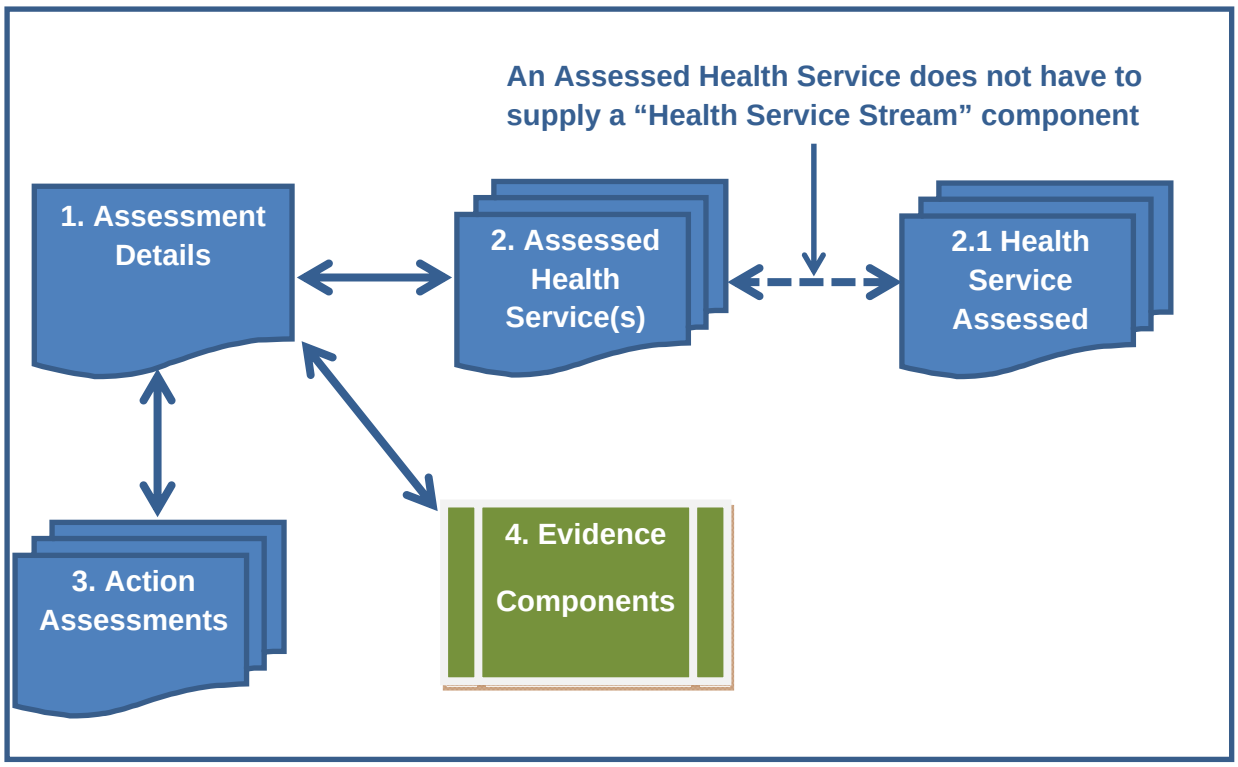
1. **Assessment Details:** Each accreditation assessment record requires a component that contains the details of the assessment.
2. **Assessed Health Service(s) details:** An accreditation assessment can be performed for one or multiple Health Services. The details of each health service assessed must be supplied.
   2.1. Health Service Assessed Stream(s): An accreditation assessment for a health service may only be performed for a health service stream (or streams). These are required to be specified if that is the case. Where a health service is assessed for all health service streams that it encompasses, then these are not required to be specified (i.e. where there are no health service streams associated with an assessed health service details component, then it is assumed that it is the entire health service that was assessed).

3. **Action Assessments:** Each action with the NSQHS Standards is required to have an "Action Assessment" component supplied for the assessment record (in the first version of the Standards, there are 256 Actions). Those actions that have been declared as 'not applicable' will still need to have a record supplied with a rating of not applicable. Assessment will be against the following rating scale:
   Not Met – the actions required have not been achieved.
   Satisfactorily Met – the actions required have been achieved.
   Met with Merit – in addition to achieving the actions required, measures of good quality and a higher level of achievement are evident. This would mean a culture of safety, evaluation and improvement is evident throughout the organisation in relation to the action or standard under review.
   Not applicable

   Collectively, items 1,2 and 3 constitute the ***Accreditation Outcome Results.***

4. **Evidence Components:** There are 18 evidence component types, along with an evidence data summary, that can have data supplied for an accreditation assessment record. Many of the evidence items have multiple data items that may need to be supplied. Some of these evidence items can be supplied multiple times in the one accreditation assessment record.

Accreditation Assessment Records Model



Accreditation Outcome Results

Facility information **Each facility that has been included in an assessment must have its details recorded** – **Hospital (public and private)** – **Day Procedure (public and private)** – **Other**	
Health Service Identifier	Unique identifier for each health service accredited.
Establishment – Australian state/territory identifier	Unique states and territories identifier
Facility Health Service Type	Unique identifier for non – Hospital or non - Day Procedure services.
Name of the facility/network/stream	Title of the health service, network or cluster of services assessed.
Description of health service accredited	Detail of individual hospitals, day procedure services, community based services and health service streams assessed
Facility Physical Location	Provided for all health services without a unique health service identifier.
Facility Private/Public status	Provided for all health services without a unique health service identifier.
Overall Assessment information **Each assessment will require the following information to be recorded**	
Assessment type	This may be: – organisation wide assessment – mid cycle assessment, or – period review
Initial Assessment Date	Commencement of the assessment cycle.
Final Assessment Date	Date of onsite visit
Date accreditation awarded	Date accreditation award is valid
Date accreditation award expires	Date the accreditation award expires.
Accreditation Award Status	Accreditation status at the conclusion of the assessment process
Estimated Next Assessment Date	Date next assessment is due
Next Assessment Type	Assessment event.
Individual Action Assessment information **For each assessment, the following information must be recorded for each action in the NSQHS Standards**	
Initial Assessment Compliance Result.	Initial outcome of assessment of each action that was not met.
Initial Assessment Non-Compliance Rationale	Reason action was not met.
Final Assessment Compliance	Final outcome of assessment of actions.
Final Assessment Compliance Result	Actions rating – not met, satisfactorily met, met with merit, not applicable declared, not applicable nominatedt.

Unique Identifiers	
Accrediting Agency Identifier	Unique identifier for accrediting agencies
Assessment Identifier	Unique identifier for data batch uploaded.
Standards Identifier	Identifier for each Standard.
Action Identifier	Identifier for each action
Version of the standards assessed against	Standards version identifier
Version of Core Actions assessed against	Core actions version.
Unique Assessment Number for Accrediting Agency	Unique identifier for assessment.

Evidence of implementation

NSQHS Standard	Measure	Description	#	Reference
1 Governance for safety and quality in health service organisations	Measurement of patient experience – admitted overnight patients	List of mechanisms (such as surveys, interviews or focus groups) used to seek feedback about experiences from admitted overnight inpatients where feedback is monitored within the organisation's governance system	1a	PAF 6.2.2.1 NSQHSS 1.20.1
	Measurement of patient experience – same day admitted patients	List of mechanisms (such as surveys, interviews or focus groups) used to seek feedback about experiences from same day admitted patients where feedback is monitored within the organisation's governance system	1b	PAF 6.2.2.1 NSQHSS 1.20.1
	Use of agreed clinical guidelines	List of agreed clinical guidelines where use by the clinical workforce is monitored	2	NSQHSS 1.7.1, 1.7.2
	Monitoring of core, hospital-based outcome indicators	Specification of the core, hospital-based outcome indicators which are regularly reported to the executive level of governance: CHBOI 1 Hospital standardised mortality ratio (HSMR) CHBOI 2 Death in low-mortality Diagnosis Related Groups (DRGs) CHBOI 3 In-hospital mortality for: a. acute myocardial infarction (AMI) b. stroke c. fractured neck of femur d. pneumonia CHBOI 4 Unplanned/unexpected same-hospital readmission rate for patients discharged following management of: a. acute myocardial infarction (AMI) b. knee replacements c. hip replacements d. paediatric tonsillectomy and adenoidectomy	3	PAF 6.2.1.1 6.2.1.2 6.2.1.3 6.2.1.4 NSQHSS 1.2.1
	Reporting of sentinel events	Reporting and review of sentinel events by the highest level of governance	4	ROGS NSQHSS 1.14.2
3 Preventing and controlling healthcare associated infections	Compliance with the National Hand Hygiene Initiative	The percentage of observations compliant with the National Hand Hygiene Initiative, by Moment (1-5) and type of healthcare worker (nurse, medical doctor, personal care staff, allied health, domestic staff, administrative and clerical staff, invasive technician, students, other)	5	*MyHospitals* NSQHSS 3.5.1, 3.5.2
	Completion of hand hygiene training	The percentage of the clinical workforce who have completed online modules in hand hygiene delivered by Hand Hygiene Australia, by staff category (medical, nursing/midwifery, allied health, non-clinical staff)	6	NSQHSS 1.4.1, 1.4.2, 3.5.1, 3.5.2
	Rate of healthcare associated *Staphylococcus aureus* bacteraemia	Patient episodes of healthcare associated *Staphylococcus aureus* bacteraemia per 10,000 patient days	7	PAF 6.2.1.5 NHA PI 39 ROGS NSQHSS 3.2.1

NSQHS Standard	Measure	Description	#	Reference
	Monitoring of hospital-identified *Clostridium difficile* infection (CDI)	The number of cases of hospital-identified *Clostridium difficile* infection (CDI)	8	PAF 6.2.1.6 NSQHSS 3.2.1 AHMC 2008
4 Medication safety	Medication reconciliation	Based on a routine audit sample, the percentage of patients whose current medications are documented and reconciled at admission	9	NSQHSS 4.8.1
5 Patient identification and procedure matching	Patient identification and procedure matching	Based on a routine audit sample, the percentage of patients that have identification bands that are compliant with the national specifications	10	NSQHSS 5.1.2, 5.3.1
6 Clinical handover	Clinical handover – discharge summary	Based on a routine audit sample, the percentage of patients whose discharge summary has been sent to their general practitioner within 48 hours of discharge	11	NSQHSS 6.1.2, 6.3.1
7 Blood and blood products	Wastage of blood and blood products	The percentage of blood products discarded - red cells	12	NSQHSS 7.8.1, 7.8.2
8 Preventing and managing pressure injuries	Assessment of risk of pressure injuries	Based on a routine audit sample, the percentage of patients with documented pressure injury risk assessment undertaken within eight hours of admission	13a	NSQHSS 8.3.1, 8.5.1, 8.5.2, 8.5.3, 8.6.2
	Pressure injuries acquired during admission.	Based on a routine audit sample, the rate of pressure injuries acquired during admission, reported by Grade (I-IV), unstaged pressure injury and suspected deep tissue injury	13b	NSQHSS 8.2.1, 8.2.2, 8.2.3, 8.6.1, 8.8.3
9 Recognising and responding to clinical deterioration in acute health care	Staff training in basic life support	The percentage clinicians who have achieved certification, or received refresher training in basic life support, by category (medical, nursing/midwifery, allied health)	14	NSQHSS 1.4.1, 1.4.2, 9.6.1
	Completeness of documentation of core physiological observations	Based on a routine audit sample, the percentage of patient charts where a complete set of observations is part of the last set of recorded observations, in agreement with their monitoring plan	15	NSQHSS 1.9.1, 1.9.2, 9.3.2, 9.3.3
10 Preventing falls and harm from falls	Falls resulting in injury for admitted hospital patients	The rate of falls resulting in injury for admitted hospital patients	16	NSQHSS 10.2.1, 10.2.2, 10.2.3

Detail of accreditation outcome results

Facility information **Each facility that has been included in an assessment must have its details recorded** – **Hospital (public and private)** – **Day Procedure (public and private)** – **Other**	
Health Service Identifier	If the facility is a Hospital or Day Procedure Service, the Health Service Identifier must be recorded. The Commission will issue approved Accrediting Agencies with a table of identifiers for the health services they accredit. Identifier should be a unique code for the health care establishment used in that state/territory. This data element concept will be replaced by the NEHTA Healthcare Provider Identifiers – Organisation (HPI-O). Information about the HPI-O is shown below. NEHTA has engaged Medicare Australia to design and build Australia's first national healthcare identification service, to provide the requisite identification service for the people and organisations involved in healthcare across Australia, by way of: • Individual Healthcare Identifiers (IHIs) to identify all Australian healthcare consumers • Healthcare Provider Identifiers - Individual (HPI-Is), to identify individual healthcare providers, such as general practitioners, clinicians, nurses and pharmacists • Healthcare Provider Identifiers – Organisation (HPI-Os), to identify healthcare organisations such as hospitals and clinics. Initially, it is assumed that the Individual Healthcare Identifiers (IHIs) and jurisdictional and local system identifiers (including Medical Record Numbers [MRNs] and Unique Patient Identifiers [UPIs]) will coexist. However, in the longer term, IHIs, HPI-Is and HPI-Os are expected to replace these existing, localised identifiers.
Establishment – Australian state/territory identifier	This is a unique identifier for states and territories of Australia. The Commission will provide approved Accrediting Agencies with the table of identifiers.
Facility Health Service Type	This must be provided for all non – Hospital or non - Day Procedure services. That is for all health services that do not have a unique health service identifier.
Name of the facility/network/stream	This includes the title of the health service, network or cluster of services being accredited and is to be provided for all health services that do not have a unique health service identifier.
Description of health service accredited	This includes all individual hospitals, day procedure services, community based services and health service streams included in this assessment process.
Facility Physical Location	This is to be provided for all health services that do not have a unique health service identifier.
Facility Private/Public status	This is to be provided for all health services that do not have a unique health service identifier.
Overall Assessment information **Each assessment will require the following information to be recorded**	
Assessment type	This may be: – organisation wide assessment – mid cycle assessment, or – period review

Initial Assessment Date	This is the commencement of the assessment cycle, however defined for that assessment product.
Final Assessment Date	This is the final day of the onsite visit
Date accreditation awarded	This is the first date the accreditation award is valid
Date accreditation award expires	This will be the last date the accreditation award is valid.
Accreditation Award Status	This may be: – Accredited – Not Accredited – Continued Accreditation – Discontinued Accreditation
Estimated Next Assessment Date	The estimated date that the next assessment is due
Next Assessment Type	This may be: – organisation wide assessment – mid cycle assessment, or – period review
Individual Action Assessment information **For each assessment, the following information must be recorded for each action in the NSQHS Standards**	
Initial Assessment Compliance Result.	Action 'not met' – both core and developmental at the time of the initial report from a site visit. This will be the same data that is provided to the health service in the report provided within 7 days of assessment.
Initial Assessment Non-Compliance Rationale	The basis for awarding 'not met'. This will be the same data that is provided to the health service in the report provided within 7 days of assessment.
Final Assessment Compliance	Action 'not met' – for both core and developmental not met by the health service at the final assessment of all applicable actions following the final assessment (i.e. not rectified within the 90 or 120 day period).
Final Assessment Compliance Result	Actions rating – not met, satisfactorily met, met with merit, not applicable declared, not applicable nominated – for core and developmental actions by the health service at the final assessment.
Unique Identifiers	
Accrediting Agency Identifier	Each approved accrediting agency will be issued with a unique identifier that is to be included with all data submitted.
Assessment Identifier	Each data batch loaded will have a date style identifier.
Standards Identifier	This identifies which standard number the action assessment record is associated with, eg Standard 1 is 01.
Action Identifier	This identifies which action the assessment record is associated within a single Standard.
Version of the standards assessed against	The version of the standards that the assessment has been performed against, provided by ACSQHC, currently version 1.
Version of Core Actions assessed against	The version of the core/developmental determinations for the actions, on which the assessment was performed. The core/developmental determinations will change at a different rate to the versions of the standards. This will be provided by ACSQHC, currently version 1.
Unique Assessment Number for Accrediting Agency	The number is the accrediting agency's identifier for the assessment. This number can be used by an accrediting agency to match their systems records.

Detail of evidence of implementation

1a Measurement of patient experience – admitted overnight patients

Identifying and definitional attributes

Short name:	Measurement of patient experience – admitted overnight patients
Description:	List of mechanisms (such as surveys, interviews or focus groups) used to seek feedback about experiences from admitted overnight inpatients where this feedback is monitored within the organisation's governance system
National Safety and Quality Standard:	1. Governance for safety and quality in health service organisations
Rationale:	Patient experience is part of a balanced approach to patient safety measurement and the experience of patients is linked to clinical quality and safety.[16] This measure is included in the Performance and Accountability Framework (PAF 6.2.2.1). [2] NSQHS Standards Action: 1.20.1 Data collected from patient feedback systems are used to measure and improve health services in the organisation

Collection and usage attributes

Computation:	List of mechanisms (such as surveys, interviews or focus groups) used during the reference period to seek feedback about experiences from admitted overnight inpatients where this feedback is monitored within the organisation's governance system Involves measurement of patients' direct experience of specific aspects of their treatment and/or care provided by the health service, including pre- and post-discharge where the patient has been admitted.

Measurement may be through:

- a written survey (paper, telephone or online) completed by the patient and/or their carer
- face-to-face or telephone interview with the patient or their carer
- a focus group involving the patient and/or their carer.

Measurement of the experience of patients using these methods could be done directly by the health service, or centrally by another organisation (such as the state or territory department of health or a commercial provider).

Measurement of patient experience should:

- examine the experiences of patients within the health service, rather than the satisfaction of patients with the health service
- be designed to draw attention to aspects of care where improvements can be made
- be documented
- be reviewed for use at defined intervals.

Numerator: N/A

Denominator: N/A

Ineligible health services: Day procedure services

Comments: It is recognised that hospitals may also measure patient experience with non-admitted patients (e.g. emergency, outpatients) and specific subsets of admitted of patients (e.g. maternity, mental health). This measure and measure 1b currently relate to admitted patients by same day and overnight only.

In some cases feedback may be sought from inpatients about their experiences, where this feedback is not monitored within the organisation's governance system. These processes do not need to be included within this measure.

References

Reference documents:	Australian Commission on Safety and Quality in Health Care, *Safety and Quality Improvement Guide Standard 1: Governance for Safety and Quality in Health Service Organisations*, ACSQHC, Sydney.[6] National Health Performance Authority, *Performance and Accountability Framework*, NHPA, Sydney.[2]

Information to be recorded by surveyors:	Information will be recorded about mechanisms that are used during the reference period to seek information about the experience of admitted overnight patients, where this feedback is monitored within the organisation's governance system. For each mechanism, the following information will be recorded: • type of mechanism (such as survey, interview, focus group) • where a patient experience survey is used, name of survey, and/or organisation administering survey • where a patient experience survey is administered locally, the size of the sample • where focus groups are used, number of focus groups and participants • name of governance body reviewing results of patient experience measurement. Where there are no mechanism is in use, this is to be stated. This is a free text field of up to 500 characters for each mechanism identified.

1b Measurement of patient experience – same day admitted patients

Identifying and definitional attributes

Short name: Measurement of patient experience - same day admitted patients

Description: List of mechanisms (such as surveys, interviews or focus groups) used to seek feedback about experiences from same day admitted patients where this feedback is monitored within the organisation's governance system

National Safety and Quality Standard: 1. Governance for safety and quality in health service organisations

Rationale: Patient experience is part of a balanced approach to patient safety measurement and the experience of patients is linked to clinical quality and safety.[16] This measure is included in the Performance and Accountability Framework (PAF 6.2.2.1). [2]

NSQHS Standards Action:

1.20.1 Data collected from patient feedback systems are used to measure and improve health services in the organisation

Collection and usage attributes

Computation: List of mechanisms (such as surveys, interviews or focus groups) used during the reference period to seek feedback from about experiences from same day admitted patients where feedback is monitored within the organisation's governance system

Involves measurement of patients' direct experience of specific aspects of their treatment and/or care provided by the hospital, including pre- and post-discharge where the patient has been admitted.

Measurement may be through:

- a written survey (paper, telephone or online) completed by the patient and/or their carer
- face-to-face or telephone interview with the patient or their carer
- a focus group involving the patient and/or their carer.

Measurement of the experience of patients using these methods could be done directly by the health service, or centrally by another organisation (such as the state or territory department of health or a commercial provider).

Measurement of patient experience should:

- examine the experiences of patients within the health service, rather than the satisfaction of patients with the health service
- be designed to draw attention to aspects of treatment/care where improvements can be made
- be documented
- be reviewed for use at defined intervals.

Numerator: N/A

Denominator: N/A

Ineligible health services: Health service organisations without same day admitted patients

Comments: It is recognised that hospitals may also measure patient experience non-admitted patients (e.g. emergency, outpatients) and specific subsets of admitted of patients (e.g. maternity, mental health). This measure and measure 1a currently relate to admitted patients by same day and overnight only.

In some cases feedback may be sought from inpatients about their experiences, where this feedback is not incorporated within the organisation's governance system. These processes do not need to be included within this measure.

References

Reference documents:

Australian Commission on Safety and Quality in Health Care, *Safety and Quality Improvement Guide Standard 1: Governance for Safety and Quality in Health Service Organisations*, 2012, ACSQHC, Sydney.[6]

National Health Performance Authority, *Performance and Accountability Framework*, 2012, NHPA, Sydney.[2]

Information to be recorded by surveyors:	Information will be recorded about mechanisms that are used during the reference period to seek information about the experience of same day admitted patients, where this feedback is monitored within the organisation's governance system. For each mechanism, the following information will be needed: • type of mechanism (such as survey, interview, focus group) • where a patient experience survey is used, name of survey, and/or organisation administering survey • where a patient experience survey is administered locally, the size of the sample • where focus groups are used, number of focus groups and participants • name of governance body reviewing results of patient experience measurement. Where there are no mechanisms in use, this is to be stated.

2 Use of agreed clinical guidelines

Identifying and definitional attributes

Short name:	Use of agreed clinical guidelines
Description:	List of agreed clinical guidelines where use by the clinical workforce is monitored
National Safety and Quality Standard:	1. Governance for safety and quality in health service organisations
Rationale:	NSQHS Standards Actions: 1.7.1 Agreed and documented clinical guidelines and/or pathways are available to the clinical workforce 1.7.2 The use of agreed clinical guidelines by the clinical workforce is monitored

Collection and usage attributes

Computation:	List of agreed clinical guidelines used by the clinical workforce during the reference period where use is monitored within the organisation's governance system Agreed clinical guidelines are evidence-based clinical practice guidelines that the executive level of governance of a health service organisation has agreed are relevant for use in that health service. These guidelines can be national, state or local guidelines but should meet the criteria noted for evidence-documented as defined on the NHMRC clinical practice guidelines portal (www.clinicalguidelines.gov.au/about.php), specifically: "*Corroborating documentation can be produced that a systematic literature search and review of existing scientific evidence published in peer reviewed journals was performed during the guideline development. A guideline is not excluded if corroborating documentation can be produced detailing specific gaps in scientific evidence for some of the guideline's recommendations*."[17]
Numerator:	N/A
Denominator:	N/A
Ineligible health services:	Nil
Comments:	No further comments

References

Reference documents:

The definition of an evidence documented clinical guideline is provided on the NHMRC Clinical Guidelines Portal: www.clinicalguidelines.gov.au/about.php

Australian Commission on Safety and Quality in Health Care, *Safety and Quality Improvement Guide Standard 1: Governance for Safety and Quality in Health Service Organisations*, 2012, ACSQHC, Sydney.[6]

Information to be recorded by surveyors:	Information will be recorded for each guideline for which use by the clinical workforce is monitored during the reference period and reported within the organisation, either regularly or occasionally. For each of these guidelines, the following information should be provided: • name of guideline • name of guideline developer • year of publication of guideline. Where there are no guidelines that are reported on during the reference period, this is to be stated.

3 Monitoring of core, hospital-based outcome indicators

Identifying and definitional attributes

Short name: Monitoring of core, hospital-based outcome indicators

Description: Specification of the core, hospital-based outcome indicators which are regularly reported to the executive level of governance. These indicators are included in the Performance and Accountability Framework (PAF):

CHBOI 1 Hospital standardised mortality ratio (HSMR) [PAF 6.2.1.1]

CHBOI 2 Death in low-mortality Diagnosis Related Groups (DRGs) [PAF 6.2.1.2]

CHBOI 3 In-hospital mortality [PAF 6.2.1.3] for:

a. acute myocardial infarction (AMI)

b. stroke

c. fractured neck of femur

d. pneumonia

CHBOI 4 Unplanned/unexpected [PAF 6.2.1.4], same-hospital readmission rate for patients discharged following management of:

a. acute myocardial infarction (AMI)

b. knee replacements

c. hip replacements

d. paediatric tonsillectomy and adenoidectomy

National Safety and Quality Standard: 1. Governance for safety and quality in health service organisations

Rationale: These indicators were endorsed by Health Ministers for routine review at hospital level in November 2009[18], and are specified in the Performance and Accountability Framework (PAF) for reporting at hospital level by the National Health Performance Authority.[2]

NSQHS Standards Action:

1.2.1 Regular reports on safety and quality indicators and other safety and quality performance data are monitored by the executive level of governance

Collection and usage attributes

Computation:

List of the core, hospital-based outcome indicators which are monitored by the executive level of governance during the reference period

Core, hospital-based outcome indicators (CHBOI) are specified in the *National core, hospital-based outcome indicator specification.*[19] They include:

CHBOI 1 Hospital standardised mortality ratio (HSMR)

CHBOI 2 Death in low-mortality Diagnosis Related Groups (DRGs)

CHBOI 3 In-hospital mortality for:

a. acute myocardial infarction (AMI)

b. stroke

c. fractured neck of femur

d. pneumonia.

CHBOI 4 Unplanned/unexpected, same-hospital readmission rate for patients discharged following management of:

a. acute myocardial infarction (AMI)

b. knee replacements

c. hip replacements

d. paediatric tonsillectomy and adenoidectomy.

CHBOI 3 should be counted as four separate indicators, i.e. 3a AMI, 3b stroke, 3c fractured neck of femur and 3d pneumonia. CHBOI 4 should be counted as four separate indicators, i.e. 4a acute myocardial infarction (AMI), 4b knee replacements. 4c hip replacements and 4d paediatric tonsillectomy and adenoidectomy. Therefore, together with CHBOI 1 and 2, there are ten possible indicators to be monitored.

	Only those indicators that are applicable to the facility scope of service should be included in the local monitoring process. The governance bodies that monitor these indicators may include the board, executive committees, safety and quality committees and individuals in specific positions.
Numerator:	N/A
Denominator:	N/A
Ineligible health services:	Health service organisations for whom these indicators will not be generated as part of the Performance and Accountability Framework (PAF) Day procedure services
Comments:	The focus of this measure is on demonstrating that the CHBOIs are routinely reviewed at the highest level of governance within the health service organisation. Note that not all of the CHBOIs will be applicable to all facilities, in line with the scope of practice of the facility. This measure requires only those indicators that are applicable to be monitored locally. For example, if a health service does not manage patients with AMI, then the AMI mortality (CHBOI 3a) and unplanned readmission (CHBOI 4a) will not be eligible for reporting. Note however that although volumes for quarterly monitoring may be too low for some facilities, they may be sufficient for annual monitoring.

References

Reference documents:	Australian Commission on Safety and Quality in Health Care, *National core, hospital-based outcome indicator specification, Version 1.1, Consultation draft*, 2012, ACSQHC, Sydney.[19] www.safetyandquality.gov.au/our-work/information-strategy/indicators/core-hospital-based-outcome-indicators/ National Health Performance Authority, *Performance and Accountability Framework*, 2012, NHPA, Sydney.[2]

Information to be recorded	Information will be recorded about the indicators routinely

by surveyors:	reviewed by the executive level of governance during the reference period. The following information will be recorded: • which CHBOIs are eligible for review for the health service • which eligible CHBOIs are reviewed • statement of frequency of review, by indicator • governance group which reviews the indicators.

4 Reporting of sentinel events

Identifying and definitional attributes

Short name:	Reporting of sentinel events
Description:	Reporting and review of sentinel events by the highest level of governance
National Safety and Quality Standard:	1. Governance for safety and quality in health service organisations
Rationale:	Sentinel event reporting is mandatory for all hospitals. The classification was revised by Health Ministers in 2009. (See Appendix) NSQHS Standards Action: 1.14.2 Systems are in place to analyse and report on incidents

Collection and usage attributes

Computation: Number of sentinel events by category of event reported during the reference period

"'Sentinel events' is defined as the number of reported adverse events that occur because of hospital system and process deficiencies, and which result in the death of, or serious harm to, a patient."[3]

Australian Health Ministers agreed on a national core set of sentinel events, which public hospitals are required to report. The eight sentinel events are:[3]

1. procedures involving the wrong patient or body part resulting in death or major permanent loss of function
2. suicide of a patient in an inpatient unit
3. retained instruments or other material after surgery requiring re-operation or further surgical procedure
4. intravascular gas embolism resulting in death or neurological damage
5. haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility
6. medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs

7. maternal death or serious morbidity associated with labour or delivery
8. infant discharged to the wrong family.

Numerator: N/A

Denominator: N/A

Ineligible health services: Private day procedure services

Comments: No further comments

References

Reference documents:

Steering Committee for the Review of Government Service Provision, *National Agreement Performance Information 2010-11: National Healthcare Agreement*, 2011, Productivity Commission, Melbourne.[4]

Steering Committee for the Review of Government Service Provision, *Report on Government Services 2012*, 2012, Productivity Commission, Melbourne.[3]

Note: The sentinel event classification used by the Review of Government Services, and the state and territory event classifications are shown in the Appendix of this report.

Information to be recorded by surveyors:	• Number of each sentinel event type, reported during the reference period • Overview of the review protocol for each sentinel event reported

5 Compliance with the National Hand Hygiene Initiative

Identifying and definitional attributes

Short name: Compliance with the National Hand Hygiene Initiative

Description: The percentage of observations compliant with the National Hand Hygiene Initiative, by *Moment* (1-5) and type of healthcare worker (nurse, medical doctor, personal care staff, allied health, domestic staff, administrative and clerical staff, invasive technician, students, other)

National Safety and Quality Standard: 3. Preventing and controlling healthcare associated infections

Rationale: "*Improving hand hygiene among healthcare workers is currently the single most effective intervention to reduce the risk of hospital-acquired infections in Australian hospitals.*"[20]

NSQHS Standards Actions:

3.5.1 Workforce compliance with current national hand hygiene guidelines is regularly audited

3.5.2 Compliance rates from hand hygiene audits are regularly reported to the highest level of governance in the organisation

Collection and usage attributes

Computation: 100 x (numerator ÷ denominator) for each audit conducted during the reference period, by Moment (1-5) and type of healthcare worker

A 'Moment' is when there is a perceived or actual risk of pathogen transmission from one surface to another via the hands. The five moments are:[21]

Moment 1: Before touching a patient

Moment 2: Before a procedure

Moment 3: After a procedure or body fluid exposure risk

Moment 4: After touching a patient

Moment 5: After touching a patient's surroundings

Hand Hygiene Australia provide definitions for the following categories of healthcare worker that should be used to

	classify data about compliance:[21] • nurse • medical doctor • personal care staff • allied health • domestic staff • administrative and clerical staff • invasive technician • students • other.
Numerator:	The total number of appropriately performed Hand Hygiene Moments in the audit sample, reported separately by Moment and healthcare worker group
Numerator criteria:	N/A
Denominator:	The total number of Moments observed in the audit sample, reported separately by Moment and healthcare worker group
Denominator criteria:	N/A
Ineligible health services:	Small health service organisations (less than 50 beds) reporting on compliance with National Hand Hygiene Guidelines within their governance structure using measures **other than** observation of the 5 Moments
Comments:	These data are provided by hospitals to Hand Hygiene Australia. Audits are conducted by trained auditors, according to guidelines by Hand Hygiene Australia, which can be found at: www.hha.org.au/UserFiles/file/Manual/HHAManual_2010-11-23.pdf

References

Reference documents:	Grayson, LM, Russo, P, Ryan, K, Bellis, K, Havers, S, Heard, K & Simpson, P. *Five Moments for Hand Hygiene*, 2010, Hand Hygiene Australia, Melbourne.[21] Australian Commission on Safety and Quality in Health Care, *Safety and Quality Improvement Guide Standard 3: Preventing and Controlling Healthcare Associated*

Infections, 2012, ACSQHC, Sydney.[8]

Information to be recorded by surveyors:	• Total number of compliant observations, by Moment (1-5) and professional group, for each audit conducted during the reference period • Total number of moments observed, by professional group, for each audit conducted for the reference period. • Number of audits conducted.

6 Completion of hand hygiene training

Identifying and definitional attributes

Short name:	Completion of hand hygiene training
Description:	The percentage of the healthcare workers who have completed online modules in hand hygiene delivered by Hand Hygiene Australia, by category (medical, nursing/midwifery, allied health, non-clinical staff)
National Safety and Quality Standard:	3. Preventing and controlling healthcare associated infections
Rationale:	NSQHS Standards Actions: 1.4.1 Orientation and ongoing training programs provide the workforce with the skill and information needed to fulfil their safety and quality roles and responsibilities 1.4.2 Annual mandatory training programs to meet the requirements of these Standards 3.5.1 Workforce compliance with current national hand hygiene guidelines is regularly audited 3.5.2 Compliance rates from hand hygiene audits are regularly reported to the highest level of governance in the organisation

Collection and usage attributes

Computation:	100 x (numerator ÷ denominator), reported separately for medical, nursing/midwifery, allied health, non-clinical staff Online training is at: www.hha.org.au/LearningPackage/olp-home.aspx Healthcare workers include (but are not limited to), doctors, nurses, midwives, allied health professionals, personal care staff, blood collectors, porters and some administrative staff.
Numerator:	Head count of healthcare workers who have completed online training modules in hand hygiene with Hand Hygiene Australia during the reference period, reported separately for medical, nursing/midwifery, allied health, non-clinical staff

Numerator criteria:	Inclusions • Healthcare workers, including non-clinical staff who have contact with patients Exclusions • Other health facility staff with no patient contact (i.e. non-healthcare workers)
Denominator:	Head count of the health service organisation workforce during the reference period, calculated separately for medical, nursing/midwifery, allied health, non-clinical staff
Denominator criteria:	Inclusions • Healthcare workers, including non-clinical staff who have contact with patients Exclusions • Other health facility staff with no patient contact (i.e. non health care workers).
Ineligible health services:	Nil
Comments:	No further comments

References

Reference documents:

Hand Hygiene Australia training can be found at: www.hha.org.au/LearningPackage/olp-home.aspx

Australian Commission on Safety and Quality in Health Care, *Safety and Quality Improvement Guide Standard 3: Preventing and Controlling Healthcare Associated Infections*, 2012, ACSQHC, Sydney.[8]

Information to be recorded by surveyors:	Percentage of healthcare workers who have completed online training during the reference period, by medical, nursing/midwifery, allied health, non-clinical staff

7 Rate of healthcare associated *Staphylococcus aureus* bacteraemia

Identifying and definitional attributes

Short name:	Rate of healthcare associated *Staphylococcus aureus* bacteraemia
Description:	Patient episodes of healthcare associated *Staphylococcus aureus* bacteraemia per 10,000 patient days
National Safety and Quality Standard:	3. Preventing and controlling healthcare associated infections
Rationale:	Many infections caused by *Staphylococcus aureus* bacteraemia are associated with healthcare procedures. They are a frequent and serious cause of morbidity and mortality, and are potentially preventable. This measure is included in the Performance and Accountability Framework (PAF 6.2.1.5). [2] NSQHS Standards Action: 3.2.1 Surveillance systems for healthcare associated infections are in place

Collection and usage attributes

Computation:	10,000 x (numerator ÷ denominator)
Numerator:	Patient episodes of healthcare associated *Staphylococcus aureus* bacteraemia (SAB) during the reference period
Numerator criteria:	A patient episode of bacteraemia is defined as a positive blood culture for *Staphylococcus aureus*. For surveillance purposes, only the first isolate per patient is counted, unless at least 14 days has passed without a positive blood culture, after which an additional episode is recorded. A *Staphylococcus aureus* bacteraemia (SAB) will be considered to be healthcare associated if:[22] EITHER • the patient's first SAB blood culture was collected more than 48 hours after hospital admission or less than 48 hours after discharge OR • the patient's first SAB blood culture was collected

less than or equal to 48 hours after hospital admission and one or more of the following key clinical criteria was met for the patient-episode of SAB:

1. SAB is a complication of the presence of an indwelling medical device (e.g. intravascular line, haemodialysis vascular access, CSF shunt, urinary catheter).
2. SAB occurs within 30 days of a surgical procedure where the SAB is related to the surgical site
3. SAB was diagnosed within 48 hours of a related invasive instrumentation or incision
4. SAB is associated with neutropenia (less than 1 x 109/L) contributed to by cytotoxic therapy

Inclusions

- Same-day patients

Exclusion

- Cases where a known previous positive test has been obtained within the last 14 days

Denominator: The total number of days for all patients who were admitted for an episode of care and who separated during the reference period

Denominator criteria:

Inclusions

- Total patient days, including those for same day and overnight admitted patients

Ineligible health services: Health service organisations that are not required to report SAB to their state or territory, or ownership group

Day procedure services

Comments: No further comments

References

Reference documents: For a detailed specification for this indicator, see: Australian Commission on Safety and Quality in Health Care, *National core, hospital-based outcome indicator specification, Version 1.1, Consultation draft*, 2012,

ACSQHC, Sydney.[19]
www.safetyandquality.gov.au/our-work/information-strategy/indicators/core-hospital-based-outcome-indicators/

The national definition of healthcare associated *Staphylococcus aureus* bacteraemia can be found in: Australian Commission on Safety and Quality in Health Care, *Implementation Guide for Surveillance of Staphylococcus aureus bacteraemia Consultation Edition*, 2011, ACSQHC, Sydney.[22]
www.safetyandquality.gov.au/wp-content/uploads/2012/02/Implementation-guide-SAB-Consultation-Edition-November-20111.pdf

Australian Commission on Safety and Quality in Health Care, *Safety and Quality Improvement Guide Standard 3: Preventing and Controlling Healthcare Associated Infections*, 2012 ACSQHC, Sydney.[8]

Information to be recorded by surveyors:	Rate of healthcare associated *Staphylococcus aureus* bacteraemia during the reference period

8 Monitoring of hospital-identified *Clostridium difficile* infection (CDI)

Identifying and definitional attributes

Short name: Monitoring of hospital-identified *Clostridium difficile* infection (CDI)

Description: The number of cases of hospital-identified *Clostridium difficile* infection (CDI)

National Safety and Quality Standard: 3. Preventing and controlling healthcare associated infections

Rationale: Health Ministers endorsed routine hospital-level surveillance of CDI in 2008, as part of a national approach requiring hospital-level monitoring and reporting. This measure is included in the Performance and Accountability Framework (PAF 6.2.1.6). [2]

Clostridium difficile (CDI) contributes to extended length of stay for infected patients and is potentially preventable. CDI rates are a marker of effective antibiotic stewardship, hand hygiene and environmental cleanliness.

NSQHS Standards Action:

3.2.1 Surveillance systems for healthcare associated infections are in place

Collection and usage attributes

Computation: Number of patient episodes of hospital-identified CDI (total hospital CDI cases) during the reference period

A *Clostridium difficile* infection case is defined as a case of diarrhoea that meets the following criteria:

EITHER

- the stool sample yields a positive result in a laboratory assay for CDI infection toxin A and/or B

OR

- a toxin-producing CDI organism is detected in the stool sample by culture or other means.

A hospital-identified CDI case is:

- a case diagnosed in a patient attending a hospital

(that is, it includes positive specimens obtained from admitted patients and those attending the emergency department, and outpatient departments).

Exclusions

- Cases where a known previous positive test has been obtained within the last 8 weeks (that is, only include cases once in an 8 week period).
- Patients less than 2 years old.

Note: An additional positive test obtained from a specimen collected from the same patient more than 8 weeks since the last positive test is regarded as a new case.

Numerator: N/A

Denominator: N/A

Ineligible health services: Health service organisations that are not required to report CDI to their state or territory, or ownership group

Day procedure services

Comments: No further comments

References

Reference documents: For a detailed specification for this indicator, see: Australian Commission on Safety and Quality in Health Care, *National core, hospital-based outcome indicator specification, Version 1.1, Consultation draft*, 2012, ACSQHC, Sydney.[19]
www.safetyandquality.gov.au/our-work/information-strategy/indicators/core-hospital-based-outcome-indicators/

The national definition for hospital-identified *Clostridium difficile* infection (CDI) bacteraemia can be found in: Australian Commission on Safety and Quality in Health Care, *Implementation Guide for Surveillance of* Clostridium difficile *Infection Consultation Edition*, 2011, ACSQHC, Sydney.[23]
www.safetyandquality.gov.au/wp-content/uploads/2012/02/Implementation-guide-CDI-Consultation-Edition-November-20111.pdf

	Australian Commission on Safety and Quality in Health Care, *Safety and Quality Improvement Guide Standard 3: Preventing and Controlling Healthcare Associated Infections*, 2012, ACSQHC, Sydney.[8]
Information to be recorded by surveyors:	Number of cases of hospital-identified *Clostridium difficile* infection identified during the reference period.

9 Medication reconciliation

Identifying and definitional attributes

Short name: Medication reconciliation

Description: Based on a routine audit sample, the percentage of patient episodes where current medicines are documented and reconciled at admission

National Safety and Quality Standard: 4. Medication safety

Rationale: "*Adverse drug events are commonly caused by lack of effective communication about medicines management, especially in the transition between the community and hospital setting.*"[24]

NSQHS Standards Action:

4.8.1 Current medicines are documented and reconciled at admission and transfer of care between healthcare settings

Collection and usage attributes

Computation: 100 x (numerator ÷ denominator) for audits conducted during the reference period

Medication reconciliation… involves verifying the list of medications a patient is currently taking, identifying variances, and rectifying medication errors at interfaces of care. The purpose is to avoid errors of transcription, omission, duplication of therapy, drug-drug and drug-disease interactions and other errors that may result in adverse drug events." [25]

Documentation and reconciliation of medicines should occur at admission, but no later than the next calendar day. Reconciliation performed at a pre-admission clinic is acceptable.

'Current medicines' refers to "*all medications taken prior to admission*."[25]

Documented and reconciled means "*the following steps have been undertaken and explicitly documented in the medical record:*[25]

1. *Obtaining a list of current medicines*

2. *Verifying the list of current medicines*
3. *Reconciling subsequent orders with the verified list."*

Numerator: Number of patient episodes audited where current medicines were documented and reconciled at admission (or no later than the next calendar day following admission)

Numerator criteria: Inclusions

Admitted patient episodes in hospital for at least 24 hours

Denominator: Number of admitted patient episodes audited

Denominator criteria: The sample size should be as per the *Guide to Auditing the NIMC.*[26] The sample sizes based on the number of adult beds in the hospital are shown in the Table below.

Number of adult beds in hospital	**Sample size**
150 or more	20% of current patients
30 -149	30% current patients
Less than 30	All current patients

Source: NSW TAG, 2007,.p.54[24]

Inclusions

- Admitted patient episodes in hospital for at least 24 hours

Ineligible health services: Health services that have approved and verified not applicable status for Action 4.8.1

Comments: "*Data collection for this indicator relies on documentation of medication reconciliation in the medical record. In the absence of a purpose-designed template or form, documentation of the reconciliation process is likely to be limited. Good documentation supports quality patient care. Poor communication can result in adverse drug events. Thus it is assumed that absence of explicit documentation means that medication reconciliation did not take place. This indicator does not examine reconciliation at other points of transition, or communication of medication information to subsequent care providers. Medication reconciliation is only complete when reconciliation occurs at all transition points including discharge.*"[25]

Note: A revision of the 2007 NSW TAG publication will be published in 2013.

References

Reference documents:

Australian Commission on Safety and Quality in Health Care, *Guide to Auditing the National Inpatient Medication Chart (NIMC)*, 2009, ACSQHC, Sydney.[26]
www.safetyandquality.gov.au/wp-content/uploads/2012/02/Guide-to-Auditing-the-NIMC.pdf

Australian Commission on Safety and Quality in Health Care, *Medication reconciliation*, 2011, ACSQHC, Sydney.[27]
www.safetyandquality.gov.au/our-work/medication-safety/medication-reconciliation

NSW Therapeutic Advisory Group, *Indicators for Quality Use of Medicines in Australian Hospitals*, 2007, Sydney.[24]
www.ciap.health.nsw.gov.au/nswtag/documents/publications/QUMIndicators/Manual0408.pdf

NSW Therapeutic Advisory Group, *Summary of Indicators for Quality Use of Medicines in Australian Hospitals Version 2*, NSW Therapeutic Advisory Group Inc., Sydney. [NOT YET AVAILABLE][25]

Australian Commission on Safety and Quality in Health Care, *Safety and Quality Improvement Guide Standard 4: Medication Safety*, 2012, ACSQHC, Sydney.[9]

Information to be recorded by surveyors:	Number of admitted patient episodes where current medicines were reconciled and documented in audits during the reference period, and the number of episodes audited.

10 Patient identification and procedure matching

Identifying and definitional attributes

Short name:	Patient identification and procedure matching
Description:	Based on a routine audit sample, the percentage of patients that have identification bands that are compliant with the national specifications
National Safety and Quality Standard:	5. Patient identification and procedure matching
Rationale:	Identification bands are a critical tool to prevent errors associated with mismatching patients and their care. These bands contain important information about the patient, and are essential for establishing and checking identity throughout the care process. Standardising the processes of care, such as patient identification bands, is an important way of reducing patient safety risks.[28] NSQHS Standards Actions: 5.1.2 Action is taken to improve compliance with the patient identification matching system 5.3.1 Inpatient bands are used that meet the national specifications for patient identification bands

Collection and usage attributes

Computation:	100 x (numerator ÷ denominator) for audits conducted during the reference period The *Specifications for a standard national patient identification band* describe the standard features that patient identification bands should have.[29] The specifications relate to 7 elements, of which the following should be the minimum requirement of the audit: 1. colour 2. information presentation
Numerator:	Number of patients audited whose identification bands are compliant with the national specifications
Numerator criteria:	<u>Inclusions</u> • Patients who are required to wear identification bands according to the policy of the health service organisation

	Exclusions • Patients who are not required to wear identification bands according to the policy of the health service organisation
Denominator:	Number of patients audited
Denominator criteria:	Inclusions • All admitted patient episodes audited where patients are required to wear identification bands according to the policy of the health service organisation Exclusions • Admitted patient episodes where patients are not required to wear identification bands according to the policy of the health service organisation
Ineligible health services:	Health services organisations that have approved and verified not applicable status for Action 5.3.1
Comments:	In some cases health services may consider that it is necessary to use an identification band that varies from the specifications. This is not encouraged, but is acceptable if a risk management process is undertaken and documented.[10] This process requires assessment of potential risks associated with any proposed changes, and identification of strategies to ameliorate these risks. Where such a risk assessment process has been conducted and a band is in use that varies from the specifications, the audit should examine the percentage of patients that have identification bands that are compliant with documented policy.

References

Reference documents:	Australian Commission on Safety and Quality in Health Care, *Specifications for a standard patient identification band*, 2008, ACSQHC, Sydney.[29] www.safetyandquality.gov.au/wp-content/uploads/2012/02/Specs-PatID-Band.pdf Australian Commission on Safety and Quality in Health Care, *Safety and Quality Improvement Guide Standard 5: Patient Identification and Procedure Matching*, 2012, ACSQHC, Sydney.[10]

Information to be recorded by surveyors:	Number of patients with identification bands compliant with the minimum requirements specified, for all audits during the reference period, and the number of patients audited.

11 Clinical handover – discharge summary

Identifying and definitional attributes

Short name: Clinical handover

Description: Based on a routine audit sample, the percentage of patients whose discharge summary has been sent to their general practitioner within 48 hours of discharge

National Safety and Quality Standard: 6. Clinical handover

Rationale: "*Approximately 7 068 000 clinical handovers occur annually in Australian hospitals and about 26 200 000 clinical handovers are carried out in community care settings. Current handover processes are highly variable and may be unreliable, causing clinical handover to be a high risk area for patient safety. Breakdown in the transfer of information has been identified as one of the most important contributing factors in serious adverse events and is a major preventable cause of patient harm*."[1]

NSQHS Standards Actions:

6.1.2 Action is taken to maximise the effectiveness of clinical handover policies, procedures and/or protocols

6.3.1 Regular evaluation and monitoring processes for clinical handover are in place

Collection and usage attributes

Computation: 100 x (numerator ÷ denominator) for audits conducted during the reference period

Clinical handover is 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*."[1]

One of the processes of clinical transfer is the provision, within a timely manner, of a comprehensive discharge summary to the patient's general practitioner.

Numerator: Number of patient episodes audited where the discharge summary has been sent to the patient's general practitioner within 48 hours of discharge.

Numerator criteria:

Inclusions

- Admitted patients for whom a discharge summary is generated

Exclusions

- Admitted patients for whom a discharge summary is not required
- Patient who have not nominated a general practitioner

Denominator: Number of admitted patient episodes audited

Denominator criteria:

Inclusions

- All admitted patient episodes audited where patients are required to have a discharge summary generated according to the policy of the health service organisation

Exclusions

- All admitted patient episodes audited where patients are not required to have a discharge summary generated according to the policy of the health service organisation
- Patients who do not have a general practitioner nominated

Ineligible health services: Day procedure services

Comments: The *Electronic Discharge Summary Systems Self-Evaluation Toolkit* describes the proportion of Electronic Discharge Summary (EDS) delivered to a general practitioner within 48 hours of patient discharge as a "*measure of success*".[30]

References

Reference documents:

Australian Commission on Safety and Quality in Health Care, *Safety and Quality Improvement Guide Standard 6: Clinical Handover*, 2012, ACSQHC, Sydney.[11]

Australian Commission on Safety and Quality in Health Care, *Electronic Discharge Summary Systems Self-Evaluation Toolkit*, 2011, ACSQHC, Sydney.[30]

Information to be recorded by surveyors:	Number of admitted patient episodes where discharge summaries were sent to their general practitioner within 48 hours of discharge for all audits in the reference period, and the number of episodes audited.

12 Wastage of blood and blood products

Identifying and definitional attributes

Short name:	Wastage of blood and blood products – red cells
Description:	The percentage of blood products discarded – red cells
National Safety and Quality Standard:	7. Blood and blood products
Rationale:	Health service organisations have systems to receive, store, transport and monitor wastage of blood and blood products safely and efficiently. Monitoring of discarded blood and blood products is a necessary component of managing these products to enhance their safe use, and for minimising wastage. NSQHS Standards Actions: 7.8.1 Blood and blood product wastage is regularly monitored 7.8.2 Action is taken to minimise wastage of blood and blood products

Collection and usage attributes

Computation:	100 x (numerator ÷ denominator)
Numerator:	Number of red cells units of discarded during the reference period
Numerator criteria:	<u>Inclusions</u> • All red cells units discarded, for any reason
Denominator:	Number of red cells units received by the health service during the reference period
Denominator criteria:	N/A
Ineligible health services:	Health services that have approved and verified not applicable status for actions 7.8.1 and 7.8.2
Comments:	"*Product discard is an important component of wastage. Note that due to the short shelf life of some products (particularly fresh blood products), health service organisations may have some policies in place to ensure enough product is available to meet clinical need and these*

policies may present limits to the complete elimination of wastage. The goal is to minimise discard while still ensuring product availability."[12]

"[Currently] *the NBA is developing a framework that will allow a set of key performance indicators, aligned with the national health performance framework, to be developed for use in benchmarking and monitoring the blood sector*."[31]

References

Reference documents:

Australian Commission on Safety and Quality in Health Care, *Safety and Quality Improvement Guide Standard 7: Blood and Blood Products*, 2012, ACSQHC, Sydney.[12]

Information to be recorded by surveyors:	Number of red cells units discarded during the reference period, and total number received by the health service.

13a Assessment of risk of pressure injuries

Identifying and definitional attributes

Short name: Assessment of risk of pressure injuries

Description: Based on a routine audit sample, the percentage of patients with documented pressure injury risk assessment undertaken within eight hours of admission

National Safety and Quality Standard: 8. Prevention and management of pressure injuries

Rationale: "*In Australia … [h]ospital acquired PI* [pressure injuries] *accounted for 67.6% of PI identified… Despite being a largely preventable health problem, PIs remain prevalent and extract a considerable fiscal and social cost.*"[32]

NSQHS Standards Actions:

8.3.1 Quality improvement activities are undertaken to prevent pressure injuries and/or improve the management of pressure injuries

8.5.1 An agreed tool to screen for pressure injury risk is used by the clinical workforce to identify patients at risk of a pressure injury

8.5.2 The use of the screening tool is monitored to identify the proportion of at-risk patients that are screened for pressure injuries on presentation

8.5.3 Action is taken to maximise the proportion of patients who are screened for pressure injury on presentation

8.6.2 Patient clinical records, transfer and discharge documentation, are periodically audited to identify at-risk patients with documented skin assessments

Collection and usage attributes

Computation: 100 x (numerator ÷ denominator) for audits conducted during the reference period

Pressure injuries "*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*."[1]

	Patients should be assessed for risk of pressure injury as soon as possible following admission to the service and within a minimum of eight hours, as specified in the *Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury.*[32] Assessment should be undertaken using validated tools that are appropriate to the patient population (e.g. adults, paediatrics, patients in the intensive care unit). Examples are listed in the *Pan Pacific* guidelines.[32]
Numerator:	Number of episodes audited where the patient is assessed for risk of pressure injury within eight hours of admission, and the assessment is documented
Numerator criteria:	Inclusions • Overnight admitted patient episodes Exclusions • Same day admitted episodes
Denominator:	Number of patient episodes audited
Denominator criteria:	Inclusions • Overnight admitted patient episodes Exclusions • Same day admitted episodes
Ineligible health services:	Health services that have approved and verified not applicable status for actions 8.5.1, 8.5.2, 8.5.3 and 8.6.2
Comments:	No further comments

References

Reference documents:

Australian Wound Management Association, 2012, *Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury,* 2012, Osborne Park, WA.[32]
www.awma.com.au/publications/2012_AWMA_Pan_Pacific_Guidelines.pdf

Australian Commission on Safety and Quality in Health Care, *Safety and Quality Improvement Guide 8: Preventing and Managing Pressure Injuries*, 2012, ACSQHC, Sydney.[13]

Information to be recorded by surveyors:	Number of patients with a documented pressure injury risk assessment undertaken within eight hours of admission, for all audits conducted within the reference period, and number of episodes audited

13b Pressure injuries acquired during admission

Identifying and definitional attributes

Short name: Pressure injuries acquired during admission

Description: Based on a routine audit sample, the rate of patients acquiring pressure injuries during admission, reported by Grade (I-IV, unstaged, or suspected deep tissue injury)

National Safety and Quality Standard: 8. Prevention and management of pressure injuries

Rationale: "*In Australia … [h]ospital acquired PI* [pressure injuries] *accounted for 67.6% of PI identified… Despite being a largely preventable health problem, PIs remain prevalent and extract a considerable fiscal and social cost.*"[32]

NSQHS Standards Actions:

8.2.1 An organisation-wide system for reporting pressure injuries is in use

8.2.2 Administrative and clinical data are used to regularly monitor and investigate the frequency and severity of pressure injuries

8.2.3 Information on pressure injuries is regularly reported to the highest level of governance in the health service organisation

8.6.1 Comprehensive skin inspections are undertaken and documented in the patient clinical record for patients at risk of pressure injuries

8.8.3 Patient clinical records are monitored to determine compliance with evidence-based pressure injury management plans

Collection and usage attributes

Computation: 100 x (numerator ÷ denominator) for patients audited during the reference period, reported by (Grade I-IV, unstaged or suspected deep tissue injury).

Pressure injuries "*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."[1] Gradings are based on the following classification from the European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel:[33] • Grade I – skin discolouration, usually red, blue, purple or black. • Grade II – some skin loss or damage involving the top-most skin layers. • Grade III – necrosis (death) or damage to the skin patch, limited to the skin layers. • Grade IV – necrosis or damage to the skin patch and underlying structures, such as tendon, joint or bone • Unstaged pressure injury – full thickness tissue loss, covered in slough • Suspected deep tissue injury – localised discolouration, intact skin, with underlying soft tissue damage
Numerator:	Number of patient episodes audited with a pressure injury acquired during admission, for each PI Grade (I – IV, unstaged and suspected deep tissue)
Numerator criteria:	<u>Inclusions</u> • Overnight admitted patient episodes <u>Exclusions</u> • Same day admitted episodes
Denominator:	The number of patient episodes audited
Denominator criteria:	<u>Inclusions</u> • Overnight admitted patient episodes <u>Exclusions</u> • Same day admitted episodes
Ineligible services:	Health services that have approved and verified not applicable status for actions 8.6.1 and 8.8.3
Comments:	Hospitals have different populations of high-risk patients.

References

Reference documents:

European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel, *Treatment of pressure ulcers: Quick Reference Guide*, 2009, National Pressure Ulcer Advisory Panel, Washington DC.[33]
www.epuap.org/guidelines/Final_Quick_Treatment.pdf

Australian Wound Management Association, *Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury,* 2012, Osborne Park, WA.[32]
www.awma.com.au/publications/2012_AWMA_Pan_Pacific_Guidelines.pdf

Australian Commission on Safety and Quality in Health Care, *Safety and Quality Improvement Guide Standard 8: Preventing and Managing Pressure Injuries,* 2012, ACSQHC, Sydney.[13]

Information to be recorded by surveyors:	Number of patient episodes where pressure injuries were acquired during admission for each grade of pressure injury, for all audits conducted within the reference period, and the number of patient episodes audited.

14 Staff training in basic life support

Identifying and definitional attributes

Short name:	Staff training in basic life support
Description:	The percentage of clinicians who have achieved certification, or undergone refresher training in basic life support, by category (medical, nursing/midwifery, allied health)
National Safety and Quality Standard:	9. Recognising and responding to clinical deterioration in acute health care
Rationale:	NSQHS Standards Actions: 1.4.1 Orientation and ongoing training programs provide the workforce with the skill and information needed to fulfil their safety and quality roles and responsibilities 1.4.2 Annual mandatory training programs to meet the requirements of these Standards 9.6.1 The clinical workforce is trained and proficient in basic life support

Collection and usage attributes

Computation:	100 x (numerator ÷ denominator), by category (medical, nursing/midwifery, allied health) Basic life support is "*the preservation of life by the initial establishment of, and/or maintenance of, airway, breathing, circulation and related emergency care, including use of an automated external defibrillator*."[1] Basic life support training should be compliant with guidelines from the Australian Resuscitation Council.[34] Basic life support may also be referred to as immediate life support. The clinical workforce is defined as the nursing, medical and allied health staff who provide patient care.[1]
Numerator:	Head count of the clinical workforce who have achieved certification or undergone refresher training in basic life support during the reference period, by category (medical, nursing/midwifery, allied health)
Numerator criteria:	N/A

Denominator:	Head count of the clinical workforce during reference period, by category (medical, nursing/midwifery, allied health)
Denominator criteria:	N/A
Ineligible health services	Health services that have approved and verified not applicable status for action 9.6.1
Comments:	The Australian Resuscitation Council states:[34] • "*The optimal interval for retraining [in BLS] has not been established, but repeated refresher training is needed for individuals who are not performing resuscitation on a regular basis.* • *All those trained in CPR should refresh their CPR skills at least annually*."

References

Reference documents:	Australian Resuscitation Council, *Guideline 10.1: Basic Life Support Training*, 2010, Melbourne.[34] www.resus.org.au/policy/guidelines/section_10/guideline-10-1dec2010.pdf Australian Commission on Safety and Quality in Health Care, *Safety and Quality Improvement Guide Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care*, 2012, ACSQHC, Sydney.[14]

Information to be recorded by surveyors:	Percentage of the clinical workforce who have achieved certification, or undergone refresher training in basic life support during the reference period, by category (medical, nursing/midwifery, allied health) Where there are no staff in a a category of the clinical workforce, this is to be recorded.

15 Completeness of documentation of core physiological observations

Identifying and definitional attributes

Short name: Completeness of documentation of core physiological observations

Description: Based on a routine audit sample, the percentage of patient charts where a complete set of observations is part of the last set of recorded observations, in agreement with their monitoring plan

National Safety and Quality Standard: 9. Recognising and responding to clinical deterioration in acute health care

Rationale: NSQHS Standards Actions:

1.9.1 Accurate, integrated and readily accessible patient clinical records are available to the clinical workforce at the point of care

1.9.2 The design of the patient clinical record allows for systematic audit of the contents against the requirements of these Standards

9.3.2 Mechanisms for recording physiological observations are regularly audited to determine the proportion of patients that have complete sets of observations recorded in agreement with their monitoring plan

9.3.3 Action is taken to increase the proportion of patients with complete sets of recorded observations, as specified in the patient's monitoring plan

Collection and usage attributes

Computation: 100 x (numerator ÷ denominator) for all patient charts audited during the reference period

For adults, core physiological observations are as specified in Element 1.6 of the *National Consensus Statement*,[35] and include:

- respiratory rate
- oxygen saturation

- heart rate
- blood pressure
- temperature
- level of consciousness

For other patient populations (e.g. paediatrics):

- one or several of these measures may not be indicated, and
- other condition- or population-specific measures may be included.

The physiological observations monitored should be as appropriate for the patient population.

The last set of recorded observations is the set of observations conducted most recently before the audit and documented on the patient's observation chart or clinical record.[36]

Numerator: Number of patient charts audited where the last set of recorded observations was completed in agreement with their monitoring plan

Numerator criteria: Inclusions

- Acute admitted patient episodes (same day and overnight).

Denominator: Number of patient charts audited

Denominator criteria: Inclusions

- Acute admitted patient episodes (same day and overnight).

Ineligible health services: Health services that have approved and verified not applicable status for action 9.3.2 and 9.3.3

Comments: No further comments

References

Reference documents: Australian Commission on Safety and Quality in Health Care, *National Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration*, 2010, ACSQHC, Sydney.[35]
www.safetyandquality.gov.au/our-work/recognition-and-

response-to-clinical-deterioration/the-national-consensus-statement/

Australian Commission on Safety and Quality in Health Care, *A Guide to Support Implementation of the National Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration*, 2011 ACSQHC, Sydney.[36]

www.safetyandquality.gov.au/our-work/recognition-and-response-to-clinical-deterioration/implementing-r-and-r-systems/implementation-guide/

Australian Commission on Safety and Quality in Health Care, *Safety and Quality Improvement Guide Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care*, 2012, ACSQHC, Sydney.[14]

Information to be recorded by surveyors:	Number of patient charts with a complete set of observations according to their monitoring plan, for all audits conducted during the reference period, and number of charts audited

16 Falls resulting in injury for admitted hospital patients

Identifying and definitional attributes

Short name:	Falls resulting in injury for admitted hospital patients
Description:	The rate of falls resulting in injury for admitted hospital patients
National Safety and Quality Standard:	10. Preventing falls and harm from falls
Rationale:	NSQHS Standards Actions: 10.2.1 Regular reporting, investigating and monitoring of falls incidents is in place 10.2.2 Administrative and clinical data are used to monitor and investigate regularly the frequency and severity of falls in the health service organisation 10.2.3 Information on falls is reported to the highest level of governance in the health service organisation

Collection and usage attributes

Computation:	100 x (numerator ÷ denominator) A fall "*is an event which results in a person coming to rest inadvertently on the ground or floor or other lower level.*"[37] The Commission uses the *Prevention of Falls Network Europe (ProFaNE)* (www.profane.eu.org) to define injurious falls: "*The ProFaNE definition considers that the only injuries that could be confirmed accurately using existing data sources are peripheral fractures – defined as any fracture of the limb girdles or of the limbs.* *Head, maxillo-facial, abdominal, soft tissue and other injuries are <u>not</u> included in the recommendation for a core dataset.*
Numerator:	Number of falls reported during the reference period for admitted patients that resulted in injury
Numerator criteria:	<u>Inclusions</u> • Admitted patient episodes (same day and overnight)
Denominator:	Number of admitted patient episodes during the reference

	period
Denominator criteria:	Inclusions • Admitted patient episodes (same day and overnight)
Ineligible health services	Health service organisations that have approved and verified not applicable status for action 10.2.1, 10.2.2 and 10.2.3
Comments:	No further comments.

References

Reference documents:	Australian Commission on Safety and Quality in Health Care, *Preventing Falls and Harm From Falls in Older People: Best Practice Guidelines for Australian Hospitals*, 2009, ACSQHC, Sydney.[37] www.safetyandquality.gov.au/wp-content/uploads/2012/01/Guidelines-HOSP1.pdf Australian Commission on Safety and Quality in Health Care, *Safety and Quality Improvement Guide Standard 10: Preventing Falls and Harm from Falls*, 2012, ACSQHC, Sydney.[15]

Information to be recorded by surveyors:	Number of falls resulting in injury during the reference period, and total number of admitted patient episodes.

Appendix – Sentinel events and incident severity classifications

This appendix references jurisdictional policies on incident reporting and severity classification. The following is an excerpt from the *Report on Government Services 2012.*[3]

Box 10.15 **Sentinel events**

'Sentinel events' is defined as the number of reported adverse events that occur because of hospital system and process deficiencies, and which result in the death of, or serious harm to, a patient. Sentinel events occur relatively infrequently and are independent of a patient's condition (DHS 2004). Sentinel events have the potential to seriously undermine public confidence in the healthcare system.

Australian health ministers have agreed on a national core set of sentinel events for which all public hospitals are required to provide data. The eight nationally agreed core sentinel events are:

1. Procedures involving the wrong patient or body part resulting in death or major permanent loss of function.
2. Suicide of a patient in an inpatient unit.
3. Retained instruments or other material after surgery requiring re-operation or further surgical procedure.
4. Intravascular gas embolism resulting in death or neurological damage.
5. Haemolytic blood transfusion reaction resulting from ABO (blood group) incompatibility.
6. Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs.
7. Maternal death or serious morbidity associated with labour or delivery.
8. Infant discharged to the wrong family.

A low or decreasing number of sentinel events is desirable.

Over time, an increase in the number of sentinel events reported might reflect improvements in incident reporting mechanisms and organisational cultural change, rather than an increase in the frequency of such events. However, trends need to be monitored to establish whether this is the underlying reason (DHS 2004).

Data reported for this indicator are not complete or directly comparable.

Data quality information for this indicator is under development.

Reference documents:

Australian Capital Territory

ACT Health, *Mandatory Reporting of Significant Incidents*, 2006, ACT Health, Canberra.[38]
http://health.act.gov.au/c/health?a=dlpol&policy=1151123230

New South Wales

NSW Department of Health, *Policy Directive: Incident Management PD2007_061*, 2007, NSW Department of Health, Sydney.[39]
www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_061.pdf

Queensland

Centre for Healthcare Improvement, *Patient Safety: From Learning to Action IV*, Fourth Queensland Health Report on Clinical Incidents and Sentinel Events in the Queensland Public Health System 2008/09, 2001, Queensland Health, Brisbane.[40]
www.health.qld.gov.au/psq/reports/docs/lta4.pdf

South Australia

SA Health, *Incident Management Policy Directive*, 2011,SA Health, Adelaide.[43]
www.sahealth.sa.gov.au/wps/wcm/connect/8ae14680490db3a3adf4fd7675638bd8/IncidentManagementPolicy-PHCS-SQ-1110.pdf?MOD=AJPERES&CACHEID=8ae14680490db3a3adf4fd7675638bd8

SA Health, *Safety Assessment Code Matrix* (V3), SA Health, Adelaide.[44]
www.sahealth.sa.gov.au/wps/wcm/connect/9defbf00439f41338790cfed1a914d95/Safety+Assessment+Code+Matrix.pdf?MOD=AJPERES&CACHEID=9defbf00439f41338790cfed1a914d95&CACHE=NONE)

Tasmania

Tasmania, *DHHS Client/Patient Clinical Incidents – Severity Assessment Code Risk Matrix 2011* (under review)

Victoria

Department of Health, *Victorian health incident management policy*, 2011, Victorian Government, Melbourne.[41]
http://docs.health.vic.gov.au/docs/doc/Victorian-health-incident-management-policy

Department of Human Services, *Victorian Health Incident Management System (VHIMS): data set specification*, 2008, Victorian Government, Melbourne.[42]
http://docs.health.vic.gov.au/docs/doc/B0D77F3F1FA7C558CA257902000F6406/$FILE/VHIMS-overview-data_spec.pdf

Western Australia

Western Australia Department of Health, *Clinical Incident Management Policy, Government of Western Australia*, 2011 Perth.[45]
www.safetyandquality.health.wa.gov.au/docs/aims/Incident_Reporting_policy.pdf

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4.Steering Committee for the Review of Government Service Provision. National Agreement Performance Information 2010-11: National Healthcare Agreement. Melbourne. Productivity Commission, 2011.
5.MyHospitals. AIHW, 2012. (Accessed October 2012, 2012, at http://www.myhospitals.gov.au/.)
6.Australian Commission on Safety and Quality in Health Care. Safety and Quality Improvement Guide Standard 1: Governance for Safety and Quality in Health Service Organisations. Sydney. ACSQHC, 2012.
7.Australian Commission on Safety and Quality in Health Care. Safety and Quality Improvement Guide Standard 2: Partnering with Consumers. Sydney. ACSQHC, 2012.
8.Australian Commission on Safety and Quality in Health Care. Safety and Quality Improvement Guide Standard 3: Preventing and Controlling Healthcare Associated Infections. Sydney. ACSQHC, 2012.
9.Australian Commission on Safety and Quality in Health Care. Safety and Quality Improvement Guide Standard 4: Medication Safety. Sydney. ACSQHC, 2012.
10.Australian Commission on Safety and Quality in Health Care. Safety and Quality Improvement Guide Standard 5: Patient Identification and Procedure Matching. Sydney. ACSQHC, 2012.
11.Australian Commission on Safety and Quality in Health Care. Safety and Quality Improvement Guide Standard 6: Clinical Handover. Sydney. ACSQHC, 2012.
12.Australian Commission on Safety and Quality in Health Care. Safety and Quality Improvement Guide Standard 7: Blood and Blood Products. Sydney. ACSQHC, 2012.
13.Australian Commission on Safety and Quality in Health Care. Safety and Quality Improvement Guide Standard 8: Preventing and Managing Pressure Injuries. Sydney. ACSQHC, 2012.
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17.Clinical Practice Guidelines Portal. 2012. (Accessed 27 September 2012, 2012, at http://www.clinicalguidelines.gov.au/about.php.)
18.Core, Hospital-based Outcome Indicators. ACSQHC, 2012. (Accessed October 2012, 2012, at http://www.safetyandquality.gov.au/our-work/information-strategy/indicators/core-hospital-based-outcome-indicators/.)
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29.Australian Commission on Safety and Quality in Health Care. Specifications for a standard patient identification band. Sydney. ACSQHC, 2012.
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31.National Blood Authority. Blood Sector Performance Benchmarking. Canberra. NBA, 2012.
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33.European Pressure Ulcer Advisory Panel and National Pressure Ulcer Advisory Panel. Treatment of pressure ulcers: Quick Reference Guide. Washington DC. National Pressure Ulcer Advisory Panel, 2009.
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