

AUSTRALIAN COMMISSION  
ON SAFETY AND QUALITY IN HEALTH CARE

# Annual Report

2013/14



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# Letter of transmittal

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## AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

**The Honourable Peter Dutton MP**

**Minister for Health**

Parliament House  
Canberra ACT 2600

Dear Minister

On behalf of the Board of the Australian Commission on Safety and Quality in Health Care (the Commission), I am pleased to submit our annual report for the financial year ending 30 June 2014.

The report reflects the requirements of the *National Health Reform Act 2011* and section 9 of the *Commonwealth Authorities and Companies Act 1997* (CAC Act).

The report and the audited financial statements were prepared in accordance with the Commonwealth Authorities and Companies Orders (Financial Statements for reporting periods ending on or after 1 July 2011), made by the Finance Minister under the authority of section 48 of the CAC Act.

This report was approved for presentation to you in accordance with a resolution of the board on 18 September 2014.

I commend this report to you as a record of our achievements and compliance.

Yours sincerely



**Professor Villis Marshall AC**

Chair

Australian Commission on Safety and Quality in Health Care  
22 September 2014

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This annual report was prepared and submitted in accordance with parliamentary reporting and legislative requirements. It provides an overview of the Australian Commission on Safety and Quality in Health Care's operations and performance for the financial year ending 30 June 2014.

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## Overview

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## About the Commission

The Australian Commission on Safety and Quality in Health Care (the Commission) commenced as an independent statutory authority on 1 July 2011. The Australian, state and territory governments initially established the Commission in 2006 to lead and coordinate national improvements in healthcare safety and quality. The Commission's permanent status was confirmed with the assent of the *National Health and Hospitals Network Act 2011*. The Commission was subsequently included within the *National Health Reform Act 2011*.

### Our mission

The Commission's mission is to lead and coordinate national improvements in the safety and quality of health care.

### Our vision

The Commission aims to provide a health system that is informed, supported and organised to deliver safe and high-quality health care that contributes to:

- better experiences for patients and consumers
- better health outcomes for the population
- improved productivity
- greater sustainability.

### Our role

The Council of Australian Governments established the Commission to lead and coordinate national improvements in the safety and quality of health care. Our role is to provide health ministers with strategic advice on best practices to bring about these improvements. The Commission develops and supports national safety and clinical standards; formulates and implements national accreditation schemes; and develops national health-related data sets. The Commission is also working to reduce unwarranted variations in practice and outcomes for individuals and populations, and undertaking nationally coordinated action to address healthcare associated infections and antimicrobial resistance.

*The National Health Reform Act 2011* specifies the Commission's roles and responsibilities as a permanent independent authority under the *Commonwealth Authorities and Companies Act 1997* (CAC Act). For details of the Commission's specific functions under section 9 of the *National Health Reform Act 2011* see page 16.

## Our values

The Commission values close, collaborative relationships with our partners from across the healthcare sector. These partners include consumers, healthcare providers, governments, and other healthcare organisations and agencies.

The Commission and its people act with independence, transparency, fairness, respect, accuracy and accountability. The Commission is committed to producing high-quality work, making ongoing improvements and enhancing a supportive work culture.

## Our accountability

As a statutory authority of the Australian Government, the Commission is accountable to the Parliament and the Minister for Health for achieving the outcomes of our agreed work plan and priorities. The Honourable Peter Dutton MP is the Minister for Health and has been the Commission's responsible Minister since 18 September 2013. The Honourable Tanya Plibersek MP was the Minister for Health and the Commission's responsible Minister from 1 July 2013 to 17 September 2013.



## Highlights 2013/14

July  
2013

137 hospitals and day procedure services had been assessed against the National Safety and Quality Health Service (NSQHS) Standards since the scheme commenced in January 2013.

To support the development of a comprehensive National Antimicrobial Resistance (AMR) Strategy for Australia, the Commission convened the Australian One Health AMR Colloquium. The colloquium was convened on behalf of the Australian AMR Prevention and Containment Steering Group and brought together experts and industry representatives from the human and animal health, food, agriculture and academic sectors to discuss key priorities and strategies for addressing AMR in Australia.

August

The Commission's Australian Open Disclosure Framework was officially endorsed by the following professional organisations: Australian College of Nursing; Australian and New Zealand College of Anaesthetists; The Royal Australian and New Zealand Colleges of Obstetricians and Gynaecologists; The Royal Australasian College of Physicians; Royal Australasian College of Surgeons; and The Society of Hospital Pharmacists of Australia. In December 2013, all Australian health ministers also officially endorsed the framework.

September

With project funding provided by the Department of Social Services, the Commission finalised the development of a draft *Handbook for improving safety and providing high quality care for people with cognitive impairment in acute care* and released it for national consultation. From October to December 2013, the Commission consulted extensively with healthcare professionals and consumer representatives across the country.

The Commission coordinated a series of public lectures and workshops led by an international expert in healthcare variation, Professor Sir Muir Gray. Sir Muir was responsible for developing the National Health Service (NHS, UK) Atlas of Variation in Healthcare series of publications.



October

The Commission released its first annual publication detailing the state of safety and quality in Australian health care, *Vital Signs 2013*.

Professor France Légaré, Chair of Shared Decision Making in Primary Care at the Université Laval Québec, visited Australia to conduct a public lecture on shared decision making in health care. Professor Légaré also led a workshop to identify some key areas where shared decision making could be improved in Australia.

November

The Commission's work to develop and implement the National Safety and Quality Health Service (NSQHS) Standards achieved national recognition, receiving two awards at the Prime Minister's Awards for Excellence in Public Sector Management. The awards recognised excellence in planning and collaboration in an area of considerable significance for public welfare and confidence.

The Australian Government Chief Medical Officer, Professor Chris Baggoley, and the Chief Veterinary Officer, Dr Mark Schipp, launched Antibiotic Awareness Week 2013, which took a 'One Health' approach to encouraging collaboration across animal health, agriculture and human health. Antibiotic Awareness Week is coordinated annually by the Commission.

December

The Commission released the first drafts of its Clinical Care Standards for antimicrobial stewardship and acute coronary syndromes for public consultation. The aim of the Clinical Care Standards program is to reduce unwarranted healthcare variation, ensure appropriate clinical care, improve patient experiences and enable sharing of decision making between consumers and healthcare providers. The draft Clinical Care Standard for stroke was released in March 2014. Each draft Clinical Care Standard undergoes a process of public consultation. Overall, more than 300 responses were received.

The Antimicrobial Utilisation and Resistance in Australia (AURA) Surveillance Project was established by the Commission as the platform for quantifying the prevalence and impact of AMR, and informing interventions aimed at reducing its incidence.

As of 30 December 2013, 550 hospitals and day procedure services had been assessed against the NSQHS Standards since 1 July 2013.

## Highlights 2013/14

January  
2014

The Commission released the *Draft National Consensus Statement: Essential Elements for Safe and High-Quality End-of-Life Care in Acute Hospitals* and commenced a national consultation including workshops for healthcare professionals and consumers in every state and territory. This high-level consensus statement will detail guiding principles, elements of care and organisational prerequisites for the delivery of end-of-life care.

February

The Commission welcomed Professor John Turnidge, who was appointed to lead the AURA Surveillance Project as a Senior Medical Advisor. Professor Turnidge is eminently qualified in the field of AMR, having been involved in high-profile societies and committees both nationally and internationally dealing with issues of AMR and its management.

March

The Commission commenced development of a new strategic plan to determine priorities for the following three to five years. The strategic planning process involved a range of activities to determine the current health landscape in Australia and the safety and quality issues that health service organisations, clinicians and consumers may face in the future.

The Commission appointed two medical advisors, Professor Anne Duggan and Dr Matthew Anstey, to provide clinical expertise for priority projects aimed at reducing unwarranted healthcare variation.

The Commission finalised development of a standardised National Residential Medication Chart (NRMC) for use in residential aged-care facilities (RACFs) funded by the Australian Government. The NRMC is designed to be the main communication tool for passing information between those responsible for prescribing, dispensing, administering and reconciling medicines.

April

The Commission finalised the development of the *Accreditation Workbook for Mental Health Services*. The workbook was distributed nationally to support health service organisations implementing, and being accredited to, the NSQHS Standards and the National Standards for Mental Health Services.

May

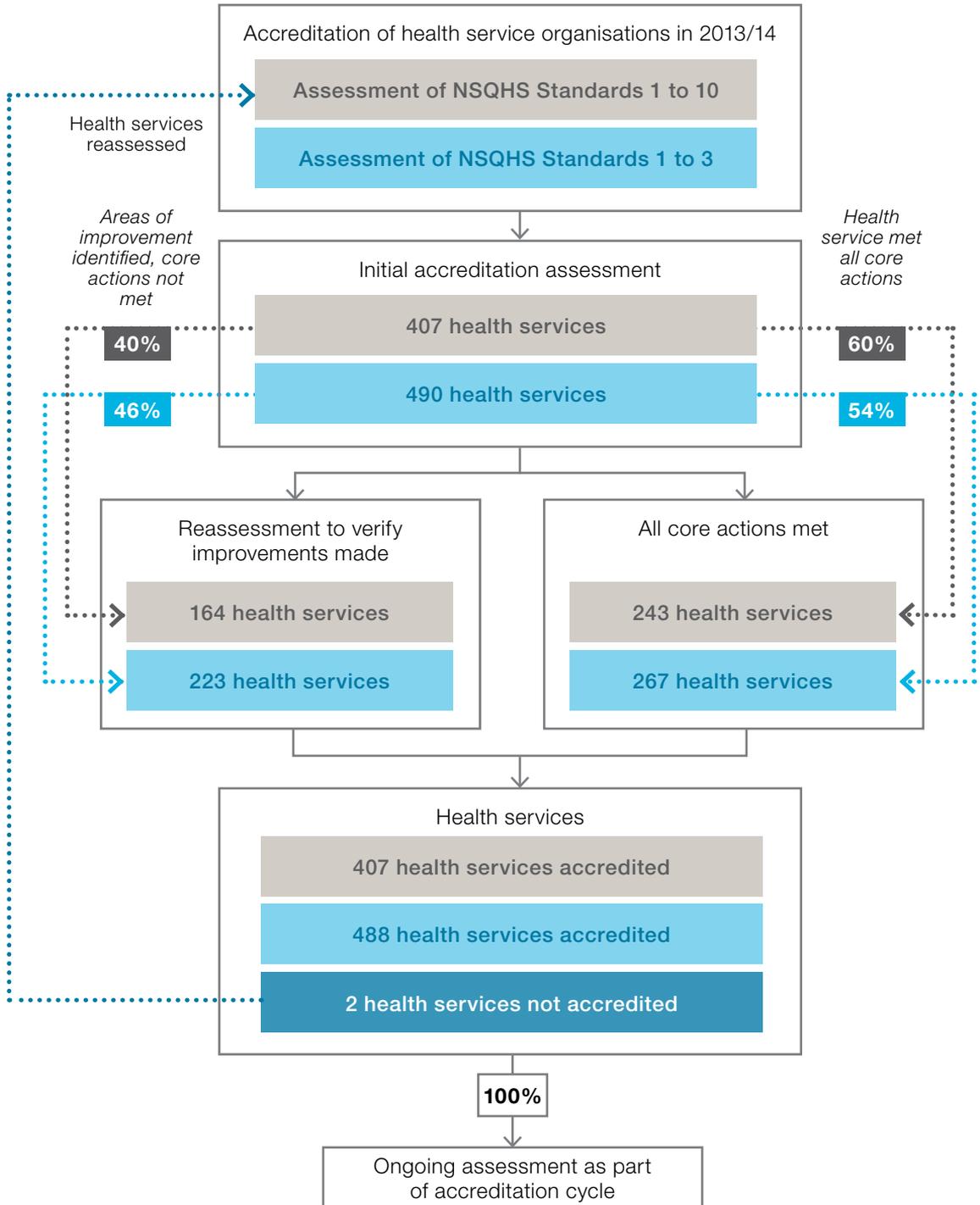
The Commission and the Australian Institute of Health and Welfare jointly released the report *Exploring Healthcare Variation in Australia: Analyses Resulting from an OECD Study* for discussion and public feedback. The report examines variation in the rates of several common procedures, such as knee surgery and hysterectomy, undertaken in hospitals during 2010–11.

June

Dr Robert Herkes was welcomed as the Commission's new Clinical Director. Dr Herkes is a highly experienced clinician with a longstanding interest in health system improvement.

As of 30 June 2014, 897 hospitals and day procedure services had been assessed against the NSQHS Standards since 1 July 2013. To support health service organisations to implement the NSQHS Standards, the Commission held network meetings, conducted mediations and answered 1,565 queries via the Commission's Accreditation Advice Centre during 2013/14.

# Health service accreditation 2013/14



Actions ranked in order of greatest challenge for health services

NSQHS Standard 3		<ul style="list-style-type: none"> <li>• Antimicrobial stewardship monitoring of antimicrobial usage</li> <li>• Auditing aseptic technique</li> <li>• Improving the effectiveness of antimicrobial stewardship</li> <li>• Training the clinical workforce in aseptic technique</li> </ul>
NSQHS Standard 2		<ul style="list-style-type: none"> <li>• Training clinical leaders, senior managers and the work force in patient-centred care</li> </ul>
NSQHS Standard 3		<ul style="list-style-type: none"> <li>• Increasing compliance with aseptic technique protocols</li> </ul>
NSQHS Standard 1		<ul style="list-style-type: none"> <li>• Monitoring and improving informed consent compliance</li> </ul>
NSQHS Standard 3		<ul style="list-style-type: none"> <li>• Antimicrobial stewardship program is in place</li> <li>• Training in invasive device protocols</li> </ul>
NSQHS Standard 1		<ul style="list-style-type: none"> <li>• Use of an organisation-wide risk register</li> </ul>

Actions where there was exceptional performance

NSQHS Standard 1		<ul style="list-style-type: none"> <li>• Managing safety and quality across an organisation</li> <li>• Effective incident management, complaints and investigation systems</li> </ul>
NSQHS Standard 4		<ul style="list-style-type: none"> <li>• Establishing robust systems to respond to medication incidents</li> </ul>
NSQHS Standard 6		<ul style="list-style-type: none"> <li>• Implementing structured and documented processes for clinical handover</li> </ul>
NSQHS Standard 7		<ul style="list-style-type: none"> <li>• Minimising wastage of blood and blood products</li> </ul>
NSQHS Standard 8		<ul style="list-style-type: none"> <li>• Ongoing monitoring of pressure injuries</li> </ul>
NSQHS Standard 9		<ul style="list-style-type: none"> <li>• Reviewing the circumstances and outcomes of emergency calls</li> </ul>
NSQHS Standard 10		<ul style="list-style-type: none"> <li>• Implementing robust systems to respond to falls incidents</li> </ul>



## Report from the Chair

Professor Willis Marshall AC

Australia has one of the safest health systems in the world. Our care to patients is generally of high quality, providing the best possible health outcomes. However, lapses in the safety and quality of care can occur and may have significant impact on people's lives, as well as financial implications for the health system.

Throughout 2013/14, the Commission made significant progress towards its vision for a health system that is better informed, supported and organised to deliver safe and high-quality care.

Some of the highlights of the year included:

### **Ongoing implementation of the NSQHS Standards**

Phased implementation of the NSQHS Standards began 18 months ago. During 2013/14, accreditation of hospitals and day procedure centres against the NSQHS Standards has progressed ahead of schedule. Early indications suggest the NSQHS Standards are achieving their aim of reducing the risk of harm to patients. Almost half of the hospitals and day procedure centres that had been assessed had to implement improvements to achieve accreditation. Those hospitals and day procedure centres are now safer for patients.

Anecdotal feedback from health service organisations that have undergone accreditation also suggests that the NSQHS Standards are being well received by healthcare providers and having a positive impact on patient care.

### **Development of the first Clinical Care Standards**

The Clinical Care Standards team and the topic working groups for acute coronary syndromes, antimicrobial stewardship and stroke have made tremendous strides towards the first sets of Clinical Care Standards. Drafts of the Clinical Care Standards for acute coronary syndromes, antimicrobial stewardship and stroke were released for public consultation during 2013/14.

Work has already commenced to identify the next set of Clinical Care Standards. It is envisaged these will link to current Commission work on unwarranted variation.

## Exploring healthcare variation in Australia

In 2013/14, the Commission established a new priority program to reduce unwarranted variation in clinical practice and in healthcare use. Unwarranted variation – or variation that cannot be attributed to a patient’s preference – raises serious questions about healthcare quality, efficiency and value.

The first phase of the Commission’s work was an exploration of the current rates of variation for common procedures across the country. This study, and the resulting discussion paper, is useful for health services and clinicians seeking to improve quality of care. The paper also highlights areas where it might be possible to achieve better value for the healthcare dollar.

## Acknowledgments

In March 2014, the Board farewelled two long standing members, Russell McGowan and Shelly Park. I’d like to thank them both for their valuable contributions to the Commission over the years of their appointment.

I would also like to take this opportunity to thank the Standing Council on Health, Board members, the Commission’s Executive Management team and staff members for their continued commitment to the Commission’s vision. Their significant achievements are described in detail throughout this report.



## Report from the CEO

Professor Debora Picone AM

It was another busy and successful year, during which the Commission worked with our partners to improve the safety and quality of patient care in the Australian health system.

Some of our many notable achievements included:

### Recognition for the NSQHS Standards

In November 2013, the Commission was pleased to receive two Prime Minister's Awards for Excellence in Public Sector Management for the development and implementation of the National Safety and Quality Health Service Standards (NSQHS Standards). The awards recognised the Commission's considerable planning and collaborative efforts in an area of significance for public welfare and confidence.

This national recognition came in addition to a stream of positive feedback on the NSQHS Standards. Health services across Australia have indicated that implementation of the NSQHS Standards has been effective in driving improvements and increasing engagement of clinical staff and board members alike in safety and quality initiatives.

### Surveillance of antimicrobial resistance and usage

Antimicrobial resistance (AMR) is a critical health issue, with urgent action being called for by the World Health Organization. In Australia, some resistant bacterial pathogens that were primarily the concern of hospitals are now seen with increasing frequency in the community.

In the 2013/14 Australian Federal Budget, the Commission received funding for a three-year project to coordinate national surveillance of AMR and antibiotic usage in human health, to support the prevention and containment of AMR. The Commission has established a highly qualified team to lead this priority program which builds on many achievements to date and will continue to use the technical and clinical advisory expertise available through its existing committees. In addition, the Commission has been working with Australian Government agencies, state and territory governments, professional organisations, the private healthcare sector and key experts to establish the nationally coordinated AMR and antimicrobial utilisation surveillance system.

## Future work

The Commission will continue to support the implementation of the NSQHS Standards and coordinate the Australian Health Services Safety and Quality Accreditation Scheme. During 2014/15, the Commission will also commence a review of the NSQHS Standards and an evaluation of the impact they are having on the safety and quality of care in Australian hospitals.

The Commission will continue to ensure that consumers, patients, families and carers are at the centre all of our work programs. Once finalised, the five-year strategic plan will underpin the Commission's future priority areas.

## Acknowledgements

I would like to acknowledge and thank the Standing Council on Health, jurisdictional Chief Executives, the Department of Health, Inter-jurisdictional Committee and our many committee members for contributing their insights and expertise to the Commission's work.

Finally, I would like to acknowledge the commitment of the Commission's staff members. It's a privilege to lead such a hardworking group of individuals. Their achievements are presented throughout this report.



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## Our work

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## Our work priorities

The Commission leads and coordinates improvements in the safety and quality of health care in Australia by identifying issues and priority areas that require action, and determining policy directions.

Section 9 of the *National Health Reform Act 2011* details the Commission's specific functions as:

- formulating standards, guidelines and indicators relating to healthcare safety and quality matters
- advising health ministers on national clinical standards
- promoting, supporting and encouraging the implementation of these standards, and related guidelines and indicators
- monitoring the implementation and impact of these standards
- promoting, supporting and encouraging the implementation of programs and initiatives relating to healthcare safety and quality matters
- formulating model national schemes that provide for the accreditation of organisations that provide healthcare services and relate to healthcare safety and quality matters
- collecting, analysing, interpreting and disseminating information relating to healthcare safety and quality matters
- publishing reports and papers relating to healthcare safety and quality matters.

There were no changes to the *National Health Reform Act 2011* or the Commission's legislative functions during the 2013/14 financial year.

In line with these functions, the Commission set the following work priorities for 2013/14:

1. National safety and clinical standards.
2. Formulation and implementation of national accreditation schemes.
3. Reduction in unwarranted variation.
4. Nationally coordinated action to address healthcare associated infections and antimicrobial resistance.
5. National data set development.
6. Publishing and reporting.
7. Knowledge and leadership for safety and quality.

These priorities also take into account functions spelt out in the *National Health Reform Agreement* signed by the state, territory and Australian governments, and the work that health ministers identified for the Commission, including the Australian Safety and Quality Goals for Health Care. The projects and deliverables for each of these priority areas are detailed in the following pages.

## National safety and quality standards and accreditation

At the request of health ministers, the Commission developed 10 National Safety and Quality Health Service (NSQHS) Standards in collaboration with healthcare providers, consumers and governments. Nationally, 1,352 hospitals and day procedure services will be required to undergo accreditation against all NSQHS Standards by 2016. The Commission continues to support the use of the NSQHS Standards by developing and promoting resources that facilitate their implementation.

The Commission is coordinating national accreditation reforms for health system regulators, accrediting agencies and health services in line with the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme.

During 2013/14, the Commission continued a program of work to help mental health service providers apply safety and quality standards in mental healthcare settings. A new body of work focused on improving the management of cognitive impairment using the NSQHS Standards.

In addition, the Commission is developing national Clinical Care Standards to improve patient care outcomes. The Commission is progressing this work for the priority areas identified in the Australian Safety and Quality Goals for Health Care.

The Commission is also finalising its commitment to the Australian Health Ministers' Advisory Council (AHMAC) to develop national standards for clinical quality registries.

### The NSQHS Standards

The aim of the NSQHS Standards accreditation process is to promote and support safe patient care and quality improvements across all care settings.

The NSQHS Standards provide a framework for health services to improve patient care and to implement relevant safety and quality systems. The NSQHS Standards are the basis for accrediting Australian hospitals and day procedure services, as they determine how, and against what criteria, a health service's performance will be assessed.

The 10 NSQHS Standards are:

- **Standard 1:** Governance for Safety and Quality in Health Service Organisations
- **Standard 2:** Partnering with Consumers
- **Standard 3:** Preventing and Controlling Healthcare-Associated Infections
- **Standard 4:** Medication Safety
- **Standard 5:** Patient Identification and Procedure Matching
- **Standard 6:** Clinical Handover
- **Standard 7:** Blood and Blood Products
- **Standard 8:** Preventing and Managing Pressure Injuries
- **Standard 9:** Recognising and Responding to Clinical Deterioration in Acute Health Care
- **Standard 10:** Preventing Falls and Harm from Falls.

### Supporting implementation

The Commission's NSQHS Standards Accreditation Advice Centre provides significant guidance and support for health service organisations, surveyors and accrediting agencies.

As of 30 June 2014, the Advice Centre had received more than 1,565 enquiries. The most common queries related to individual standards and their requirements (most commonly NSQHS Standards 4, 3 and 9). Users also requested implementation resources, particularly high-resolution NSQHS Standards icons for reproduction in service-specific documents.

The Advice Centre also coordinated network meetings to provide information to address local implementation issues. During 2013/14, the Commission convened more than 34 network meetings with approximately 1,978 healthcare representatives from public and private hospitals, day procedure centres and community services.

The Commission also provides a service to mediate unresolved issues between health services and surveyors during accreditation visits. Mediation was sought on nine occasions during 2013/14. In each incidence, the issues that led to mediation were resolved.

### Key achievements 2013/14

The Commission received two Prime Minister's Awards for Excellence in Public Sector Management for the development and implementation of the NSQHS Standards.

The Commission issues advisories to accrediting agencies and health service organisations to clarify assessment processes and interpretation of the NSQHS Standards and ensure the accreditation process is consistent and reliable. During 2013/14, seven advisories were issued on topics such as the collection and reporting of accreditation evidence by accrediting agencies; the assessment of training requirements for credentialed medical and other clinical practitioners and visiting medical officers; cessation of flexible transition arrangements; and assessing 'not applicable' and developmental actions.

## Implementation progress

- Nationally, 1,352 hospitals and day procedure services will be required to undergo accreditation against all NSQHS Standards by 2016.
- In 2013/14, 624 hospitals and day procedure services were scheduled to be assessed against the standards. As of 30 June 2014, 897 had been assessed. Of these, 388 were assessed against all 10 NSQHS Standards as part of their accreditation cycle, while 490 hospitals and day procedure services were assessed against standards 1 to 3. There were also 19 new health services that underwent interim assessment to the NSQHS Standards in 2013/14.
- In 2013/14, 43% of those assessed needed to implement improvements in order to achieve accreditation. This means assessment against the NSQHS Standards reduced risks to patients in the care of these health service organisations.

### Key achievements 2013/14

**43%** of health services are now accredited against all 10 NSQHS Standards.

**55%** of health services have been assessed against NSQHS Standards 1, 2 and 3.

**2%** of health services were newly established and underwent interim accreditation to the NSQHS Standards.

## NSQHS Standard 2 implementation survey

NSQHS Standard 2: Partnering with Consumers aims to ensure health services are responsive to patient, carer and consumer needs. It requires consumers to be engaged in the development and review of health services. During 2013, it was reported that some health services found the actions within NSQHS Standard 2 challenging to implement.

In July 2013, the Commission developed a survey to identify the greatest areas of difficulty in complying with NSQHS Standard 2 and the types of resources that could be developed to support specific actions. The survey was targeted at health services undergoing or preparing for accreditation.

There were 415 respondents to the survey, most of whom worked in public hospitals, private hospitals, day procedure services and community-based services.

Respondents indicated that the most difficult actions to implement were those that involved consumers and carers in clinical training (action 2.6.2) and in governance (action 2.1.1). In private hospitals and day procedure services, difficulties appeared to occur at the organisational level (such as in setting up systems and processes to engage with consumers), while public hospitals experienced more difficulties with the way staff members understood the intent of and need for the standard. Most concerns within community-based services were related to the initial engagement of consumers.

The Commission is developing fact sheets to help health service organisations engage consumers and carers in governance and in training for the clinical workforce. Additional fact sheets will provide specific information on how day procedure, small or stand-alone services can meet the requirements of NSQHS Standard 2.

### AHSSQA Scheme

The Australian Health Services Safety and Quality Accreditation (AHSSQA) Scheme coordinates accreditation nationally and monitors safety and quality improvements across the health system. All Australian hospitals and day procedure centres must be accredited, and other health services are increasingly using the accreditation scheme to ensure quality of care.

The Commission coordinates the AHSSQA Scheme and provides support to state and territory health departments that regulate the scheme, health services undergoing accreditation and the accrediting agencies that assess health services.

Accrediting agencies provide the Commission and regulators with data that show whether health services comply with NSQHS Standards. During 2013/14, the Commission convened two panels to assess four applications from accrediting agencies for approval. This included two applications resulting from merges and two from agencies that had previously not held approvals to assess health services. The Commission participated in five training workshops for surveyors from these agencies involved in the accreditation assessment of health services.

In 2014/15, a review of the effectiveness of the approvals process will be undertaken prior to accrediting agencies seeking re-approval of their accrediting role. Collaboration with regulators and accrediting agencies is essential to ensure accrediting processes are consistently applied.

The Commission is working with the Department of Health's Enterprise Data Warehouse team to build a secure system that will hold and report on health service assessment data. It is informing accrediting agencies about the data that needs to be submitted and the establishment of collection systems and tools. The data collection and reporting systems are expected to be fully operational by the end of 2014.

#### Key achievements 2013/14

**10** accrediting agencies were approved to assess health services to the NSQHS Standards.

## Evaluating the impact of the NSQHS Standards

The Department of Health is funding the Commission to evaluate the impact of the NSQHS Standards. The Commission is working with states and territories to identify and analyse relevant data sources and has commissioned work to determine patient and carer perceptions of care in the context of the NSQHS Standards.

The Commission will obtain advice from advisory groups, health service organisations and state and territory jurisdictions on the safety and quality impacts of the NSQHS Standards, as these groups implement the AHSSQA Scheme.

Early indications suggest the NSQHS Standards are achieving their aim of reducing the risk of harm to patients. For instance, the recognition and response systems for clinical deterioration and the New South Wales Between the Flags program have resulted in a 38% decrease in cardiac arrests, which translates to approximately 800 fewer deaths since 2010.

In addition, a combination of strategies developed by the Commission – including the hand hygiene and antimicrobial stewardship programs and the introduction of NSQHS Standard 3: Preventing and Controlling Healthcare-Associated Infections – have resulted in a steady decrease in the incidence of healthcare associated multi-resistant *Staphylococcus aureus* bacteraemia in hospitals. The national rate of *Staphylococcus aureus* bacteraemia has decreased from 1.1 cases per 10,000 patient days to 0.9 cases per 10,000 patient days.

The project to evaluate the effects of the NSQHS Standards is expected to be finalised by the end of 2015.

### Feedback from health service organisations on the NSQHS Standards



‘Despite the challenges, I found the overall accreditation experience rewarding and reassuring, knowing that our organisation is committed to provide safe and high-quality healthcare services to our patients. I am actually looking forward to the next periodic review!’

#### Acting Assistant Director of Pharmacy, The Prince Charles Hospital, Queensland

‘I want to say “well done” on the NSQHS Standards. I think that some of the work that we have done around pressure injury, falls and deteriorating patients as a result of this new framework has really made a tangible impact on the quality of our care and the outcomes for our patients. I think that’s a really good start.’

#### Health Service Executive, Horsham, Victoria

## Safety and quality in primary care

The primary care sector is diverse and complex covering a range of services across numerous settings of care. During 2013/14, the Commission has been working with community health services, dental practices and general practices to improve the safety and quality of the care they provide.

### Community health services

The NSQHS Standards are being implemented in a range of community health services, particularly where they form part of a continuum of care provided by a local health district or private hospital ownership group. During 2013/14, the Commission worked with the community health sector to develop resources that describe the intent of the NSQHS Standards and provide strategies for meeting their requirements. An electronic monitoring tool is also being developed to enable community health services to track their progress with implementation of the NSQHS Standards.

Piloting of these resources will commence in the second half for 2014.

### Dental practice

The majority of public dental practices in Australia are required to be accredited to the NSQHS Standards. While accreditation for private dental practices is voluntary, the Australian Dental Association supports their participation.

To facilitate the application of the NSQHS Standards in dental practices, the Commission is developing a resource that outlines continuous quality improvement strategies and guidance on improving

safety and quality in dental practices. This resource will be released for consultation later in 2014.

### General practice accreditation

In 2013, the Royal Australian College of General Practitioners (RACGP) and the Commission embarked on a project to develop a governance and reporting framework for general practice accreditation in Australia. The aim of this project is to:

- identify any issues general practices have with the existing accreditation scheme
- maximise safety and quality of patient care through the application of accreditation
- coordinate general practice accreditation nationally.

During the initial consultation process from August to September 2013, the Commission interviewed 15 general practice based organisations.

During July and August 2014, the Commission will consult with General Practitioners and Practice Managers across the country to inform the development of a framework for accreditation in general practices. A literature review and further consultations with the sector will follow.

### Clinical Care Standards

The Clinical Care Standards program aims to facilitate the provision of appropriate clinical care to people by addressing clinical areas where unwarranted variation in health care exists. Thus improving patient experiences, and enabling decision making to be shared between consumers and healthcare providers.

Clinical Care Standards comprise a set of quality statements that describe key components of the clinical care a person should be offered for a specified part of their patient journey.

During 2013/14, the Commission collaborated with established working groups comprised of consumers, clinicians and other healthcare experts to develop the initial sets of Clinical Care Standards for acute coronary syndromes, antimicrobial stewardship and stroke. These Clinical Care Standards focus on the care people should receive from the onset of their symptoms and throughout their care in the hospital. The Clinical Care Standards highlight the need for communication with primary care providers prior to a patient being sent home.

The draft Clinical Care Standards for acute coronary syndromes and antimicrobial stewardship were released for public consultation from December 2013 to March 2014. Consultation on the draft Clinical Care Standard for stroke took place from March to May 2014. Across the three consultations, more than 300 responses were received.

Feedback from formal submissions was broadly supportive of the Clinical Care Standards. A report on the findings from the consultation process will be released later in 2014.

Based on the consultation feedback, further work will be undertaken to improve the Clinical Care Standards ahead of their release for implementation in early 2015.

The Commission has begun work on an implementation plan for the Clinical Care Standards, working with representatives from across the sector to investigate ways of integrating the standards into current clinical practice and policies and programs.

### Feedback on the draft Clinical Care Standards



‘We recognise the importance of national Clinical Care Standards in improving the delivery of Australian healthcare services by aiding in the reduction of inappropriate variation in clinical practice. The Clinical Care Standards will also serve as a valuable tool to improve patient understanding of and satisfaction with care provided, by enhancing the communication and decision-making process between patients and their health professionals.’

‘Overall, we commend the Commission on the development of the Clinical Care Standards, which bring together best practice in clinical care and support health practitioners, consumers and health organisations in providing high-quality and safe clinical care.’

‘We understand that the aim of the draft Clinical Care Standards is to support delivery of appropriate care, reduce unwarranted variation in care, and aid shared decision making between patients, carers and clinicians. As such, we are pleased to note that work on the standards was guided by the inclusion of consumer representatives on each of the working groups responsible for developing these standards.’

### Comments received from participants in consultations on the draft Clinical Care Standards

### National standards for mental health services

The Commission has undertaken a number of initiatives to support the implementation of national standards in mental healthcare settings. This work has included the development of networks and links with other agencies, including the National Mental Health Commission, the Department of Health, Safety and Quality Partnership Standing Committee and Private Mental Health Alliance.

In March 2014, the Commission released the *Accreditation Workbook for Mental Health Services*. The workbook will help mental health services to understand and comply with both the NSQHS Standards and the National Standards for Mental Health Services (NSMHS). The idea for the workbook arose from collaborations between the Commission, the Department of Health, and the Safety and Quality Partnership Standing Committee (Mental Health and Drug and Alcohol Principal Committee). National consultation on a draft of the workbook took place during 2012/13. Feedback from several service providers noted that the draft workbook was a useful tool for working through implementation.

During 2013/14, the Commission continued work on a scoping study with the National Mental Health Commission on implementing the NSQHS Standards and the NSMHS. The study involved both service users and service providers around Australia and focused on compliance with the two sets of standards in the public, private and community-managed mental health sectors. The study also aimed to identify the enablers, barriers and challenges health services face in

complying with the standards and pinpoint gaps in the standards' framework with respect to safety and quality.

From July to September 2013, the Commission's mental health team travelled around Australia and talked with 150 mental health service providers and consumers in 22 focus groups and interviews. The focus groups enabled the Commission to further explore the views of service providers and service users and focus on the issues raised by the 425 participants in the national survey conducted earlier in the study.

The report on the scoping study is expected to be finalised in July 2014. The Commission will confer with the National Mental Health Commission on the recommendations arising from the report.

#### Key achievements 2013/14

**1,400** copies of the *Accreditation Workbook for Mental Health Services* were distributed to hospitals and mental health services across Australia.

More than **2,000** downloads of the *Accreditation Workbook for Mental Health Services* were made from the Commission's web site.

**575** service providers and consumers were consulted as part of the scoping study on national standards for mental health.

## Improving the management of cognitive impairment using the NSQHS Standards

During 2013/14, the Commission received funding from the Department of Social Services to use the NSQHS Standards and other mechanisms to coordinate national improvement in the care of patients with cognitive impairment (including dementia and delirium) in acute care.

The project began in June 2013, guided by an oversight committee. The first phase involved drafting a handbook on improving the care of people with cognitive impairment within the context of the NSQHS Standards. Safety and quality issues specific to caring for patients with cognitive impairment were identified during the development of the handbook.

*The Handbook for improving safety and providing high quality care for people with cognitive impairment in acute care: A consultation paper* was released in September 2013. The Commission consulted extensively with health service providers, consumers and carers around Australia between October and December 2013. The national consultation consisted of 16 health service organisation forums, 10 focus groups with consumers and an online survey. The consultation not only enabled feedback on the draft handbook but also allowed those living with and caring for people with cognitive impairment to raise issues and make recommendations on improving care. The Commission is incorporating this feedback into a revised handbook and will launch an e-resource in September 2014, targeting health service managers, clinicians and consumers.

This resource has been developed to apply across the diverse range of

hospital facilities in Australia, from major tertiary teaching hospitals to small rural multipurpose services. While the resource focuses on the acute and sub-acute care settings, there is recognition that people with cognitive impairment are also managed in primary care, community and residential care. For the best possible outcome for patients, these services need to be seamlessly linked. As such, the resource includes strategies to be effected at the point of transitions in care. These address information exchange and communication between hospitals and general practice, primary care, aged community and residential care.

The second phase of the project to improve the care of people with cognitive impairment involves developing solutions for safety and quality issues that have not been adequately addressed within the NSQHS Standards. This includes setting a new Clinical Care Standard for delirium and developing recommendations to address cognitive impairment in the Commission's 2015 review of the NSQHS Standards. The project is due to be completed in June 2015.

### Key achievements 2013/14

**299** health service providers participated in consultation forums on the *Handbook for improving safety and providing high quality care for people with cognitive impairment in acute care: A consultation paper*.

**78** consumers attended focus groups, 178 individuals completed an online survey and 18 written submissions were received from individuals and organisations.

## National clinical quality registries

Clinical quality registries collect, analyse and report on patient-related information to help improve the quality and safety of health care. In particular, clinical quality registries provide information about:

- the appropriateness of health care (whether the care delivered to patients is based on the best available evidence)
- the effectiveness of health care, measured by the degree to which the care benefits the patient.

Developing standardised national registries of the quality of clinical care is a cost-effective way to monitor the degree to which health care benefits the patient and how closely the care aligns with evidence-based practice.

Clinical quality registries add to historical research information by monitoring the quality of health care on a routine basis and reporting in a timely manner. Registry reports can be compared against peers, standards and benchmarks, thereby driving improvements in care. However, few clinical quality registries achieve national coverage, and most operate under varying arrangements with mixed buy-in from health system funders and operators.

During 2013/14, the Commission developed a *Framework for Australian clinical quality registries*, working with state and territory jurisdictions and the registries community. The framework specifies national arrangements under which hospitals and clinical quality registries can partner with the hospital sector and peak clinical groups to monitor and report on the appropriateness and effectiveness of health care. The framework also provides extensive technical guidance on best-practice building and operation of national registries.

The *Framework for Australian clinical quality registries* was endorsed by the AHMAC in March 2014. State and territory health departments have also agreed to use the framework.

In 2014/15, the Commission will work with states and territories to identify high-priority clinical domains for the development of national clinical quality registries within the framework.

## Supporting quality practice and clinical standards

The Commission is continuing its work to develop and enhance a range of programs and initiatives to support high-quality clinical practice. While the development of Clinical Care Standards (detailed on page 22) was a priority this year, the Commission's work for other clinical areas includes:

- clinical communications
- end-of-life care
- falls prevention
- health literacy
- medication safety
- a National Patient Contact Protocol
- open disclosure
- recognising and responding to clinical deterioration in mental state
- reducing children's radiation exposure from CT scans.

### Clinical communications

The Commission's Clinical Communication program is applied to the key areas known to influence quality and safety outcomes throughout the patient journey and transitions in care. This includes supporting the implementation of the NSQHS Standard 6: Clinical Handover.

Effective patient-clinician communication is particularly important to ensure the coordination and continuity of care as patients transfer within and between services. Communicating with patients at transitions of care is new for many healthcare providers. Information and resources to guide and support clinicians in effectively engaging patients in this type of communication are limited.

The role and potential benefits of engaging patients in this form of communication are also not widely recognised. This lack of understanding has been identified as a barrier and disincentive to change healthcare practice and implementation. A strong case for change must be presented to healthcare providers, along with supporting tools and resources that will help them engage more effectively with patients, families and carers at transitions in care.

In 2013/14, the Commission expanded the Clinical Communication program to focus on communication that engages clinicians, patients and their families and carers during transitions of care in acute health facilities. This work will support the implementation of NSQHS Standard 6 and other Commission programs focusing on health literacy, cognitive impairment and open disclosure. It will also inform other NSQHS Standards dealing with effective communication.

To progress this work, the Commission contracted a consortium of researchers to conduct a scoping review on engaging patients in communication at transitions of care. The review will identify which communications strategies work in healthcare settings including acute care facilities, and which tools and resources are available or required to help healthcare providers apply these strategies.

The review is scheduled to be completed in August 2014.

## End-of-life care

More than half the people who die in Australia each year do so in acute hospitals where the quality and safety of end-of-life care can vary greatly.

In August 2013, the Commission released the findings of scoping work and preliminary consultations on the safety and quality of end-of-life care in acute hospitals. It showed that, despite considerable work to improve end-of-life care across Australia, there are significant gaps and opportunities for improvement. One key gap is the lack of an agreed statement about the standard of end-of-life care that patients, families and carers should expect.

In mid-2013, the Commission began working with consumers, healthcare providers and other experts to develop a national consensus statement on the essential elements of end-of-life care in acute hospitals. The draft consensus statement was released in January 2014. It is a high-level statement on the guiding principles, elements of care and organisational prerequisites that shape the way care should be delivered.

Although the consensus statement is primarily focused on care that people receive in hospitals, it is also relevant for people at the end of their life who are being cared for in other settings, such as remote clinics, hospital in the home services or aged care facilities. The links between acute and primary care services are particularly important for ensuring that people receive the care that they need at the end of their life.

Consultation workshops were held in every state to hear the views of health consumers and healthcare professionals, and 75 formal submissions were also received. The feedback from these formal submissions and consultation workshops was broadly supportive of the document.

A consultation report will be prepared and further work undertaken to examine the scope and application of the consensus statement among specific populations, such as children. The revised consensus statement will be submitted for endorsement by the Australian Health Ministers' Advisory Council in November 2014.

### Key achievements 2013/14

*The Safety and Quality of End-of-Life Care in Acute Hospitals* background paper was released and distributed to all hospitals, and state and territory jurisdictions.

*The Draft National Consensus Statement: Essential Elements of Safe and High-Quality End-of-Life Care in Acute Hospitals* was released for consultation.

**75** formal submissions were received regarding the consensus statement, and consultation workshops held around Australia gathered input from 350 participants.

### Feedback on the draft consensus statement

'The [draft] consensus statement can be used as an impetus for change in end-of-life care delivery. We have already been using the draft to give us the push to do this.'

**Nurse Consultant, Tasmania**

## Falls prevention

Falls, and injuries from falls, remain the largest reported causes of harm in Australian health care.<sup>1</sup> The Commission has convened a group of experts to advise how best to support the implementation of evidence-based strategies to achieve the requirements of NSQHS Standard 10: Preventing Falls and Harm from Falls. This group met three times during 2013/14.

The group also considered how to monitor progress against NSQHS Standard 10 and identify emerging falls issues. The experts' recommended a range of strategies that can be implemented by health services and jurisdictions.

### Key achievements 2013/14

**205** individuals participated in Falls Prevention Network meetings.

## Health literacy

'Health literacy' refers to how people understand information about health and health care, and how they can apply that information to their lives. Health literacy is important because it shapes people's health and the safety and quality of health care.

The Commission separates health literacy into two components:

- Individual health literacy refers to the skills, knowledge, motivation and capacity of a person to access, understand, appraise and apply information to make effective decisions about health and health care, and take appropriate action.
- The health literacy environment comprises the infrastructure, policies, processes, materials, people and relationships that make up the health system and have an impact on the way people access, understand, appraise and apply health-related information and services.

Health literacy is a significant issue for Australia. Health-related information and services need to be easy for consumers to understand and use if they are to meaningfully engage with the system.

However, healthcare information and systems have become increasingly complex.<sup>2,3</sup> A number of studies support the need for action, given only about 40% of Australian adults have the level of individual health literacy needed to effectively understand information and make decisions about health care.<sup>4</sup> This combination of complex health information and low individual levels of health literacy can contribute to poorer health and lower quality of care.<sup>5</sup>

From June to September 2013, the Commission conducted a public consultation on the draft discussion paper *Consumers, the health system and health literacy: Taking action to improve safety and quality*. Over 100 written submissions were received from a range of organisations and individuals. Overall, those who provided submissions strongly supported the Commission undertaking work in health literacy, and were satisfied with the approach of the paper and proposed future work in this area.

In June 2014, the Commission finalised the *Health literacy: Taking action for safety and quality* paper and developed an accompanying national statement on health literacy. These documents provide information about the concept of health literacy, how it relates to partnerships with consumers and the rationale for taking action.

In these papers, the Commission has also stated that effectively addressing health literacy requires a coordinated and collaborative approach across all healthcare settings focusing on:

- embedding health literacy into systems, including developing and implementing systems and policies at an organisational and societal level that support action to address health literacy
- ensuring effective communication, including providing print, electronic or other communication that is appropriate to the needs of consumers; as well as supporting effective partnerships, communication and interpersonal relationships between consumers and people working within the health system
- integrating health literacy into education, including educating consumers and healthcare providers.

The papers are scheduled to be sent to health ministers for endorsement in late 2014.

Following the release of the final paper and national statement, the Commission aims to address health literacy by fostering action nationally. The need to address health literacy is fundamental to a range of actions within the NSQHS Standards.

### Key achievements 2013/14

**114** submissions were received during public consultation on a health literacy discussion paper.

## Medication safety

Medicines are the most common treatment used in health care and contribute to significant improvements in preventing and treating disease. However, mistakes can happen when medicines are prescribed, dispensed, administered or taken by consumers, which may result in harm.

**The majority of medication errors are preventable. Reducing harm to people through safe and effective medication management is a key safety and quality priority for the Commission, as recognised in NSQHS Standard 4: Medication Safety.**

In December 2013, the Commission published a literature review, *Medication Safety in Australia*, which provides the latest information on the extent and nature of medication errors in Australia and the effectiveness of prevention strategies.<sup>6</sup> The evidence supports the use of standardised medication charts, improved medication distribution systems, electronic medication management systems for prescribing medicines and medication reconciliation at transitions of care.

This data also supports the Commission's approach of focusing on five streams of work in medication safety, including:

- standardisation and systems improvement
- continuity of care to improve the accuracy of medicines information communicated during transitions of care
- reducing gaps in practice by encouraging evidence-based approaches
- ensuring the safety of electronic medication initiatives
- advocating safety and quality of care in the use of medicines.

Knowledge about who is most at risk of adverse medicines events, where the errors are occurring and which interventions are most successful in reducing the risk of these events can be used by individual practitioners, healthcare facilities and policy makers to improve the quality of care and safety in the use of medicines. This information will also guide the Commission's future medication safety work.



### Standardisation to reduce the risk of medication errors and patient harm

The risk of medication errors and other adverse medication events can be reduced by standardising the presentation of medicines information through the use of medication charts. This has been demonstrated in the acute care sector with the implementation of the National Inpatient Medication Chart (NIMC).<sup>7</sup>

During 2013/14, the Commission continued to support and promote the use of the NIMC. This work included:

- the release of new versions of the NIMC incorporating a venous thromboembolism prophylaxis section
- updates to the NIMC online training tool to incorporate the venous thromboembolism prophylaxis section
- the release of private hospital versions of the NIMC for paediatric settings
- the release of educational resource materials and an electronic audit tool to help health services implement the new NIMC versions
- the publishing of the 2012 *NIMC National Audit Report Supplement: From measurement to action* to help health services improve the safety and quality of prescribing and documentation on the NIMC
- the addition of two new reports to the NIMC audit system to provide hospitals with access to additional information on medication errors.

The use of medicines and the incidence of medication-related problems are significant in aged-care facilities given the high numbers of comorbidities that require complex medicine regimens.

Most residents of aged-care facilities require multiple medicines.<sup>8,9</sup> In March 2014, the Commission finalised the development of a standardised National Residential Medication Chart (NRMC) for use in residential aged-care facilities (RACFs) funded by the Australian Government through the Fifth Community Pharmacy Agreement.

The NRMC defines the standard requirements for medication charts to be used in RACFs. It is designed to be the main communication tool for the transfer of medicines information between those responsible for prescribing, dispensing, administering and reconciling medicines in RACFs, including general practitioners, community pharmacists and RACF staff. It is also designed to facilitate the supply of medicines and allows for Pharmaceutical Benefit Scheme (PBS) and Repatriation Pharmaceutical Benefit Scheme (RPBS) claiming directly from the chart, reducing the need for individual prescriptions for most PBS and RPBS medicines.

From April to November 2013, the Commission conducted a phased implementation of the NRMC in 22 RACFs in New South Wales to test its functionality and usability. An audit of the phased implementation revealed a reduction in the number of medicines prescribed, fewer administration errors, fewer errors in the supply of medicines via drug administration aids, and improved documentation of the medicines administered.

Pharmacy supply errors were reduced by the removal of separate signing sheets and improvements in version control of medication charts, enabling pharmacies to pack medicines from the most recent medication orders.

Direct claiming of rebates for PBS and RPBS prescriptions from the NRMC reduced the administrative workload for prescribers, pharmacists and RACF staff. This workload reduction occurred gradually as personnel became used to using the new chart.

Another important standardisation piloted throughout 2013 was a national subcutaneous insulin chart that combines records of insulin prescribed, dispensed and administered with documentation of patient blood glucose levels and clinical decision support.

The pilot, conducted in eight hospitals across Australia, demonstrated that this new chart improved:

- monitoring and documentation of blood glucose levels
- clarity of insulin prescribing
- notification documentation
- follow-up management of hypoglycaemia and hyperglycaemia.



Throughout 2013/14, the Commission also published enhancements to the National Labelling Recommendations for User-Applied Labelling of Injectable Medicines, Fluids and Lines, and issued a joint statement with the Australian and New Zealand College of Anaesthetists supporting user-applied labelling standardisation of injectable medicines and fluids.

### Key achievements 2013/14

**4,673** charts were audited as part of the phased implementation of the NRMC.

27% reduction in pharmacy supply errors during the phased implementation of the NRMC.

The incidence of blood glucose levels of less than 4 mmol/L were reduced by 29% during the pilot of the new insulin chart.

The incidence of blood glucose levels greater than 20 mmol/L were reduced by 28% during the pilot of the new insulin chart.

### Improving the quality of communication about medicines

Improving the accuracy of information on patients' medicines reduces the risk of medication errors and adverse medicine events. This can occur when patients are admitted to or discharged from hospital, and especially when they are transferred within or between health service organisations.

As many as 60% to 80% of patients have at least one error recorded in their medication history on admission to hospital. Error rates range from one to 2.5 per patient, with the most common error – an omitted medicine – accounting for 40% to 60% of errors.<sup>6</sup> The most accurate medication history is achieved when using a structured process for interviewing patients and/or their carers and families about the medicines the patient is taking, and verifying with one or more other sources (such as the patients' medicines, medicines list or community pharmacy records). In July 2013, the Commission released a training video, *Get it right! Taking a Best Possible Medication History*, for health services and universities to use in training medical, nursing and pharmacy students and practitioners.

Throughout 2013/14, the Commission coordinated Australia's involvement in the World Health Organization (WHO) High 5s Medication Reconciliation Project. This five-year project involving 12 Australian health service organisations aims to assess the feasibility and effectiveness of implementing a standard operating protocol for medication reconciliation – a process for improving the accuracy of medicines information communicated across the continuum of care.

An interim report on the project was published by WHO is due to be released later in 2014. The Commission is also developing an Australian interim report which shows that in hospitals involved in the project, the average rate of medication errors on admission was less than the benchmark 0.3 per patient since reporting commenced in December 2010.

### Key achievements 2013/14

**5,080** people viewed the *Get it right! Taking a Best Possible Medication History* video.

Medications errors on admission were less than the benchmark of 0.3 per patient in hospitals participating in the High 5s project.

### Reducing gaps in practice by encouraging evidence-based approaches

Medication administration in acute care continues to have a significant risk of error. Direct observational studies report estimated error rates of 19% to 27% in medicines administered to patients.<sup>10</sup>

In 2013/14, the Commission published five evidence briefings on interventions to reduce medication administration and dispensing errors and improve the efficiency of medication distribution systems.

The evidence briefings consider:

- automated dispensing systems
- barcode medicine administration systems
- electronic medication administration records
- double-checking medicine administration
- interventions to reduce interruptions during medicines preparation and administration.

The briefings provide the basis for a comparative analysis of the relative effectiveness of the different interventions and will help individual health services to identify the most appropriate intervention for their service.

It is estimated that 60% of Australians aged 15–74 do not have the basic health literacy skills needed to understand information such as the instructions on a medication dispensing label. However, the pharmacy label is often the only individually tailored information that a consumer receives about their medicines.

In November 2013, the Commission co-hosted a national roundtable discussion on improving the safety and quality of pharmacy dispensing labels with the Clinical Excellence Commission (NSW). The purpose was to engage pharmacy organisations, consumers, educators, software vendors, health literacy experts and patient safety agencies to formulate a set of priorities for improving pharmacy labels and identify appropriate agencies to lead the work required.

Clinical indicators are useful tools to measure gaps in practice. A revised version of *Indicators for Quality Use of Medicines in Australian Hospitals* is due to be released in August 2014. These indicators help clinicians and health service organisations measure improvements in the quality and safety of medicine use and medication management systems. The revised version includes two new indicators for medication reconciliation at discharge and five indicators for mental health. The indicators have been mapped to the NSQHS Standards. Data collection tools for each indicator were also developed.

### Key achievements 2013/14

**5** evidence briefings were released on interventions to reduce medication administration and dispensing errors and improve the efficiency of medication distribution systems.

### Ensuring the safety of electronic medication initiatives

Electronic medication management systems can help health service organisations improve the safety and quality of their services. However, they can also introduce new errors and risks.

The Commission has started work on guidelines for the safe display of medicines information on screens in electronic health records. This includes the Personally Controlled Electronic Health Record (PCEHR), electronic medication management systems, medicines lists and electronic discharge systems.

The objectives are to enhance the safety of the PCEHR and clinical information systems, ensure medicines are displayed safely onscreen, standardise onscreen display of medicines and migrate existing standardised medicines information into the electronic environment.

The guidelines on the safe display of medicines information on screens in electronic health records are expected to be completed later in 2014.

### Advocating for medication safety and quality

The Commission collaborates with other organisations to advocate medication safety and quality. In 2013/14, the Commission worked with NPS MedicineWise to develop consumer information resources under the banner *Mistakes can happen with your medicines* to encourage consumers to keep a current list of medicines.

The aim was to help prevent medication errors when patients go in and out of hospital or consult different health professionals. NPS MedicineWise has adapted the information into brochures and is distributing them to general practices, hospitals and community pharmacies.

## National Patient Contact Protocol

Various Australian inquiries have identified significant deficiencies in arrangements for contacting patients with implanted medical devices – such as breast and hip implants – when a hazard alert is issued due to serious safety concerns about those devices. Contacting individuals in such incidents is:

- a patient and consumer right
- a core responsibility of the healthcare system
- a normal part of an episode of care should the unexpected occur
- a critical element of clinical communications.

To address the deficiencies identified, the Commission has been working with the Department of Health, state and territory jurisdictions and the private healthcare sector to develop a national protocol for contacting patients with implanted medical devices in the event of a hazard alert.

A draft of the protocol, *National patient contact protocol for patients with Implanted Medical Devices subject to Hazard Alerts*, was provided to three hospital pilot sites in May 2014 for testing.

The draft protocol defines the procedures that should be implemented when medical devices that have been implanted in patients in public and private hospitals, day procedure centres and professional consulting suites are subject to Class I (potentially life-threatening) or Class II (serious) Hazard Alerts. The management and governance responsibilities defined are consistent with the requirements of NSQHS Standard 1: Governance for Safety and

Quality in Health Service Organisations, which requires integrated systems of governance to actively manage patient safety and quality risks.

The protocol complements the Uniform Recall Procedure for Therapeutic Goods – an agreement between the therapeutic goods industry and Australian, state and territory health departments – and will support reliable, sensitive and timely contact with patients when hazard alerts are issued.

The draft protocol and a guide to support its implementation will be submitted for endorsement by the AHMAC after further consultation and testing. An evaluation framework has been provided to monitor the effectiveness of the protocol over the first year of use.

## Open disclosure

Open disclosure is a discussion between a healthcare provider and a patient, their family, carers and other support persons about the incidents that took place in cases where harm occurred to a patient while receiving health care. Open disclosure is an important element of quality health care and is recognised as an accreditation requirement under NSQHS Standard 1: Governance for Safety and Quality in Health Service Organisations.

The objective of the Commission's Open Disclosure program is to increase the extent, quality and consistency of open disclosure in Australia. In 2013, the Commission released the Australian Open Disclosure Framework following a comprehensive review of evidence and a national consultation process.

The framework was endorsed by Australian health ministers in December 2013.

During 2013/14, the framework was also formally supported by the following professional organisations:

- Australian College of Nursing
- Australian and New Zealand College of Anaesthetists
- The Royal Australian and New Zealand Colleges of Obstetricians and Gynaecologists
- The Royal Australasian College of Physicians
- Royal Australasian College of Surgeons
- The Society of Hospital Pharmacists of Australia
- Australasian College of Emergency Medicine
- The Royal College of Pathologists of Australasia.

State and territory health departments have indicated they are moving towards adopting the Australian Open Disclosure Framework in their localised Open Disclosure policies and procedures. The Department of Health, Victoria, is using the framework as its guiding policy for open disclosure and has developed a suite of resources on the Commission's tools and resources. Health departments in New South Wales, South Australia and Western Australia are finalising revisions of their existing Open Disclosure policies to align with the Australian Open Disclosure Framework.

### Key achievements 2013/14

The Australian Open Disclosure Framework was endorsed by all Australian health ministers.

States and territories are revising localised Open Disclosure policies to align with the Australian Open Disclosure Framework.

## Recognising and responding to deterioration in mental state

Since its inception in 2009, the Commission's Recognising and Responding to Clinical Deterioration program has focused on physical deterioration of patients. In April 2013, the Commission began scoping a new area of work for recognising and responding to deterioration in mental state. The scoping review was commissioned to explore and report on:

- the current knowledge base for recognising and responding to deterioration in mental state for inpatients in acute care settings
- gaps that could be addressed by the Commission
- whether and how the existing framework for recognising and responding to physiological deterioration could be usefully applied to deterioration in a person's mental state.

As part of the scoping review, a review of the relevant literature was undertaken along with broad consultation with a range of stakeholders, including people with lived experience of mental health issues and their carers, families and friends; managers and health professionals from both the public and private sectors; and policy and academic experts.

The findings of the scoping review reflect the complexity of the issues and situations that can cause deterioration in mental state and how these might be managed. Patients can experience deterioration in their mental state for a range of reasons and in a range of care settings.

### Healthcare professionals are also likely to have varied levels of expertise in recognising and responding to deterioration in a person's mental state.

For example, patients with pre-existing mental health conditions may be admitted to acute care services for physical health care, may present to an emergency department because of an acute deterioration in mental state, or may severely deteriorate while being treated in an acute inpatient mental health unit. The systems and resources available to manage deterioration in mental state in each of these settings may vary considerably.

The scoping review provides useful context for future work in this area and identifies a number of gaps in current systems for recognising and responding to deterioration in mental state.

These include:

- understanding the nature, scale and consequences of failures to effectively recognise and respond to deterioration in mental state
- standardised markers, tools, processes and systems for recognising deterioration
- agreement on the key competencies required for clinicians to recognise and respond to deterioration in mental state.

Although the scoping review focused on deterioration in acute care settings, the way in which care is provided in the community is particularly important for deterioration in mental state, and the issues identified in the review also apply in community settings.

The report on the scoping review will be released in July 2014. Future work in this area will include targeted consultation focused on two of the recommended actions in the scoping report: identification of the key adverse events associated with deterioration in mental state and reaching agreement on markers of deterioration in mental state.

#### Key achievements 2013/14

**167** individuals, nine organisations and 48 survey respondents contributed to the scoping review for recognising and responding to deterioration in mental state.

## Reduction in children's radiation exposure from CT scans

More than 60,000 computed tomography (CT) scans are performed on children and adolescents (0–19 years) in Australia each year. CT scans are an essential diagnostic tool, particularly in emergency situations such as head trauma where the CT provides vital information to inform time-critical treatment for children.

Recent Australian research indicates that the incidence of cancer is higher in people who have been exposed to radiation from CT scans as children, particularly where multiple scans have occurred. It is therefore essential to use the best available evidence to assist clinicians and parents in decisions about the risks and benefits of CT scans as part of diagnostic and treatment options.

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**In April 2014, the Department of Health provided funding to the Commission for a project to support the reduction of inappropriate referrals and unnecessary radiation exposure from CT scans for children.**

**This will be achieved through the development of enhanced decision-making tools and referral guidance for clinicians, as well as information resources for parents and carers.**

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The work will complement and build on a number of initiatives already underway, most notably a series of roundtable discussions chaired by Australia's Chief Medical Officer, Professor Chris Baggoley, resulting in two fact sheets available through the Australian Radiation Protection and Nuclear Safety Agency (ARPANSA). The project is being undertaken in conjunction with the Department of Health, states and territories, ARPANSA and other relevant medical colleges and professional bodies.

The work will involve a review of existing data systems for CT scans and the types of CT scanners used in Australia; an assessment of the materials and resources that currently guide clinicians and the need for new or enhanced guidance materials; and the development of an effective mechanism to maintain and promulgate the resource materials. A Project Reference Group of relevant experts has been convened to advise on the types of materials of value to patients, carers and referring clinicians.

## Reduction in unwarranted variation

Variation in clinical practice and healthcare use is an emerging priority area in Australia and overseas. While some variation is desirable, variation that is not related to patient need or preference – often referred to as unwarranted variation – raises questions about healthcare quality, efficiency and value. Unwarranted variation may also mean that scarce health resources are not being put to best use.

The Commission's healthcare variation program aims to reduce unwarranted variation and improve patients' care and outcomes while ensuring value for Australia's healthcare spending. During 2013/14, the focus of this work was a study of healthcare variation by the Organisation for Economic Cooperation and Development (OECD), and the development of an *Australian Atlas of Healthcare Variation*.

### OECD study of healthcare variation

In 2012, the Commission began a program of work to coordinate Australia's contribution to the study of healthcare variation by the OECD. Australia is one of 13 countries participating in the OECD project, which aims to:

- document healthcare variations, with a focus on variations within countries
- analyse the possible causes of healthcare variations
- explore policy options to reduce unwarranted variations and improve resource allocation.

The project was undertaken with support from all state and territory governments and the Australian Government, with technical input from the Australian Institute of Health and Welfare. A number of clinical experts also provided advice and commentary.

In May 2014, the Commission published the results of the Australian study in a discussion paper, *Exploring Healthcare Variation in Australia: Analyses Resulting from an OECD Study*. The paper examined variation in the rates of several common procedures nominated for study by the OECD, including knee surgery (knee arthroscopy and knee replacement), cardiac procedures (cardiac catheterisation,



percutaneous coronary intervention and coronary artery bypass grafting), caesarean section and hysterectomy.

Procedures were undertaken in hospitals and day procedure centres, both public and private, during 2010-11. Variation was measured according to the Medicare Local area where patients lived. Variations occurred with all interventions, although it is not possible to know how much of this was unwarranted or to comment on the relative performance of health services in one Medicare Local compared with another.

### Key achievements 2013/14

The discussion paper *Exploring Healthcare Variation in Australia: Analyses Resulting From an OECD Study* was released for public consultation.



## Australian Atlas of Healthcare Variation

Building on the work of the OECD healthcare variation project, in January 2014 the Commission started developing an *Australian Atlas of Healthcare Variation* (the Atlas). The Australian Government has provided funding for the project, which will enable additional areas of variation to be examined and approaches to reducing unwarranted variation to be identified.

An advisory group has been established to select and refine a broad range of topics for inclusion in the Atlas. National data will be collated to identify areas of variation in care. Areas where substantial variation is identified will be further investigated to explore the extent to which the variation is warranted. Strategies, tools and resources that aim to reduce unwarranted variation will be developed at the local and national level.

Developing the *Australian Atlas of Healthcare Variation* is an important first step to providing more appropriate care to patients.<sup>11</sup> The Atlas is expected to be released in 2016.

By world standards, Australia has excellent healthcare services staffed by highly qualified, dedicated and hard-working people. Yet Australians who have the same health conditions, concerns or problems do not necessarily receive the same health care.

## Nationally coordinated action to prevent and contain antimicrobial resistance

The Commission recognises the challenge that antimicrobial resistance (AMR) presents to the effective delivery of health care and has responded by initiating a range of programs and activities to prevent and contain AMR.

When bacteria that are resistant to multiple antimicrobials are prevalent, healthcare providers need to use broader spectrum and usually more expensive agents to treat seriously ill patients. This contributes to increasing healthcare and societal costs.<sup>12 13</sup>

There is growing global concern about the emergence of AMR. The World Health Organization (WHO) has encouraged countries to commit to comprehensive national plans to combat AMR.<sup>14 15</sup>

### Healthcare associated infection

The Commission's national healthcare associated infection prevention program provides a coordinated suite of initiatives to promote a sustainable national approach to reducing preventable healthcare associated infections. The Commission continues to support health service organisations with the implementation of NSQHS Standard 3: Preventing and Controlling Healthcare Associated Infections.

### National Hand Hygiene Initiative

The hands of healthcare workers are the single most important sources of preventable hospital-acquired infections. The Commission contracted Hand Hygiene Australia (HHA) to implement the National Hand Hygiene Initiative (NHHI), a program based on WHO's *5 Moments for Hand Hygiene*.

During 2013/14, the NHHI regularly audited and assessed hand hygiene compliance in Australian hospitals. An audit conducted in April 2014 demonstrated that hand hygiene compliance rates continue to improve across all jurisdictions and the private sector, with a national compliance rate of over 80%.

Participation in the NHHI continued to increase during 2013/14. More than 95% of public hospital and over 50% of private hospital beds are regularly audited.

In 2014/15, the Commission will identify further opportunities for that standardisation of data to improve the quality of reporting, ensure ongoing review and to enhance a hand hygiene database. This will reduce the time taken to gather audit data, and provide additional resources and opportunities for education of the workforce. The inclusion of standardised hand hygiene assessments in the curricula of postgraduate training organisations will further highlight the importance of hand hygiene in reducing preventable healthcare associated infections.

### Key achievements 2013/14

**80%** compliance to hand hygiene standards in Australian hospitals.

Over **750** hospitals regularly submit data about hand hygiene.

Over **700,000** healthcare providers have been trained and assessed in hand hygiene.

### Standardised national surveillance

The Commission's National Surveillance Initiative continues to explore opportunities to monitor healthcare associated infection, improve the quality of surveillance data and provide timely feedback to state and territory jurisdictions and clinicians.

During 2013/14, the Commission worked with states and territories on implementation guides to assist health service organisations and surveillance units to collect and report on the incidence of *Staphylococcus aureus* bacteraemia (SAB) and *Clostridium difficile* infection (CDI). These implementation guides were released in February 2014.

In October 2013, the Commission undertook a review of SAB and CDI surveillance definitions used across state and territory jurisdictions. The Commission found that, while systems and processes vary widely, the widespread implementation of national surveillance definitions has led to improved consistency in the collection and reporting of data on SAB and CDI.

All state and territory jurisdictions are using the Commission's national surveillance case definition for healthcare associated SAB. Those jurisdictions with an active healthcare associated infection surveillance unit and a state-based surveillance information system are able to support data validation, comply with national surveillance definitions, provide education and support for hospital infection prevention and control practitioners, and provide hospital-level reports.

The Commission is exploring other areas where standardised national surveillance can be used to monitor healthcare associated infection, improve the quality of surveillance data and provide timely feedback to jurisdictions and clinicians.

### Key achievements 2013/14

The rate of SAB infections has dropped from 1.2 per 10,000 bed days in 2009/10 to 0.9 per 10,000 bed days in 2012/13.

**66%** increase in hospitals providing data on SAB infections.

### Antimicrobial stewardship

Interventions to promote responsible use of antimicrobials are essential to reduce the development and spread of AMR. Health service organisations can improve antimicrobial use through organised antimicrobial management programs, known as antimicrobial stewardship (AMS).

These programs involve a range of complementary strategies, including the use of treatment guidelines to inform local prescribing, formulary management, the auditing of prescribing practices, the monitoring of antimicrobial usage

and resistance, and the education of clinicians and patients. These strategies work together to ensure appropriate antimicrobial prescribing.

The Commission's work in this area promotes a national approach to AMS and supports compliance with NSQHS Standard 3, which requires all hospitals and day procedure services to have an AMS program in place.

During 2013/14, AMS work focused on supporting small hospitals that may have fewer specialist resources. In September 2013, the Commission conducted an AMS workshop specifically for small hospitals at the annual conference of the Australasian College for Infection Prevention and Control. This workshop enabled participants to share experiences and discuss practical ideas for AMS implementation in smaller hospitals.

### Antibiotic Awareness Week 2013

Antibiotic Awareness Week (AAW) is another means of raising awareness about the problem of AMR and programs to address resistance.

As AMR is an issue that extends across both human and animal health, the Commission coordinated a 'One Health' approach to AAW in November 2013, with collaboration across animal health, agriculture and human health.

The Commission's activities targeted hospital-based clinicians and focused on the theme of *No action today, no cure tomorrow* (adapted from WHO work). The Commission developed a range of resources and promotional materials to help health service organisations highlight

the problem of AMR and promote the importance of appropriate antibiotic use among staff members.

To jointly launch AAW 2013, Australia's Chief Medical Officer, Professor Chris Baggoley, and Chief Veterinary Officer, Dr Mark Schipp, were interviewed. They highlighted the importance of responsible antimicrobial use across agriculture, animal health and human health. The interview was promoted via the Commission's YouTube channel.

To coincide with AAW 2013, Melbourne Health's National Health and Medical Research Council Antimicrobial Stewardship Research team coordinated the National Antimicrobial Prescribing Survey (NAPS) with support from the Commission. Over 150 health service organisations participated in the NAPS, which provided hospitals with a valuable opportunity to audit their antimicrobial prescribing patterns and identify strengths and opportunities for improvement.

As part of AAW 2013, the Commission also published articles and participated in a global Twitter chat to raise the profile of AMR and to promote strategies for dealing with it.

#### Key achievements 2013/14

Australian Antibiotic Awareness Week takes a 'One Health' approach.

The Commission's AAW web page received 7,910 visits during the campaign period.

AAW posters were downloaded 1,194 times.

150 hospitals participated in the National Antimicrobial Prescribing Survey.

### Multi-drug resistant gram-negative guidance

An emerging threat worldwide is gram-negative bacteria, which have developed high levels of resistance to a wide range of antibiotics. Of particular concern are a group of organisms called carbapenem-resistant enterobacteriaceae (CRE). These bacteria have been a major cause of illness and death in a number of countries, and there are early signs of their emergence and spread in Australia.

CRE place patients at greater risk of potentially untreatable infection following invasive procedures or other components of modern hospital care. Patients in residential care are also potentially at increased risk.

To assist health service organisations in the prevention and containment of this group of bacteria, the Commission, in consultation with professional organisations and colleges, finalised the *Recommendations for the control of Multi-drug resistant Gram-negatives: carbapenem resistant Enterobacteriaceae* report. Their purpose is to alert healthcare professionals and communities to the emerging threat represented by CRE in Australia and provide recommendations and resources to assist healthcare professionals in preventing, detecting and containing CRE.

In December 2013, the recommendations were issued to all hospitals in Australia, as well as state and territory health departments, for use at the local level.

### Antimicrobial utilisation and resistance

The Commission was engaged by the Department of Health to develop a national antimicrobial utilisation and resistance surveillance system – the AURA Surveillance Project – as the platform for quantifying the AMR problem and informing interventions to reduce its prevalence and impact. The AURA Surveillance Project commenced in December 2013 with the establishment of an AMR surveillance coordination unit within the Commission. Professor John Turnidge joined the Commission in February 2014 to provide dedicated clinical leadership and advice to the project.

The Commission's work builds on many achievements to date and will continue to use the technical and clinical advisory expertise available through its existing committees. In addition, the Commission has been working with Australian Government agencies, state and territory government bodies, professional organisations, the private healthcare sector and key experts to establish the nationally coordinated AMR and antimicrobial utilisation (AU) surveillance system. A number of preliminary steps are required to ensure the system is well defined and does not unnecessarily duplicate existing systems.

In the first half of 2014, the Commission commenced its first three pieces of work for the AURA Project:

- The *Preliminary Report on AMR and AU Surveillance in Australia* is a contemporary assessment of both AMR and AU in Australia, based on the analysis of data sets, literature, reports and other information currently available.
- A *Scoping Study Report on AMR and AU Surveillance* analyses current procedures, laboratory and pharmacy systems, surveillance reporting systems, and data for AMR and AU to determine gaps and propose ways of enhancing, expanding and integrating surveillance systems.
- A feasibility study aimed at assessing the potential to use existing passive resistance surveillance systems will serve as an initial platform for a national passive surveillance system.

The Commission will continue to build the national AMR and AU surveillance system through to 2015/16.

## A national standard for hospital cumulative antibiograms

Efforts by the Commission to reduce the inappropriate use of antimicrobials that lead to the emergence of resistant bacteria have been supported by the development of a standard for cumulative antibiograms. The NSQHS Standard 3: Antimicrobial Stewardship requires health services to monitor resistance to antibiotics. Microbiology laboratories produce antimicrobial susceptibility summary tables, known as cumulative antibiograms, to inform the prescribing of antimicrobials as part of antimicrobial stewardship.

In September 2012, the Commission initiated this work through the development of a standard approach to testing antimicrobial susceptibility, and cumulative analysis and reporting of antibiograms. The intent was to provide a minimum specification for hospital-level monitoring of antimicrobial susceptibility in patients with infections.

A working group of clinical experts, informed by expert roundtable discussions, developed the *Specification for a Hospital-Level Cumulative Antibiogram*. The specification was published in October 2013 following endorsement from state and territory jurisdictions. It recommends an antibiogram be produced each calendar year for hospitals or hospital networks.

### Key achievements 2013/14

*Specification for a Hospital-Level Cumulative Antibiogram* was endorsed by jurisdictions.

## Data set development

The Commission is required to formulate indicators under *The National Health Reform Act 2011* and to recommend datasets that will assist the improvement of safety and quality under the National Health Reform Agreement.

During 2013/14, the Commission continued to develop core, hospital-based outcome indicators and hospital mortality indicators to underpin a national model for reporting on patient safety in hospitals.

The Commission has also been progressing health information strategies to create a national standard for hospital-cumulative antibiograms and a national set of core, common patient experience questions for hospitals. These projects feed into the Commission's broader work programs, such as the NSQHS Standards.

In 2013/14, the Commission also started a project addressing issues with the reporting of maternal sentinel events and post-partum haemorrhage.

**The Commission has developed a data plan for 2014–17 to underpin its work plan and articulate its data functions with reference to the *National Health Reform Act 2011* and National Health Reform Agreement. These include indicator formulation, dataset specification, and the analysis and interpretation of health datasets to report on the state of safety and quality in Australian health care.**

## Core, hospital-based outcome indicators and hospital mortality indicators

The provision of clinical indicators to hospital managers and clinical groups is an essential element of quality improvement. When hospitals regularly monitor and review a set of outcome-based indicators, significant variance in the results can draw attention to quality-of-care issues.

During 2013/14, the Commission maintained and developed the use of locally generated hospital mortality indicators with support from the National Core Indicators Working Party (CIWP). The CIWP has worked with the private and public sectors to develop and refine a toolkit for a core hospital-based outcome indicator suite, comprising hospital mortality measures, re-admission rates and infection rates.

The toolkit allows state and territory jurisdictions and private ownership groups to routinely review hospital mortality indicators adjusted for each hospital's patient population (or casemix), and reference each hospital's mortality measures within the range of national results.

In June 2013, the Commission convened a Hospital Mortality Indicator Advisory Group (HMI Advisory Group) to evaluate the usefulness and limitations of hospital mortality indicators. The HMI Advisory Group recommended that the Commission continue to maintain and refine the hospital mortality indicators in close consultation with jurisdictions and experts; continue

to monitor and review hospital mortality measurement and review literature; and prepare a guide to assist hospital CEOs and boards with using HMIs.

During 2013/14 the Commission also:

- developed a literature review to support the HMI Advisory Group and broader hospital community in their understanding of national and international approaches to hospital mortality measurement and reporting
- convened a jurisdictional roundtable to consider approaches to and presentation of hospital mortality data.

In 2014/15, the Commission will collaborate with the National Health Performance Authority and the Australian Institute of Health and Welfare, in consultation with jurisdictional experts, to assess newer models for calculating hospital mortality indicators. These analyses will be based on international innovations to hospital-standardised mortality ratio methodologies.

## National set of core, common patient experience questions for hospitals

The NSQHS Standards require health service organisations to form partnerships with consumers to create services that are responsive to consumers' input and needs. One aspect of this partnership involves measuring and responding to patient experiences. Most hospitals survey patients upon discharge from hospital to monitor their experiences and identify areas for improvement.

The Commission has been working with the states and territories, the private hospital sector, patient experience experts and consumers to specify a standard set of core, common questions for inclusion in hospital patient experience surveys. These have been tested on consumers by the Australian Bureau of Statistics and validated for use in telephone surveys by the South Australian Department of Health.

In August 2013, the National Health Information and Performance Principal Committee (NHIPPC) noted the endorsement of the national set of core common patient experience questions by the National Health Information Standards and Statistics Committee (NHISSC). Following this endorsement, the question set was adapted and validated for use via telephone surveying by day procedure facilities and endorsed by the Australian Private Hospitals Association. Since then, a number of private hospitals and day procedure facilities have expressed an interest in using the question set. The question set was also validated by the Bureau of Health Information for use via written and online modes of administration.

In 2013/14, the Commission validated the question set in New South Wales hospitals and five day procedure centres across the country.

A survey by the Australian Institute of Health and Welfare, on behalf of the NHISSC, indicated that states and territories are ready to incorporate the questions into their own public hospital surveys. The private hospital sector is also strongly supportive of the use of the question set.

A number of the survey questions are subject to a licence agreement. In March 2014, jurisdictions agreed to support a national licence. The Commission has worked with the AHMAC Secretariat to acquire and manage the licence for use in Australian hospitals, funded on a cost-share basis by states and territories.

### Maternal sentinel events and post-partum haemorrhage

Public hospitals are required to report sentinel events to their state or territory health department, or an agreed third party. States and territories use this data to contribute to an annual national report on sentinel events. One of the eight sentinel events hospitals are required to report on is maternal death or serious morbidity associated with labour or delivery.

In June 2013, the Commission convened the Maternal Sentinel Event and Post-Partum Haemorrhage Working Group to address jurisdictional concerns regarding difficulties in the application of the maternal sentinel events definition and anecdotal reports that severe post-partum haemorrhage (PPH) may be on the increase.

An expert roundtable was convened to investigate current jurisdictional practices in the area of maternal sentinel event identification, the classification and reporting of serious maternity incidents, and the definitions and monitoring of PPH.

Over the second half of 2013, the working group developed four major recommendations. Jurisdictions and the Commission's Board supported the proposed national definition of maternal sentinel events; the need for routine measurement of PPH as part of existing perinatal data collections; and that data regarding the sentinel event severe acute maternal morbidity (SAMM) be routinely captured, reviewed and analysed for feedback into the broader system.

In February 2014, the Board accepted the working group's recommendation that the WHO definition of maternal death be applied to sentinel event reporting.

Following concurrent work by midwives and obstetricians working with the Australian Institute of Health and Welfare (AIHW) and the National Perinatal and Epidemiology Statistics Unit, states and territories have agreed to move towards routine monitoring of PPH as part of national perinatal data collection.

With regard to SAMM, the working group recommended that every case be reviewed confidentially by expert clinical teams, with de-identified case analyses fed back into the system.

This work coincided with a review of the national perinatal minimum dataset by clinical and epidemiological leaders, convened by the AIHW. As a result of that National Maternity Data Development Project, states and territories signed off on the data elements that will allow ongoing monitoring of PPH.

## Publishing and reporting

During 2013/14, the Commission produced more than 23 publications and reports as part of its project work. These included implementation resources, review reports, discussion papers and literature reviews, each supporting the objectives of improving safety and quality in health care.

These resources are made available on the Commission's web site and in hard copy where necessary. During 2013/14, the Commission web site was visited on more than 550,167 occasions (an increase of 69% on 2012/13), and there were more than 347,509 downloads of documents and publications.

The following pages highlight a number of key publications released during 2013/14.

A full list of publications and reports is included in Appendix A on page 120. A list of research articles published during 2013/14 can be found in Appendix B on page 124.

### Key achievements 2013/14

The Commission's web site had

**550,167**

visits during 2013/14.



## Exploring Healthcare Variation in Australia discussion paper and summary

In 2012, the OECD undertook an international study of healthcare variation involving a number of countries. The Commission coordinated Australia's contribution to this study. In May 2014, the Commission and the AIHW released a discussion paper detailing findings from the Australian study.

The paper, *Exploring Healthcare Variation in Australia: Analyses Resulting from an OECD Study*, was intended to stimulate a national discussion on healthcare variation, particularly around how to determine which variations are unwarranted and how any unwarranted variation can be reduced.

A summary paper, *Exploring Healthcare Variation in Australia: In Brief*, was released in tandem with the discussion paper.

The summary paper outlines healthcare variation in the rates of several common procedures and interventions across Australia, with the intention of making general readers aware of some of the concerns and complexities surrounding healthcare variation.

These papers are part of a program of work by the Commission that aims to reduce unwarranted healthcare variation and to improve patients' care and outcomes, while also ensuring value for our health spending.

For more information on this and other projects related to healthcare variation, see pages 41–42.

## Vital Signs 2013

In October 2013, the Commission released its first annual publication reporting on the state of safety and quality in Australian health care. *Vital Signs 2013* provides an overview of what is happening in Australia for a series of important safety and quality topics. It is structured around three important questions that members of the public can ask about their health care:

- Will my care be safe?
- Will I get the right care?
- Will I be a partner in my care?

*Vital Signs 2013* includes three case studies that focus on the quality of care in some important clinical areas. These case studies present a detailed description and analysis of key quality issues that affect outcomes for patients. The case studies also illustrate the in-depth work needed to properly understand issues of safety and quality in health care, and to develop solutions to address them.

For a summary of the second report, *Vital Signs 2014*, see pages 60–62.

## Accreditation Workbook for Mental Health Services

In March 2014, the Commission released the *Accreditation Workbook for Mental Health Services*. The workbook is designed to guide mental health services through the accreditation process for the NSQHS Standards, and highlight areas where mental health services will also have substantially complied with relevant NSMHS criteria.

The workbook is the result of collaboration between the Commission, the Department of Health, and the Safety and Quality Partnership Standing Committee of the Mental Health Drug and Alcohol Principal Committee of the AHMAC, reflecting revisions made following national consultation. It was distributed to 1,400 hospitals and mental health services across Australia during April 2014.

For more information about the Commission's mental health projects, see pages 24–25.

## Draft National Consensus Statement: Essential Elements for Safe and High-Quality End-of-Life Care in Acute Hospitals

As part of its work on improving the safety and quality of end-of-life care in acute hospitals, in January 2014 the Commission developed a draft *National Consensus Statement: Essential Elements for Safe and High-Quality End-of-Life Care in Acute Hospitals*. The draft consensus statement aims to guide health services to develop systems for delivering safe, timely and high-quality end-of-life care in a way that is tailored to their population, resources and available personnel, and in line with relevant jurisdictional or other programs.

The Commission held an open consultation in early 2014 that sought written submissions on the draft consensus statement. This was followed by a series of consultation workshops for consumers and health professionals in each of Australia's capital cities.

## Recommendations for the control of Multi-drug resistant Gram-negatives: carbapenem resistant Enterobacteriaceae

Carbapenem-resistant enterobacteriaceae (CRE) place patients at increased risk of potentially untreatable infection following invasive procedures or other components of modern hospital care.

To help health service organisations prevent and contain this group of bacteria, the Commission, in consultation with professional organisations and colleges, finalised *Recommendations for the control of Multi-drug resistant Gram-negatives: Carbapenem resistant Enterobacteriaceae*. The purpose of the recommendations is to alert healthcare professionals and communities to the emerging threat represented by CRE in Australia. The recommendations will help healthcare professionals to prevent, detect and contain CRE, and provide resources for healthcare professionals and consumers.

In December 2013, the *Recommendations for the control of Multi-drug resistant Gram-negatives: carbapenem resistant Enterobacteriaceae* were issued to all hospitals in Australia, as well as state and territory health departments, for use at the local level.

## On the Radar

The Commission produces a weekly summary of recent research, resources and publications about safety and quality in health care, to ensure up-to-date and relevant knowledge is available and accessible. As of 30 June 2014, more than 3,300 individuals subscribed to the Commission's online summary, *On the Radar* – an increase of 38% in 12 months. During 2013/14, almost 140,000 virtual copies of *On the Radar* have been distributed to subscribers.

The most accessed links from issues of *On the Radar* during 2013/14 included:

- *Viva la Evidence*, a YouTube music video promoting the virtues of evidence-based medicine
- *Helping measure person-centred care*, a paper by The Health Foundation (UK)
- *The Third Healthcare Revolution*, a presentation by Professor Sir Muir Gray coordinated by the Commission
- *Vital Signs 2013: The State of Safety and Quality in Australian Health Care*, the Commission's first annual publication reporting on safety and quality in Australian health care
- *Quality improvement made simple*, a resource by The Health Foundation (UK).

## Knowledge and leadership in safety and quality

The Commission works collaboratively with education providers, professional organisations, peak bodies, jurisdictions and researchers to embed safety and quality into the national curricula for healthcare-related undergraduate and postgraduate education, training and continuing professional development.

In leading and coordinating national initiatives in safety and quality in health care, the Commission is required to contribute to other national initiatives that affect safety and quality in health care.

## Supporting education, training and research

Embedding safety and quality in health education, training and research will help ensure healthcare providers adhere to evidence-based safety and quality practices. The Commission supports this objective by contributing to professional education and research; developing training tools; and participating in workshops, conferences, external committees and advisory groups.

## Healthcare providers' education

Delivering effective and appropriate care relies on healthcare providers' knowledge and competency in patient safety, improving the quality of care, and communicating with patients and consumers. The Commission continues to advocate for the inclusion of key competencies related to providing safe, appropriate and effective care in healthcare providers' training.

The Commission is building a program of work to determine the extent to which safety- and quality-related training is incorporated in healthcare education. In July 2013, the Commission concluded a national survey of nursing schools to identify curriculum content and assessments related to specific safety and quality topics that are part of the NSQHS Standards. Survey responses were received from 18 of the 37 schools of nursing. The data from the undergraduate nursing survey were provided to WHO as a part of the WHO/OECD Review of Quality of Care in the Asia-Pacific Region. The Commission will use the information to promote the inclusion of safety and quality topics in education curricula.

### Participation in research

Evidence-based knowledge of safety and quality in health care informs all the Commission's work. The Commission participates in, contributes to and funds a range of research activities related to safety, quality and best practice in health care. A full list of research activities that the Commission has been involved in during 2013/14 is provided in Appendix C on page 125.

### Conferences and meetings

Conferences, meetings and forums provide a platform for the Commission to communicate directly with key stakeholders, including healthcare providers and executives, policy makers and advisors, peak bodies and consumer groups.

In July 2013, the Commission convened the Australian One Health AMR Colloquium on behalf of the Australian AMR Prevention

and Containment Steering Group. The colloquium helped inform the development of a comprehensive national AMR strategy.

In 2013/14, the Commission coordinated a series of lectures and workshops led by international experts in the fields of healthcare variation and shared decision making.

In September 2013, 200 people attended a public lecture on health reform and medical practice variation by Professor Sir Muir Gray, who was responsible for developing the National Health Service (NHS, UK) Atlases of Variation in Healthcare. Sir Muir also led a workshop on developing atlases of variation in health care, providing further detail on the NHS experience. Selected state and territory representatives presented their organisation's initiatives to reduce clinical variation. The workshop was attended by 40 people.

In October 2013, the Commission hosted international expert in shared decision making, Professor France Légaré. Professor Légaré is the Chair of Implementation of Shared Decision Making in Primary Care at the Université Laval, Québec. She presented at a public lecture and led two shared decision-making workshops.

In February 2014, the Commission invited visiting Professor Dilip Nathwani, Consultant Physician in Infectious Diseases and Honorary Professor of Infection at Ninewells Hospital and Medical School, Dundee, UK, to lead a master class in antimicrobial stewardship (AMS). The master class was attended by members of the AMS and Healthcare Associated Infection Advisory Committees and AMS Jurisdiction. The class focused on Professor Nathwani's experience in AMS implementation and education in Scotland.

The Commission also participates in externally convened conferences, meetings and forums that link closely with our work. In 2013/14, Commission representatives presented papers at more than 60 external conferences, meetings and forums, reaching more than 8,000 healthcare providers and other key stakeholders.

The Commission also sponsored three healthcare-related conferences. A list of the sponsored events can be found in Appendix D on page 127.

### Training and workshops

The Commission coordinates and participates in workshops as required to facilitate the adoption of its programs. During 2013/14, Commission representatives contributed to 35 workshops nationally.

The Commission also develops and maintains a number of online training tools to support improvements in healthcare safety and quality. During 2013/14, the Commission managed and maintained:

- modules about prescribing antimicrobials in the National Prescribing Curriculum (in partnership with NPS MedicineWise)
- online interactive education modules for infection prevention and control
- an infection prevention and control orientation package for health care workers.

### External representations

The Commission promotes evidence-based safety and quality in health care by participating in numerous international, national and jurisdictional committees, organisations and agencies.

A full list of the Commission's external representations in 2013/14 is included in Appendix E on page 128.

### Contributing to national initiatives

During 2013/14, the Commission continued its involvement in two major national initiatives: the implementation of the Personally Controlled Electronic Health Record (PCEHR) system, and the Independent Hospital Pricing Authority's (IHPA) work regarding the pricing of Australian public hospital services.

The Commission also led Australia's contribution to an OECD study of variations in health care. See page 41 for details on this study.

### Auditing the clinical safety of the PCEHR system

The introduction of the PCEHR system in 2012 has brought new benefits to healthcare consumers and providers. Monitoring and assuring the system's clinical safety is a critical governance function.

During 2013/14, the Commission has continued its involvement in the national implementation of the PCEHR system, in partnership with the Department of Health.

The PCEHR Clinical Governance Advisory Group provides advice to the Commission and the PCEHR System Operator. The group is chaired by Australian Chief Medical Officer, Professor Chris Baggoley, and includes users of the system and experts in clinical safety and governance, health IT and patient safety. The PCEHR Clinical Governance Advisory Group met four times during 2013/14.

The Commission completed the third clinical safety audit of the PCEHR system in December 2013 and made recommendations to improve the presentation of information in the PCEHR and the clinical governance of the system. All recommendations and findings from the report were accepted by the System Operator. The fourth clinical safety audit was completed in June 2014.

The Commission also completed two structured reviews of incidents reported in the PCEHR following notification by the PCEHR System Operator.

### Collaboration with the Independent Hospital Pricing Authority

During 2013/14, the Commission has continued to collaborate with the IHPA on examining ways to incorporate safety and quality in the pricing of Australian public hospital services. A joint working party comprising clinicians, consumers and policy makers oversaw this work and provided advice to both agencies.

Following a comprehensive literature review and additional research on this topic, three projects examining potential uses of casemix data routinely collected in Australian hospitals were completed in 2013/14.

These include:

- a clinician-led process to identify, specify and group a national set of high-priority hospital complications for routine local monitoring
- analysis of hospital-acquired diagnoses and their effect on case complexity and resource use
- an environmental scan of how casemix data is being used to drive quality improvement.

A discussion paper, *Options for Incorporating Safety and Quality into Public Hospital Pricing*, was developed and distributed to states, territories and the Commonwealth for comment and feedback in January 2014. The outcomes of this consultation will be presented to the Commission and IHPA boards for consideration.

In March 2014, an investigation began into how routinely collected administrative data can be used to drive improvement in safety and quality at local level. This includes addressing the recommendations of the three reports completed in 2013/14.

#### Key achievements 2013/14

**3** reports examining potential uses of casemix data were released.



# 3

## Assessment of safety and quality in health care

Safety and quality in health care in Australia

60

As part of its legislative functions, the Commission is required to report on the state of safety and quality in the Australian health system. This chapter provides an overview of key safety and quality themes. A full report can be found in the Commission's publication *Vital Signs 2014: The State of Safety and Quality in Australian Health Care*.

## Safety and quality in health care in Australia

Safety and quality is a complex field that is integrated into all aspects of health care. Many people and organisations are involved in ensuring that people receiving health care in Australia are safe and receive high-quality care. This means that there is no single source of data that can provide comprehensive information about the safety and quality of the Australian health system. It is necessary to draw on a range of different sources of data to understand whether and how things might be changing.

When such data is brought together it is possible to get a sense of the improvements that might exist and the issues that need further examination. Based on examination of data from a variety of sources it is reasonable to conclude that patient safety is improving, but there is more work to do to ensure that people always get the right care.



### Patient safety is improving

In many respects, people receiving health care in Australia are safer than they have been in the past. Rates of infection with the potentially fatal *Staphylococcus aureus* bacteraemia in hospitals across Australia have been dropping since 2009/10. One study has estimated over the last 10 years, 2,500 fewer Australians experienced a *Staphylococcus aureus* bacteraemia infection, saving approximately 50 lives per year.

Systems are now in place in Australia to identify people whose condition deteriorates in hospital and provide the appropriate care. In New South Wales, one such system, Between the Flags, was introduced in 2010. Since that time there has been a 38% reduction in the rate of cardiac arrests in hospitals in New South Wales, and it is estimated that there has been 800 fewer deaths because of this.

Care of people with a mental illness whose condition deteriorates has also improved. Seclusion is the practice of confining a patient in a room so that they are not able to leave. It has been reported to cause trauma for the patients who are secluded, and concerns about the practice have led to calls for its elimination. There has been a decrease in the rate of seclusion events in Australia by over 50% between 2008/9 and 2012/13.

As well as these data from national or state-based initiatives, smaller studies also show promising signs of improvement. Australia has been participating in an international project run by the World Health Organization (WHO). This project has looked at the way in which medicines are recorded and communicated when patients are admitted to hospital, transferred within hospital, and discharged. This process, known as medication reconciliation, has been shown to reduce potentially adverse medicine-related events by more than 50%. The 12 Australian hospitals participating in the study have found that there were generally very low rates of the discrepancies which can cause such problems, and these have been maintained through the three years of the project.

## The NSQHS Standards will help to drive further improvements in safety

While all of these results are positive, further efforts are needed to nationally embed successful patient safety initiatives into routine practice; the NSQHS Standards can help to make this happen.

The success of the first year of the new national accreditation scheme – and the assessment of more than half of all Australian hospitals and day procedure services against the NSQHS Standards – indicates further progress towards safer care. The NSQHS Standards apply to areas where too many people suffer harm because of their health care, and where there is good evidence of how to provide better care. Hospitals and day procedure services that meet the NSQHS Standards are taking the steps required to ensure the safety of people receiving their services.

Although all hospitals and day procedure services will not be assessed against the NSQHS Standards until December 2015, the Commission is starting to look at how the next version of the NSQHS Standards can be strengthened when they commence in 2017. There are opportunities to reflect on some of the emerging issues for safety and quality in the NSQHS Standards, to ensure that all people receive the best care.

## Work needs to continue to ensure that everyone gets the right care

In 2013/14, with the Australian Institute for Health and Welfare and the Australian Department of Health, the Commission participated in an international study coordinated by the Organisation for Economic Co-operation and Development (OECD) to examine variation in healthcare procedures in 13 countries.

The study found variation in all of the procedures examined. Procedures with relatively larger variations included coronary artery bypass grafting, knee arthroscopies and hysterectomies (when performed on women who did not have a diagnosis of cancer). For each of these procedures there was approximately three-fold variation between the highest and lowest rates of these procedures across the country. For example, 726 people living in the area covered by Country North Medicare Local in South Australia were admitted for a knee arthroscopy per 100,000 population, compared to 232 people in Inner West Sydney Medicare Local.

Sometimes variation in health care is expected and warranted. For example, people living in one area may have different healthcare needs from those living in a

different area. Variation in health care may also reflect differences in people's preferred treatment options, or their cultural or personal preferences. However some healthcare variation is unwarranted, particularly where it cannot be explained by patient needs or preferences. Unwarranted variation may mean that some patients are not receiving the most appropriate or effective care, or that resources are not being put to the best use.

More work is needed to examine whether the variation that was found in this study was unwarranted. The Commission is working with clinical groups to examine the results of the study in more detail, and to develop appropriate responses to the observed variation. In addition, increasing patients' involvement in making decisions about their health care is one way to minimise unwarranted variation.

## Partnering with patients and consumers is essential for safety and quality

Across all of the work of the Commission, there is an increasing recognition of the important role of consumers, patients, family members and carers in ensuring healthcare safety and quality. Consumers need to be true partners in health and healthcare processes in order to achieve a sustainable and effective health system that provides safe and high-quality care.

Measurement of the impact that patients and consumers can have on safety and quality is a developing area. There is now consistent evidence that people who are partners in their care, who understand and use health information effectively, who share decisions and who actively engage

with care processes are more likely to have a better experience of health care, and better results from that care.

A core requirement for effective partnerships is health literacy. For partnerships to work, everyone involved in the partnership needs to be able to give, receive, interpret and act on information in an effective way. These conditions create the potential to improve the safety and quality of health care, and reduce health disparities and increase equity.

The first contact that most people have with the health system is through general practice. Health services and healthcare providers in the community are essential for ensuring that people receive safe and high-quality care. Opportunities to improve the safety and quality of care provided in the community will come through many aspects of the Commission's work, including improving the process for accreditation of general practices, examining the extent and nature of healthcare variation in Australia, and supporting people in the community to be involved in making decisions about their own health care. Because of the unique nature of general practice and other care provided in the community, it is also important to have an understanding of the particular safety and quality issues that are relevant in this environment. The Commission will continue to work with partners to improve the safety and quality of care provided in the community.

A full report on safety and quality of health care in Australia can be found in the Commission's publication *Vital Signs 2014: The State of Safety and Quality in Australian Health Care*.

# 4

## Corporate governance and accountability

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This chapter outlines the Commission's legislative requirements, corporate governance and accountability processes, including internal and external scrutiny arrangements and risk-management and fraud-control procedures. It also includes profiles of the Commission's Board members and committees.

## Legislation and requirements

The Commission is a statutory authority of the Australian Government, accountable to the Parliament and the Australian Minister for Health. The Commission's principle legislative basis is the *National Health Reform Act 2011* (NHR Act), which sets out its purpose, powers, functions, and administrative and operational arrangements. The NHR Act also sets out the Commission's Constitution, the process for appointing the Board of Directors and the Chief Executive Officer (CEO), and the operation of board meetings.

The Commission must fulfil the requirements of the *Commonwealth Authorities and Companies Act 1997* (CAC Act), which regulates certain aspects of the financial affairs of Commonwealth authorities; their reporting, accountability, banking and investment obligations; and the conduct of their directors and officers.

## Strategic planning

The NHR Act requires the Commission to prepare a work plan for each financial year and submit it to the Minister for Health. The Minister consults with the health ministers in each state and territory about the work plan. The Standing Council on Health endorses the final work plan.

The work plan for 2013/14 set out the Commission's activities in seven priority areas and was endorsed by the Standing Council in June 2013.

In 2013/14, the Commission's Board started work on a new strategic plan that would describe the high-level priorities for the Commission over the next three to five years. The strategic plan will come into effect in 2014/15 and will complement and inform the Commission's more detailed work plans.

In developing this strategic plan, the Commission undertook a variety of activities to gain an understanding of the current state of safety and quality in Australian health care and how it could be improved. These activities included:

- research with the general public about the safety and quality of health services in Australia
- consultation with consumers and consumer groups about key safety and quality priorities

- focus groups with staff members from public and private hospitals about safety and quality challenges and priorities
- interviews with leaders from key national health organisations about safety and quality and the role of the Commission
- a health economic analysis on safety and quality, sustainability and productivity.

## Ministerial Directions

Section 16 of the NHR Act empowers the Minister for Health to make directions with which the Commission must comply. The Minister for Health made no such directions during the 2013/14 reporting period.

Standing left to right: Professor Christopher Brook PSM, Professor Phillip Della, Dr Helena Williams, Dr Shaun Larkin and Ms Christine Gee.

Seated: Professor Villis Marshall AC and the Honourable Verity Firth.

## Commission Board

The Commission's Board governs the organisation and is responsible for the proper and efficient performance of its functions. The Board establishes the Commission's strategic direction, including directing and approving its strategic plan and monitoring the plan's implementation by management. It also oversees the Commission's operations, and ensures that appropriate systems and processes are in place so that the Commission operates in a safe, responsible and ethical manner, consistent with its regulatory requirements.

The Board is established and governed by the provisions of the NHR Act and the CAC Act.



## Board membership 2013/14

The Board consists of a Chair and nine members, who among them have extensive experience in healthcare administration, the law, management and clinical work. The Board also includes a patient and consumer representative. Women make up 50% of the Board's membership.

### Professor Villis Marshall AC (Chair)

Professor Villis Marshall brings to the Board experience in providing healthcare services, managing public hospitals, and improving safety and quality. Professor Marshall has had significant clinical experience as a urologist, and as Clinical Director (Surgical and Specialties Service) for the Royal Adelaide Hospital, and Clinical Professor of Surgery at The University of Adelaide.

His previous appointments include General Manager at Royal Adelaide Hospital, Senior Specialist in Urology and Director of Surgery at Repatriation General Hospital, and Professor and Chair of Surgical and Specialty Services at Flinders Medical Centre.

**Qualifications:** MD, MBBS and FRACS

**Board membership:** First appointed 1 April 2012; appointed as Chair on 1 April 2013.

### Professor Christopher Brook PSM

Professor Christopher Brook has experience in public healthcare administration and improving the safety and quality of health care. He is currently the Chief Advisor for Innovation, Safety and Quality for the Department of Health, Victoria.

As a personal appointment, Professor Brook is also the State Health and Medical Commander (Emergency Management) for Victoria. He also sits on the Clinical Trials Advisory Committee auspiced by the Australian Government Department of Industry; and sits on the Advisory Board of the National Blood Authority.

**Qualifications:** MB, BS, FRACP (Gastroenterology), FAFPHM, FIPAA and FRACMA

**Board membership:** First appointed on 1 April 2012; reappointed on 1 April 2013.

### Professor Phillip Della

Professor Phillip Della has experience in public administration (health care), providing professional healthcare services, and improving safety and quality. Previously Deputy Pro Vice-Chancellor of Health Science at Curtin University, Professor Della continues to hold a number of positions at the university, including Professor and Head of the School of Nursing and Midwifery.

Previous roles also include Chief Nursing Officer and Principal Nursing Advisor for the Western Australian Department of Health.

**Qualifications:** PhD, FACN

**Board membership:** First appointed on 1 April 2013.

### The Honourable Verity Firth

The Honourable Verity Firth has legal expertise and experience in public healthcare administration.

Ms Firth served as a member of the New South Wales Legislative Assembly from 2007 to 2011. During this time, she served as Minister for Women, Minister for Science

and Medical Research, Minister Assisting the Minister for Health (Cancer), Minister for Climate Change and the Environment and Minister for Education and Training.

**Qualifications:** BA LLB

**Board membership:** First appointed on 1 April 2013.

### Ms Christine Gee

Christine Gee brings to the board extensive experience in private hospital administration, having held executive management positions for over 25 years. She has been the CEO of Toowong Private Hospital since 1997 and is Chair of the Commission's Private Hospitals Sector Committee.

Ms Gee is also involved in numerous national boards and committees, including the Australian Private Hospitals Association, the Private Hospitals Association of Queensland, the Queensland Board of the Medical Board of Australia, the Australian Government's Second Tier Advisory Committee and the Minter Ellison Health and Ageing Industry Group Advisory Board.

**Qualifications:** MBA

**Board membership:** First appointed as a Commission member in March 2006; appointed to the Board, as established under the CAC Act, on 1 July 2011.

### Professor Jane Halton PSM

Professor Jane Halton was Secretary of the Australian Department of Health from 2002 until July 2014. She gained a wealth of experience through her roles with numerous leading national and international boards and committees.

Professor Halton was a board member of the Australian Institute of Health and Welfare and the National E-Health Transition Authority. She is also on the executive board of the Institute for Health Metrics and Evaluation at the University of Washington in the USA, and on the advisory boards of the Centre for Applied Philosophy and Public Ethics, and the Melbourne Institute.

Professor Halton was the Chair of the OECD Health Committee, and the WHO Executive Board. She was also previously an executive board member of WHO; President of the World Health Assembly; Vice-Chair of the WHO Executive Board; and Chair of the WHO's Program, Budget and Administration Committee.

Prior to her appointment as Secretary of the Department of Health, Professor Halton was a Deputy Secretary in the Department of Prime Minister and Cabinet. Professor Halton was recently appointed Secretary of the Department of Finance.

**Qualifications:** BA (Hons) Psychology

**Board membership:** First appointed as Commission member in March 2006; appointed to the board, as established under the CAC Act, on 1 July 2011.

### Dr Shaun Larkin

Shaun Larkin is Managing Director of HCF, Australia's largest not-for-profit health insurance fund, which cares for the health of over 1.6 million Australians.

Prior to joining HCF, Dr Larkin was based in Singapore for four years where he led the establishment of a chain of ambulatory medical centres throughout Asia.

Before this he worked for eight years as an executive for a large private hospital operator (Ramsay Health Care) in Australia and the United States.

**Qualifications:** HlthScD, MHSc, MBA and BHA

**Board membership:** First appointed on 1 April 2013.

### Mr Russell McGowan

Russell McGowan provided the Board with the consumer perspective on healthcare safety and quality issues. He survived a bone marrow transplant in the early 1990s and has been actively involved in the healthcare consumer movement ever since. Mr McGowan is a member of the Australian Government's Medical Services Advisory Committee, the Specialist Education Accreditation Committee of the Australian Medical Council and the Board of the Public Health Association of Australia.

He has previously served on the boards of the Consumer Health Forum of Australia, the Australian Council on Healthcare Standards, the Australian General Practice Network, the Cancer Council of Australia and the National Blood Authority.

**Qualifications:** BA

**Board membership:** First appointed as a Commission member in December 2008; appointed to the Board, as established under the CAC Act, on 1 July 2011. His term as Board member expired on 31 March 2014.

### Ms Shelly Park

Shelly Park has a wealth of experience in hospital and health service management in both the public and private health systems. She is currently the Chief Executive of Monash Health, a health service organisation that provides a comprehensive range of primary, secondary and tertiary healthcare services to a population of over one million people in the south-east of Melbourne.

Prior to her current role, Ms Park was Executive Director of Monash Medical Centre at Southern Health and Executive Director of Jessie McPherson Private Hospital. Her previous positions include General Manager of Medical and Surgical Services at Christchurch Hospital in New Zealand, and Director of Nursing and Service Support at Burwood Hospital in Canterbury, New Zealand.

**Qualifications:** BA, GAICD, FAIM and Fellow Ethical Leadership

**Board membership:** First appointed as a Commission member in June 2009; appointed to the Board, as established under the CAC Act, on 1 July 2011. Her term as a Board member expired on 31 March 2014.

### Dr Helena Williams

Dr Helena Williams brings to the Board her clinical expertise as a GP and as the previous Executive Clinical Director of Southern Adelaide–Fleurieu–Kangaroo Island Medicare Local Ltd. She is currently also the Presiding Member of the Southern Adelaide Local Health Network Governing Council.

Dr Williams' previous board directorships include the Cancer Council SA, Noarlunga Health Services, the South Australian Divisions of General Practice, the Australian General Practice Network, and the Southern Adelaide Health Service.

**Board membership:** First appointed as a Commission member in April 2008; appointed to the Board, as established under the CAC Act, on 1 July 2011.

**Qualifications:** MB, BS and FRACGP

## Board meetings and attendance

**Table 1: Board meetings and attendance**

Name	Board meeting				
	22 Aug 2013	18 Sep 2013	21 Nov 2013	27 Feb 2014	8 May 2014
Prof. Willis Marshall (Chair)	✓	✓	✓	✓	✓
Prof. Christopher Brook	✓	✓	✓	✓	✓
Prof. Phillip Della	✓	x	✓	✓	✓
The Hon. Verity Firth	✓	✓	✓	✓	✓
Christine Gee	✓	x	✓	✓	✓
Prof. Jane Halton	✓	✓	✓	✓	✓
Dr Shaun Larkin	✓	✓	✓	x	✓
Russell McGowan <sup>1</sup>	✓	✓	✓	✓	–
Shelly Park <sup>1</sup>	✓	✓	✓	✓	–
Dr Helena Williams	✓	x	✓	✓	✓

✓ Present    x Absent    – Not a member at time of meeting

<sup>1</sup> Term concluded 31 March 2014

## Board development and review

New Board members undertake a formal induction to their role, including a meeting with the Chair and CEO. They receive an Induction Manual that includes details on the Board Governance Charter.

Board members are briefed on relevant topics at meetings as appropriate, and are required to undertake ongoing professional development relevant to and in line with the Commission's needs. The Commission supports Board members to pursue these activities.

Two sitting members retired from the Board during 2013/14: Russell McGowan and Shelly Park. The terms of the remaining seven members were not due for review. See Board Membership 2013/14 on pages 66–69 for dates of Board members' appointments.

## Ethical standards

The Board Governance Charter provides a Directors' Code of Conduct. The charter includes guidelines for managing conflicts of interest – including material personal interests – as required by the CAC Act.

## Related-entity transactions

In accordance with section 15 of the Commonwealth Authorities (Annual Reporting) Orders 2011, there were no related-entity transactions during 2013/14.

## Remuneration and expenses

In accordance with section 23 of the NHR Act and the relevant determinations of the Remuneration Tribunal, the Commission's Board members are entitled to remuneration and allowances. Details of Board members' remuneration and interests are set out in note 12 of the financial statements on page 111.

## Indemnity and insurance

The Commission holds directors' and officers' liability insurance cover through Comcover, the Australian Government's self-managed fund. As part of its annual insurance renewal process, the Commission reviewed its insurance coverage in 2013/14 to ensure the coverage was still appropriate for its operations.

During the year, no indemnity-related claims were made, and the Commission knows of no circumstances likely to lead to such claims being made. Many liability limits under the Commission's Schedule of Cover are standard Australian Government limits, such as \$100 million in cover for general liability and professional indemnity, as well as directors' and officers' liability. The minimum period of cover available for business interruption is 36 months. Motor vehicle, third-party property damage and expatriate cover have not been taken out, as they don't apply to the Commission.

## Committees

An Audit and Risk Committee advises the Commission and its board on audit, risk and finance. An Inter-Jurisdictional Committee (IJC) meets regularly throughout the year to provide advice to the Commission and the board.

Additional standing committees and reference groups provide sector and topic-specific advice on the Commission's programs and projects.

### Audit and Risk Committee

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

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

The Audit and Risk Committee met five times during the 2013/14 financial year. Ms Jennifer Clark attended all five meetings.

The Board members sitting on the Audit and Risk Committee from 1 July 2013 to 30 June 2014 were the Honourable Verity Firth and Ms Shelly Park (to 31 March 2014). Mr Trevor Burgess held the position of external member of the Audit and Risk Committee during 2013/14.

## Inter-Jurisdictional Committee

The Inter-Jurisdictional Committee (IJC) comprises healthcare safety and quality representatives from the Australian, state and territory governments. It is responsible for advising on policy development and facilitating jurisdictional engagement. The IJC's role is to:

- advise the Commission on the adequacy of the policy development process, in particular policy implementation
- ensure health departments and ministries are aware of new policy directions and can review local systems accordingly
- monitor national actions to improve patient safety, as approved by health ministers
- participate in national data collections on safety and quality
- build effective mechanisms within jurisdictions to enable national public reporting.

The IJC met four times during the 2013/14 financial year.

## Other committees and consultations

The Commission has two standing committees that provide specific advice and support across all relevant areas of its work. These are the:

- Private Hospital Sector Committee
- Primary Health Committee.

The Commission also has a number of time-limited expert committees, working parties and reference groups to inform and support its work. These groups allow the Commission to draw on expert knowledge, consult with relevant key stakeholders and develop appropriate implementation strategies.

The Commission consults widely with subject-matter experts, peak bodies, jurisdictions, consumers and other relevant individuals and parties. The consultation includes ongoing discussions with key national and other organisations, and with an extensive network of formal reference and advisory groups. These networks provide links with healthcare providers, consumers, subject-matter experts and jurisdictional representatives. The Commission also undertakes formal consultations on specific issues. See Appendix F on page 130 for a list of the formal consultations that occurred during 2013/14.

## Internal governance arrangements

The CEO manages the Commission's day-to-day administration and is supported by an Executive Management team, internal management committees and staff members. The Commission's internal governance arrangements include internal management, risk management, fraud control and internal audit.

### Internal management

The Commission has two internal management committees and one panel:

- The Executive and Management Committee meets fortnightly to facilitate information sharing and help with decision making.
- The Occupational Health and Safety Committee develops and promotes strategies to support the health and safety of all staff members and visitors.
- The Study Leave Review Panel reviews staff applications for study leave and makes recommendations to the Chief Operating Officer.

### Risk management

Risk management is part of the Commission's strategy to promote accountability through good governance and robust business practices. The Commission is committed to embedding risk management principles and practices consistent with the *Australian Standards for Risk Management – Principles and guidelines* (AS/NZS ISO 31000:2009) into its organisational culture; governance and accountability arrangements; and its reporting, performance review,

business transformation and improvement processes. Through the risk management framework and its supporting processes, the Commission formally establishes and communicates its approach to ongoing risk management, and guides staff members in their actions and abilities to accept and control risks.

### Fraud control

The Commission recognises the responsibility of all Australian Government authorities to develop, encourage and implement sound financial, legal and ethical decision making. The Commission's Fraud Control Plan complies with the Commonwealth Fraud Control Guidelines. The Fraud Control Plan minimises the potential for instances of fraud within the Commission's programs and activities, whether conducted by employees or those external to the Commission. Fraud risk assessments help the Commission understand fraud risks, identify internal control gaps or weaknesses, and develop strategies to mitigate those risks. These assessments are conducted regularly across the organisation, taking into consideration the entity's business activities, processes and accounts.

### Internal audit

Internal audit is a key component of the Commission's governance framework, providing an independent, ongoing appraisal of the organisation's internal control systems. The internal audit process provides assurance that the Commission's financial and operational controls can manage the organisation's risks and are operating in an efficient, effective and ethical manner.

An external firm has been appointed as the Commission's auditor. The firm provides assurance of the overall state of the Commission's internal controls and on any systemic issues that require management attention.

## External scrutiny

External scrutiny of the Commission includes parliamentary and ministerial oversight, freedom of information and judicial decisions, and reviews by outside bodies such as the Commonwealth Ombudsman.

## Parliamentary and ministerial oversight

The Commission is a statutory authority of the Australian Government and part of the Health portfolio. As such, it is accountable to the Australian Parliament and the Minister for Health.

## Freedom of information

Agencies subject to the *Freedom of Information Act 1982* (FOI Act) are required to publish information available to the public as part of the Information Publication Scheme (IPS). This requirement is in Part II of the FOI Act and has replaced the former requirement to publish a section 8 statement in an annual report. The Commission displays a plan on its web site ([www.safetyandquality.gov.au](http://www.safetyandquality.gov.au)) showing which information it publishes in accordance with IPS requirements. See Appendix G on page 133 for a table summarising the list of FOI activities for 2013/14.

## Judicial decisions and reviews by external bodies

No judicial decisions or decisions of administrative tribunals had a significant effect on the Commission's operations during 2013/14.

## Developments and significant events

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The Commission is required under section 15 of the CAC Act to notify the Minister of developments and events that have significantly affected or may significantly affect its operations. In 2013/14, there were no such developments or significant events. There have also been no such developments or significant events since 30 June 2014.

## *National Health Reform Act amendments*

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No amendments to the NHR Act were made during the 2013/14 financial year.

## Environmental performance and ecologically sustainable development

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Section 516A of the *Environment Protection and Biodiversity Conservation Act 1999* (EPBC Act) requires Australian Government organisations and authorities to include in their annual reports about their environmental performance and their contribution to ecologically sustainable developments. The Commission is committed to making a positive contribution to ecological sustainability. The Commission's ecologically sustainable activities are detailed in Appendix H on page 134.



# 5

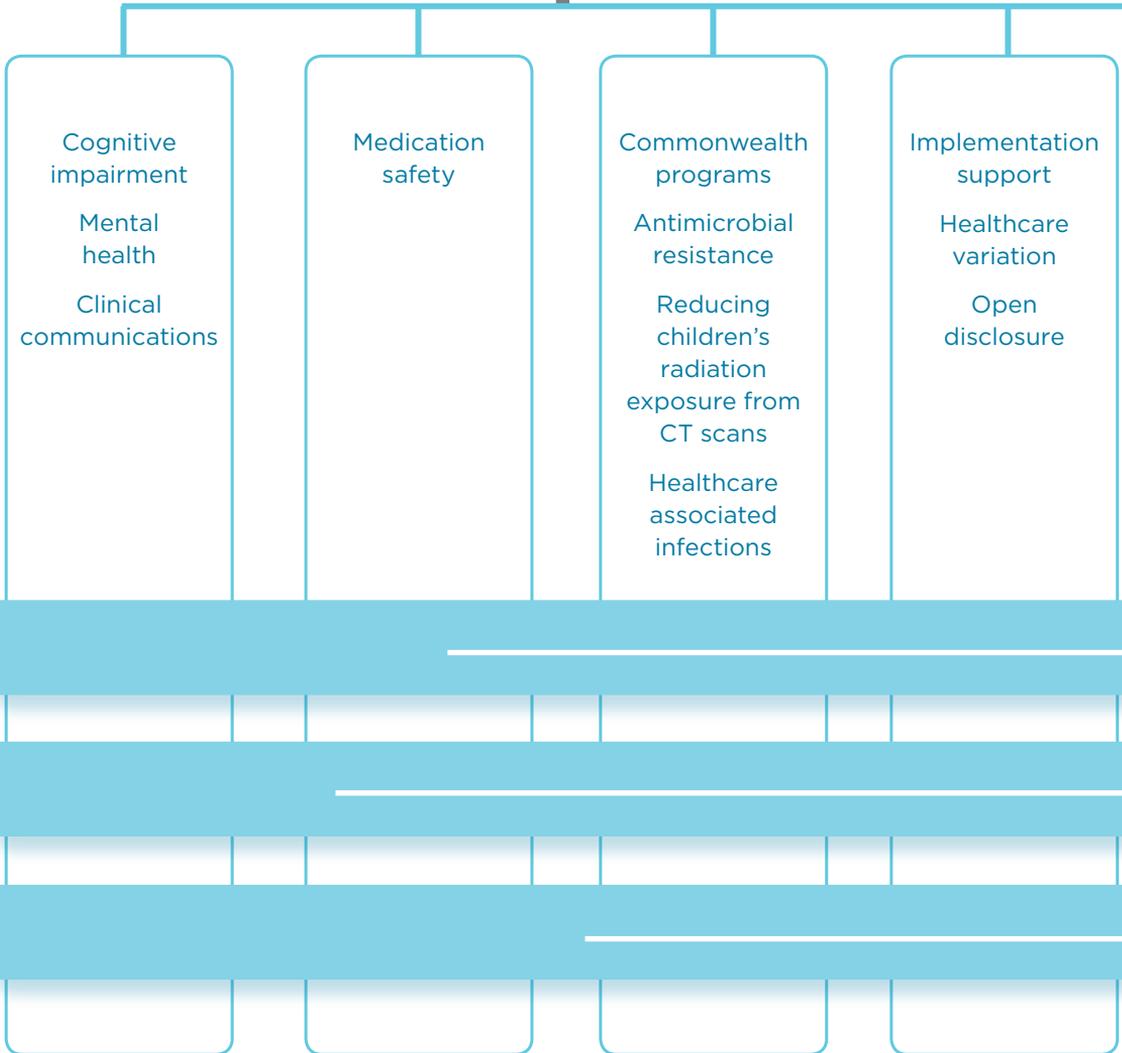
## Our organisation

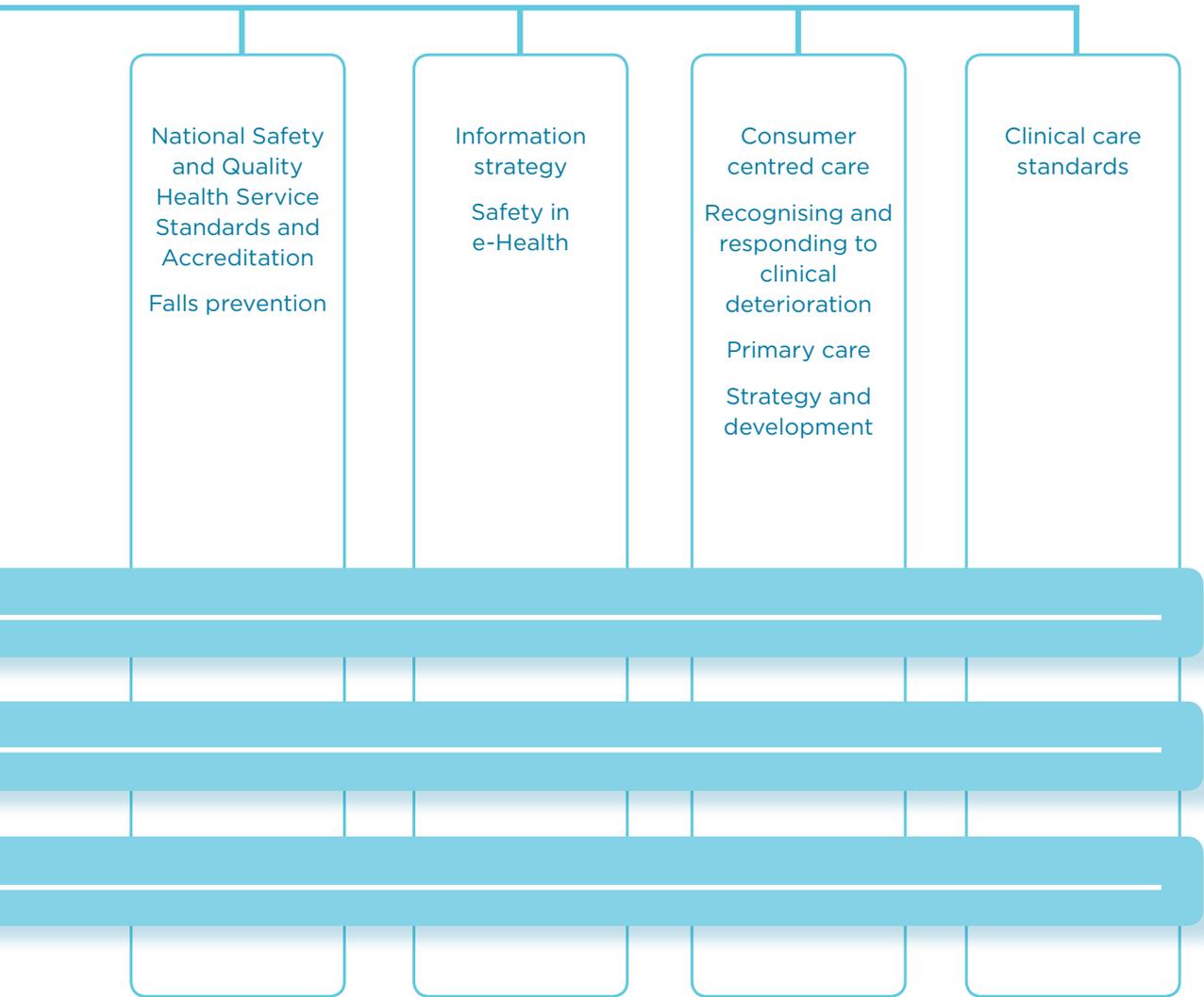
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## Organisational structure

**Australian Commission on Safety and Quality  
in Health Care Board**

**Chief Executive Officer**





The Commission employs a diverse range of highly skilled and professional staff with experience across the healthcare industry. Because of the nature of our work, the Commission has a strong national presence in safety and quality in both the public and private sectors.

The Commission is committed to managing and developing its staff to achieve the objectives and outcomes contained in its work plan.

### People management

In 2013/14, the Commission developed its Learning and Development Strategy and people management policies to ensure the successful recruitment, retention and rewarding of staff now and into the future.

The Commission continues to deliver high performance by providing ongoing support through performance management systems and by embedding a strong sense of direction across the organisation.

All staff members were provided with information on the reforms to the *Public Service Act* that came into effect on 1 July 2013, including changes to the Australian Public Service (APS) Values, APS Employment Principles and APS Code of Conduct.

The Commission also participates in the Australian Public Service Commission online induction program, giving all new employees the opportunity to learn about how the APS operates and behaviours expected of all staff.

In May 2014, the Commission's staff was encouraged to participate in the APSC's Census survey, and the Commission's Corporate Governance Framework and finance and HR delegations were updated to help staff efficiently respond to customers and clients.

### Staff profile

As at 30 June 2014, the Commission employed 61 full-time equivalent staff. All staff are located in Sydney, except for one staff member who shares their time between Sydney and Melbourne. The following table provides a breakdown of the Commission's staffing figures by classification, gender, full-time and part-time status, and ongoing and non-ongoing employment.

**Table 2: Staff numbers by classification as at 30 June 2014**

Classification	Female				Male				Total
	Ongoing		Non-ongoing		Ongoing		Non-ongoing		
	F/T	P/T	F/T	P/T	F/T	P/T	F/T	P/T	
CEO			1						1
MO6	1							1.1	2.1
MO4								0.2	0.2
EL 2	5	0.8	2		5		3		15.8
EL 1	11	4.3	3	3.5	1	0.6	1		24.4
APS 6	7	1.5	4		1				13.5
APS 5	2		1						3
APS 4							1		1
<b>Total</b>	<b>26</b>	<b>6.6</b>	<b>11</b>	<b>3.5</b>	<b>7</b>	<b>0.6</b>	<b>5</b>	<b>1.3</b>	<b>61</b>

F/T: Full-time      P/T: Part-time

## Non-salary benefits

In addition to salary and superannuation benefits, all Commission staff members are eligible for and have access to the following non-salary benefits:

- influenza vaccinations
- an annual Christmas close-down period
- eyesight testing and reimbursement of prescribed eyewear costs
- access to an Employee Assistance Program (EAP)
- time off for blood donations
- home-based working arrangements
- reimbursement of costs associated with obtaining financial advice (for staff over 54 years of age)
- reimbursement of costs associated with damage to clothing or personal effects
- support for professional and personal development
- access to accrued leave at half pay.

## Workplace health and safety

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The Commission continues to promote health and safety in the workplace and is committed to meeting its obligations under the *Work Health and Safety Act 2011* (WHS Act) and the *Safety, Rehabilitation and Compensation Act 1988* (SRC Act 1988).

During 2013/14, the Commission developed a suite of Work Health and Safety policies and procedures to ensure its compliance with the WHS Act.

All Commission staff members are required to complete the Comcare work health and safety e-learning training module on commencement.

Workplace safety is monitored by internal health and safety representatives and regular WHS Committee meetings.

During 2013/14, the Commission undertook a number of activities aimed at preventing illness and injury in the workplace, including:

- conducting ergonomic workstation assessments for all staff
- appointing new internal health and safety representatives and workplace harassment contact officers
- conducting bi-annual workplace inspections and encouraging all staff members to report on any incidents, accidents or hazards in the workplace
- making influenza vaccinations available to all staff members.

Three workplace health and safety incidents were reported in 2013/14.

## Learning and development

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The Commission values the talent and contribution of its staff and recognises the importance of building expertise within its organisation. Learning and development needs and opportunities are primarily identified through the performance development scheme (PDS).

During 2013/14, nine staff accessed study support assistance to undertake a variety of tertiary courses, including Master of Public Health, PhD in Nursing, Master of Health Service Management, Masters of Business and Technology, and Bachelors of Arts and Science degrees.

The Commission will formulate a learning and development strategy later in 2014 to ensure staff members continue to perform at a high level. Core skill development tailored to our business needs will be one focus.

The Commission offers all staff members the opportunity to attend regular continuing professional development (CPD) sessions. Seventeen CPD sessions were held in 2013/14.

## Disability strategy

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The Commission is required under clause 12 of the CAC Act to establish a Disability Action Plan. The Commission is committed to developing and implementing its Disability Action Plan during 2014/15.

# 6

## Financial statements

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## INDEPENDENT AUDITOR'S REPORT

### To the Minister for Health

I have audited the accompanying financial statements of the Australian Commission on Safety and Quality in Health Care for the year ended 30 June 2014, which comprise: a Statement by the Directors, Chief Executive and Chief Financial Officer; the Statement of Comprehensive Income; Statement of Financial Position; Statement of Changes in Equity; Cash Flow Statement; Schedule of Commitments and Notes to and forming part of the Financial Statements comprising a Summary of Significant Accounting Policies and other explanatory information.

### *Directors' Responsibility for the Financial Statements*

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

### *Auditor's Responsibility*

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

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

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

***Independence***

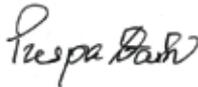
In conducting my audit, I have followed the independence requirements of the Australian National Audit Office, which incorporate the requirements of the Australian accounting profession.

***Opinion***

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

- (a) have been prepared in accordance with the Finance Minister's Orders made under the *Commonwealth Authorities and Companies Act 1997*, including the Australian Accounting Standards; and
- (b) give a true and fair view of the matters required by the Finance Minister's Orders including the Australian Commission on Safety and Quality in Health Care's financial position as at 30 June 2014 and its financial performance and cash flows for the year then ended.

Australian National Audit Office



Puspa Dash  
Executive Director

Delegate of the Auditor-General

Canberra  
18 September 2014

## Australian Commission on Safety and Quality in Health Care

### Statement by the Directors, Chief Executive and Chief Financial Officer

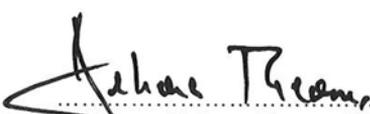
In our opinion, the attached financial statements for the year ended 30 June 2014 are based on properly maintained financial records and give a true and fair view of the matters required by the Finance Minister's Orders made under the *Commonwealth Authorities and Companies Act 1997*, as amended.

In our opinion, at the date of this statement, there are reasonable grounds to believe that the Australian Commission on Safety and Quality in Health Care will be able to pay its debts as and when they become due and payable.

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

  
.....  
Professor Villis Marshall AC  
Chair

Date: 16.9.2014

  
.....  
Professor Debora Picone AM  
Chief Executive Officer

Date: 18.9.2014

  
.....  
Mike Wallace  
Chief Operating Officer /  
Chief Financial Officer

Date: 18.9.2014

## Statement of Comprehensive Income

for the period ended 30 June 2014

	Notes	2014 \$'000	2013 \$'000
<b>EXPENSES</b>			
Employee benefits	3A	8,600	6,718
Suppliers	3B	9,977	7,119
Depreciation and amortisation	3C	87	120
Finance costs	3D	6	7
Impairment of assets	3E	56	-
<b>Total expenses</b>		<b>18,726</b>	<b>13,964</b>
<b>LESS:</b>			
<b>OWN-SOURCE INCOME</b>			
<b>Own-source revenue</b>			
Rendering of services	4A	6,104	2,413
Interest	4B	312	431
External contributions	4C	6,335	5,665
<b>Total own-source revenue</b>		<b>12,751</b>	<b>8,509</b>
<b>Net cost of services</b>		<b>5,975</b>	<b>5,455</b>
Revenue from Government	4D	6,335	5,665
<b>Surplus (deficit)</b>		<b>360</b>	<b>210</b>
<b>OTHER COMPREHENSIVE INCOME</b>			
Changes in asset revaluation reserves		-	(3)
<b>Total other comprehensive income (loss)</b>		<b>-</b>	<b>(3)</b>
<b>Total comprehensive income (loss)</b>		<b>360</b>	<b>207</b>
<b>Total comprehensive income (loss)</b>		<b>360</b>	<b>207</b>

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

## Statement of Financial Position

as at 30 June 2014

	Notes	2014 \$'000	2013 \$'000
<b>ASSETS</b>			
<b>Financial Assets</b>			
Cash and cash equivalents	6A	13,159	7,050
Trade and other receivables	6B	2,214	1,161
<b>Total financial assets</b>		<b>15,373</b>	<b>8,211</b>
<b>Non-Financial Assets</b>			
Property, plant and equipment	7A,B	56	199
Other non-financial assets	7C	155	57
<b>Total non-financial assets</b>		<b>211</b>	<b>256</b>
<b>Total assets</b>		<b>15,584</b>	<b>8,467</b>
<b>LIABILITIES</b>			
<b>Payables</b>			
Suppliers	8A	2,233	2,478
Other payables	8B	10,135	3,548
<b>Total payables</b>		<b>12,368</b>	<b>6,026</b>
<b>Provisions</b>			
Employee provisions	9A	1,504	1,229
Other provisions	9B	389	249
<b>Total provisions</b>		<b>1,893</b>	<b>1,478</b>
<b>Total liabilities</b>		<b>14,261</b>	<b>7,504</b>
<b>Net assets</b>		<b>1,323</b>	<b>963</b>
<b>EQUITY</b>			
Contributed equity		1,836	1,836
Reserves		5	5
Accumulated deficit		(518)	(878)
<b>Total equity</b>		<b>1,323</b>	<b>963</b>

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

# Statement of Changes in Equity

for the period ended 30 June 2014

	Retained earnings		Asset revaluation Reserve		Contributed equity		Total equity	
	2014 \$'000	2013 \$'000	2014 \$'000	2013 \$'000	2014 \$'000	2013 \$'000	2014 \$'000	2013 \$'000
<b>Opening balance</b>	<b>(878)</b>	(1,088)	<b>5</b>	8	<b>1,836</b>	1,836	<b>963</b>	756
<b>Comprehensive income</b>								
Other comprehensive income	-	-	-	(3)	-	-	-	(3)
Surplus (Deficit) for the period	<b>360</b>	210	-	-	-	-	<b>360</b>	210
<b>Total comprehensive income</b>	<b>360</b>	210	-	(3)	-	-	<b>360</b>	207
<b>Transactions with owners</b>								
<b>Contributions by owners</b>								
Equity injection	-	-	-	-	-	-	-	-
<b>Sub-total transactions with owners</b>	<b>-</b>	-	-	-	-	-	<b>-</b>	-
<b>Closing balance as at 30 June</b>	<b>(518)</b>	(878)	<b>5</b>	5	<b>1,836</b>	1,836	<b>1,323</b>	963
<b>Closing balance attributable to the Australian Government</b>	<b>(518)</b>	(878)	<b>5</b>	5	<b>1,836</b>	1,836	<b>1,323</b>	963

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

## Cash Flow Statement

for the period ended 30 June 2014

	Notes	2014 \$'000	2013 \$'000
<b>OPERATING ACTIVITIES</b>			
<b>Cash received</b>			
Receipts from Government		6,335	5,665
External contributions		6,335	5,665
Rendering of services		10,796	5,597
Interest		301	449
Net GST received		529	1,226
Lease incentive received		1,180	-
<b>Total cash received</b>		<b>25,476</b>	<b>18,602</b>
<b>Cash used</b>			
Employees		(8,250)	(10,320)
Suppliers		(11,117)	(13,072)
<b>Total cash used</b>		<b>(19,367)</b>	<b>(23,392)</b>
<b>Net cash from (used by) operating activities</b>	10	<b>6,109</b>	<b>(4,790)</b>
<b>INVESTING ACTIVITIES</b>			
<b>Cash used</b>			
Purchase of property, plant and equipment		-	(144)
<b>Total cash used</b>		<b>-</b>	<b>(144)</b>
<b>Net cash from (used by) investing activities</b>		<b>-</b>	<b>(144)</b>
<b>Net increase (decrease) in cash held</b>		<b>6,109</b>	<b>(4,934)</b>
<b>Cash and cash equivalents at the beginning of the reporting period</b>		<b>7,050</b>	<b>11,984</b>
<b>Cash and cash equivalents at the end of the reporting period</b>	6A	<b>13,159</b>	<b>7,050</b>

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

## Schedule of Commitments

as at 30 June 2014

	2014	2013
	\$'000	\$'000
<b>BY TYPE</b>		
<b>Commitments receivable</b>		
Project Commitments <sup>1</sup>	15,056	7,127
Net GST recoverable on commitments	298	136
<b>Total commitments receivable</b>	<u>15,354</u>	<u>7,263</u>
<b>Commitments payable</b>		
Operating lease <sup>2</sup>	1,636	793
Other Commitments <sup>3</sup>	1,955	1,964
<b>Total commitments payable</b>	<u>3,591</u>	<u>2,757</u>
<b>Net commitments by type</b>	<u>11,763</u>	4,506
<b>BY MATURITY</b>		
<b>Commitments receivable</b>		
One year or less	10,216	5,340
From one to five years	5,138	1,923
<b>Total receivable on commitments</b>	<u>15,354</u>	<u>7,263</u>
<b>Commitments payable</b>		
<b>Operating lease</b>		
One year or less	1,091	666
From one to five years	545	127
<b>Total operating lease commitments payable</b>	<u>1,636</u>	<u>793</u>
<b>Other commitments</b>		
One year or less	1,784	1,887
From one to five years	171	77
<b>Total other commitments payable</b>	<u>1,955</u>	<u>1,964</u>
<b>Total commitments payable</b>	<u>3,591</u>	<u>2,757</u>
<b>Net commitments by maturity</b>	<u>11,763</u>	4,506

Note: Commitments are GST inclusive where relevant.

1. Project commitments: services committed to be provided by the Commission, under signed agreements, where the Commission has yet to perform the services required.
2. Operating lease commitments: the Commission has committed to a 2 year lease term agreement which commenced in December 2013. The lease is effectively non-cancellable. Lease payments are subject to annual increases or reviews until the end of the lease.
3. Other commitments: amounts committed under signed agreements where the contracted organisation has yet to perform the services required.

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

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## Notes to and forming part of the Financial Statements for the period ended 30 June 2014

### Note 1: Summary of Significant Accounting Policies

#### 1.1 Objectives of the entity

The Australian Commission on Safety and Quality in Health Care (the Commission) is an Australian Government controlled entity. It is a not-for-profit entity. The objective of the Commission is to lead and coordinate health care safety and quality improvements in Australia.

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

The Commission is structured to meet a single outcome:

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

The continued existence of the Commission in its present form and with its present programs is dependent on Government policy and on continuing funding by Parliament for the Commission's administration and programs. The 2014-15 Budget proposed the merger of the Commission with a number of other Commonwealth entities to create a new health productivity and performance commission. This is subject to consultation with the States and Territories and currently no further details are provided on the role or timeframe for creation of the merged entity.

#### 1.2 Basis of Preparation of the Financial Statements

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

The financial statements have been prepared in accordance with:

- a) Finance Minister's Orders (FMOs) for reporting periods ending on or after 1 July 2011; and
- b) Australian Accounting Standards and Interpretations issued by the Australian Accounting Standards Board (AASB) that apply for the reporting period.

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

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

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

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

### 1.3 Significant Accounting Judgements and Estimates

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

### 1.4 New Australian Accounting Standards

#### Adoption of New Australian Accounting Standard Requirements

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

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

#### Future Australian Accounting Standard Requirements

New standards, revised standards and interpretations that were issued by the Australian Accounting Standards Board prior to the sign off date and are applicable to the future reporting period are not expected to have a material future financial impact on the Commission.

### 1.5 Revenue

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

- a) the amount of revenue, stage of completion and transaction costs incurred can be reliably measured; and
- b) the probable economic benefits associated with the transaction will flow to the Commission.

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

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

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

#### Revenue from Government - CAC Act body payment item

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

## 1.6 Gains

### Resources Received Free of Charge

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

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

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

### Sale of Assets

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

## 1.7 Transactions with the Government as Owner

### Equity Injections

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

### Restructuring of Administrative Arrangements

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

### 1.8 Employee Benefits

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

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

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

#### Leave

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

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

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

#### Superannuation

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

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

The liability for defined benefits is recognised in the financial statements of the Australian Government and is settled by the Australian Government in due course. This liability is reported by the Department of Finance's administered schedules and notes.

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

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

## 1.9 Leases

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

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

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

## 1.10 Borrowing Costs

All borrowing costs are expensed as incurred.

## 1.11 Fair Value Measurement

The entity deems transfers between levels of the fair value hierarchy to have occurred at the end of the period.

## 1.12 Cash

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

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

## 1.13 Financial Assets

The Commission classifies its financial assets as loans and receivables.

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

### Effective Interest Method

The effective interest method is a method of calculating the amortised cost of a financial asset and of allocating interest income over the relevant period. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, or, where appropriate, a shorter period.

Income is recognised on an effective interest rate basis except for financial assets that are recognised at fair value through profit or loss.

### Loans and Receivables

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

### Impairment of Financial Assets

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

If there is objective evidence that an impairment loss has been incurred for loans and receivables, the amount of the loss is measured as the difference between the asset's carrying amount and the present value of estimated future cash flows discounted at the asset's original effective interest rate. The carrying amount is reduced by way of an allowance account. The loss is recognised in the statement of comprehensive income.

## 1.14 Financial Liabilities

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

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

## 1.15 Contingent Liabilities and Contingent Assets

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

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

## 1.16 Acquisition of Assets

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

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

## 1.17 Property, Plant and Equipment

### Asset Recognition Threshold

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

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

### Revaluations

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

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

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

### Depreciation

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

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

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

<b><u>Asset Class</u></b>	<b><u>2014</u></b>	<b><u>2013</u></b>
Leasehold improvements	Lease term	Lease term
Plant and equipment	5 years	5 years

### Impairment

All assets were assessed for impairment at 30 June 2014. Where indications of impairment exist, the asset's recoverable amount is estimated and an impairment adjustment made if the asset's recoverable amount is less than its carrying amount.

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

### Derecognition

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

## 1.18 Taxation

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

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

- i) where the amount of GST incurred is not recoverable from the Australian Taxation Office; and
- ii) for receivables and payables.

## Note 2: Events After the Reporting Period

No matters or circumstances have arisen since the end of the financial year which significantly affected or may affect the operations of the Commission.

## Note 3: Expenses

	2014	2013
	\$'000	\$'000

### Note 3A: Employee Benefits

Wages and salaries	6,428	5,072
Superannuation:		
Defined contribution plans	908	666
Defined benefit plans	195	209
Leave and other entitlements	1,033	735
Other employee benefits	36	36
<b>Total employee benefits</b>	<b>8,600</b>	<b>6,718</b>

### Note 3B: Suppliers

#### Goods and services

Consultants	34	31
Contracts for services	5,820	4,371
Travel	723	517
Information and communication	693	516
Printing and postage	162	117
Property outgoings	447	138
Other	881	656
<b>Total goods and services</b>	<b>8,760</b>	<b>6,346</b>

#### Goods and services are made up of:

Provision of goods – external parties	189	127
Rendering of services – related parties	1,054	1,321
Rendering of services – external parties	7,517	4,898
<b>Total goods and services</b>	<b>8,760</b>	<b>6,346</b>

#### Other supplier expenses

Operating lease rentals		
Minimum lease payments – external parties	672	53
Sublease – related parties	452	651
Workers compensation expenses	93	69
<b>Total other supplier expenses</b>	<b>1,217</b>	<b>773</b>
<b>Total supplier expenses</b>	<b>9,977</b>	<b>7,119</b>

<b>2014</b>	2013
<b>\$'000</b>	\$'000

**Note 3C: Depreciation and Amortisation**

**Depreciation:**

Property, plant and equipment	<u>87</u>	120
<b>Total depreciation</b>	<u>87</u>	<u>120</u>

**Note 3D: Finance Costs**

Unwinding of discount	<u>6</u>	7
<b>Total finance costs</b>	<u>6</u>	<u>7</u>

The unwinding of discount relates to make good on lease.

**Note 3E: Impairment of Assets**

Impairment of property, plant and equipment	<u>56</u>	-
<b>Total impairment of assets</b>	<u>56</u>	<u>-</u>

During the period, the Commission relocated office premises. Leasehold improvements not transferrable to the new office premises were impaired.

## Note 4: Income

	<b>2014</b>	2013
<b>OWN-SOURCE REVENUE</b>	<b>\$'000</b>	\$'000

### Note 4A: Rendering of Services

Rendering of services – related parties	<b>6,104</b>	2,379
Rendering of services – external parties	-	34
<b>Total sale of goods and rendering of services</b>	<b>6,104</b>	2,413

### Note 4B: Interest

Deposits	<b>312</b>	431
<b>Total interest</b>	<b>312</b>	431

### Note 4C: External Contributions

States and Territories contributions	<b>6,335</b>	5,665
<b>Total external contributions</b>	<b>6,335</b>	5,665

## REVENUE FROM GOVERNMENT

### Note 4D: Revenue from Government

<b>Department of Health:</b>		
CAC Act body payment item	<b>6,335</b>	5,665
<b>Total revenue from Government</b>	<b>6,335</b>	5,665

## Note 5: Fair Value Measurement

The following tables provide an analysis of assets and liabilities that are measured at fair value.

The different levels of the fair value hierarchy are defined below:

- Level 1: Quoted prices (unadjusted) in active markets for identical assets or liabilities that the entity can access at measurement date.
- Level 2: Inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly.
- Level 3: Unobservable inputs for the asset or liability.

### Note 5A: Fair Value Measurement

Fair value measurements at the end of the reporting period by hierarchy for assets and liabilities in 2014:

	Fair value measurements at the end of the reporting period using			
	Fair value \$'000	Level 1 inputs \$'000	Level 2 inputs \$'000	Level 3 inputs \$'000
<b>Non-financial assets</b>				
Recurring - Property, Plant and Equipment	56	-	56	-
<b>Total non-financial assets</b>	<b>56</b>	<b>-</b>	<b>56</b>	<b>-</b>
<b>Total fair value measurements</b>	<b>56</b>	<b>-</b>	<b>56</b>	<b>-</b>

## Note 5B: Level 1 and Level 2 Transfers for Recurring Fair Value Measurements

There were no transfers between Levels 1 and 2 during the period.

The Commission's policy for determining when transfers between levels are deemed to have occurred can be found in Note 1.

## Note 5C: Valuation Technique and Inputs for Level 2 and Level 3 Fair Value Measurements

Level 2 and 3 fair value measurements - valuation technique and the inputs used for assets and liabilities in 2014:

	Category (Level 2 or 3)	Fair value \$'000	Valuation technique(s)	Inputs used
<b>Non-financial assets</b>				
Recurring - Property, Plant and Equipment	Level 2	56	Depreciated Replacement Cost	Replacement cost Useful life

## Note 6: Financial Assets

<b>2014</b>	2013
<b>\$'000</b>	\$'000

### Note 6A: Cash and Cash Equivalents

Cash on hand and at bank	<b>13,159</b>	7,050
<b>Total cash and cash equivalents</b>	<b>13,159</b>	7,050

### Note 6B: Trade and Other Receivables

#### Good and Services:

Related parties – Department of Health	<b>1,806</b>	1,000
External parties	<b>170</b>	-
<b>Total receivables for goods and services</b>	<b>1,976</b>	1,000

#### Other receivables:

GST receivable from the Australian Taxation Office	<b>212</b>	134
Interest - related parties	<b>4</b>	4
Interest - external parties	<b>22</b>	11
Other - related parties	<b>-</b>	12
<b>Total other receivables</b>	<b>238</b>	161
<b>Total trade and other receivables (gross)</b>	<b>2,214</b>	1,161

#### Less impairment allowance account:

Goods and services	<b>-</b>	-
<b>Total impairment allowance account</b>	<b>-</b>	-
<b>Total trade and other receivables (net)</b>	<b>2,214</b>	1,161

#### Receivables are expected to be recovered in:

No more than 12 months	<b>2,214</b>	1,161
<b>Total trade and other receivables (net)</b>	<b>2,214</b>	1,161

#### Receivables are aged as follows:

Not overdue	<b>2,214</b>	1,149
Overdue by 61 to 90 days	<b>-</b>	12
<b>Total trade and other receivables (net)</b>	<b>2,214</b>	1,161

No receivables were impaired at 30 June 2014 (2013: Nil).

## Note 7: Non-Financial Assets

2014	2013
\$'000	\$'000

### Note 7A: Property, Plant and Equipment

Fair value	384	384
Accumulated depreciation	(272)	(185)
Accumulated impairment losses	(56)	-
<b>Total property, plant and equipment</b>	<b>56</b>	<b>199</b>

During 2014, the Commission relocated office premises from 1 Oxford Street Darlinghurst to 255 Elizabeth Street Sydney.

Leasehold improvements not relocated from 1 Oxford Street are expected to be disposed of upon expiry of the lease in September 2014. The net book values of these assets were fully impaired on date of relocation.

No other property, plant or equipment was expected to be sold or disposed of within the next 12 months.

The Commission only held leasehold improvements, plant and equipment.

#### Revaluations of non-financial assets

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

### Note 7B: Reconciliation of the opening and closing balances of property, plant and equipment

2014	2013
\$'000	\$'000

<b>As at 1 July</b>		
Gross book value	384	300
Accumulated depreciation and impairment	(185)	(65)
<b>Net book value 1 July</b>	<b>199</b>	<b>235</b>
Additions:		
By purchase	-	84
Depreciation expense	(87)	(120)
Impairments recognised in other comprehensive income	(56)	-
<b>Net book value 30 June</b>	<b>56</b>	<b>199</b>

#### Net book value as of 30 June represented by:

Gross book value	384	384
Accumulated depreciation and impairment	(328)	(185)
	<b>56</b>	<b>199</b>

**2014**      2013  
**\$'000**      \$'000

**Note 7C: Other Non-Financial Assets**

Prepayments	<b>155</b>	57
<b>Total other non-financial assets</b>	<b>155</b>	57

**Total other non-financial assets - are expected to be recovered in:**

No more than 12 months	<b>155</b>	57
<b>Total other non-financial assets</b>	<b>155</b>	57

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

**Note 8: Payables**

**2014**      2013  
**\$'000**      \$'000

**Note 8A: Suppliers**

Trade creditors and accruals	<b>2,233</b>	2,478
<b>Total supplier payables</b>	<b>2,233</b>	2,478

**Supplier payables expected to be settled within 12 months:**

Related entities - Department of Health	<b>109</b>	947
Related entities - Other	<b>158</b>	191
External parties	<b>1,966</b>	1,340
<b>Total</b>	<b>2,233</b>	2,478

Settlement is usually made within 30 days.

**Note 8B: Other Payables**

Salaries and wages	<b>204</b>	150
Superannuation	<b>33</b>	24
Unearned income	<b>9,025</b>	3,368
Lease incentive	<b>850</b>	-
Other	<b>23</b>	6
<b>Total other payables</b>	<b>10,135</b>	3,548

**Other payables expected to be settled:**

No more than 12 months	<b>9,852</b>	3,548
More than 12 months	<b>283</b>	-
<b>Total other payables</b>	<b>10,135</b>	3,548

## Note 9: Provisions

<b>2014</b>	2013
<b>\$'000</b>	\$'000

### Note 9A: Employee Provisions

Leave	1,504	1,229
<b>Total employee provisions</b>	<b>1,504</b>	<b>1,229</b>

#### Employee provisions are expected to be settled in:

No more than 12 months	937	708
More than 12 months	567	521
<b>Total employee provisions</b>	<b>1,504</b>	<b>1,229</b>

### Note 9B: Other Provisions

Provision for restoration obligations	255	249
Provision for surplus lease space	134	-
<b>Total other provisions</b>	<b>389</b>	<b>249</b>

#### Other provisions are expected to be settled in:

No more than 12 months	389	-
More than 12 months	-	249
<b>Total other provisions</b>	<b>389</b>	<b>249</b>

#### *Reconciliation of the opening and closing balances of other provisions:*

	Provision for surplus lease space \$'000	Provision for restoration \$'000	Total \$'000
<b>Carrying amount at 1 July 2013</b>	-	249	249
Provisions made	314	-	314
Amounts recognised in other comprehensive income	(180)	6	(174)
<b>Closing balance at 30 June 2014</b>	<b>134</b>	<b>255</b>	<b>389</b>

During the period, the Commission relocated office premises from Level 7, 1 Oxford Street Darlinghurst NSW to Level 5, 255 Elizabeth Street Sydney.

The rental agreement for Oxford Street is non-cancellable and expires in September 2014. A provision for surplus lease space has been recorded to reflect the expected remaining rental agreement payments.

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

## Note 10: Cash Flow Reconciliation

	<b>2014</b>	2013
	<b>\$'000</b>	\$'000
<b>Reconciliation of cash and cash equivalents as per Balance Sheet to Cash Flow Statement</b>		
<b>Cash and cash equivalents as per:</b>		
Cash flow statement	<b>13,159</b>	7,050
Balance sheet	<b>13,159</b>	7,050
<b>Difference</b>	<b>-</b>	-
<b>Reconciliation of net cost of services to net cash from operating activities:</b>		
Net cost of services	<b>(5,975)</b>	(5,455)
Add revenue from Government	<b>6,335</b>	5,665
<b>Adjustments for non-cash items</b>		
Depreciation and amortisation	<b>87</b>	120
Impairment of assets	<b>56</b>	-
Movements in operating recognised in equity	-	(3)
Capitalisation of accruals not classified as operating	-	60
<b>Changes in assets / liabilities</b>		
(Increase) / decrease in net receivables	<b>(1,053)</b>	1,707
(Increase) / decrease in prepayments	<b>(98)</b>	17
Increase / (decrease) in employee provisions	<b>275</b>	310
Increase / (decrease) in supplier payables	<b>(245)</b>	(10,401)
Increase / (decrease) in other payables	<b>6,587</b>	3,180
Increase / (decrease) in other provisions	<b>140</b>	10
<b>Net cash from (used by) operating activities</b>	<b>6,109</b>	(4,790)

## Note 11: Contingent Assets and Liabilities

### Quantifiable Contingencies

As at 30 June 2014, the Commission had no quantifiable contingencies (2012-13: nil).

### Unquantifiable Contingencies

As at 30 June 2014, the Commission had no unquantifiable contingencies (2012-13: nil).

### Significant Remote Contingencies

As at 30 June 2014, the Commission had no material remote contingencies (2012-13: nil).

## Note 12: Directors Remuneration

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

	2014	2013
	No.	No.
\$0 to \$29,999*	9	12
\$30,000 to \$59,999	-	1
\$60,000 to \$89,999	1	-
	10	13

Total remuneration received or due and receivable by directors of the Commission

**\$190,652**    \$154,584

\* 4 directors included in this band waived their right or were not eligible to receive remuneration during 2014 (2013: 5). Remuneration of executive directors is included in Note 13: Senior Executive Remuneration.

## Note 13: Related Party Disclosures

The directors of the Commission during the year were:

	<u>Commenced</u>	<u>Ceased</u>
Professor Villis Marshall AC (Chair from 1 April 2013)	1/04/2012	
Professor Chris Brook PSM	1/04/2012	
Professor Phillip Della	1/04/2013	
The Hon Verity Firth	1/04/2013	
Christine Gee	1/07/2011	
Professor Jane Halton PSM	1/07/2011	
Dr Shaun Larkin	1/04/2013	
Russell McGowan	1/07/2011	31/03/2014
Shelly Park	1/07/2011	31/03/2014
Dr Helena Williams	1/07/2011	

The aggregate remuneration of directors is disclosed in Note 12.

### Transactions with directors of director related entities

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

Several directors of the Commission hold directorships with other organisations. All transactions between the Commission and organisations with a director common to the Commission, or any dealings between the Commission and directors individually, are conducted using commercial and arms-length principles.

During the year, Dr Helena Williams provided project support and expert advice to the Commission. Fees paid by the Commission for these services were \$10,226 (2013: nil).

### Transactions with related parties

Transactions between related parties are on normal commercial terms and conditions unless otherwise stated.

## Note 14: Senior Executive Remuneration

### Note 14A: Senior executive remuneration expenses for the reporting period

	2014	2013
	\$	\$
Short-term employee benefits		
Salary	987,774	809,068
Performance bonuses	71,918	24,200
<b>Total short-term employee benefits</b>	<b>1,059,692</b>	<b>833,268</b>
Post-employment benefits		
Superannuation	134,175	100,013
<b>Total post-employment benefits</b>	<b>134,175</b>	<b>100,013</b>
Other long-term benefits		
Annual leave accrued	81,063	74,828
Long service leave	20,252	14,302
<b>Total other long-term benefits</b>	<b>101,315</b>	<b>89,130</b>
Termination benefits	-	-
<b>Total</b>	<b>1,295,182</b>	<b>1,022,411</b>

**Notes:**

- Note 14A is prepared on an accruals basis. Therefore, the performance bonuses expenses disclosed above may differ from the cash bonus paid in Note 14B.
- Note 14A excludes acting arrangements and part-year service where remuneration expensed for a senior executive was less than \$195,000.



## Note 14C: Other Highly Paid Staff

Average annual reportable remuneration <sup>1</sup>	2014					
	Staff No.	Reportable salary <sup>2</sup> \$	Contributed superannuation <sup>3</sup> \$	Reportable allowances <sup>4</sup> \$	Bonus paid <sup>5</sup> \$	Total \$
<b>Total remuneration (including part-time arrangements):</b>						
\$195,000 to \$224,999	4	165,978	27,858	161	14,611	208,608
\$225,000 to \$254,999	1	186,721	27,853	606	17,590	232,770
\$255,000 to \$284,999	1	206,921	36,304	-	26,311	269,536
<b>Total</b>	<b>6</b>					
Average annual reportable remuneration <sup>1</sup>	2013					
	Staff No.	Reportable salary <sup>2</sup> \$	Contributed superannuation <sup>3</sup> \$	Reportable allowances <sup>4</sup> \$	Bonus paid <sup>5</sup> \$	Total \$
\$195,000 to \$224,999	3	158,612	27,060	-	16,915	202,586
\$225,000 to \$254,999	1	183,182	27,160	892	17,078	228,312
\$255,000 to \$284,999	1	200,333	31,240	377	25,245	257,195
<b>Total</b>	<b>5</b>					

### Notes:

1. This table reports staff:

- who were employed by the Commission during the reporting period;
- whose reportable remuneration was \$195,000 or more for the financial period; and
- were not required to be disclosed in Notes 14A, 14B or director disclosures.

Each row is an averaged figure based on headcount for individuals in the band.

2. 'Reportable salary' includes the following:

- gross payments (less any bonuses paid, which are separated out and disclosed in the 'bonus paid' column);
- reportable fringe benefits (at the net amount prior to 'grossing up' to account for tax benefits);
- reportable employer superannuation contributions; and
- exempt foreign employment income (nil paid by the Commission during the year).

3. The 'contributed superannuation' amount is the average cost to the Commission for the provision of superannuation benefits to other highly paid staff in that reportable remuneration band during the reporting period.

4. 'Reportable allowances' are the average actual allowances paid as per the 'total allowances' line on individuals' payment summaries.

5. 'Bonus paid' represents average actual bonuses paid during the reporting period in that reportable remuneration band. The 'bonus paid' within a particular band may vary between financial years due to various factors such as individuals commencing with or leaving the Commission during the financial year.

## Note 15: Remuneration of Auditors

	2014	2013
	\$'000	\$'000

Financial statement audit services were provided to the Commission by the Australian National Audit Office (ANAO).

### Cost of the services provided

Financial statement audit services	50	50
<b>Total</b>	<b>50</b>	<b>50</b>

No other services were provided by the auditors of the financial statements.

## Note 16: Financial Instruments

### Note 16A: Categories of financial instruments

	2014	2013
	\$'000	\$'000

#### Financial assets

##### Loans and receivables:

Cash on hand and at bank	13,159	7,050
Trade and other receivables	2,002	1,027
<b>Total</b>	<b>15,161</b>	<b>8,077</b>
<b>Carrying amount of financial assets</b>	<b>15,161</b>	<b>8,077</b>

#### Financial liabilities

##### At amortised cost:

Trade creditors and accruals		
Suppliers	2,233	2,478
<b>Total</b>	<b>2,233</b>	<b>2,478</b>
<b>Carrying amount of financial liabilities</b>	<b>2,233</b>	<b>2,478</b>

### Note 16B: Net income and expense from financial assets

Loans and receivables		
Interest revenue	312	431
<b>Net gain/(loss) loans and receivables</b>	<b>312</b>	<b>431</b>
<b>Net gain/(loss) from financial assets</b>	<b>312</b>	<b>431</b>

## Note 16C: Fair value of financial instruments

	<b>Carrying amount 2014 \$'000</b>	Carrying amount 2013 \$'000
<b>Financial assets</b>		
<b>Loans and receivables:</b>		
Cash and cash equivalents	13,159	7,050
Trade and other receivables	2,002	1,027
<b>Total</b>	<b>15,161</b>	<b>8,077</b>
<b>Carrying amount of financial assets</b>	<b>15,161</b>	<b>8,077</b>
<b>Financial liabilities</b>		
<b>At amortised cost:</b>		
Suppliers	2,233	2,478
<b>Total</b>	<b>2,233</b>	<b>2,478</b>
<b>Carrying amount of financial liabilities</b>	<b>2,233</b>	<b>2,478</b>

There are no potential differences between the carrying amounts and fair values of financial assets and liabilities.

## Note 16D: Credit risk

The Commission was exposed to minimal credit risk as loans and receivables were cash and trade receivables. The maximum exposure to credit risk was the risk that arises from potential default of a debtor. This amount was equal to the total amount of trade and other receivables at 30 June 2014: \$2,002,000 (2013: \$1,015,000).

The Commission manages its debtors by undertaking recovery processes for those receivables which are considered to be overdue. The risk of overdue debts arising is minimised through the implementation of credit assessments on potential customers.

The Commission holds no collateral to mitigate against credit risk.

The credit quality of financial instruments not past due or individually determined as impaired:

	<b>Not past due nor impaired</b>		<b>Past due or impaired</b>	
	<b>2014</b>	2013	<b>2014</b>	2013
	<b>\$'000</b>	\$'000	<b>\$'000</b>	\$'000
Cash and cash equivalents	13,159	7,050	-	-
Trade and other receivables	2,002	1,015	-	12
<b>Total</b>	<b>15,161</b>	8,065	-	12

## Note 16E: Liquidity risk

The Commission's financial liabilities comprise trade creditors, research project creditors, and other payables. The exposure to liquidity risk is based on the notion that the Commission will encounter difficulty in meeting its obligations on its financial liabilities. This is highly unlikely due to Commonwealth, State and Territory government funding, the Commission's ability to draw down on cash reserves, and internal policies and procedures put in place to ensure there are appropriate resources to meet its financial obligations.

The Commission manages liquidity risk by ensuring all financial liabilities are paid in accordance with terms and conditions on demand. In addition, the Commission has no past experience of defaults in its current and prior forms.

### Maturities for financial liabilities 2014:

	On demand \$'000	Within 1 year \$'000	Total \$'000
<b>Other financial liabilities</b>			
Suppliers	-	2,233	2,233
<b>Total</b>	-	2,233	2,233

### Maturities for financial liabilities 2013:

	On demand \$'000	Within 1 year \$'000	Total \$'000
<b>Other financial liabilities</b>			
Suppliers	-	2,478	2,478
<b>Total</b>	-	2,478	2,478

## Note 16F: Market risk

The Commission holds basic financial instruments that do not expose the Commission to certain market risks, such as 'currency risk' or 'other price risk'.

The only interest-bearing items on the statement of financial position were the cash and cash equivalents, which bear interest at prevailing bank interest rates. Their values do not fluctuate due to changes in the market interest rate.

## Note 17: Financial Assets Reconciliation

	Notes	2014 \$'000	2013 \$'000
<b><u>Financial assets</u></b>			
<b>Total financial assets as per balance sheet</b>		<b>15,373</b>	8,211
Less: non-financial instrument components:			
Other receivables	6B	<b>212</b>	134
Total non-financial instruments components		<b>212</b>	134
<b>Total non-financial assets as per financial instruments note</b>		<b>15,161</b>	8,077

## Note 18: Compensation and Debt Relief

No payments were made during the reporting period for compensation and debt relief (2013: Nil).

## Note 19: Reporting of Outcomes

### Note 19A: Net Cost of Outcome Delivery

The Commission is structured to meet one outcome:

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

	Outcome 1	
	2014	2013
	\$'000	\$'000
<b>Expenses</b>		
Departmental	<b>18,726</b>	13,964
<b>Income from non-government sector</b>		
Sale of goods and rendering of services	<b>6,104</b>	2,413
Interest	<b>312</b>	431
External contributions	<b>6,335</b>	5,665
<b>Total income from non-government sector</b>	<b>12,751</b>	8,509
<b>Net cost of outcome delivery</b>	<b>5,975</b>	5,455

The primary statements of these financial statements represent the Major Classes of Departmental Expense, Income, Assets and Liabilities by Outcome, as required by the FMOs. Accordingly these tables are not repeated in note 19.

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## Appendix A

### Publications

The following table summarises the key publications released by the Commission during 2013/14, as discussed on page 51. Additional newsletters, resources and other materials that have been released throughout the year have not been listed here but are available via the Commission’s web site.

**Table 3: Key Commission publications released during 2013/14**

Publication	Description	Date released
<b>Clinical Care Standards</b>		
<i>Consultation draft Clinical Care Standard for Acute Coronary Syndrome</i>	This draft Clinical Care Standard describes the care that a person with acute coronary syndrome should receive from the onset of symptoms to the completion of their treatment in hospital. The draft was released as part of a public consultation process	December 2013
<i>Consultation draft Clinical Care Standard for Antimicrobial Stewardship</i>	This draft Clinical Care Standard describes the care a person should receive when they have, or are suspected to have, a bacterial infection in hospital. The draft was released as part of a public consultation process	December 2013
<i>Consultation draft Clinical Care Standard for Stroke</i>	This draft Clinical Care Standard describes the care a person with stroke should receive from the onset of symptoms to the completion of their treatment in hospital. The draft was released as part of a public consultation process	April 2014
<b>End-of-life care</b>		
<i>Safety and Quality of End-of-life Care: A Background Paper</i>	An overview of the current policy and clinical framework for end-of-life care within the Australian acute healthcare settings as interpreted by consumers, clinicians and policy makers	September 2013

Publication	Description	Date released
<b>Health literacy</b>		
<i>Health Literacy: Taking Action to Improve Safety and Quality</i>		June 2014
<i>National Statement – Health Literacy: Taking Action to Improve Safety and Quality</i>		June 2014
<b>Healthcare associated infection</b>		
<i>A Specification for a Hospital Level Cumulative Antibiogram</i>	This specification specifies the minimum clinical elements of a cumulative antibiogram to support antimicrobial prescribing and stewardship	December 2013
<i>Recommendations for the control of Multi-drug resistant Gram-negatives: carbapenem resistant Enterobacteriaceae</i>	Recommendations for patient management that are contained in the Australian Guidelines for the Prevention and Control of Infection in Healthcare and the NSQHS Standards	December 2013
<i>Clostridium difficile infection (CDI) Surveillance Implementation Guide</i>	A guide designed to support and standardise existing surveillance activities in line with the national definition for CDI	
<i>Staphylococcus aureus bacteraemia (SAB) Surveillance Implementation Guide</i>	A guide designed to support and standardise existing surveillance activities in line with the national definitions for SAB	
<b>Healthcare variation</b>		
<i>Medical Practice Variation Background Paper</i>	A background briefing on medical practice variation and upcoming work in the area	November 2013
<i>Exploring Healthcare Variation in Australia: Analyses Resulting from an OECD Study</i>	A discussion paper of the Australian results of an OECD lead study in 13 countries of variation in healthcare	May 2014
<i>Exploring Healthcare Variation in Australia: Analyses Resulting from an OECD Study. In Brief</i>	A summary of the discussion paper <i>Exploring Healthcare Variation in Australia: Analyses Resulting from an OECD Study</i>	May 2014
<b>Information strategy</b>		
<i>Framework for clinical quality registries</i>	Guidance for jurisdictions in their dealings with clinical quality registries	June 2014

<b>Publication</b>	<b>Description</b>	<b>Date released</b>
<b>Medication safety</b>		
<i>Evaluation of standardised medicine syringe labels in interventional cardiac catheter and radiology laboratories</i>	Presents results of evaluation of pre-printed sterile labels to identify medicines and fluids removed from their original containers in interventional cardiology and radiology	November 2013
<i>2012 NIMC National Audit Report</i>	A snapshot of the NIMC use across Australia contributed to by 241 public and 71 private hospitals	July 2013
<i>2012 NIMC National Audit Report Supplement: From Measurement to Action</i>	Recommended actions for improving the use of the NIMC and related charts	January 2014
<i>Improving the Safety of Pharmacy Dispensing Labelling National Round Table Report</i>	A report of round table outcomes including recommendations for an Australian standard on pharmacy dispensing labelling	January 2014
<i>Evidence briefings on interventions to improve medication safety; Automated dispensing systems</i>	A review of the effect of automated dispensing systems on reducing medication administration errors and improving efficiency	December 2013
<i>Evidence briefings on interventions to improve medication safety: Barcode medicine administration systems</i>	A review of the effect of barcode medicine administration systems on reducing medication administration errors and improving efficiency	December 2013
<i>Evidence briefings on interventions to improve medication safety: electronic medication administration records</i>	A review of the effect of electronic medication administration records on reducing medication administration errors and improving efficiency	December 2013
<i>Evidence briefings on interventions to improve medication safety: double checking medicine administration</i>	A review of the effect of double checking of medicine administration on reducing medication administration errors and improving efficiency	December 2013
<i>Evidence briefings on interventions to reduce interruptions during medicines preparation and administration</i>	A review of the effect of reducing interruptions during medicines preparation and administration on reducing medication administration errors and improving efficiency	December 2013
<i>Literature Review: Medication Safety in Australia</i>	A review of literature (2008–2013) on the extent of medication related problems in Australia, strategies for improving medication safety and international evidence for intervention strategies	December 2013

Publication	Description	Date released
<b>Mental health</b>		
<i>Handbook for improving safety and providing high quality care for people with cognitive impairment in acute care: A consultation paper</i>	A consultation draft handbook intended as an evidence-based resource for clinicians and managers to improve safety and quality care for people with cognitive impairment in acute care	October 2013
<i>Accreditation workbook for mental health services</i>	A workbook developed to guide mental health services through the accreditation process for the NSQHS Standards and highlight areas where mental health services will also have substantively achieved relevant NSMHS criteria	March 2014
<b>Safety and quality in Australian health care</b>		
<i>Vital Signs: The State of Safety and Quality in Australian Health Care</i>	An annual publication providing an overview of what is happening in Australian health care for a series of important safety and quality topics	October 2013

## Appendix B

### Published articles

The following table lists the journal articles published during 2013/14 that Commission staff members have contributed to.

**Table 4: Published articles with contributions from the Commission**

Article name/authors	Publication/Date
<i>Patient safety in hospitals – can we measure it?</i> Board N.	<i>Medical Journal of Australia</i> October 2013
<i>Global collaboration to encourage prudent use of antibiotics</i> Earnshaw S, Mendez A, Monnet D, Hicks L, Cruickshank M, Weekes L, Njoo H, Ross S.	<i>The Lancet Infectious Diseases</i> December 2013
<i>Taking Action to Preserve the Miracle of Antibiotics</i> Cruickshank M, Duguid M, Gotterson F, Carter D.	<i>Australian Veterinary Journal</i> January 2014
<i>Standardization in patient safety: the WHO High 5s Project</i> Leotsakos A, Zheng H, Croteau R, Loeb JM, Sherman H, Hoffman C, Morganstein L, O’Leary D, Bruneau C, Lee P, Duguid M, Thomeczek C, van der Schrieck-De Loos E, Munier B.	<i>International Journal for Quality in Health Care</i> March 2014 (vol. 26 no.2 pp109–116)

## Appendix C

### Engagement in research

The following table summarises the research activities and projects that the Commission has been involved with during 2013/14, as discussed on page 55.

**Table 5: Commission engagement in research during 2013/14**

Research	Research organisation	Brief description	Commission role	Project status
Listen to me, I really am sick! Understanding patient and family perspectives in triggering responses to medical emergencies	Deakin University	<p>The aims of this study are to:</p> <ol style="list-style-type: none"> <li>1. Investigate the role and influence of patients and relatives in triggering responses from health providers to critical patient deterioration in hospital</li> <li>2. Identify communication strategies that may decrease preventable serious adverse events.</li> </ol> <p>A qualitative design using patient and family member interviews and medical record reviews will be undertaken. Data will be analysed using narrative enquiry</p>	Participation on project advisory panel	Project to be completed in 2015
Centre for Research Excellence in Primary Health Care Microsystems: Stream 2 – Improving Safety and Quality in Primary Health Care	Centre for Research Excellence in Primary Health Care Microsystems is a consortium of the University of Queensland, Greater Green Triangle Department of Rural Health, Flinders University, University of NSW, Australian National University and the Mater Hospital	The CRE research program addresses primary health care quality, safety, governance, performance measurement and sustainability issues identified within the national health reform agenda	Associate Investigator and national partner organisation	Program to be completed in 2014

Research	Research organisation	Brief description	Commission role	Project status
ECCHO Effective Clinical Communication in Handover	University of Technology Sydney, Flinders University, University of Adelaide, University of Melbourne, University of Queensland, Curtin University and health departments from New South Wales, the Australian Capital Territory, South Australia, Western Australia, Victoria and Queensland	The ECCHO project is a three-year national research studying effective (and ineffective) communication during clinical handovers.  The research team is working with healthcare providers in hospitals in New South Wales, the Australian Capital Territory, Western Australia and South Australia to observe, describe and analyse how healthcare providers in different hospital settings do their clinical handovers	National Representative member of National Clinical Advisory Group	Project to be completed in 2014
Centre for Informing Policy in Health with Evidence from Research (CIPHER) questionnaire testing	CIPHER	The CIPHER is undertaking an extensive project to develop tools to explore how research is used in policy making. The purpose of this specific sub-section of the research is to test a questionnaire being developed by CIPHER on use of research in policy, in particular to determine whether the measures it will be using are stable	Commission staff are participating in testing of the questionnaire	Project is ongoing
Qualitative research on the development of NSQHS Standard 2: Partnering with Consumers	Australian Institute of Health Innovation, University of New South Wales ACCREDIT project	This is one of 12 projects looking at the effectiveness and application of accreditation. Project 4 on Key New Standards – consumer participation	Participation on project advisory panel, and participation in research data collection and participate on Advisory Committee	To be completed in 2016

## Appendix D

### Event sponsorship

The Commission sponsored three events during 2013/14, as discussed on page 55.

**Table 6: Event sponsorship 2013/14**

Event name	Organiser	Date held	Sponsorship amount
Health Informatics Conference	Health Informatics Society of Australia	15–18 July 2013	\$11,000
7th International Conference on Safety Quality Audit and Outcomes	Australian and New Zealand Intensive Care Society	29–31 July 2013	\$5,500
Australian General Practice Accreditation Limited (AGPAL) Safety and Quality Award, at International Health Care Conference	Hosted by The Australian Association of Practice Managers Ltd, and Quality Innovation Performance	27 September 2013	\$3,520

## Appendix E

### External representations

The following table lists the various international, national and jurisdictional committees and organisations within which the Commission has been represented during 2013/14, as discussed on page 56.

**Table 7: Commission external representation 2013/14**

Committee/Organisation
Access to appropriate primary health care relative to need among people with acute and chronic conditions Advisory Committee
Acute Coronary Syndrome Implementation and Advocacy Working Group (Heart Foundation)
Australian Consortium for Classification Development: AR-DRG Classification Refinement and Development Services ICD Technical Group
Australian Health Services Research Institute: Electronic Persistent Pain Outcomes Collaboration (ePPOC) National Reference Group
Australian Medical Council Medical School Assessment Team
Better Cardiac Care for Aboriginal and Torres Strait Islander People: Performance Improvement and Coordination of Care Working Group
Breastscreen Australia Accreditation Review Committee
Centre for Culture Ethnicity and Health, Health Literacy Advisory Group
Centre for Research Excellence in Primary Health Care Microsystems, National Advisory Committee and Advisory Committee for Stream 2: Quality and Safety in Primary Care
Centre of Research Excellence in post-market surveillance of medicines and medical devices
Clinical Excellence Commission: In Safe Hands Steering Group
Council of Australian Therapeutic Advisory Groups Expert Advisory Group on Achieving Effective Medicines Governance
Deakin University Centre for Quality and Patient Safety Research External Advisory Committee
Department of Health: Data Governance Council
Department of Veterans Affairs Pay for Performance Advisory Committee
Haemovigilance Advisory Committee (National Blood Authority)
Health Literacy Network (NSW Clinical Excellence Commission)
National Health Enterprise Data Warehouse Board
National Centre for Research Excellence in Nursing Expert Reference Group
National Health Information and Performance Principal Committee
National Health Information and Statistical Standards Committee
National Health Performance Authority GP Care Advisory Committee
National Heart Foundation/Australian Healthcare and Hospitals Association: Lighthouse Hospital Project Phase II External Advisory Group

### Committee/Organisation

National Lead Clinicians Group

NPS MedicineWise Antibiotic Resistance Reference Group

Organ and Tissue Authority: Vigilance and Surveillance Working Group

Queensland Health Patient Safety and Quality Improvement Service, State-wide Clinical Handover Reference Group

Queensland Health Recognising and Responding to Clinical Deterioration Reference Group

Reducing Adverse Medications Events in Mental Health Working Party, Safety and Quality Partnerships Standing Committee

Royal District Nursing Service Research Advisory Committee

Safety and Quality Partnerships Standing Committee of the Mental Health and Drug and Alcohol Principal Committee

Standing Committee on Performance Reporting

Youth Cancer Service Strategic Advisory Group

## Appendix F

### Formal consultations

The following table summarises the formal consultations undertaken during 2013/14 to inform the Commission’s work with respect to specific issues, as discussed on page 56.

**Table 8: Summary of formal consultations undertaken during 2013/14**

Consultation topic	Method	Information received	Date
<b>Consumer centred care</b>			
Health literacy	Call for written submissions	113 written submissions	June – August 2013
<b>Information strategy</b>			
Development of national patient contact protocol for high-risk implantable devices	Workshops in Brisbane, Sydney, Melbourne, Adelaide and Canberra. Targeted interviews with the Australian Medical Association, the Royal Australasian College of Surgeons, the Consumer Health Forum, the Therapeutic Goods Administration, and Medical Technology Association of Australia	Iterative feedback	November – December 2013
<b>Clinical Care Standards</b>			
Draft Clinical Care Standard for acute coronary syndrome	Online survey and request for written submissions	57 written submissions 11 survey responses	July 2012 – June 2013
Draft Clinical Care Standard for antimicrobial stewardship	Online survey and request for written submissions	60 written submissions 19 survey responses	December 2013 – March 2014
Draft Clinical Care Standard for stroke	Online survey and request for written submissions	65 written submissions 130 survey responses	March – May 2013

Consultation topic	Method	Information received	Date
<b>End-of-life care</b>			
Draft National Consensus Statement: Essential Elements of Safe and High Quality End-of-Life Care in Acute Hospitals	Online survey, request for written submissions and workshops held across the country	75 written submissions and input from 350 workshop participants	February – June 2014
<b>Mental health</b>			
National scoping study on national standards in mental health services	National focus groups and stakeholder interviews	22 focus groups with participation from 111 service providers and 39 people with lived experience of mental health issues, support people and carers. 9 stakeholder interviews	July – September 2013
Improving the management of cognitive impairment using the NSQHS Standards	Online survey, request for written submissions, focus groups and meetings held across the country	26 focus groups with 299 service providers and 78 service users. 178 responses to the online survey. 18 written submissions received from individuals and organisations	October – December 2013
<b>Radiation exposure to children from CT scans</b>			
Reduction in radiation exposure to children from CT scans	Consultations with Department of Health, states and territories, other government agencies and professional bodies to inform the objectives of the project	8 face-to-face and teleconference sessions	May – June 2014
<b>Antimicrobial resistance</b>			
Antimicrobial Utilisation and Resistance in Australia (AURA) Surveillance Project	Letters, meetings and online survey	To be compiled upon completion	May 2014, continuing to August 2014
<b>Information strategy</b>			
Draft National Patient Contact Protocol	Workshops in capital cities, targeted interviews, consultation with IJC, private hospital sector committee and Board review	Iterative feedback	October 2013 – May 2014

Consultation topic	Method	Information received	Date
<b>Information strategy</b>			
Clinical Quality Registries – a National Framework	Expert and inter-jurisdictional roundtable	Iterative feedback	September 2013
<b>NSQHS Standards</b>			
Survey of CRANA members on the implementation of the NSQHS Standards	Online survey	25 survey responses from a range of rural and remote services	May 2014
Survey of the medical colleges on post graduate and continuing professional development training relevant to the NSQHS Standards	Online survey and review of curriculum documents provided	14 of the 15 colleges represented on the Committee of Presidents of Medical Colleges participated in the survey	June 2014
<b>Healthcare variation</b>			
Exploring Healthcare Variation in Australia: Analyses Resulting from an OECD Study	Request for written submissions	To be complied upon completion	May 2014, continuing to August 2014

## Appendix G

### Freedom of Information summary

The following table summarises the year's Freedom of Information (FOI) requests and their outcomes, as discussed on page 74.

**Table 9: Freedom of Information summary 2013/14**

Activity	Number
<b>Requests</b>	
On hand at 1 July 2013	0
New requests received	2
Total requests handled	2
Total requests completed as at 30 June 2014	2
<b>Action of request</b>	
Access granted in full	1
Access granted in part	0
Access refused	0
Access transferred in full	0
Request withdrawn	0
No records	1
<b>Response times</b>	
0–30 days	1
30–60 days	1
<b>Internal review</b>	
On hand as at 1 July 2013	0
Requests received	0
Decision affirmed	0
Decision amended	0
Request withdrawn	0
<b>Review by Administrative Appeals Tribunal</b>	
Applications received	0
<b>Review by the Officer of the Australian Information Commissioner</b>	
Applications received	0

## Appendix H

### Compliance to ecologically sustainable development

The Commission is committed to making a positive contribution to ecological sustainability. The following table details the Commission’s activities in accordance with section 156A(6) of the *Environment Protection and Biodiversity Conservation Act 1999* (EPBC Act).

**Table 10: Summary of Commission’s compliance to ecologically sustainable development**

EPBC Act requirement	Commission response
The activities of the Commission and its administration of legislation during 2013/14 accord with the principles of ecologically sustainable development.	The Commission gives appropriate consideration to the effects its activities may have on the environment, including in terms of its work plan and corporate governance. Instances where the Commission’s activities have environmental impacts are mitigated wherever possible. The Commission is not responsible for administering any legislation.
Outcomes specified for the Commission in an appropriations Act for 2013/14 contribute to ecologically sustainable development.	The Commission’s single appropriations outcome focuses on improving safety and quality in health care across the health system rather than environmental outcomes and, as such, has no implications on environmental protection and biodiversity conservation.
Effects of the Commission’s activities on the environment.	The Commission’s offices are located in a 5-star (NABERS rating) building and the Commission’s staff works proactively with the building manager to achieve energy savings where possible. Office lighting is automated to power off outside business hours. The Commission encourages its staff members to view documents online where possible and print only when necessary. The Commission’s waste practices are in accordance with the National Waste Policy.
Measures the Commission is taking to minimise its impact on the environment.	The Commission is working hard to further reduce its environmental effects, particularly in the area of information and communication technology (ICT). In 2013/14, the Commission implemented a number of initiatives required by the Australian Government ICT Sustainability Plan 2010–2015. These initiatives included introducing and using 100% post-consumer recycled paper and modifying the Commission’s ICT infrastructure, which will deliver desktop energy savings and reduce the Commission’s carbon footprint. The Commission is also partnering with the City of Sydney’s CitySwitch program to explore further environmental sustainability options.
Mechanisms for reviewing and increasing the effectiveness of those measures.	The Commission is implementing a number of initiatives to reduce its environmental impact, with a view to introducing a formal environmental policy. Review mechanisms will be included in this policy.

# 8

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## Acronyms and abbreviations

AHMAG	Australian Health Ministers' Advisory Council
AHSSQA Scheme	Australian Health Service Safety and Quality Accreditation Scheme
AURA Surveillance Project	Antimicrobial Utilisation and Resistance in Australia Surveillance Project
CAC Act	<i>Commonwealth Authorities and Companies Act 1997</i>
CHBOI	core, hospital-based outcome indicators
the Commission	Australian Commission on Safety and Quality in Health Care
EPBC Act	<i>Environment Protection and Biodiversity Conservation Act 1999</i>
HAI	Healthcare associated infection
HHA	Hand Hygiene Australia
IHPA	Independent Hospital Pricing Authority
IJC	Inter-Jurisdictional Committee
NEHTA	National E-Health Transition Authority
NHHI	National Hand Hygiene Initiative
NHMRC	National Health and Medical Research Council
NHR Act	<i>National Health Reform Act 2011</i>
NIMC	National Inpatient Medication Chart
NSQHS Standards	National Safety and Quality Health Service Standards
OECD	Organization for Economic Co-operation and Development
PBS	Pharmaceutical Benefits Scheme
PCEHR	Personally Controlled Electronic Health Record
RPBS	Repatriation Pharmaceutical Benefits Scheme
SRC Act	<i>Safety, Rehabilitation and Compensation Act 1988</i>
WHO	World Health Organization
WHS Act	<i>Work Health and Safety Act 2011</i>

## Glossary

**Accreditation:** A status that is conferred on an organisation or individual when they have been assessed as having met particular standards. The two conditions for accreditation are compliance with an explicit definition of quality (that is, a standard) and passing an independent review process aimed at identifying the level of congruence between practices and quality standards.<sup>16</sup>

**Acute healthcare facility:** A hospital or other healthcare facility providing healthcare services to patients for short periods of acute illness, injury or recovery.

**Adverse event:** An incident in which harm resulted in a person receiving health care.

**Antibiogram:** A profile of the antimicrobial resistance and susceptibility of a particular microorganism.<sup>17</sup>

**Antimicrobial:** A chemical substance that inhibits or destroys bacteria, viruses and fungi, including yeasts or moulds.<sup>18</sup>

**Antimicrobial stewardship:** A program implemented in a health service organisation to reduce the risks associated with increasing microbial resistance, and to extend the effectiveness of antimicrobial treatments. Antimicrobial stewardship may incorporate a broad range of strategies, including monitoring and reviewing antimicrobial use.<sup>18</sup>

**Blood glucose levels:** The blood glucose level is the amount of glucose in the blood. Glucose is a sugar that comes from food and is also formed and stored inside the body. It's the main source of energy for the cells in the body, and is carried to each cell through the bloodstream.

**Casemix data:** The Department of Health manages a number of hospital-related data collections. These contain information about hospital activity in the public and private systems. 'Casemix data' is a shorthand term for the National Admitted Patient Care Dataset, which contains de-identified patient-level hospital separation information, including patient demographics, hospital episode and clinical information (ICD-10-AM).

**Clinical communication:** An exchange of information that occurs between healthcare providers treating a patient. Communication can be formal (for example, when a message conforms to a predetermined structure in a health record or stored electronic data), or informal (when a message's structure is determined solely by the relevant parties; for example, in a face-to-face or telephone conversation).<sup>19</sup>

**Clinical handover:** The transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.<sup>20</sup>

**Clinical practice guidelines:** Systematically developed statements to help practitioners and patients make decisions about appropriate health care for specific circumstances.<sup>21</sup>

**Clinician:** A healthcare provider, trained as a health professional. Clinicians include registered and non-registered practitioners, or teams of health professionals providing health care who spend the majority of their time delivering direct clinical care.

**Consumers:** Patients and potential patients, carers and organisations representing consumers' interests.<sup>22</sup>

**Consumer-centred care:** A consumer-centred approach to care involves treating consumers and/or carers with dignity and respect; communicating and sharing information between consumers and/or carers and healthcare providers; encouraging and supporting consumers' participation in decision making; and fostering collaboration with consumers and/or carers and healthcare organisations in planning, designing, delivering and evaluating health care. Other terms are used internationally, such as patient-based, person-centred, relationship-based, patient-centred, and patient- and family-centred care.

### **Core, hospital-based outcome**

**indicators:** A succinct set of indicators that hospitals routinely monitor and review. These hospital-based outcome indicators can be generated by the jurisdictions or private hospital owners that hold the source data and reported back to the facilities that provide healthcare services.

**Dataset:** A collection of data elements that are collected as a set.

**Dataset specifications:** Specifies a group of data elements and the conditions under which this group is collected. A dataset specification can define the sequence in which data elements are included, whether they are mandatory, what verification rules should be employed and the characteristics of the collection (for example, its scope).

### **Electronic medication management**

**system:** Enables medicines to be prescribed, supplied, administered and reconciled electronically.

**Fall:** An event that results in a person inadvertently coming to rest on the ground.<sup>23</sup>

**Hand hygiene:** A general term referring to any hand-cleansing action.

### **Hand Hygiene Australia (HHA):**

An organisation engaged by the Commission to implement the National Hand Hygiene Initiative.

**Health care:** Services provided to individuals or communities to promote, maintain, monitor or restore health. Health care is not limited to medical care, and it includes self-care.

**Health literacy:** The skills, knowledge, motivation and capacity of a person to access, understand, appraise and apply information to make effective decisions about health and health care and take appropriate action.

### **Health literacy environment:**

The infrastructure, policies, processes, materials, people and relationships that make up the health system and have an impact on the way in which people access, understand, appraise and apply health-related information and services.

### **Healthcare associated infections:**

Infections that are acquired in healthcare facilities (nosocomial infections) or that occur as a result of healthcare interventions (iatrogenic infections). Healthcare associated infections may manifest after people leave healthcare facilities.<sup>24</sup>

**Healthcare provider:** Any person working within the health sector (at the service or jurisdictional level) who is responsible for providing or organising the provision of care and/or treatment to patients.

**Healthcare variation:** This occurs where patients with the same condition receive different types of care. For example, among a group of patients with the same condition, some may have no active treatment, some may be treated in the community and others in hospital, and some may have surgery while others receive medication. Some variation in how health care is provided is desirable because of differences in patients' needs, wants and preferences.<sup>25</sup>

**Health service organisation:** A separately constituted health service that is responsible for the clinical governance, administration and financial management of service units that provide health care. A service unit is a group of healthcare providers and others working in a systematic way to deliver health care to patients. This can take place in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' homes, community settings, medical practices and healthcare providers' clinics.

**Hospital:** A healthcare facility licensed by the respective regulator as a hospital or declared as a hospital.

**Hyperglycaemia:** An abnormally high blood glucose level. It usually affects people who have diabetes. Several factors can contribute to hyperglycemia in people with diabetes, including food and physical activity choices, illness, non-diabetes medications, or not taking enough glucose-lowering medication.

**Hypoglycaemia:** An abnormally low blood glucose level. It is also known as a "hypo" or low blood glucose. Hypoglycaemia can occur in people with diabetes using insulin, and certain diabetes medications. It usually occurs when the blood glucose level falls below 4mmol/L.

**Infection:** The invasion and reproduction of pathogenic or disease-causing organisms inside the body. This may cause tissue injury and disease.<sup>18</sup>

**Infection control or infection control measures:** Actions to prevent the spread of pathogens between people in a healthcare setting. Examples of infection control measures include targeted healthcare-associated infection surveillance, infectious disease monitoring, hand hygiene and wearing personal protective equipment.<sup>18</sup>

**Jurisdictions:** State and territory governments.

**Medicare Locals:** A nation-wide network of primary health care organisations to support health providers, to improve the delivery of primary care services at a local level and to improve access to after hours primary care.

**Medication:** Using medicine for therapy or for diagnosis, its interaction with the patient and its effects.

**Medication chart:** A chart used by an authorised prescriber to record medication and treatment orders, as well as by nursing staff to record and monitor the administration of such medicines and treatment.

**Medication error:** Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare provider or consumer.<sup>26</sup>

**Medication reconciliation:** The process of obtaining, verifying and documenting an accurate list of a patient's current medications on admission to a healthcare facility, and comparing this list to the admission, transfer and/or discharge medication orders to identify and resolve discrepancies. At the end of the period of care, the verified information is transferred to the next care provider.

**Medicine:** A chemical substance given to prevent, diagnose, cure, control or alleviate disease, or otherwise improve the physical or mental welfare of people. Prescription, non-prescription and complementary medicines, irrespective of their administration route, are included in this definition.<sup>27</sup>

**Monitor:** To check, supervise, observe critically or record the progress of an activity, action or system on a regular basis to identify and track change.

**National Hand Hygiene Initiative (NHHI):** An initiative to develop a national approach to improving hand hygiene and monitor its effectiveness.

**National Inpatient Medication Chart (NIMC):** A suite of nationally standardised medication charts, both paper and electronic, that present and communicate information on the medicines prescribed, dispensed, administered and reconciled for individual inpatients consistently between healthcare providers.

**National Residential Medication Chart (NRMC):** The medication chart or set of standard elements for a medication chart developed by the Commission. It permits Pharmaceutical Benefits Scheme (PBS) prescribers to prescribe, and eligible approved suppliers to claim for eligible PBS and Repatriation Pharmaceutical Benefits Scheme (RPBS) medicines. It also sets out required fields for safely using medicines in residential aged-care facilities.

**National Safety and Quality Health Service (NSQHS) Standards:**

Ten standards developed by the Commission in consultation and collaboration with jurisdictions, technical experts and healthcare providers and patients. The NSQHS Standards aim to protect the public from harm and to improve the quality of health services. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure minimum safety and quality standards are met, and a quality improvement mechanism that allows health services to realise aspirational or developmental goals.

**Open disclosure:** An open discussion with a patient about incidents that resulted in harm to that patient while they were receiving health care. The elements of open disclosure are an apology or expression of regret (including the word "sorry"), a factual explanation of what happened, an opportunity for the patient to relate their experience, and an explanation of the steps being taken to manage the event and prevent recurrence. Open disclosure may take place over several meetings.

**Patient:** A person receiving health care. Synonyms for "patient" include consumer and client.

**Patient safety:** Reducing the risk of unnecessary harm associated with health care to an acceptable minimum.

**Perioperative:** Pertaining to the period of time surrounding a surgical procedure, including the preoperative, intraoperative and postoperative periods.

**Practice gaps:** The difference between actual and ideal performance and/or patient outcomes.

**Practice-level indicators:** Indicators designed for voluntary inclusion in quality improvement strategies at the local practice or service level. They are intended for local use by organisations and individuals providing primary healthcare services.

**Pressure injuries:** These are localised to the skin and/or underlying tissue, usually over a bony prominence and caused by unrelieved pressure, friction or shearing. Pressure injuries occur most commonly on the sacrum and heel but can develop anywhere on the body. Pressure injury is a synonymous term for pressure ulcer.

**Prophylaxis:** A measure taken for the prevention of a disease.

**Quality of care:** The degree to which health services for individuals and populations increase the likelihood of desired health outcomes, and are consistent with current professional knowledge.

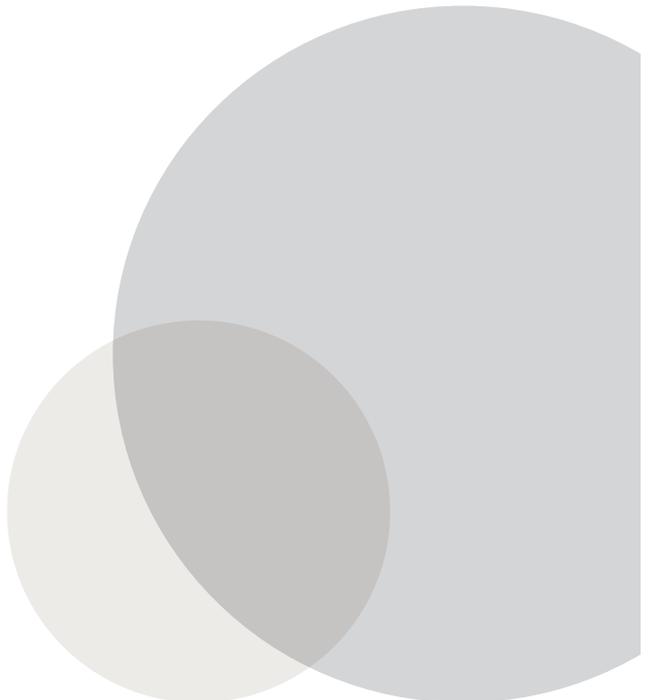
**Residential aged-care facility:** A facility that cares for older patients, operated by an approved provider. It replaces the older terms “nursing home” and “hostel”.

**Shared decision making:** Shared decision making involves the integration of a patient’s values, goals and concerns with the best available evidence about benefits, risks and uncertainties of treatment to achieve appropriate health care decisions.<sup>28</sup>

**Standard:** Agreed attributes and processes designed to ensure that a product, service or method will perform consistently at a designated level.

**Unwarranted healthcare variation:** Variation not attributed to patients’ needs, wants or preferences that cannot be explained on the basis of a patient’s illness, medical evidence or preferences.<sup>29</sup> Unwarranted variation raises questions about quality, equity and efficiency in health care.<sup>25</sup>

**Venous thromboembolism:** The blocking of a blood vessel by a blood clot dislodged from its site of origin. It includes both deep vein thrombosis and pulmonary embolism.



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## Compliance index

The Commission is bound by various legislative requirements to disclose certain information in this annual report. The main requirements are detailed in the Commonwealth Authorities (Annual Reporting) Orders 2011 (CAC Orders) and the *National Health Reform Act 2011* (NHR Act).

**Table 11: Mandatory reporting orders as per the CAC Orders or the NHR Act**

Requirement	Reference	Page listing compliant information
Amendments to the Commission's enabling legislation and to any other legislation directly relevant to its operation	CAC Orders 2011, sub-clause 16(d)	75
Approval by Directors	CAC Orders 2011, clause 6	1
Assessment of the effect of each of the Commission's functions	NHR Act 2011	15–57
Assessment of the performance of each of the Commission's functions	NHR Act 2011	15–57
Assessment of safety of healthcare services provided	NHR Act 2011	15–57
Board committees	CAC Orders 2011, clause 14	71–72
Commonwealth Disability Strategy	CAC Orders 2011, clause 12	82
Statement on governance	CAC Orders 2011, clause 14	63–75
Directors	CAC Orders 2011, clause 13	66–68
Ecologically sustainable development and environmental performance	CAC Orders 2011, sub-clause 12, ref <i>Environment Protection and Biodiversity Conservation Act 1999</i> , section 516A	75
Education and performance review processes for Directors	CAC Orders 2011, clause 14	70
Enabling legislation, functions and objectives	CAC Orders 2011, clause 10	2–3, 16, 64
Ethics and risk management policies	CAC Orders 2011, clause 14	70, 73
Financial statements	Sub-clause 1(b) and sub-clause 2(1) of Schedule 1 to the CAC Act. Finance Ministers' Orders for Financial Reports July 2009	83–118
Financial statements certification: a statement, signed by the Directors	Sub-clause 2(3) of Schedule 1 to the CAC Act	86
Financial statements certification: Auditor-General's Report	Sub-clause 1(c) and Part 2 of Schedule 1 to the CAC Act	84–85
Fraud risk assessment and control	Commonwealth Fraud Control Guidelines 2002	73

Requirement	Reference	Page listing compliant information
General policies of the Australian Government and General Policy Orders	CAC Orders 2011, clause 12	n/a
Indemnities and insurance premiums for officers	CAC Orders 2011, clause 19	70
Information Publication Scheme Statement	CAC Orders 2011, clause 12	74
Judicial decisions and decisions by administrative tribunals	CAC Orders 2011, clause 17	74
Key activities and changes that have affected the Commission	CAC Orders 2011, clause 16	15–57, 75
Letter of transmittal detailing approval by Directors	CAC Orders 2011, clause 6	74
Location of major activities and facilities	CAC Orders 2011, clause 14	inside cover, 80
Ministerial Directions	CAC Orders 2011, sub-clause 12	65
Operational and financial results	CAC Orders 2011, sub-clause 16(b)	83–118
Organisational structure	CAC Orders 2011, clause 14	78–79
Other legislation	CAC Orders 2011, clause 12	75
Related-entity transactions	CAC Orders 2011, clause 15	70
Reporting of significant events, as required by section 15 of the CAC Act	CAC Orders 2011, sub-clause 16(a)	75
Reports about the Commission by the Auditor-General, a parliamentary committee, the Commonwealth Ombudsman or the Office of the Australian Information Commissioner	CAC Orders 2011, clause 17	74
Responsible Minister	CAC Orders 2011, clause 11	3
Review of performance	CAC Orders 2011, clause 16	15–57
Work health and safety	CAC Orders 2011, clause 12, ref Work Health and Safety Act 2011, Schedule 2, Part 4	82

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Page references in **bold** type refer to major discussions of a topic.

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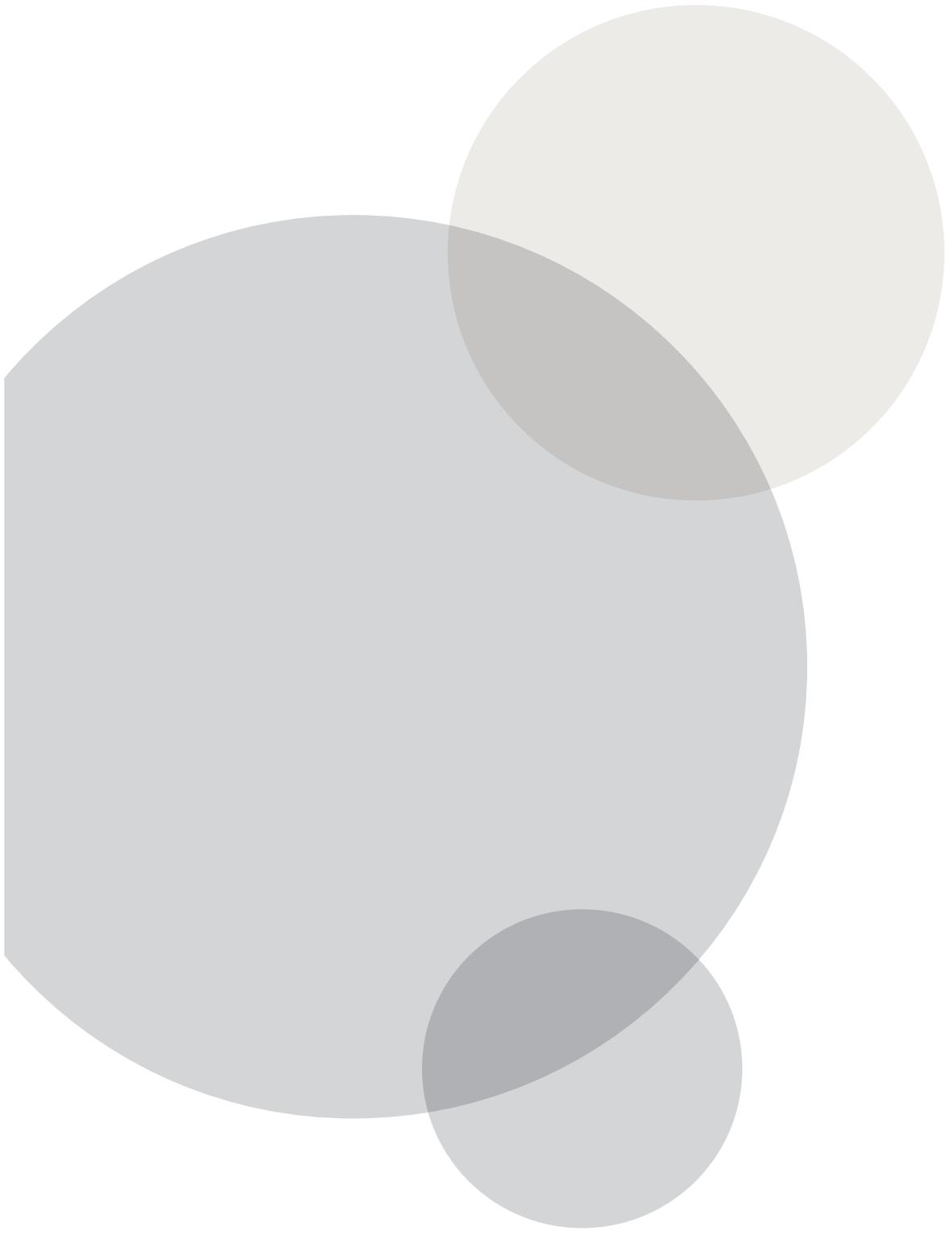
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## References

1. Kannus P KK, Lord S. Preventing falls among elderly people in the hospital environment. *Medical Journal of Australia*. 2006; 184: 372–3.
2. US Institute of Medicine. *Crossing the quality chasm: a new health system for the 21st century*. Washington: National Academy Press, 2001.
3. Kohn LT, Corrigan JM and Donaldson MS. *To err is human: Building a safer health system*. Washington D.C.: National Academy Press, 1999.
4. Australian Bureau of Statistics. Health Literacy, Australia. Canberra: Australian Bureau of Statistics, 2008.
5. Berkman ND, Sheridan SL, Donahue KE, et al. Health literacy interventions and outcomes: an updated systematic review. 2011.
6. Australian Commission on Safety and Quality in Health Care. Literature Review: Medication Safety in Australia. Sydney: ACSQHC, 2013.
7. Coombes ID, Reid C, McDougall D, Stowasser D, Duiguid M and Mitchell C. Pilot of a national inpatient medication chart in Australia: improving prescribing safety and enabling prescribing training. *British journal of clinical pharmacology*. 2011; 72: 338–49.
8. Baker HM, Naphine R and Federation AN. *Nurses & medication: A literature review*. Australian Nursing Federation, 1994.
9. Tong B and Stevenson C. *Comorbidity of cardiovascular disease, diabetes and chronic kidney disease in Australia*. 37th ed. Canberra: Australian Institute of Health and Welfare, 2007.
10. Westbrook JI, Rob MI, Woods A and Parry D. Errors in the administration of intravenous medications in hospital and the role of correct procedures and nurse experience. *BMJ Quality & Safety*. 2011; 20: 1027–34.
11. Appleby J, Raleigh V, Frosini F, et al. *Variations in health care: the good, the bad and the inexplicable*. King's Fund, 2011.
12. Office of the Chief Scientist. Meeting the Threat of Antibiotic Resistance: Building a New Frontline Defence. Occasional Paper Series. Canberra: Australian Government, 2013.
13. Turnidge JD, Kotsanas D, Munckhof W, Roberts S and Bennett C. Staphylococcus aureus bacteraemia: a major cause of mortality in Australia and New Zealand. *Medical Journal of Australia*. 2009; 191: 368–73.
14. Duguid M and Cruickshank M. Antimicrobial Stewardship in Australian Hospitals. Sydney: Australian Commission on Safety and Quality in Health Care, 2011.
15. Eliopoulos GM, Cosgrove SE and Carmeli Y. The impact of antimicrobial resistance on health and economic outcomes. *Clinical Infectious Diseases*. 2003; 36: 1433–7.

16. Australian Council for Safety and Quality in Health Care. Standard for Credentialling and Defining the Scope of Clinical Practice: A National Standard for credentialling and defining the scope of clinical practice of medical practitioners, for use in public and private hospitals. 2004.
17. *Medical Dictionary for the Health Professions and Nursing*. Farlex, 2012.
18. Cruickshank M and Ferguson J. Reducing Harm to Patients from Health Care Associated Infection: The Role of Surveillance. Sydney: Australian Commission on Safety and Quality in Health Care, 2008.
19. Coiera EW, Jayasuriya RA, Hardy J, Bannan A and Thorpe MEC. Communication loads on clinical staff in the emergency department. *Medical Journal of Australia*. 2002; 176: 415–8.
20. National Patient Safety Agency. Seven steps to patient safety. London: National Patient Safety Agency, 2004.
21. Field M and Lohr K. Guidelines for clinical practice: from development to use. Washington DC.: National Academy Press, 1992.
22. Consumers Health Forum of Australia. Consumer representative program policy. Consumers Health Forum of Australia, 2011.
23. World Health Organisation. Falls, Fact Sheet No 344. WHO, 2010.
24. National Health & Medical Research Council. Australian Guidelines for the Prevention and Control of Infection in Healthcare. Canberra: NHMRC, 2010, p. 260.
25. Australian Institute of Health and Welfare and Australian Commission on safety and Quality in Health Care. Exploring Healthcare Variation in Australia: Analyses Resulting from an OECD Study. Sydney: ACSQHC, 2014, p. 2.
26. National Coordinating Council for Medication Error Reporting and Prevention. What is a medication error? : National Coordinating Council for Medication Error Reporting and Prevention.
27. Australian Pharmaceutical Advisory Council. Guiding principles for medication management in the community. Canberra: Commonwealth of Australia, 2006.
28. Légaré F, Ratté S, Stacey D, et al. Interventions for improving the adoption of shared decision making by healthcare professionals. *Cochrane Database Syst Rev*. 2010; 5.
29. Wennberg JE. Tracking Medicine: A Researcher's Quest to Understand Health Care. New York: Oxford University Press, 2010, p. 4.





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