Guide to the National Safety and Quality Health Service Standards **for health service organisation boards**

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AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

NSQHS STANDARDS

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Executive summary

The *National Safety and Quality Health Service (NSQHS) Standards* were developed by the Australian Commission on Safety and Quality in Health Care (the Commission) in consultation and collaboration with jurisdictions, the private sector, health professionals and patients. The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision. Since 2013, accreditation to the NSQHS Standards has been mandatory for all Australian hospitals and day procedure services.

To fully apply the NSQHS Standards in a health service organisation, boards, management, consumers, clinicians and clinical teams need to be engaged in the implementation of actions set out in the NSQHS Standards. NSQHS Standard 1: Governance for Safety and Quality in Health Service Organisations, references the important roles boards play in leading safety and quality in health service organisations. NSQHS Standards 2 to 10 reference a number of additional roles of boards.

The Commission has developed this guide to provide advice to health service organisation boards in exercising their governance responsibilities and accountabilities in the implementation of the NSQHS Standards. Safety, quality and clinical governance of the organisation are among a board's significant responsibilities and accountabilities, and many of these aspects are interdependent.

The board of a health service organisation has ultimate responsibility for the governance of that organisation. In addition to its fiduciary and other corporate duties to act in good faith and comply with all relevant laws, the board is responsible for the clinical governance of the organisation. This means that among its other obligations, the board must ensure that:

- effective safety and quality systems and robust organisational governance practices are in place;
- safety and quality is monitored; and
- the organisation responds appropriately to safety and quality matters.

In carrying out these responsibilities, the board needs to comply with the legislative requirements and legal framework of the jurisdiction in which the board is operating.

The guide outlines the actions in the NSQHS Standards requiring health service organisation leaders, including boards, to:

- set and implement governance systems, monitor and improve the performance of the organisation; and
- communicate the importance of patient safety and quality management to all members of the workforce.

'Governance' incorporates the set of processes, customs, policy directives, laws and conventions affecting the way an organisation is directed, administered or controlled. Governance in health service organisations determines how a health service organisation delivers care and has a direct impact on the safety and quality of care.

Boards are responsible and accountable for ensuring that management has systems and processes in place to support clinicians in providing safe, high-quality care. Both boards and management have a responsibility to monitor the effectiveness of such systems and processes. For boards of health service organisations, this can be achieved through strategic planning, reviewing major safety and quality risks, ensuring safety and quality systems are in place, and monitoring and reviewing safety systems and performance. Requiring and reviewing reports on these and other safety quality issues allows boards to fulfil these roles.

While the board retains responsibility for oversight of the organisation and strategic decision making for safety and quality, the board delegates implementation to individuals and/or safety and quality committees. The board therefore oversees what management implements. The board has a responsibility to ensure that management takes action to address and remedy poor performance when identified.

Finally, the board should review its effectiveness and the effectiveness of its members in achieving its safety and quality goals.

1. Introduction

This guide has been developed to provide advice to board members in exercising their governance responsibilities and accountabilities in the implementation of the National Safety and Quality Health Service (NSQHS) Standards. The board's significant responsibilities and accountabilities include the safety and quality and clinical governance of the organisation, and many of these aspects are interdependent. Where safety and quality and clinical governance are considered alongside other organisational duties, elements and responsibilities, the effectiveness and efficiency of an organisation may be improved.

The following sections work through the 10 NSQHS Standards, highlighting the specific criteria and items that are applicable to boards, or where board consideration or action is required.

This document is intended to summarise the roles, responsibilities and accountabilities of a governing board. It provides a tool to undertake a gap analysis and thereby identify potential areas of vulnerability, and opportunities for improving the effectiveness of the board. In carrying out these responsibilities, the board needs to comply with the legislative requirements and legal framework of the jurisdiction in which the board is operating, which can impact on its role and function.

The NSQHS Standards

The NSQHS Standards were developed by the Australian Commission on Safety and Quality in Health Care (the Commission) in consultation with jurisdictions, the private sector, health professionals and patients. Health Ministers endorsed the NSQHS Standards in 2011. From 1 January 2013, all hospitals and day procedure services have been required to be accredited against these Standards. The aim of the NSQHS Standards is to protect the public from harm and to improve the quality of health service provision. They provide a framework to ensure systems are in place to meet minimum requirements for safety and quality. To be fully applied, boards, management, clinicians and clinical teams need to be engaged in the implementation of actions set out in the Standards.

National Safety and Quality Health Service Standards

1. **Governance for Safety and Quality in Health Service Organisations** which describes the quality framework required for health service organisations to implement safe systems.

2. **Partnering with Consumers** which describes the systems and strategies to create a consumer-centred health system by including consumers in the development and design of quality health care.

3. **Preventing and Controlling Healthcare Associated Infections** which describes the systems and strategies to prevent infection of patients within the healthcare system and to manage infections effectively when they occur to minimise the consequences.

4. **Medication Safety** which describes the systems and strategies to ensure clinicians safely prescribe, dispense and administer appropriate medicines to informed patients.

5. **Patient Identification and Procedure Matching** which describes the systems and strategies to identify patients and correctly match their identity with the correct treatment.

6. **Clinical Handover** which describes the systems and strategies for effective clinical communication whenever accountability and responsibility for a patient's care is transferred.

7. **Blood and Blood Products** which describes the systems and strategies for the safe, effective and appropriate management of blood and blood products so the patients receiving blood are safe.

8. **Preventing and Managing Pressure Injuries** which describes the systems and strategies to prevent patients developing pressure injuries and best practice management when pressure injuries occur.

9. **Recognising and Responding to Clinical Deterioration in Acute Health Care** which describes the systems and processes to be implemented by health service organisations to respond effectively to patients when their clinical condition deteriorates.

10. **Preventing Falls and Harm from Falls** which describes the systems and strategies to reduce the incidence of patient falls in health service organisations and best practice management when falls do occur.

2. The National Safety and Quality Health Service Standards

NSQHS Standard 1: Governance for Safety and Quality in Health Service Organisations

Governance and quality improvement systems

Governance and leadership

(Standard 1, Item 1.1: Implementing a governance system)

A health service organisation's governance system is an important element in safeguarding and improving the safety and quality of care. Evidence links high performance of health service organisations to effective governance systems.[1]

The board of a health service organisation is responsible for:

- governing all domains of organisational activity in that health service, including business performance, human resources management, information technology, work health and safety, and the safety and quality of the services the organisation delivers; and
- setting the organisation's quality improvement and risk management culture.

The ultimate responsibility for ensuring the integrity and effectiveness of the governance system rests with the governing body.[2] A board's role is to oversee management, not to manage.[3]

The board may require the organisation to establish committees or groups to support its work. These groups may address issues within the organisation such as:

- audit and risk processes
- the safety and quality framework
- consumer advisory processes
- clinical governance responsibilities.

The board will need to ensure these processes are integrated and collaborative. One way of achieving this may be through board representation on these groups.

Board roles

- Design and endorse a governance system that will enable the board to monitor, review and evaluate all aspects of organisational performance and direct the senior executive on systems to be implemented when changes are required.
- Take the lead on setting the organisation's safety and quality culture.
- Take ultimate responsibility for the safety and quality performance of the health service organisation.

Organisational policies, procedures and protocols

(Standard 1, Item 1.1: Implementing a governance system that sets out policies, procedures and/or protocols)

The board, through the senior executive, is responsible for ensuring the organisation maintains a comprehensive set of organisational policies and associated procedures and protocols, and reviews these regularly. These need to:

- provide direction for the operation of the organisation;
- address clinical safety and quality; and
- be consistent with the regulatory obligations of the organisation, board and executive.

The board should delegate responsibility to management for the development and maintenance of the policies and associated procedures and protocols. The board may seek confirmation of the use and effectiveness of these policies, procedures and protocols through reports and require management to take timely action where there are breaches in compliance.

Board roles

- Endorse the system for policy development and review.
- Ensure a comprehensive set of policies and associated procedures and protocols are developed and implemented.
- Ensure a system exists to review compliance with the organisation's policies.

Clinical governance

(Standard 1, Item 1.1: Establishing and maintaining a clinical governance framework)

The Australian Securities and Investment Commission (ASIC) identified a key duty of boards as 'know what your company is doing'.[1] For health service organisations this requires the board to understand the clinical performance of its organisation, among other things.

Good clinical governance requires strong strategic and cultural leadership of clinical services. The board should focus on:

- reviewing plans providing cultural leadership;
- ensuring the appropriate allocation of resources;
- ensuring there is appropriate delegation;
- maximising staff engagement;
- using data and information effectively to monitor and report on performance across the health service organisation, to the governing body; and
- ensuring well-designed and integrated systems are in place for identifying and managing clinical risk.[2]

The board should comprise people with an appropriate mix of skills to fulfil its governance roles, responsibilities and accountabilities. The board may also seek input from appropriately skilled individuals.

Board roles

- Define the vision, mission and values of the organisation, with particular emphasis on patient-centred care principles and practices.
- Prioritise and allocate time at board meetings to review clinical governance and to ensure the effectiveness of the systems that are in place.
- Ensure board members' and senior executives' knowledge of clinical governance is current through access to training and education opportunities.

Roles of the board and executive

(Standard 1, Item 1.2: The board, chief executive officer and/or other higher level of governance within a health service organisation taking responsibility for patient safety and quality of care)

While the board and senior executives together play a role in planning and reviewing integrated governance systems that promote patient safety and quality, their roles differ. The board provide oversight by setting the direction for the organisation, ensuring accountability and shaping culture. Senior executives are responsible for implementing the strategic direction set by the board and senior executive, and for reporting on the performance of the organisation to the board.

The board is responsible for providing leadership and direction to the health service organisation it governs, and is legally responsible for the overall performance of its health service organisation.

The board provides leadership for the organisation by:

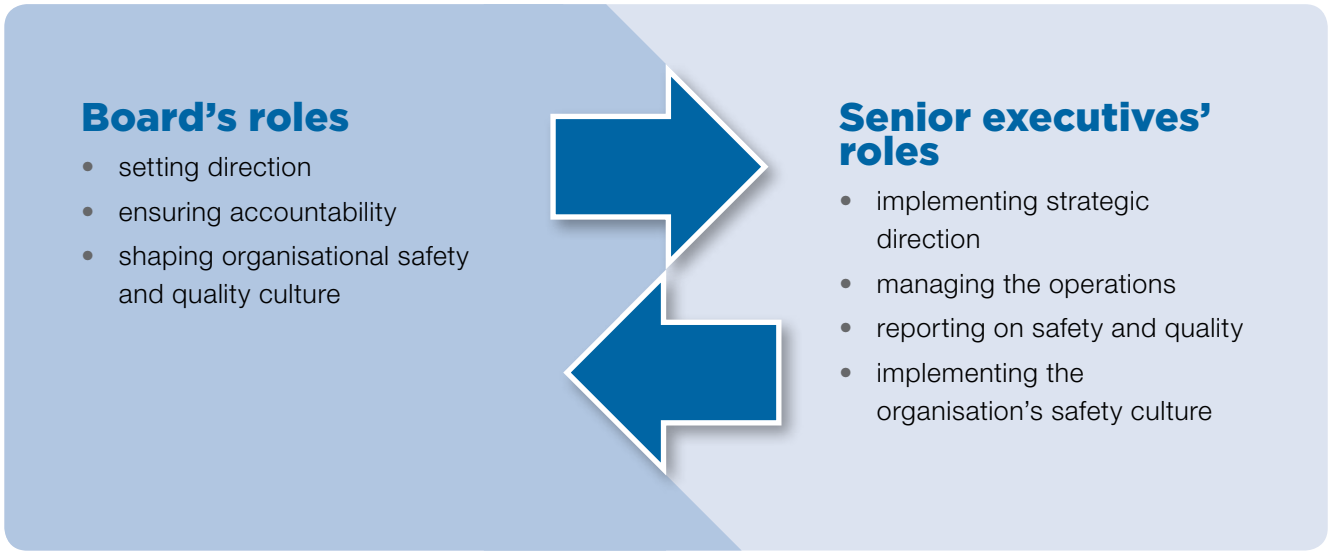
- setting goals;
- setting the organisation's safety culture;
- ensuring adequate resources are available for the implementation of safety and quality systems and initiatives by the organisation; and
- allocating time at its meetings to discuss safety and quality issues.

The board's governance functions are fulfilled by:

- ensuring accountability;
- monitoring safety and quality performance;
- overseeing compliance with the organisation's statutory and regulatory obligations; and
- ensuring that structures and systems are in place to deliver health services.

The board delegates the development and day-to-day monitoring of safety and quality plans. The overarching framework should align with the strategic direction and support the development of plans that incorporate achievable and measurable goals, with accountability for actions clearly explained.

Figure 1: Complementary safety and quality roles of the board and senior executives



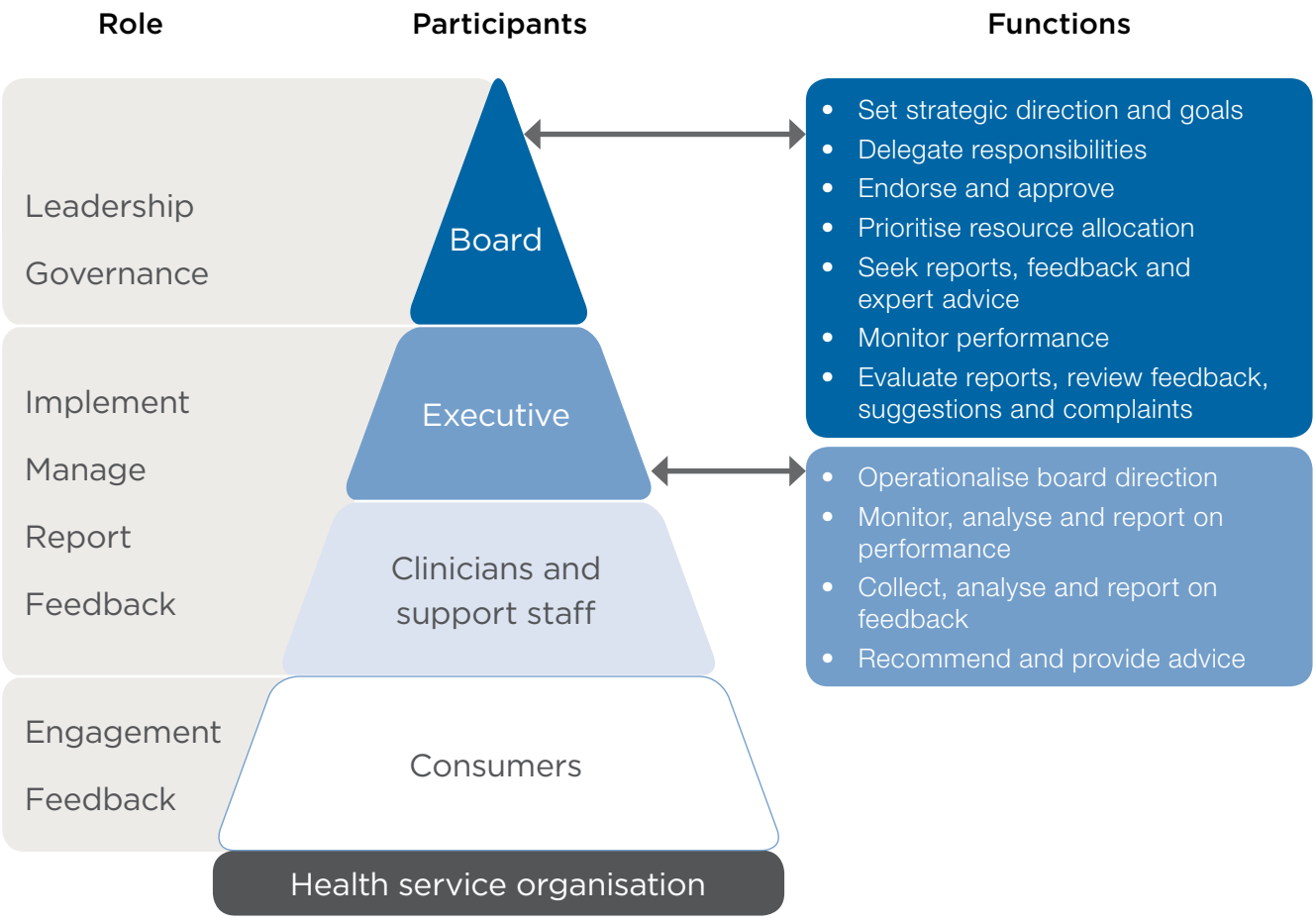
While the board delegate some functions, it should have an active role in:

- identifying the appropriate governance structure, which may include committee structures, to manage and monitor clinical performance;
- setting the requirements for timeframes, targets and reporting on safety and quality;
- monitoring the implementation of and compliance with plans; and
- describing the expected improvements in quality and safety through the organisation's stated vision, mission and goals.

Depending on the size of the organisation, a board may establish board sub-committees that report to the board to enable a more effective focus on areas such as safety and quality, and risk.

The board should ensure that newly appointed board members understand the importance of safety and quality, through appropriate board induction, training and ongoing professional development processes. Where a board member does not have the necessary capabilities to fulfil all the required roles, they may also need to be supported to develop these skills or undertake training.

Figure 2: Roles and functions of the board in a health service organisation



A board should have the capacity to:

- review the organisation's patient safety and quality plan to ensure it is comprehensive and appropriate;
- review reports on the implementation and operation of the plan;
- over time, ensure the plan on safety and quality is evaluated and review evaluation reports on the effectiveness of the plan; and
- consider recommendations for improvement.

A board will be more effective and efficient where it has agreed measures in place to focus attention on what is important, and when it has a process and schedule to receive reports and manage emerging safety and quality and risk issues.

Board roles

- Delegate the development of safety and quality plans.
- Endorse the safety and quality plans.
- Ensure new board members understand the importance of safety and quality.
- Ensure board members' skills in assessing and evaluating safety and quality are developed and maintained.

Risk management

(Standard 1, Item 1.5: Establishing an organisation-wide risk management system that incorporates identification, assessment, rating, controls and monitoring for patient safety and quality)

The provision of health care carries with it risks and hazards for patients, healthcare providers and health service organisations. As such, risk management is an essential component of governance. Ultimate responsibility for ensuring the integrity of the organisational risk management system rests with the board. The risk management system should be regularly reviewed. This may include management conducting specific audits of high-risk areas or activities. The results and recommendations of these audits may be submitted to the board for review to inform them about service performance and any areas of concern.

Changes in risk status provide an early warning sign for organisations. Management may undertake a periodic assessment of the organisational 'climate' in areas of risk, safety and quality, through the use of trend information, review of external reports, benchmarking with like organisations and information from trusted sources. Validated survey tools can assist assessment of priority areas.

The board has a responsibility and opportunity to lead an organisational culture that is demonstrably 'just' and characterised by openness and constructive learning from mistakes, and that encourages workforce involvement.

Board roles

- Integrate clinical quality into the organisation's risk management framework and audit plan.
- Ensure the risk management system has the capacity to identify high or extreme risks and that information on these risks is regularly reported to the board.
- Lead and foster an organisational culture that values open, fair and accountable behaviours, and that encourages staff members to proactively manage risk and maximise clinical safety.

Quality management

(Standard 1, Item 1.6: Establishing an organisation-wide quality management system that monitors and reports on the safety and quality of patient care and informs changes in practice)

'Quality management systems' refer to activities that organisations use to direct, control and coordinate quality for the purpose of improving the efficiency and effectiveness of the organisation's clinical performance. These activities include:

- developing an overarching quality management framework;
- adopting policies on safety and quality systems;
- setting quality objectives, planning, assurance and improvement; and
- setting performance indicators against which performance can be measured.[4]

The board should describe 'quality' and how it wants the organisation to provide quality services to its consumers through the organisation's stated mission, vision and goals. This description can include dimensions such as safety, effectiveness, appropriateness, responsiveness, continuity, accessibility and efficiency. Defining what 'good' looks like provides the health service organisation with a common language and understanding for the design and monitoring of their organisation's quality management system. The more simply this can be expressed, the easier it is for staff members and consumers to understand and participate.

By setting performance measurements a board can evaluate the success of an organisation or unit through each particular activity in which it engages. Accordingly, choosing the right key performance indicators (KPIs) relies upon a good understanding of what is important to the work of the organisation or unit.

KPIs define a set of values against which to measure outputs or outcomes. They can be summarised into the following sub-categories:

- *quantitative indicators* that can be presented with a number
- *qualitative indicators* that cannot be presented as a number
- *input indicators* that measure the amount of resources consumed during the generation of the outcome
- *process indicators* that represent the efficiency or the productivity of the process
- *output indicators* that reflect the outcome or results of the process activities
- *directional indicators* specifying whether or not an organisation is getting better
- *actionable indicators* are sufficiently in an organisation's control to effect change
- *financial indicators* used in performance measurement and compared against the budget.

Performance indicators must be measurable and must relate to the inputs and outputs of the organisation. Often success is simply the repeated, periodic achievement of some levels of operational goal (for example, zero defects, 10/10 customer satisfaction), and sometimes success is defined in terms of making progress towards strategic goals.

A schedule of data collection, reviews and audits should be developed by management to assist the board in monitoring the quality and adequacy of clinical and organisational systems. Review mechanisms should reflect the organisation's inputs, outputs and outcomes. Assessment of these systems should be based on their effectiveness in supporting safe and high-quality care for each patient and be informed by incident reports, near misses and hazards.

The board may also consider receiving regular safety and quality presentations, reports and patient stories from senior managers and clinicians. These could be scheduled in accordance with agreed criteria (for example, areas of significant risk or the highest frequency errors or incidents). Examples of safety and quality reports can be found in Section 3 of this guide.

Board roles

- Participate in defining safe and high-quality care.
- Review a dashboard of key quality outputs related to quality goals and other reporting requirements.

Clinical practice

To maximise the effectiveness of care, members of the workforce need to provide care that is current, best practice and evidence-based. Management needs to establish and facilitate systems to enable safe and high-quality patient care. The board needs to ensure there are systems in place to monitor the use and effectiveness of clinical guidelines and pathways.

Application of clinical guidelines

(Standard 1, Item 1.7: Developing and/or applying clinical guidelines or pathways that are supported by the best available evidence)

Evidence-based clinical guidelines or clinical pathways are designed to improve the quality of health care and decrease unwarranted variation in the provision of health care, or the use of ineffective or harmful interventions. Where variation in the provision or use of health care is not as a result of patient preference or clinical need, it is unwarranted. Clinical guidelines are critical links between the best available evidence and good clinical practice, and are key tools in an effective quality and safety system.

The board should ensure systems are in place to:

- make available current clinical guidelines or pathways, where they exist; and
- assist in the provision of care that is evidence-based and ensures unwarranted variations in care are minimised.

Board roles

- Ensure the organisation adopts and routinely reviews its clinical practices to ensure they are current, evidence-based and effective.
- Ensure systems are in place for the regular review of reports on participation and performance in clinical registries or audits established by professional groups and organisations.
- Review reports on audits of unwarranted clinical variation.

At-risk patients

(Standard 1, Item 1.8: Adopting processes to support the early identification, early intervention and appropriate management of patients at increased risk of harm)

The board should be made aware of consumers receiving services from the health service organisation, who are at increased risk of harm because of their age, background or culture; physical, mental or cognitive status; or other factors.

The board should consider the clinical needs of consumers at increased risk in its strategic planning, monitoring and resource allocation, and ensure evidence-based best practice screening tools and clinical practice guidelines are being used to identify and appropriately provide services to manage these at-risk patients.

Board roles

- Ensure the board is informed of the risk profile of its consumer cohort and its specific healthcare needs.
- Incorporate into strategic planning, monitoring and resources allocation strategies to meet the clinical needs of at-risk patients.
- Ensure screening tools and guidelines are in place to effectively manage at-risk groups.
- Review reports on clinical performance for at-risk patients.

Patient clinical records

(Standard 1, Item 1.9: Using an integrated patient clinical record that identifies all aspects of the patient's care)

A 'clinical record' is a documented account of a person's health, illness and treatment. Clinical records facilitate the provision of safe, high-quality care and support quality improvement, audit and research. They are a source of information when care is handed over between clinicians and health service organisations. Access at the point of care facilitates contemporaneous recording of the patient's status as well as changes to treatment. Comprehensive documentation and timely sharing of clinical information with treating clinicians improves continuity of care.

Health service organisations have a legal obligation to hold and retain information. The board should ensure that effective systems are in place for recording, communicating, using and securely storing patient clinical information.

Board roles

- Ensure a system is in place for implementation and management of all aspects of patient clinical records.
- Ensure audits are conducted of the effectiveness of the patient clinical records systems.

Performance and skills management

The provision of safe and high-quality care depends on members of the workforce including managers having the right qualifications, skills and approach to care. The board influences clinical practice by ensuring that appropriate systems and guidelines are in place for credentialing, training and seeking feedback from the workforce.

Credentialing and scope of practice

(Standard 1, Item 1.10: Implementing a system that determines and regularly reviews the roles, responsibilities, accountabilities and scope of practice for the clinical workforce)

Credentialing and defining the scope of clinical practice are essential safety and quality processes. Professional groups have different ways of describing these processes. For nursing and allied health staff, defining 'practice' and 'role' may be through position descriptions and performance management processes. Credentialing and scope of practice processes reflect a mutual commitment between the organisation and each member of the clinical workforce to the provision of safe, high-quality care. These processes also inform planning for the workforce to ensure there are sufficient levels of trained and qualified staff available to provide the planned services.

'Credentialing' of medical practitioners and some other clinicians is the formal process undertaken by a health service organisation to verify qualifications, experience, professional standing and other relevant professional attributes. Credentialing is conducted routinely, sometimes annually or at least every few years. This process helps confirm the competence, performance and professional suitability of the medical workforce to provide safe and high-quality care.

A medical practitioner's scope of practice is defined through the credentialing process. It involves documenting the extent of, and boundaries around, an individual clinician's practice within the health service organisation based on their credentials, competence, performance, professional suitability, and the needs and capability of the health service organisation.

Nurses and midwives undertake a registration process with their relevant professional bodies as required by statutory regulation. This process determines whether a nurse or midwife is suitably qualified and competent, and differs from credentialing for medical practitioners in that the process is undertaken by a professional body, not an individual health service organisation.

The board is responsible for ensuring systems are in place to ensure scope of practice is defined and monitored.

Board roles

- Ensure the system for credentialing and scope of practice meets the NSQHS Standards and jurisdictional requirements.
- Review reports on the effectiveness of the credentialing and scope of practice system.

Performance review and development

(Standard 1, Item 1.11: Implementing a performance development system for the clinical workforce that supports performance improvement within their scope of practice)

Performance review and development is an important and constructive activity that enables a health service organisation to confirm that all members of the clinical workforce meet professional requirements. Similar requirements exist for the non-clinical workforce, such as personal care assistants.

In order to be effective, performance development needs to be undertaken in a manner that does not disengage clinicians. The values of fairness, accountability and support underpin effective systems of performance development. However, patient safety is paramount so remedial strategies may be implemented to protect patient safety.

The board should ensure that a performance review and professional development system is in place across the organisation, which can include:

- providing regular feedback on performance;
- identifying opportunities for skills review and maintenance; and
- identifying and addressing issues affecting an individual's performance.

In addition, the board has a role in determining the scope and timing of its own performance review and development plan, which should include a review of its governance knowledge and leadership.

Board roles

- Review reports on the performance review and development system for the health service organisation.
- Set parameters and timing of the board performance review and development planning and participate in these.

Education and training

(Standard 1, Item 1.12: Ensuring that systems are in place for ongoing safety and quality education and training)

Induction of new members of the workforce is an important organisational quality activity that should provide the workforce with the necessary knowledge and skills to work safely within the health service organisation. Comprehensive orientation includes, but is not limited to:

- orientation to the organisation's safety and quality culture, and model of care
- systems, policies, procedures and protocols
- high risk areas, risk reporting and risk management processes
- quality assurance, improvement and monitoring systems
- performance development and human resources systems
- information systems
- baseline competency assessment.

Ongoing education and training provided to the workforce can include:

- in-service training
- on-site teaching
- undergraduate training
- self-directed training modules
- coaching and supervision
- simulated practice
- engagement with the education sector for the education and training required to meet specific health service organisation training needs
- opportunities for clinical staff to engage in research, supervision and teaching.

The board should be assured that ongoing education and training programs support, among other things, the competency of staff to provide safe care in their clinical roles and to meet the quality objectives of the organisation, as well as ensuring members of the workforce understand their safety and quality roles.

The board should ensure resources are available for training and continuing professional development and a process exists for monitoring staff participation.

Additionally, the board should ensure that board members are provided with training to promote their own understanding of how to partner with consumers in their governance and leadership roles and interpret safety and quality reports and evaluations.

Board roles

- Adopt an organisational orientation, education and training system that defines the organisation's commitment to education and training in safety and quality.
- Ensure the education and training system is adequately resourced and training attendance records are maintained.
- Ensure mandatory orientation, education, maintenance and renewal of clinical competency and training requirements are in place.
- Ensure the system includes clinician training on partnering with consumers relevant to their role.
- Receive regular reports on the implementation and outcomes of the system.

Workforce feedback

(Standard 1, Item 1.13: Seeking regular feedback from the workforce to assess their level of engagement with, and understanding of, the safety and quality system of the organisation)

Gaining an understanding of the workforce's attitude, perception, knowledge and use of safety and quality systems can provide information on the areas where additional education, change management resources or improvement of the safety and quality system should be targeted.

Feedback from members of the workforce may include informal feedback through usual collegiate and management communication processes, or formal feedback through:

- structured analysis of de-identified information gained from performance reviews
- audits and surveys targeting specific elements of the safety and quality system
- organisational climate and cultural surveys
- clinicians' engagement in governance processes
- communication with the board
- reports on de-identified staff complaints that includes analysis of the potential risks to the organisation's quality-management capacity.

The board may also wish to consider using standardised staff surveys to measure the workforce's attitude towards safety and quality. The US Department of Health and Human Service's Agency for Healthcare Research and Quality has a series of surveys on patient safety culture.[5] These surveys include simple questions for hospital staff, and allow health service organisations to compare their results with other international health service organisations through a comparative database.

Board role

- Review reports of feedback from the workforce and recommendations from management.

Incident and complaints management

Incidents can occur while providing health care and some of these can have serious consequences. Complaints and suggestions from the workforce, patients, consumers and carers are an important source of information on the safety and quality of health service organisations. It is therefore essential that health service organisations establish incident and complaints management systems.

Incident management

(Standard 1, Item 1.14: Implementing an incident management and investigation system that includes reporting, investigating and analysing incidents (including near misses), which all result in corrective actions)

The board should ensure that an incident management system is in place to support the provision of safe care by providing management with a process for identifying, reporting, managing and learning from clinical and non-clinical incidents.

Open discussion of error should be embedded in everyday practice with relevant information communicated openly to consumers. The workforce should feel supported to willingly report incidents and near misses, so there can be a focus on learning and improvement. An incident reporting framework should be implemented, identifying which data will be available and reported at each level of the organisation.

The board should receive outcome or summary reports of investigations of serious incidents and summary performance information about all other incidents. As a minimum, incident data should be trended over time and analysed to identify key causal issues, so these can be addressed. Targets for minimising or eliminating incidents should be set if appropriate.

The health service organisation should periodically review the design and performance of the clinical incident management system. The board should consider whether the system complies with best practice principles and whether adequate resources have been allocated to support effective clinical governance and risk management.

Board roles

- Ensure reported incidents are regularly audited.
- Ensure the most serious incidents are reviewed in accordance with policy and are reported to the board.
- Ensure aggregate and trended analysis provided for all other incidents is reported to the board.
- Ensure the effectiveness of the incident management system is periodically reviewed to ensure it is consistent with best practice.

Complaints management

(Standard 1, Item 1.15: Implementing a complaints management system that includes partnership with patients and carers)

The purpose of a complaints process is to provide a mechanism for identifying and responding to issues that may affect the safety and quality of the organisation's services. Complaints should trigger a response by the health service organisation consistent with a clearly defined process outlined in the organisation's policies and procedures.

The health service organisation should provide the board with reports on all serious complaints and summary performance information about all other complaints. Other information on complaints should include:

- trended data on categories of complaints;
- actions taken as a result of a specific complaint or category of complaints;
- indicators (such as response times);
- actions stemming from complaints; and
- analysis of the causes of complaints.

The health service organisation should periodically review the complaints management system. The board should consider whether the system complies with best practice principles and whether adequate resources should be allocated to support effective clinical governance and risk management.

Board roles

- Ensure the most serious complaints are regularly reviewed in accordance with policy and are reported to the board.
- Ensure aggregate and trended analysis for all other complaints is reported to the board.
- Ensure adequate resources, technology and equipment are available to support the complaints management system.
- Review audits of the complaints management system to ensure it is effective and consistent with best practice principles.

Open disclosure

(Standard 1, Item 1.16: Implementing an open disclosure process based on the national open disclosure standard)

'Open disclosure' is the open discussion with patients and/or their carers of incidents that result in harm to a patient receiving health care.[2] The Australian Open Disclosure Framework[6] has been endorsed by all Health Ministers for implementation in all health service organisations, and the board should ensure that its health service organisation's open disclosure processes comply with this framework.

The board should provide leadership for the implementation of effective open disclosure systems by:

- fostering an organisational culture characterised by openness and constructively learning from mistakes;
- ensuring the *Australian Open Disclosure Framework* is in place;
- ensuring adequate resources are allocated to support implementation of the *Australian Open Disclosure Framework*;
- ensuring responsibility for implementing the *Australian Open Disclosure Framework* is allocated to a senior manager;
- ensuring compliance with the *Australian Open Disclosure Framework* is monitored and any incidents of non-compliance are investigated; and
- regularly reviewing summary reports on performance in open disclosure.

Board roles

- Ensure the *Australian Open Disclosure Framework* is implemented.
- Ensure adequate resources are allocated to implement open disclosure systems.
- Ensure the organisation's education, training and orientation adequately address open disclosure.
- Review reports on performance in open disclosure.

Patient rights and engagement

The *Australian Charter of Healthcare Rights* (the Charter) was developed by the Commission and adopted by all Health Ministers in 2008. The Charter defines a patient's right to access, safety, respect, communication, participation, privacy and comment. These rights should translate for patients into safe, high-quality health care and the provision of information to allow participation in decisions about their care.[7]

Patients' rights

(Standard 1, Item 1.17: Implementing through organisational policies and practices a patient charter of rights that is consistent with the current national charter of healthcare rights)

Local charters of healthcare rights should be consistent with the Charter. Some jurisdictions have developed supporting information that expands on the Charter.

The board should formally adopt the Charter or its jurisdictional equivalent and delegate its implementation throughout the organisation to an individual or committee.

Board roles

- Ensure the *Australian Charter of Healthcare Rights* or its jurisdictional equivalent is adopted.
- Ensure systems exist for the effective implementation of the Charter.

Planning for care and informed consent

(Standard 1, Item 1.18: Implementing processes to enable partnership with patients in decisions about their care, including informed consent to treatment)

Consumers and carers have the right to receive easily understood information and to make informed decisions about their health care in a timely and culturally appropriate manner. The health service organisation's focus should be patient-centred care.

Open communication between consumers, carers and clinicians underpins the prevailing ethical framework for contemporary health care. The board needs to be confident that information provided to patients is accurate, relevant and meaningful to patients and addresses health literacy issues and related implications faced by the organisation.

Effective systems should be in place for informing patients and their carers about their treatment, determining their treatment preferences, and for gaining and documenting their consent to treatment. Patients should be partners in making decisions about their care.

'Advance care planning' is the process of preparing for likely scenarios near the end of life. The process usually includes: assessment of, discussion about and documentation of a patient or their carer's understanding of the consumer's medical history and condition, values, preferences, and personal and family resources. The board should periodically receive summary reports on the processes, implementation and effectiveness of advanced care planning in its organisation.

Board role

- Ensure an effective system is in place that accommodates the use of advance care planning.

Clinical record management

(Standard 1, Item 1.19: Implementing procedures that protect the confidentiality of patient clinical records without compromising appropriate clinical workforce access to patient clinical information)

A 'clinical record' is a documented account of a patient's health, illness and treatment in hard copy or electronic format (also see Item 1.9).

The confidentiality and privacy of most health information is protected by statutory or common law requirements of confidentiality, in addition to statutory provisions relating to privacy. The board should ensure through the senior executive that systems are in place to protect the privacy and confidentiality of clinical information, in accordance with the law and good practice.

Board roles

- Ensure systems for implementing privacy and confidentiality requirements are in place in accordance with good practice and the law.
- Ensure that audits of the health service organisation's clinical records system take place regularly.

Patient experience feedback

(Standard 1, Item 1.20: Implementing well designed, valid and reliable patient experience feedback mechanisms and using these to evaluate the health service performance)

Patients' experiences in receiving health care are an important element of quality of care. The board's role is to promote the organisation's awareness of, and ability to respond to, patient experience information. This is achieved by ensuring the organisation adopts valid and reliable methods of seeking feedback from patients and carers and reviewing patient stories, for the range of services offered by the organisation.

States and territories are implementing a nationally consistent set of survey questions for use in public hospitals to determine patients' experiences. The Commission has released a set of common questions that relate to the NSQHS Standards, which boards of public hospitals may consider including in their patient experience surveys.[8] The focus is now shifting to 'real time' feedback from patients and a proactive approach to addressing issues identified, to drive improvements.

Board role

- Actively use patient experience metrics to drive safety and quality improvement.

NSQHS Standard 2: Partnering with Consumers

The board should ensure that systems are in place to support partnering with patients, carers, other consumers and the organisation's community to improve the safety and quality of care in the health service organisation. Patients, carers, consumers, clinicians and other members of the workforce should use these systems for activities involving partnering with consumers.

Consumer partnership in service planning

Involving consumers in the governance of the health service organisation is an important component of establishing effective partnerships.

Consumer engagement

(Standard 2, Item 2.1: Establishing governance structures to facilitate partnerships with consumers and/or carers)

Consumers bring a different perspective, which can help to identify opportunities for improvement. A range of strategies is available for involving consumers in service planning, including involving consumers in an organisation's operational and strategic planning. It is the board's role to foster consumer participation and receive reports on the range and effectiveness of consumer engagement activities. Consumer participation should occur at multiple levels of the health service organisation and be evident in planning, policy development, health service organisation management, training programs and guideline development. The board should provide oversight to ensure consumer participation is reflective of the diverse range of backgrounds in the population served by the health service organisation.

Board roles

- Promote a culture of consumer engagement through strategic statements, and stated vision, mission and values.
- Ensure systems are in place to promote community and consumer engagement and participation.

Consumer and community feedback and partnerships

(Standard 2, Item 2.2: Implementing policies, procedures and/or protocols for partnering with patients, cares and consumers)

Evidence is building that there is a link between effective partnerships with consumers, good consumer experience and high-quality care.[9]

Using consumer feedback and involving consumers in the governance of health service organisations is an important part of the process of establishing effective partnerships and driving quality improvement. Partnering with consumers in governance is about listening to and using consumer knowledge, skills and experience in a systematic way to deliver better health care.

Seeking and using consumer and carer feedback through surveys, focus groups, patient stories, committees, compliments and complaints processes and incident management systems is increasingly being seen as a useful mechanism for establishing partnerships, informing quality improvements and improving consumers' experiences.

The board should ensure that its health service organisation's community is engaged in the decision-making process and is given opportunities to outline its expectations for the health service organisation. Feedback from communities can assist the board in planning strategic direction for future undertakings.

Board roles

- Review reports on consumer involvement in service delivery planning.
- Ensure systems are in place to promote consumer feedback and community engagement.

Training for consumers

(Standard 2, Item 2.3: Facilitating access to relevant orientation and training for consumers and/or carers partnering with the organisation)

The board should ensure that orientation is provided to consumers, to assist them to be effective partners. Training may also be required for consumers who regularly participate in partnership opportunities.

Where a board requires a formal consumer committee to be established, systems should be put in place to ensure that the selection of members is appropriate and that members are given training in their roles and responsibilities, and are oriented to their role and the organisation's governance framework to enable them to function effectively.

Board role

- Ensure resources are allocated for consumer and carer orientation and training.

Consumer assistance in developing patient information

(Standard 2, Item 2.4: Consulting consumers on patient information distributed by the organisation)

Involving consumer groups and organisations in the development of health information and materials is an effective approach for improving consumer–provider communication and partnerships with patients, consumers and carers.

The board should ensure that systems and resources are available to involve these groups in processes for developing and/or reviewing information provided to patients, and that health literacy principles are adopted in the production of this information.[10]

Board role

- Ensure systems are in place to consult with consumer groups and organisations when developing patient information.

Consumer partnership in designing care

Developing effective consumer engagement for planning and designing health service organisation environments and services can strengthen relationships between staff and consumers and align the services with the needs and preferences of consumers.[9]

Consumers' roles in planning and designing healthcare environments and services

(Standard 2, Item 2.5: Partnering with consumers and/or carers to design the way care is delivered to better meet patient needs and preferences)

Involving consumers in the planning and design of health service organisation environments and services can have significant benefits in terms of strengthening relationships between staff and consumers, as well as helping to reorient services to the needs and preferences of consumers. Design or redesign activities can vary in scope and can include designing new units such as emergency departments, and making changes to patient flow processes in outpatient clinics.

The board has a role in promoting this patient-centred approach.

Board role

- Ensure systems are in place to promote community and consumer involvement in the planning, design and redesign of the health service organisation.

Consumer partnership in service measurement and evaluation

Evidence is building on the association between consumer experiences of care and the quality of care provided. This includes a move towards providing increased reporting to the community on service measures and evaluation of services.

Sharing safety and quality performance results

(Standard 2, Item 2.7: Informing consumers and/or carers about the organisation's safety and quality performance in a format that can be understood and interpreted independently)

Health service organisations are being encouraged to provide information on safety and quality performance to their community to engage and inform their consumers. The board's role is to promote community awareness and involvement in the analysis of the health service organisation's performance. This includes communication strategies, publications released by the organisation, staff members' engagement with the community, and frameworks for partnering with consumers.

The board can ensure information about its organisation's safety and quality performance is communicated through a range of methods such as the organisation's website, printed publications, posters and information sheets, and interviews with local media.

It is also important that information on safety and quality performance is easy to understand, meaningful, and accessible to people with low health literacy or people from non-English speaking backgrounds.

Board roles

- Ensure systems are in place to promote consumer involvement in analysing the health service organisation's performance.
- Ensure the organisation's reports on patient feedback are reviewed in collaboration with consumers to identify specific issues for improvement.
- Encourage consumers to initiate and suggest improvement proposals.
- Ensure meaningful public reporting on safety and quality performance occurs.

Driving improvement in clinical safety and quality

In addition to the board's responsibilities set out in Standards 1 and 2, there are actions in the more clinically-based Standards 3 to 10 that require information to be provided to the board or some action to be taken by the board. The following sections outline the actions that should be taken by the board in relation to NSQHS Standard 3 to 10. These actions could form the basis for an annual schedule of safety and quality reporting.

There is a need for regular reporting throughout the health service organisation on a range of safety and quality metrics. One way for the board to ensure that these clinically-based Standards are being met is to seek routine reports from individuals or committees on their area of accountability.

NSQHS Standard 3: Preventing and Controlling Healthcare Associated Infections

Each year, infections associated with the provision of health care affect a large number of patients, making healthcare associated infections the most common complication for hospital patients. At least half of healthcare associated infections are thought to be preventable.[11]

Infection prevention and control aims to create safe healthcare environments through the implementation of practices that minimise the risk of transmission of infectious agents. Successful infection control requires a range of strategies across all levels of the healthcare system and a collaborative approach for successful implementation. These strategies include, but are not limited to, standard and transmission-based precautions, hand hygiene surveillance and antimicrobial stewardship.

This Standard requires that the highest level of governance in the organisation (the board) regularly receives information on the effectiveness of the infection prevention and control systems (Action 3.1.3).

Board roles

- Endorse and periodically review management's plans for infection prevention and antimicrobial stewardship systems.
- Regularly review reports on the effectiveness of the infection prevention and control systems.
- Ensure that reports on current and future risks, compliance rates from hand hygiene audits and the effectiveness of the antimicrobial stewardship system are routinely reviewed by the health service organisation.

NSQHS Standard 4: Medication Safety

Medicines are the most common treatment used in health care. Because they are so commonly used, medicines are associated with higher rates of readmission to hospitals, and a higher incidence of errors and adverse events than other healthcare interventions.[12]

Recognised solutions to prevent medication errors that may be adopted are found in standardisation and systemisation of processes. These can include:

- implementing governance systems for medication safety;
- using policies that require patient information to be documented;
- improving clinician–workforce and clinician–patient communication;
- using technology to support information recording and transfer, and to provide better access to patient information and clinical decision support at the point of care; and
- ensuring routine review and reporting on medication safety systems.

This Standard requires that governance systems are in place to support the development, implementation and maintenance of an organisation-wide medication safety system (Action 4.1.1) and that this system is regularly assessed (Action 4.5.1).

Board roles

- Endorse and periodically review plans to manage the medication safety system and allocate resources for implementation.
- Regularly review reports on the effectiveness of the medication safety system.
- Ensure that reports on current and future risks, and reports on incidents involving medication errors and actions taken to reduce errors are routinely reviewed by the health service organisation.

NSQHS Standard 5: Patient Identification and Procedure Matching

Patient identification and the matching of a patient to an intended care process is an activity that is performed routinely in all care settings to ensure the right patient receives the right care. Risks to patient safety occur when there is a mismatch between a given patient and components of their care.

Reporting by clinicians of mismatch or misidentification incidents should be supported by a no-blame culture and efficient reporting processes. The board has a role in modelling the culture it wants its organisation to have, and in overseeing the establishment of effective reporting processes.

This Standard requires an organisation-wide patient identification system that is regularly monitored and reported (Action 5.1.1).

Board roles

- Ensure a patient identification and procedure matching system is in place.
- Review reports on serious patient identification and procedure matching issues and trend analysis on all other patient identification and procedure matching issues.
- Ensure reports on the effectiveness of the patient identification system are reviewed by the health service organisation, including reports on patient identification incidents and actions taken to improve the patient identification system.

NSQHS Standard 6: Clinical Handover

Breakdown in communication is attributed to over 70% of hospital sentinel events which increase the risk of adverse events.[13] 'Clinical handover' refers to the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person, professional group, or health service organisation on a temporary or permanent basis.

Achieving sustainable improvement in clinical handover requires standardised processes and information sets. Clinical handover solutions must be fit for the purpose and appropriate to the clinical context in which handover occurs. When a standard process for clinical handover is used, the safety of patient care will improve as critical information is more likely to be transferred and acted upon.

Action 6.3.4 requires that the actions taken and the outcomes of local clinical handover reviews are reported to the executive level of governance (the board).

Board roles

- Ensure a structured clinical handover system is in place.
- Review reports on serious clinical handover issues and trend analysis on all other clinical handover issues.
- Ensure reports on the actions taken and the outcomes of local clinical handover reviews are reviewed by the health service organisation, including reports on clinical handover incidents and action taken to improve the clinical handover system.

NSQHS Standard 7: Blood and Blood Products

Blood is a valuable and limited resource. Treatment with blood and blood products can be lifesaving. However, as biological materials they are not without risk. Screening and testing donors and donated blood, and ensuring that decisions to transfuse blood or blood products follow consideration of other treatment options, all contribute to minimising the inherent risks. Health service organisations also have an obligation to minimise wastage of this resource through ensuring relevant policies, procedures and protocols are in place.

National and international research demonstrates that the dual approach of implementing governance structures and evidence-based clinical guidelines is the most effective methodology to ensure the appropriate and safe use of blood and blood products.

This Standard requires that adverse blood and blood product incidents are reported to, and reviewed by the highest level of governance in the organisation (Action 7.3.2).

Board roles

- Ensure a system is in place to manage blood and blood products.
- Review reports on serious adverse blood and blood product incidents and summary reports on other blood and blood product incidents.
- Ensure reports on blood and blood product wastage are reviewed by management.

NSQHS Standard 8: Preventing and Managing Pressure Injuries

Immobility, such as that associated with extended bed rest in hospital, can contribute to pressure injuries. Research shows that pressure injuries are a major contributor to the care needs of patients. In the majority of cases pressure injuries are preventable.[14]

Strategies for the prevention of pressure injuries have been identified and are available in multiple evidence-based resources. Management of established pressure injuries has also progressed with increasing specialisation in wound management. Implementing solutions and monitoring for compliance requires ongoing education and an awareness of relevant risk factors.

This Standard requires that information on pressure injuries is reported to the highest level of governance in the organisation (Action 8.2.3).

Board roles

- Ensure a system is in place to manage the risk of pressure injuries.
- Review reports on serious pressure injury issues and trend analysis on all other pressure injury issues.
- Ensure reports on pressure injuries and severity, including reports on actions taken to improve the frequency and harm from pressure injuries are reviewed by the health service organisation.

NSQHS Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care

Serious adverse events such as unexpected death and cardiac arrest are often preceded by observable physiological and clinical abnormalities. Early identification of deterioration may improve outcomes and lessen the intervention required to stabilise patients whose condition deteriorates in hospital.[14]

The *National Consensus Statement: Essential Elements for Recognising and Responding to Clinical Deterioration*[15] was endorsed by Health Ministers in 2010 as the national approach for recognising and responding to clinical deterioration in acute care facilities in Australia. It provides a consistent national framework to support clinical, organisational and strategic efforts to improve recognition and response systems.

Action 9.1.1 requires that governance arrangements are in place to support the development, implementation, and maintenance of organisation-wide recognition and response systems.

Board roles

- Ensure a system is in place to recognise and respond to clinical deterioration in acute health care.
- Review reports on serious recognising and responding to clinical deterioration in acute health care issues and trend analysis on all other issues relating to recognising and responding to clinical deterioration in acute health care.
- Ensure reports on the operation of the recognition and response system for clinical deterioration are reviewed by the health service organisation, including reports outlining actions taken to improve the effectiveness of the recognition and response system.

NSQHS Standard 10: Preventing Falls and Harm from Falls

Falls occur in all age groups. However, the risk of falls and harm from falls varies between individuals due to factors such as increasing age, eyesight, balance, muscle strength, bone density and medication use.

Falls are a significant issue in the safety of patients. Rates of fall-related age-standardised hospitalisations have steadily increased. Although the risk of falls is well documented for the elderly, impaired mobility is also a risk for falls and is not age-defined. Therefore, strategies such as screening to reduce falls and the harm from falls should not be limited to older Australians. Policies, procedures and protocols for other age groups need to be based on available evidence and best practice.

This Standard requires regular reporting, investigation and monitoring of falls incidents (Action 10.2.1).

Board roles

- Ensure a system is in place to manage the risks of falls.
- Review reports on serious falls issues and trend analysis on all other falls issues.
- Ensure reports on falls incidents and severity of patient harm are reviewed by the health service organisation, including reports on actions taken to reduce the incidence of falls and harm from falls.

3. Reporting to the board

Board reporting processes will depend on the type and size of the health service organisation, and the type of services provided. An appropriate reporting structure for a large tertiary hospital may be entirely inappropriate for a small day procedure service. At a minimum, however, the board should ensure it receives reports that reflect its safety and quality responsibilities. These reports could include regular safety and quality data, risk registers, audit schedules, governance and/or safety and quality frameworks and action plans.

Reporting to the board may involve developing an appropriate number of measures reflecting safety and quality goals and where possible real-time measures of clinical performance. This may change over time and should be reviewed in line with organisation performance and risk.

The board should expect that reports on trend data include commentary on actions taken to improve performance. These data can be used to track the safety and quality performance of the health service organisation on a regular basis. It can also enable benchmarking of health service organisations or distinct sections of a health service organisation.

Thought should be put into the design and quality of data reporting to ensure the presentation of the data assists with interpretation and judgement of health service organisation performance. For example, a traffic light dashboard could be used to illustrate how the health service organisation is performing against national or board-set benchmarks. Traffic light dashboards use simple visual displays to provide a high level overview of a health service organisation's performance against selected safety and quality indicator.

Where the board has subcommittees, more detailed reporting may be considered at a board quality and safety subcommittee, chaired by a board member. In the same way that a board finance committee operates, a board quality and safety committee can consider analysis and issues in greater depth than the board.

Patient safety monitoring for health service organisation boards

Indicators in the National Health Reform Performance and Accountability Framework

The Performance and Accountability Framework specifies mandatory indicators for national patient safety reporting.[16] These include a set of core hospital-based outcome indicators (see below) and one indicator of patient experience. These indicators should be reported to the board.

Other measures for monitoring hospital patient safety

The Commission's framework to support hospital patient safety monitoring outlines additional elements that health service organisation boards may wish to include in their data reporting. These elements include:

1. **Standards** – Monitoring adherence to the NSQHS Standards. Actions in the NSQHS Standards that require data collection for audit or review are summarised in Table 8 of the Commission's Accreditation Workbooks.[17] Summary data from these audits and reviews could also be reported to the board.

2. **Core hospital-based outcome indicators (CHBOI)** – The CHBOI include indicators of mortality, readmission and infection. The CHBOI are referenced in the Performance and Accountability Framework and should therefore be routinely reviewed by health service organisation boards. Further information can be found in the document *Using hospital mortality indicators to improve patient care: A guide for Boards and Chief Executives*.[18]

3. **National set of high priority hospital complications** – A review of high-priority hospital complications generated from inpatient administration systems should be considered by boards. The Commissions is currently developing a draft national set of high priority hospital complications which boards may wish to consider.[19]

4. **Conduct surveys of patient hospital experience** – The Commission has released a series of patient experience question sets. Further work is being undertaken to provide Australian public hospitals with validated patient experience surveys.[20]

5. **Structured analyses of selected sets of incident types** – Use of structured incident analysis methodology to analyse selected sets of incident categories, using information generated by incident reporting systems.

6. **Organisational culture** – Boards may also consider reviewing surveys of staff attitudes, behaviours and perceptions to understand organisational safety culture. The Commission is undertaking work to develop a national survey to assess hospital safety culture.

In addition to the regular quality performance indicator reports, the board can establish a schedule of safety and quality reports covering the key systems that are appropriate to its health service organisation. Where a board has a safety and quality subcommittee, these reports are likely to cover high-risk issues and key recommendations that require a board decision. These reports will allow analysis, discussion and decisions on any improvements or actions that need to be undertaken. The reports could follow some of the governance systems discussed in previous sections, or may be structured around divisions within the health service organisation. An example of a systems approach to reporting is provided in Figure 3, outlining topics that may be reported.

What reports should the board ensure are in place?

Figure 3: Governance system reporting

Sample report from a large health service organisation

The example below from a large health service organisation demonstrates a divisional approach to reporting and covers both the regular data reporting and the higher-level overview by service.

	Presentation	Governance	Data
March	Medical Services annual safety and quality report (including clinical registry performance results)	• Safety and quality governance committee report • Accreditation status report • Internal audit report • Root cause analysis (RCA) report • Strategic audit plan	• Safety and quality indicators • Clinical risk register report • Significant event status report • Safety and quality governance minutes
June	Mental Health Drug and Alcohol annual safety and quality report (including clinical registry performance results)	• Safety and quality governance committee report • Accreditation status report • Internal audit report • RCA report • Annual quality plan • Consent audit report • Review risk ratings matrix • Safety and quality governance framework	• Safety and quality indicators • Clinical risk register report • Significant event status report • Safety and quality governance minutes
September	Surgical Services annual safety and quality report (including clinical registry performance results)	• Safety and quality governance committee report • Accreditation status report • Internal audit report • RCA report • Quality plan progress report • Quality of care report	• Safety and quality indicators • Clinical risk register report • Significant event status report • Safety and quality governance minutes
December	Community health and rehabilitation services annual safety and quality report (including Australasian Rehabilitation Outcomes Centre results)	• Safety and quality governance committee report • Accreditation status report • Internal audit report • RCA report • Quality plan progress report • Medical indemnity claims report	• Safety and quality Indicators • Clinical risk register report • Significant event status report • Safety and quality governance minutes

Sample report from a day procedure clinic

The example below is based on a report that a small day procedure service provides its board in its meeting papers.

Safety and Quality report

CONTENTS

1. Annual Quality Action Plan
2. NSQHS Standards Accreditation Rectification Action Plan
3. Australian Commission on Safety and Quality in Health Care advisories
4. Patient experience report, focus group summation, complaints register
5. Clinical guidelines for approval
6. Hand Hygiene Australia reports
7. Incident reports
8. Benchmarking reports
9. Work place health and safety report plus risk management
10. Credentialing report

Benchmarked and graphed performance data relate to:

- patient waiting times
- vitrectomy rates
- rates of unexpected return to operating theatres
- medication errors
- post-operative infection rates
- professional indemnity rates
- patient experience result
- staff survey results
- specific audit results – anti-microbial stewardship, NSQHS Standards 1–10.

4. Evaluating board performance

The performance of a health service organisation board has a direct impact on the organisation it governs. An effective board will understand the climate, culture and environment of its organisation, and can drive improvements in safety and quality and organisational outcomes.

To ensure a board is successful, it should periodically review its effectiveness and the effectiveness of its members. When reviewing its effectiveness, a board may consider:

- organisation type
- legal framework
- constitution
- strategy
- history
- board competencies, structure and behaviour
- roles including strategy development, monitoring, risk management, compliance, policy framework, stakeholder communication and decision making
- senior executive and executive management roles and performance
- organisational performance.

Tools that are commonly used for these processes include SWOT (strengths, weaknesses, opportunities and threats) analysis, value chain analysis, Balanced Scorecard and member questionnaires. The choice of tool depends on the scope and purpose of the review.

5. Appendix: summary of roles for boards

NSQHS Standard 1: Governance for Safety and Quality in Health Service Organisations	
Item 1.1: Implementing a governance system	• Design and endorse a governance system that will enable the board to monitor, review and evaluate all aspects of organisational performance and direct the senior executive on systems to be implemented when changes are required. • Take the lead on setting the organisation's safety and quality culture. • Take ultimate responsibility for the safety and quality performance of the health service organisation.
Item 1.1: Implementing a governance system that sets out policies, procedures and/or protocols	• Endorse the system for policy development and review. • Ensure a comprehensive set of policies and associated procedures and protocols are developed and implemented. • Ensure a system exists to review compliance with the organisation's policies.
Item 1.1: Establishing and maintaining a clinical governance framework	• Define the vision, mission and values of the organisation, with particular emphasis on patient-centred care principles and practices. • Prioritise and allocate time at board meetings to review clinical governance and to ensure the effectiveness of the systems that are in place. • Ensure board members' and senior executives' knowledge of clinical governance is current through access to training and education opportunities.
Item 1.2: The board, chief executive officer and/or other higher level of governance within a health service organisation taking responsibility for patient safety and quality of care	• Delegate the development of safety and quality plans. • Endorse the safety and quality plans. • Ensure new board members understand the importance of safety and quality. • Ensure board members' skills in assessing and evaluating safety and quality are developed and maintained.
Item 1.5: Establishing an organisation-wide risk management system that incorporates identification, assessment, rating, controls and monitoring for patient safety and quality	• Integrate clinical quality into the organisation's risk management framework and audit plan. • Ensure the risk management system has the capacity to identify high or extreme risks and that information on these risks is regularly reported to the board. • Lead and foster an organisational culture that values open, fair and accountable behaviours, and that encourages staff members to proactively manage risk and maximise clinical safety.

Item 1.6: Establishing an organisation wide quality management system that monitors and reports on the safety and quality of patient care and informs changes in practice	• Participate in defining safe and high-quality care. • Review a dashboard of key quality outputs related to quality goals and other reporting requirements.
Item 1.7: Developing and/or applying clinical guidelines or pathways that are supported by the best available evidence	• Ensure the organisation adopts and routinely reviews its clinical practices to ensure they are current, evidence-based and effective. • Ensure systems are in place for the regular review of reports on participation and performance in clinical registries or audits established by professional groups and organisations. • Review reports on audits of unwarranted clinical variation.
Item 1.8: Adopting processes to support the early identification, early intervention and appropriate management of patients at increased risk of harm	• Ensure the board is informed of the risk profile of its consumer cohort and its specific healthcare needs. • Incorporate into strategic planning, monitoring and resources allocation strategies to meet the clinical needs of at-risk patients. • Ensure screening tools and guidelines are in place to effectively manage at-risk groups. • Review reports on clinical performance for at-risk patients.
Item 1.9: Using an integrated patient clinical record that identifies all aspects of the patient's care	• Ensure a system is in place for implementation and management of all aspects of patient clinical records. • Ensure audits are conducted of the effectiveness of the patient clinical records systems.
Item 1.10: Implementing a system that determines and regularly reviews the roles, responsibilities, accountabilities and scope of practice for the clinical workforce	• Ensure the system for credentialing and scope of practice meets the NSQHS Standards and jurisdictional requirements. • Review reports on the effectiveness of the credentialing and scope of practice system.
Item 1.11: Implementing a performance development system for the clinical workforce that supports performance improvement within their scope of practice	• Review reports on the performance review and development system for the health service organisation. • Set parameters and timing of the board performance review and development planning and participate in these.

NSQHS Standard 1: Governance for Safety and Quality in Health Service Organisations	
Item 1.12: Ensuring that systems are in place for ongoing safety and quality education and training	• Adopt an organisational orientation, education and training system that defines the organisation's commitment to education and training in safety and quality. • Ensure the education and training system is adequately resourced and training attendance records are maintained. • Ensure mandatory orientation, education, maintenance and renewal of clinical competency and training requirements are in place. • Ensure the system includes clinician training on partnering with consumers relevant to their role. • Receive regular reports on the implementation and outcomes of the system.
Item 1.13: Seeking regular feedback from the workforce to assess their level of engagement with, and understanding of, the safety and quality system of the organisation	• Review reports of feedback from the workforce and recommendations from management.
Item 1.14: Implementing an incident management and investigation system that includes reporting, investigating and analysing incidents (including near misses), which all result in corrective actions	• Ensure reported incidents are regularly audited. • Ensure the most serious incidents are reviewed in accordance with policy and are reported to the board. • Ensure aggregate and trended analysis provided for all other incidents is reported to the board. • Ensure the effectiveness of the incident management system is periodically reviewed to ensure it is consistent with best practice.
Item 1.15: Implementing a complaints management system that includes partnership with patients and carers	• Ensure the most serious complaints are regularly reviewed in accordance with policy and are reported to the board. • Ensure aggregate and trended analysis for all other complaints is reported to the board. • Ensure adequate resources, technology and equipment are available to support the complaints management system. • Review audits of the complaints management system to ensure it is effective and consistent with best practice principles.
Item 1.16: Implementing an open disclosure process based on the national open disclosure standard	• Ensure the *Australian Open Disclosure Framework* is implemented. • Ensure adequate resources are allocated to implement open disclosure systems. • Ensure the organisation's education, training and orientation policies adequately address open disclosure. • Review reports on performance in open disclosure.

Item 1.17: Implementing through organisational policies and practices a patient charter of rights that is consistent with the current national charter of healthcare rights	• Ensure the *Australian Charter of Healthcare Rights* or its jurisdictional equivalent is adopted. • Ensure systems exist for the effective implementation of the Charter.
Item 1.18: Implementing processes to enable partnership with patients in decisions about their care, including informed consent to treatment	• Ensure an effective system is in place that accommodates the use of advance care planning.
Item 1.19: Implementing procedures that protect the confidentiality of patient clinical records without compromising appropriate clinical workforce access to patient clinical information	• Ensure systems for implementing privacy and confidentiality requirements are in place in accordance with good practice and the law. • Ensure that audits of the health service organisation's clinical records system take place regularly.
Item 1.20: Implementing well designed, valid and reliable patient experience feedback mechanisms and using these to evaluate the health service performance	• Actively use patient experience metrics to drive safety and quality improvement.

NSQHS Standard 2: Partnering with Consumers	
Item 2.1: Establishing governance structures to facilitate partnerships with consumers	• Promote a culture of consumer engagement through strategic statements, and stated vision, mission and values. • Ensure systems are in place to promote community and consumer engagement and participation.
Item 2.2: Implementing policies, procedures and/or protocols for partnering with patients, cares and consumers	• Review reports on consumer involvement in service delivery planning. • Ensure systems are in place to promote consumer feedback and community engagement.
Item 2.3: Facilitating access to relevant orientation and training for consumers and/or carers partnering in the organisation	• Ensure resources are allocated for consumer and carer orientation and training.
Item 2.4: Consulting consumers on patient information distributed by the organisation	• Ensure systems are in place to consult with consumer groups and organisations when developing patient information.

NSQHS Standard 2: Partnering with Consumers

Item 2.5: Partnering with consumers and/or carers to design the way care is delivered to better meet patient needs and preferences	• Ensure systems are in place to promote community and consumer involvement in the planning, design and redesign of the health service organisation.
Item 2.7: Informing consumers and/or carers about the organisation's safety and quality performance in a format that can be understood and interpreted independently)	• Ensure systems are in place to promote consumer involvement in analysing the health service organisation's performance. • Ensure the organisation's reports on patient feedback are reviewed in collaboration with consumers to identify specific issues for improvement. • Encourage consumers to initiate and suggest improvement proposals. • Ensure meaningful public reporting on safety and quality performance occurs.

NSQHS Standard 3: Preventing and Controlling Healthcare Associated Infections

- Endorse and periodically review management's plans for infection prevention and antimicrobial stewardship systems.
- Regularly review reports on the effectiveness of the infection prevention and control systems.
- Ensure that reports on current and future risks, compliance rates from hand hygiene audits and the effectiveness of the antimicrobial stewardship system are routinely reviewed by the health service organisation.

NSQHS Standard 4: Medication Safety

- Endorse and periodically review plans to manage the medication safety system and allocate resources for implementation.
- Regularly review reports on the effectiveness of the medication safety system.
- Ensure that reports on current and future risks, and reports on incidents involving medication errors and actions taken to reduce errors are routinely reviewed by the health service organisation.

NSQHS Standard 5: Patient Identification and Procedure Matching

- Ensure a patient identification and procedure matching system is in place.
- Review reports on serious patient identification and procedure matching issues and trend analysis on all other patient identification and procedure matching issues.
- Ensure reports on the effectiveness of the patient identification system are reviewed by the health service organisation, including reports on patient identification incidents and actions taken to improve the patient identification system.

NSQHS Standard 6: Clinical Handover

- Ensure a structured clinical handover system is in place.
- Review reports on serious clinical handover issues and trend analysis on all other clinical handover issues.
- Ensure reports on the actions taken and the outcomes of local clinical handover reviews are reviewed by the health service organisation, including reports on clinical handover incidents and action taken to improve the clinical handover system.

NSQHS Standard 7: Blood and Blood Products

- Ensure a system is in place to manage blood and blood products.
- Review reports on serious adverse blood and blood product incidents and summary reports on other blood and blood product incidents.
- Ensure reports on blood and blood product wastage are reviewed by management.

NSQHS Standard 8: Preventing and Managing Pressure Injuries

- Ensure a system is in place to manage the risk of pressure injuries.
- Review reports on serious pressure injury issues and trend analysis on all other pressure injury issues.
- Ensure reports on pressure injuries and severity, including reports on actions taken to improve the frequency and harm from pressure injuries are reviewed by the health service organisation.

NSQHS Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care

- Ensure a system is in place to recognise and respond to clinical deterioration in acute health care.
- Review reports on serious recognising and responding to clinical deterioration in acute health care issues and trend analysis on all other issues relating to recognising and responding to clinical deterioration in acute health care.
- Ensure reports on the operation of the recognition and response system for clinical deterioration are reviewed by the health service organisation, including reports outlining actions taken to improve the effectiveness of the recognition and response system.

NSQHS Standard 10: Preventing Falls and Harm from Falls

- Ensure a system is in place to manage the risks of falls.
- Review reports on serious falls issues and trend analysis on all other falls issues.
- Ensure reports on falls incidents and severity of patient harm are reviewed by the health service organisation, including reports on actions taken to reduce the incidence of falls and harm from falls.

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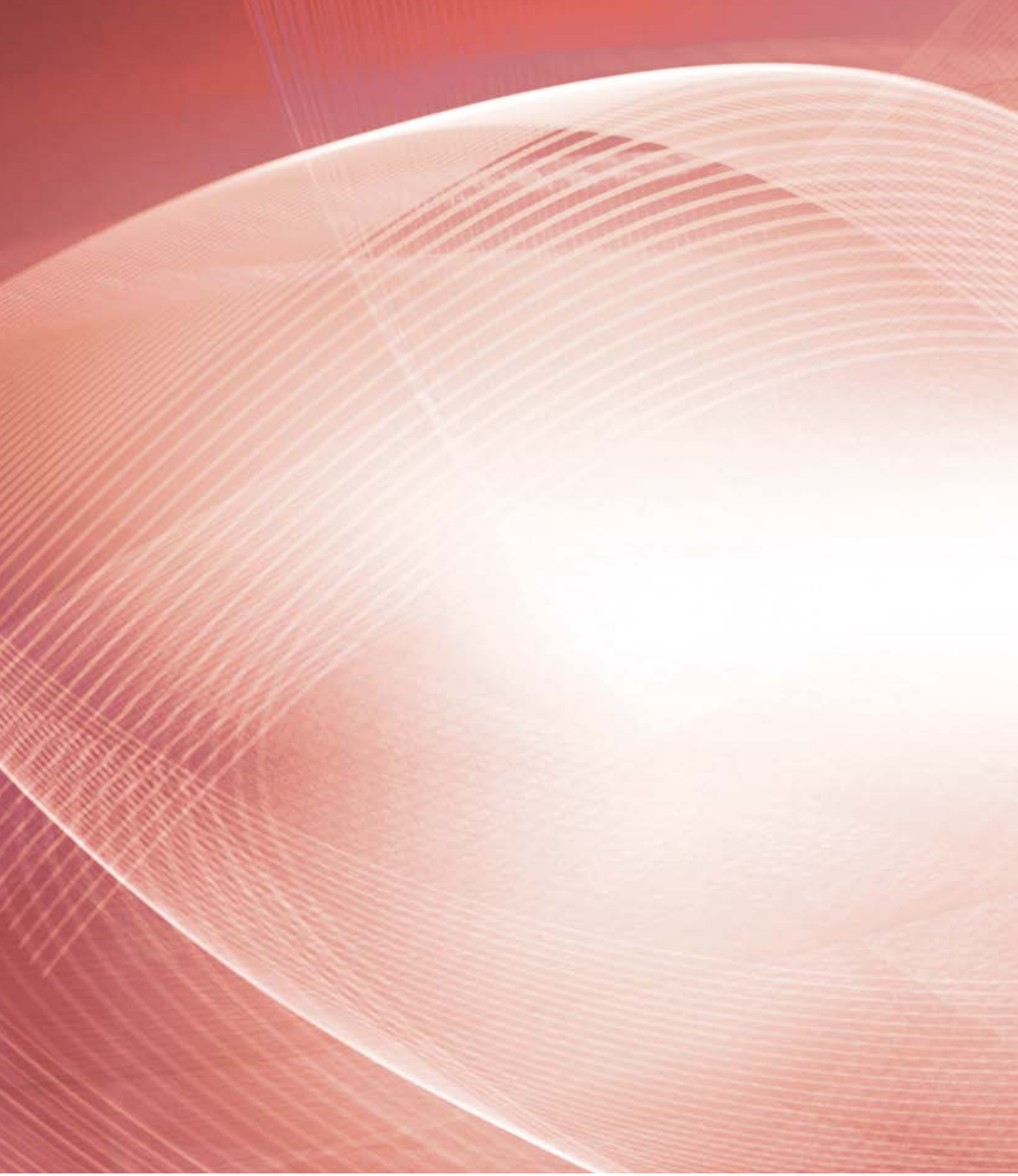

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